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OFFICE OF INSPECTOR GENERAL

AUDIT OF USAID/GUATEMALA'S FAMILY PLANNING ACTIVITIES

AUDIT REPORT NO. 1-520-07-001-P
OCTOBER 6, 2006

SAN SALVADOR, EL SALVADOR

USAID
FROM THE AMERICAN PEOPLE

Office of Inspector General

October 6, 2006

MEMORANDUM

TO: USAID/Guatemala Director, Wayne Nilsestuen

FROM: RIG/San Salvador, Timothy E. Cox /s/

SUBJECT: Report on Audit of USAID/Guatemala's Family Planning Activities (Report No. 1-520-07-001-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 includes four recommendations for your action. Management decisions for these recommendations can be recorded when we agree on a firm plan of action, with timeframes, for implementing these recommendations. Would you please let us know within 30 days what actions have been planned or taken to implement these recommendations?

I appreciate the assistance provided to the auditors on this engagement.

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SUMMARY OF RESULTS

Guatemala lags behind nearly every other country in Latin America with respect to the total fertility rate and the contraceptive prevalence rate. There are significant differences in the total fertility rates in urban and rural areas, and disparities between urban and rural areas actually increased from 1998/9 to 2002 (the latest information available). (See page 2.)

In 2005, two partners working with USAID/Guatemala were responsible for achieving family planning program objectives. The University Research Corporation, through its *Calidad en Salud II* project, provided technical and financial assistance to the Ministry of Health (MOH) and a network of non-governmental organizations that work with the MOH to improve and expand family planning services. The second partner, APROFAM, provided family planning services primarily, but not exclusively, to lower income families throughout Guatemala. (See pages 2 and 3.)

As part of its fiscal year 2006 audit plan, the Regional Inspector General/San Salvador performed this audit to answer the following questions:

- Did USAID/Guatemala family planning activities achieve the planned results described in its strategic plan, in Congressional Budget Justifications, and in cooperative agreement and contract documents?

- Did USAID/Guatemala and its partners manage family planning activities in an efficient manner? (See page 3.)

With respect to the first question, USAID/Guatemala met all of the performance targets for which information was available for FY 2005 as described in its strategic plan, in Congressional Budget Justifications, and in cooperative agreement and contract documents. (See page 4.) However, in performing field work, we noted deficiencies affecting CYP targets (page 7).

With respect to the second question, the mission and its partners managed family planning activities in an efficient manner. However, non-governmental organizations working with the MOH had excessive stocks of contraceptives. (See page 10.)

The report recommends that USAID/Guatemala revise CYP targets, disaggregate program targets between urban and rural areas, transfer excess contraceptives where they can be used expeditiously, and make sure that only one organization is given responsibility for determining contraceptive requirements for the NGOs working with the Ministry of Health. (See pages 9, 10, 12 and 13).

USAID/Guatemala was in agreement with much of the information in our draft audit report but disagreed with several specific statements and recommendations in the draft report. After reviewing the Mission's comments, we deleted one finding (dealing with incorrect reporting on CYP achieved) since the total error was less than 5 percent of the correct amounts and was therefore not considered to be significant. The Mission's other comments and our evaluation are summarized after each finding, and the Mission's comments in their entirety are included in Appendix II.

BACKGROUND

Guatemala lags behind nearly every other country in Latin America with respect to two key family planning indicators: the total fertility rate[1] of 4.4 children per woman is the highest of any country in Latin America, and the contraceptive prevalence rate[2] of 43 percent among women in union aged 15-49 is the second lowest in Latin America. Moreover, the National Maternal Child Heath Survey data presented below in Tables 1 and 2 show significant differences in total fertility rates for urban and rural women and for women with different levels of education. While total fertility rates for all women declined from 1998/9 to 2002 (the latest information available), the disparities between these groups of women actually increased.

Table 1 – Total Fertility Rates for Women Living in Urban and Rural Areas

Category	1998/99	2002
Women in urban areas	4.1	3.4
Women in rural areas	5.8	5.2
Difference between rural areas and urban areas	41%	53%

Table 2 – Total Fertility Rates by Educational Level

Category	1998/99	2002
Women with no education	6.8	6.4
Women with primary education	5.2	4.7
Women with secondary education	2.9	2.1
Difference between women with no education and women with secondary education	134%	204%

The Mission's current strategic plan focuses on increasing the national-level impact of USAID's family planning program and strengthening Guatemalan family planning institutions. The strategy is intended to increase coverage, improve the quality of family planning services, integrate family planning services with other health services, and bridge the gap between the total fertility rate in urban and rural areas. Implementation of the new strategy was to begin on October 1, 2004 and end by September 30, 2009. However, the previous strategy was extended for 6 months, from September 30, 2004 to March 31, 2005, so the previous strategy and the new strategy overlapped for six months.

To achieve these objectives, family planning assistance is provided through three components described in the following paragraphs.

***Calidad en Salud II (*Health Quality)** – The University Research Corporation (URC), through a contract signed in September 2004, provides technical and financial assistance to the Ministry of Health (MOH) of Guatemala and approximately 63 non-

[1] The total fertility rate is the number of children that an average woman gives birth to in her lifetime, assuming that prevailing fertility rates remain unchanged.

[2] The percent of currently married women of reproductive age (normally defined as the range 15 to 49 years) who use contraception.

governmental organizations that work with the MOH to extend family planning services into previously unserved rural areas. The purpose of the assistance is to improve the quality of family planning services, particularly in those geographic areas under-served by the existing MOH delivery system. To achieve this objective, the URC provided assistance to the MOH in meeting demand for family planning services, improving the logistical system for contraceptives, improving the ability of the MOH to finance its contraceptive requirements, and strengthening the capacity of the MOH to forecast, and procure its contraceptive needs.

APROFAM – Under a cooperative agreement signed in April 2005, APROFAM provides family planning services primarily, but not exclusively, to lower-income families throughout Guatemala. In providing these services, APROFAM places emphasis on quality and financial sustainability. In addition to family planning services, APROFAM offers reproductive health services that include maternity and delivery care, cancer screening, ultrasound examinations, optimal birth spacing, sexually transmitted infection (STI) prevention and treatment, and infertility treatments. The organization also provides pediatric care and general medical care including x-rays, dermatology, cardiology, general surgery, and pharmaceutical services.

Strategic Alliance for Social Investment Project (*Alianzas*) – Under a cooperative agreement signed in January 2005, the Research Triangle Institute manages *Alianzas*, a project that aims to build private sector alliances to increase access to, and improve the quality, equity, efficiency, and use of, basic health, nutrition, and education services. *Alianzas* was designed to reduce the unmet need for services, and targets its activities to underserved rural areas. Only $352,726 has been spent under the *Alianzas* activity and no results have been reported to date. Consequently, we did not include this partner in our audit.

This audit was performed in conjunction with another audit to determine whether activities under USAID/Guatemala's cooperative agreement with APROFAM complied with the Tiahrt Amendment. The Tiahrt work is the subject of a separate audit report.

From October 2004 through December 2005, USAID/Guatemala obligated $13.6 million, expended $3.9 million, and provided $233,613 in family planning commodities in support of its family planning and other health related activities.

AUDIT OBJECTIVES

As part of its fiscal year 2006 audit plan, the Regional Inspector General/San Salvador performed this audit to answer the following questions:

- Did USAID/Guatemala's family planning activities achieve the planned results described in its strategic plan, in Congressional Budget Justifications, and in cooperative agreement and contract documents?

- Did USAID/Guatemala and its partners manage family planning activities in an efficient manner?

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

AUDIT FINDINGS

Did USAID/Guatemala's family planning activities achieve the planned results described in its strategic plan, in Congressional Budget Justifications, and in cooperative agreement and contract documents?

USAID/Guatemala's family planning activities achieved the planned results described in its strategic plan, its Congressional budget justifications, and in cooperative agreement and contract documents. However, as described in the section beginning on page 7, couple-years of protection (CYP) targets need to be established in a more rigorous fashion.

In 2005, as shown in Tables 3 and 4 below, the implementers achieved their planned results.

Table 3 – Results by Implementer

Implementer	Planned Result	Target	Actual
University Research Corporation	Couple-years of protection (CYP) achieved by the Ministry of Health[3]	FY 2005 294,190	FY 2005 316,149
	CYP achieved by non-governmental organizations (NGOs) that work with the Ministry of Heath	Included in target for MOH above[4]	FY 2005 10,980
	Percentage of contraceptives purchased by the Ministry of Health (as opposed to received as donations)	2005 30%	2005 40%
APROFAM	CYP	FY 2005 210,584	FY 2005 237,582
	Level of sustainability[5]	2005 90%	2005 91%

Table 4 – Overall Program Results

Planned Result	Target	Actual
CYP[6]	FY 2005 544,702	FY 2005 564,711

[3] CYP is a common indicator used to measure the impact of family planning activities. CYP is the number of couples protected from unplanned pregnancies during a one-year period, based on the number and type of contraceptives distributed during the period.

[4] Mission officials stated that the target of 294,190 CYP for the MOH shown above included the NGOs working with the MOH. However, URC officials disagreed and maintained that the target of 294,190 CYP was only for the MOH. See the related finding beginning on page 7.

[5] The level of sustainability is calculated as locally generated revenues divided by total costs. Both the target and actual result are for calendar year 2005.

[6] The target for the overall program does not reconcile with the targets for individual partners. See the related finding on page 7.

Planned Result	Target	Actual
Total fertility rate[7]	FY 2007 4.0	Not available
Contraceptive Prevalence Rate[8]	FY 2007 49%	Not available

The following sections summarize the evidence supporting our conclusions that URC and APROFAM met their targets for providing quality family planning services and establishing a financially sustainable family planning program. Areas for improvement are discussed beginning on page 7.

University Research Corporation (URC) – *Calidad en Salud II* strengthened the capacity of the MOH to improve and expand family planning services, provide effective counseling, education and information on family planning throughout the network of MOH facilities and NGOs under the coverage extension program, URC provided training, technical, and financial assistance to the MOH. URC also provided assistance to the MOH in strengthening its capacity to measure its contraceptive needs, carrying out the financial planning necessary to ensure that it was able to finance an increasing share of its contraceptive needs, ensuring the availability of a mix of family planning methods at all MOH facilities and in establishing long-term contraceptive security.

The MOH and a network of NGOs that work with the Ministry to serve remote rural areas achieved 327,129 CYP during FY 2005, exceeding the target of 294,190 CYP. We did not find any shortages of family planning supplies at the 11 MOH facilities we visited. An annual survey conducted by URC on the 1,383 MOH facilities indicated that the MOH experienced a stock out rate of 13 percent in 2005 compared to 21 percent in 2004. There are still challenges to meet in ensuring contraceptive supplies, but URC has developed appropriate strategies that will assist the MOH. The stock out rate in 2006 decreased further to 7 percent.

The problems we encountered during our visits to MOH facilities included a lack of information, education, and communication (IEC) material and a low rate of usage of IUDs compared to other family planning methods. The URC has identified the same issues and other problems and is providing assistance to the MOH to produce and distribute IEC materials, develop a training curriculum, and promote and increase the use of long-term family planning methods.

One of the objectives of the program was to ensure that the MOH had the financial capacity to purchase needed contraceptive supplies in an environment of increasing demand. USAID has been donating contraceptives to both the MOH and a network of about 63 NGOs contracted by the MOH as part of the "extension of coverage program" providing family planning services to rural communities to extend the coverage of the MOH to 3 million people. The United Nations Population Fund has also been donating

[7] This target is to be achieved by the end of FY 2007. No current information on the total fertility rate is available since the most recent National Maternal Child Heath Survey was done in 2002.

[8] This target is to be achieved by the end of FY 2007. No current information on the contraceptive prevalence rate is available since the most recent National Maternal Child Heath Survey was done in 2002.

contraceptives provided that the MOH gradually buys an increasing portion of their contraceptive needs. In 2005, the MOH purchased 40 percent of its contraceptives, up from 30 percent in 2004.

The MOH does not charge clients for its family planning services and supplies and this creates a strain on its budget. In an effort to meet its financial needs, the Government of Guatemala has allocated 15 percent of alcohol taxes to pay for reproductive health, family planning, and alcoholism program costs. URC is also working to develop information and education materials to encourage family planning clients to consider all available family planning methods, perhaps reducing the reliance of the MOH's clients on injectable contraceptives that are relatively expensive for the MOH to purchase. (Currently, 54 percent of the MOH's family planning clients use injectable contraceptives.) Also, the MOH is beginning to discuss charges for family planning products to clients who are able to pay.

APROFAM – APROFAM had three major organizational components that provide family planning information, products, and services to all 22 regions of Guatemala. Its Clinical Services program includes a network of 30 clinics. Its Rural Development Project includes about 60 educators and 3,200 rural voluntary promoters. Its marketing department includes 11 service promotion/referral agents and three supervisors who support APROFAM's mobile surgical units that provide voluntary sterilizations and other services in non-permanent locations. APROFAM provides a wide variety of reproductive health services, medicines, and contraceptives for middle and lower-income Guatemalan families. The prices for contraceptives provided by APROFAM are much lower than the prices of commercial pharmacies. During FY 2005, APROFAM achieved 237,582 CYP, exceeding the established target of 210,584 CYP.

USAID/Guatemala supported the long-term sustainability of APROFAM by providing training to management staff and community promoters, developing monitoring statistics, purchasing computer equipment, making improvements to physical facilities, and, until 2004, donating contraceptives. APROFAM measured its sustainability by comparing locally generated revenues with total costs. In 2005, locally generated revenues covered 91 percent of APROFAM's total costs.

Along with successes in the Mission's family planning program, we noted opportunities to improve the process for setting CYP targets. These issues are discussed in the report section beginning on page 7.

Evaluation of Management Comments – In response to our mention of low levels of IUD usage above on page 5, USAID/Guatemala stated that:

> One of the fundamental principles of our family planning program is to allow participants to freely choose the contraceptive method that they feel will work best for them. Our programs do not promote one method over the other; rather, the method selected depends on a particular woman's or man's circumstances and whether the medical practitioner thinks that a long-term method may be appropriate, and the woman/man chooses that method after being fully informed of its benefits and risks. As long as a comprehensive program with a broad mix of contraceptive methods is available and women and men freely choose which family planning method is best for them, the relative level of use for different methods should not be a concern.

To supplement the Mission's comments, it is relevant to disclose that the Mission asked URC to "decrease the bias against IUDs" as explained more fully in the following excerpt from the contract between USAID/Guatemala and URC:

> According to the MSPAS [Ministry of Health] service statistics, health centers insert on average less than one IUD per month. Only seven of the twenty six health areas reported more than four insertions per month in 2001. This figure is very low considering that each health area has on average eleven health centers. Provider bias and lack of MSPAS capacity to offer the IUD (trained personnel, equipment) are limiting client's choice and access to this method, which is safe, cost-effective and long lasting. The Contractor shall work with local health providers to dispel misinformation and make them aware of the advantages of the IUD and the need to include it in the method mix offered in response to client needs/preferences. Special efforts are required so that IUD insertion services will be available at every public hospital and health center and at selected health posts via trained auxiliary nurses. The IUD could also increase the range of effective modern methods available at the community level. Each NGO contracted by the MSPAS has at least one physician or nurse that could be trained to become a proficient provider of IUD.

At the same time, USAID/Guatemala's contract with URC stated that URC would be expected to "decrease bias in favor of Depo-Provera" (an injectable contraceptive) as explained in the following passage from the contract with URC:

> Injectables are the first contraceptive choice of Guatemalan women and the program should continue to be responsive to client preferences. However, since the MSPAS does not charge for any contraceptive and the worldwide price paid by USAID and UNFPA for their donations of Depo-Provera are below commercial market value of injectables in private pharmacies by an order of twenty-fold, bias toward this high recurrent cost, heavily subsidized method is creating an increasing financial burden on the MSPAS' budget that will be impossible for the MSPAS to support in the future once donations end. The Contractor will work to assure that providers do not favor this method to the detriment of others. Policy dialogue and work with the MSPAS on beginning to charge actual cost for contraceptives to those with ability to pay and to better target its free services to the poor would be very desirable. An undesirable consequence of poor targeting of free MSPAS family planning services is a cannibalization of APROFAM's sales of contraceptives and its sustainability, because as MSPAS services grow in rural areas, people who once went to APROFAM and were willing to pay now go to the MSPAS for free Depo-Provera.

We believe that the Mission's intention was not to compel family clients to choose one family planning method over another but rather to help remove institutional constraints that artificially limited the availability of IUDS and at the same time work toward reducing the availability of subsidies that made injectable contraceptives more attractive to family planning clients. We believe that such efforts are consistent with the principle of voluntarism in family planning programs.

CYP Targets Should Be Set Through a More Rigorous Process

Summary: According to USAID guidance, performance targets should be established through a disciplined, thoughtful process that considers what can realistically be achieved under a given program. However, CYP targets were inconsistent with one another or were set too low to challenge partners to increase their performance over

time. Because no record was kept to show how targets were developed, we could not definitively determine why these problems occurred, but it appeared to us that a more rigorous, disciplined process for establishing targets would have prevented the problems from occurring. As a result of these problems, the targets were less useful than they could have been in inspiring improved performance over time.

According to USAID TIPS No. 8, program performance targets should be based on careful analysis of what is realistic to achieve, given the conditions within the country and other factors. USAID Automated Directives System (ADS) Section 203.3.4.5 states that each indicator should include a performance baseline and set performance targets that can optimistically but realistically be achieved within the stated timeframe and with the available resources. Targets that are set too low become irrelevant and are not useful for management and reporting purposes.

- The overall program target for CYP in FY 2005 of 544,702 did not reconcile with the CYP targets for individual partners, which totaled 504,774 (a difference of 7.3 percent). Similarly the overall program target for CYP in FY 2006 of 559,411 did not reconcile with the targets for individual partners, which totaled 509,650 (a difference of 8.9 percent). According to the Mission, these differences occurred because overall program targets were not updated after targets with individual partners were negotiated.

- The CYP targets for FY 2005 had already been achieved in FY 2004, before the new strategy began. Similarly, the target for FY 2006 had already been met in FY 2005. To set program targets, the Mission used an FY 2004 baseline value of 530,694 CYP, but this was 4.7 percent less than the actual baseline value of 556,717 CYP as shown in Table 5 below. According to USAID/Guatemala, this situation occurred because the targets were based on erroneous baseline information and the targets were not updated after the baseline information was corrected.

Table 5 – Program CYP Baseline, Targets, and Results

Fiscal Year	CYP Target	Actual CYP
2004 (Baseline)	NA	556,717
2005	544,702	564,711
2006	559,411	N/A
2007	574,856	N/A
2008	591,074	N/A
2009	608,102	N/A

- USAID/Guatemala stated that the FY 2005 CYP target for the MOH (294,190) included the NGOs working with the MOH through its extension program. However, URC officials who were responsible for assisting the MOH believed that the target did not include the NGOs working with the MOH. After our audit was completed, the Mission obtained URC's acknowledgment that the targets included the NGOs.

- The CYP targets established for APROFAM during the new strategy for FY 2005 to FY 2009 were to achieve 84 percent of what APROFAM achieved in 2004. Mission officials explained that they set low expectations for CYP because they wanted

APROFAM to focus on sustainability. USAID's TIPS 8, "Establishing Performance Targets," states that "A natural tension exists between the need for setting realistic targets and the value, from a motivational perspective, of setting targets high enough to ensure that staff and stakeholders will stretch to meet them." In our judgment, in this case, the Mission did not set targets high enough to motivate APROFAM's best efforts.

Table 6 – APROFAM CYP Targets and Results

Year	Target	Actual
2004 (Baseline)	NA	249,822
2005	210,584	237,582
2006	210,584	NA
2007	210,584	NA
2008	210,584	NA
2009	210,584	NA

According to USAID/Guatemala, several factors influenced the Mission's decision to set targets at this level. First, USAID funds for APROFAM were reduced from about $2.5 million per year under the previous strategy to about $1.9 million per year under the current strategy. Second, the Ministry of Health was expanding the availability of family planning services at no cost to clients, increasing competitive pressures on APROFAM. Third, in 2005, USAID changed the standard CYP conversion factor for sterilizations from 11 CYP per sterilization to 10 CYP per sterilization, reducing the number of CYP that APROFAM would get credit for if the same number of sterilizations were performed.

- While the current strategy was designed to help bridge the gap between urban and rural areas with respect to access to family planning services, targets were not disaggregated between urban and rural areas. Therefore, USAID and its partners did not have a shared understanding of what was expected in terms of bridging this gap, and USAID and its partners were not able to monitor progress toward bridging the gap.

Because no record was kept to show how targets were developed, we could not definitively determine why these problems occurred, but it appeared to us that a more rigorous, disciplined process for establishing targets would have prevented the problems from occurring.

As a result, some targets were set too low to encourage improved performance over time, and the lack of disaggregated urban and rural targets meant that the Mission and its partners could not monitor progress toward making family planning services more accessible in rural areas.

Recommendation No.1: We recommend that USAID/Guatemala revise its targets for couple-years of protection so that partners will be challenged to improve on past performance and also to make targets consistent with one another.

Recommendation No. 2: We recommend that USAID/Guatemala disaggregate established targets between urban and rural areas for the total fertility rate, the contraceptive prevalence rate, and couple-years of protection.

Evaluation of Management Comments – In its response to the above finding and recommendations, USAID/Guatemala clarified the reasons that led to some of the situations above and provided specific comments on the recommendations.

In response to Recommendation No. 1, the Mission established new targets for FY 2004 through FY 2006. These included a "lower target" (which is the same as the current target that we criticize above as not being sufficiently challenging) and an "upper target" for each year for APROFAM. In our opinion, the new targets do not fully respond to the intent of the recommendation. First, targets have only been established for fiscal years that have now ended. What is needed is to establish targets for future periods. Second, in our opinion, establishing a "lower target" and an "upper target" for APROFAM creates more problems than it solves. Which of the two targets will be used to measure APROFAM's performance? If the "lower target" is used, then establishing the "upper target" serves no useful purpose and nothing substantive has changed. If, on the other hand, the "upper target" will be used, then keeping the "lower target" serves no purpose.

The Mission did not agree with Recommendation No. 2. The Mission noted that current reporting systems in use by APROFAM and the MOH do not permit reliable reporting on achievements in urban and rural areas, although this information will be gathered and reported on in the 2007 demographic and health survey in Guatemala.

We continue to believe that separate targets for urban and rural areas are needed. "What gets measured gets done," and the last demographic and health survey in 2002 indicated that disparities between urban and rural areas were getting larger, not smaller (see page 2 above). Annual reporting on these differences would be very desirable, in our opinion, and we do not see any insurmountable obstacles to such reporting. For the MOH, all that would be needed is to classify each MOH facility as an urban or rural facility. For APROFAM, whose facilities draw clients from wider areas that may include both urban and rural clients, the change would be more difficult, but, according to the cognizant technical officer, USAID already plans to help APROFAM implement and improved family planning information system. Even if annual reporting on accomplishments in urban and rural areas turns out not to be feasible – and we are not convinced that this is the case – we would still advocate establishing separate targets for the five-year periods covered by the demographic and health surveys. Otherwise, there is little assurance that USAID and its partners will focus on reducing the large disparities between access to family planning services in urban and rural areas.

Did USAID/Guatemala and its partners manage family planning activities in an efficient manner?

USAID/Guatemala and its partners managed family planning activities in an efficient manner. USAID had developed two efficiency indicators to measure the efficiency of operations of both APROFAM and the MOH, and these performance indicators were met.

In 2005, APROFAM was expected to cover 90 percent of its total costs with locally generated revenues and in fact it covered 91 percent of its total costs, slightly exceeding the target. We verified APROFAM's reporting on the sustainability of its operations by reviewing audited financial statements and recalculating the percentage of total costs covered by locally generated revenues.

In FY 2005, the MOH was expected to purchase 30 percent of its contraceptive needs, and it exceeded the expected level of performance by purchasing 40 percent of its contraceptive needs. We verified the reported percentage by reviewing supporting documentation provided by URC.

While USAID/Guatemala and its partners were managing family planning activities in an efficient manner, we did find one opportunity to improve efficiency which is discussed below.

Non-Governmental Organizations Working With the MOH Had Excess Contraceptive Stocks

Summary: USAID guidance recommends an end-of-year stock level for contraceptives of not more than 12 months' needs. At the end of 2005, the stock level of USAID donated contraceptives for the MOH's extension program with NGOs represented more than three years' needs. This overstock situation occurred because there was no clear accountability for programming and projecting annual contraceptive consumption and because the NGOs' family planning programs were slow in getting underway. As a result, unnecessary expenses were incurred to purchase and store contraceptives that were not needed, and the contraceptives were at risk of loss or expiration.

The USAID Contraceptive Procurement Guide and Product Catalog recommends a year-end stock level that should generally not exceed 12 months to ensure continuous availability of stock without the necessity of managing excess stocks that would waste resources and risk expiry of contraceptives.

As shown in Table 7 below, at the end of 2005, the year-end stock level of USAID donated family planning commodities to the MOH NGOs was more than three years. (We calculated average annual consumption by examining experience for the last two years as recommended by USAID's Contraceptive Procurement Guide and Product Catalog.)

Table 7 – MOH NGOs USAID Donated Contraceptive Stock Levels

Contraceptive	Stock Levels as of 12/31/2005	Average Annual Consumption	Years' Supply on Hand	Expiration Date
Condom	98,577	26,504	3.7	June 2009
Oral contraceptive	25,886	7,672	3.4	November 2009
Injectable contraceptive	87,118	26,803	3.3	January 2009

According to the cooperative agreement between USAID and APROFAM, APROFAM is responsible for the storage and distribution of contraceptives donated by USAID to the NGOs working with the MOH. Specifically, APROFAM is responsible for:

- Preparing the contraceptive procurement tables in coordination with the MOH and USAID.

- Receiving the contraceptives and temporarily warehousing them.

- Receiving from the MOH monthly consolidated reports on consumption of each of the contraceptive for each NGO partner, with the objective of planning the future contraceptive needs.

- Receiving requests for contraceptives from each of the MOH NGOs.

- Distributing in a timely manner the contraceptives to the NGOs.

The cooperative agreement also states that other activities will be carried out by MOH "to assure the management and destination of the donated contraceptives" but it did not explain these other activities or describe the MOH's responsibilities.

Since responsibility for projecting annual contraceptive consumption was shared by the MOH, APROFAM, and USAID/Guatemala, no one was clearly accountable for the decisions made. Also, the MOH extension program with the NGOs was slow in starting: while the MOH was expected to work with 100 NGOs, only 63 NGOs were active in the program as of December 2005 and only 35 were active during the period from January to April 2006.

USAID/Guatemala officials said that they first learned about the excess supply of contraceptives at the NGO level during site visits to three NGOs, two of whom held excess supplies of contraceptives, in March 2006. They reduced the stocks at these two NGOs by transferring contraceptives to other NGOs that had just joined the program. The Mission also adjusted contraceptive orders for 2006, canceling one shipment and significantly reducing another shipment. In June 2006, during our audit, the Mission requested APROFAM to dispatch additional contraceptives to new NGOs just entering the program. This has significantly reduced the stocks held for the NGOs in the APROFAM warehouse. However, it remains to be seen how quickly the supplies can be used by the new NGOs.

Because of the excess supplies as of December 2005, the cost of storing the commodities was higher than necessary as was the risk of loss. Given usage levels from January through April 2006, we estimate that $80,905 of the contraceptives on hand exceeded needs and should be transferred to the MOH or another family planning organization that can use the supplies before they expire.

Recommendation No. 3: We recommend that USAID/Guatemala review the quantity of contraceptives on hand estimated at $80,905 for the NGOs working with the MOH and transfer excess contraceptives to the Ministry of Health or another family planning organization to reasonably ensure that they will be used before they expire.

Recommendation No. 4: We recommend that USAID/Guatemala ensure that a single organization is responsible for programming and projecting annual contraceptive consumption for the NGOs working with the Ministry of Health.

Evaluation of Management Comments – In its comments on the draft audit report USAID/Guatemala reported that it had transferred excess contraceptives to MOH facilities. While this action is sufficient to close the recommendation, we need to keep the recommendation open to resolve a difference of opinion on the amount of USG-funded contraceptives that were put to a better use (i.e., transferred to other organizations) as a result. The Mission did not specifically comment on Recommendation No. 4 since it was not included in our draft report but was instead added during the process of finalizing our audit report to help correct the underlying cause of the problem we found.

SCOPE AND METHODOLOGY

Scope

The Regional Inspector General/San Salvador conducted this audit in accordance with generally accepted government auditing standards to (1) determine whether the program achieved the planned results described in USAID/Guatemala's strategic plan, in Congressional Budget Justifications, and in cooperative agreement and contract documents; and (2) determine whether USAID/Guatemala and its partners managed program activities in an efficient manner. The audit focused on the period beginning October 1, 2004, when USAID/Guatemala's current family planning strategy became effective, and ending on December 31, 2005.

In planning and performing the audit, we obtained an understanding of and assessed the Mission's controls related to the management of its family planning program. The management controls identified included performance monitoring plans; the Mission's Annual Reports; the Mission's annual self-assessment of management controls pursuant to the Federal Managers Financial Integrity Act; and Cognizant Technical Officers' field visits, reviews of progress reports, and day-to-day interaction with implementers.

We judgmentally selected sites to visit, giving preference to communities in which a higher number of family planning services were performed by APROFAM. Our site selection was also designed to include a representative mix of urban and rural communities. In total, we visited 11 of Guatemala's 22 regions, covering 11 of 1,383 MOH health facilities, 9 of APROFAM's 30 fixed clinics and 8 temporary sites where APROFAM's mobile units had provided voluntary sterilization services and other health services. The number of locations visited and the number of sites receiving assistance through USAID/Guatemala's implementers are detailed in the table 8 below:

Table 8 – Breakdown of Sites Visited, by Implementer

Implementer	Type of Facility Visited	Total Receiving Assistance	Number visited
APROFAM	Clinics	30	9
	Mobile Unit Sites	N/A	8
URC - Ministry of Health	Health centers and health posts	1,383	11

N/A means data was not available.

We also conducted audit work at the offices of USAID/Guatemala and its implementers in Guatemala City from March 27, 2006 through June 11, 2006.

From October 2004 through December 2005, USAID/Guatemala obligated $13.6 million, expended $3.9 million, and provided $233,613 in family planning commodities in support of its family planning and other health activities.

Methodology

To answer the audit objectives, we visited health care facilities of the MOH and APROFAM clinics and mobile unit. At the MOH facilities, we interviewed family service providers and administrators. We collected and analyzed data on contraceptives provided by the health care facilities, verified inventory, and reviewed reconciliations. At APROFAM we interviewed 228 family planning clients, and 107 personnel from the head office and all three organizational components that provide family planning information, products, and services as shown in table 9 below.

Table 9 – Breakdown of APROFAM Personnel Interviewed by Program Component

Program Component	Total Population	Sample Interviewed
Head Office	**N/A**	**11**
Clinical Services	**N/A**	**38**
Medical Staff	N/A	30
Others	N/A	8
Marketing Department	**25**	**19**
Supervisor	3	3
Sale promoter	11	8
Mobile Unit: Medical doctors	3	3
Mobile Unit: Nurses	8	5
Rural Development Project	**3,244**	**39**
Coordinators	4	4
Educators	56	14
Volunteer Promoters	3,184	21
TOTAL	**N/A**	**107**

N/A means data was not available.

We interviewed USAID Mission Cognizant Technical Officers and other responsible officials and examined documents such as the Mission's performance monitoring plan and Annual Report. We visited with officials of the Mission's implementing partners and examined agreements, work plans, financial statements, performance monitoring plans, and progress reports.

To answer our first audit objective, we selected all indicators for which information was available from the Mission's strategic plan and contract and grant documents related to family planning. We evaluated the indicator measuring couple-years of protection (CYP) since it was the strategic objective indicator that belongs to both implementers, had been evaluated in the data quality assessment, and had been reported in both the Annual Report and the Congressional Budget Justifications. We also evaluated the percentage of contraceptives purchased by the MOH (as opposed to received from donations) and the level of sustainability of APROFAM. To answer the second audit objective on efficiency we evaluated the two efficiency indicators included in the strategic plan.

Our audit team included a demographer with experience in implementing family planning and public health activities. To determine the significance of our findings, we judged that

the Mission met planned results if all of the conditions stipulated in indicator definitions included in the Mission's strategic plan and Annual Report were completed as described based on our review of supporting documentation and our observations during site visits. In judging the significance of variances found during the audit between reported accomplishments and supporting documentation, we considered variances of 5 percent or more to be significant and reportable.

MANAGEMENT COMMENTS

September 8, 2006

MEMORANDUM

To: **Tim Cox, Regional Inspector General**

From: **Wayne Nilsestuen, Mission Director, USAID/Guatemala**

Subject: **Comments on the Draft Audit Report on USAID/Guatemala Family Planning Activities**

Thank you for the opportunity to review the formal draft of the Audit Report of USAID/Guatemala's Family Planning Activities. We appreciate the extensiveness and quality of the audit on our family planning program. The comprehensive and detailed nature of this audit gives us a high degree of confidence in your principal findings that (a) USAID/Guatemala achieved the planned results described in the strategic plan, in Congressional Budget Justifications, and in cooperative agreement and contract documents and (b) USAID/Guatemala and our partners managed family planning activities in an efficient manner.

With direct assistance from USAID, Guatemala has made tremendous strides in recent years to provide increased and more equitable access to reproductive health information and services. Through our efforts to identify and reduce barriers that stand in the way of couples' ability to protect and plan their family's health and well-being, awareness of family planning even in Guatemala's most remote areas has risen dramatically and more women and men are making their own informed decisions regarding the number and spacing of their children. Contraceptive use increased from 38 percent in 1999 to 43 percent in 2002, a remarkable gain of 1.7 percent per year. Total fertility rates fell from 5.1 children per woman in 1999 to 4.4 in 2002.

For more than three decades, USAID has been the major donor of contraceptives to Guatemala, and has provided sustained technical assistance to public and private sector providers to strengthen the contraceptive supply chain and the provision of family planning services. The health ministry is now the largest contributor to family planning, serving 44 percent of users nationwide and providing 57 percent of contraceptives distributed in the country, including to rural and indigenous populations previously not served. A remarkable success has been the ability of NGO providers to purchase contraceptives on their own after receiving USAID-donated contraceptives for several decades. At the end of this year, USAID will no longer purchase contraceptives even for the health ministry. The political commitment to provide government financing for contraceptives and family planning services-- secured through USAID-supported, proactive policy dialogue and advocacy-- has paved the way for its future sustainability. With USAID's help, our partners have responded to demand for information and services and have built a solid infrastructure to get safe contraceptives and other family planning services to women and men who have opted to use them. The combination of thoughtful counseling, clear information, effective product supply, and accessible

delivery points has enhanced decision-making among rural and urban couples for the first time in Guatemala's history. We are pleased that the Audit Report of USAID/Guatemala's Family Planning Activities has affirmed that our activities are managed efficiently and are achieving results to bring welcomed changes to the lives of thousands of Guatemalans.

Comments on specific audit findings and assertions

Did USAID/Guatemala's family planning activities achieve the planned results?

Low level of IUD use - The audit report states that a problem encountered during visits to Ministry of Health (MOH) facilities included "a low rate of usage of IUDs compared to other family planning methods." One of the fundamental principles of our family planning program is to allow participants to freely choose the contraceptive method that they feel will work best for them. Our programs do not promote one method over the other; rather, the method selected depends on a particular woman's or man's circumstances and whether the medical practitioner thinks that a long-term method may be appropriate, and the woman/man chooses that method after being fully informed of its benefits and risks. As long as a comprehensive program with a broad mix of contraceptive methods is available and women and men freely choose which family planning method is best for them, the relative level of use for different methods should not be a concern. In fact, the MOH program offers a broad mix of contraceptive methods.

CYP Targets Should Be Set Through a More Rigorous Process.

USAID/Guatemala can explain various findings outlined in the audit:

Process for determining targets - The CYP indicator targets were preliminarily set in regional discussions related to the CAM Strategy and its Performance Management Plan in late 2003 and were revised in 2004 for the Guatemala Country Plan "Investing in People" (520-023). Records from our files were provided to the auditors that show how the targets were developed (see attachment 1).

Reconciliation of overall and partner targets - The overall CYP program target for FY 2005 was set in 2004 and we failed to update that target to reconcile the figures after negotiating separate targets with individual partners. Changes that occurred to affect target levels developed for partners include: 1) USAID postponement of a new APROFAM agreement in order to address concerns about internal governance issues – which meant that APROFAM operated for six months in FY 2005 under a no-cost extension, and 2) mutual agreement to emphasize building sustainability during the period of the new agreement and recognition that this emphasis might imply less-rapid expansion of family planning services.

Target levels set below previously achieved levels – In transitioning to an Agency-wide requirement for fiscal year reporting, the Mission made an error in estimating and calculating the FY 2004 baseline. Using that baseline led to CYP targets for FY 2005 and FY 2006 that ended up being below the actual level when final figures were reported (see attachment 1). This error has been corrected and partners have been advised.

Inclusion of MOH-funded NGOs in MOH targets – The draft report refers to a discrepancy between USAID and contractor (URC) personnel regarding whether CYPs

associated with MOH-funded NGO programs were included in MOH target figures. The attached letter from URC acknowledges that the MOH target is for both the MOH and the MOH NGOs (see attachment 2). URC collects and reports CYP from MOH institutional facilities and USAID/Guatemala adds those numbers to the CYP reported by the MOH's unit responsible for MOH-funded NGO services to yield the total MOH CYP. Because the NGO consumption figures are recorded in a system that is different than the one used by MOH institutional facilities, they are reported directly to USAID/Guatemala and USAID/Guatemala consolidates the MOH NGO data and the data reported by URC for the MOH.

Targets set below previous levels to focus on sustainability – The draft audit report incorrectly states that *" with the exception of sterilization services, more CYP implies greater sustainability, not less."* APROFAM family planning services do not pay for themselves, they are subsidized by other services. It is not the contraceptive that is expensive, it is the service. Gross profit from temporary contraceptive methods may seem high (two to three times the cost), but this marginal profit must support other costs such as counseling, education, and information activities and taking the service to more remote areas. The success of APROFAM has been its carefully established system of cross-subsidy between family planning and the profitable, non-family planning-related services.

Therefore, when USAID and APROFAM agreed to focus on achieving full sustainability in the new agreement, we recognized that achieving that goal while simultaneously expanding family planning services at previous rates would be difficult. USAID agreed that APROFAM would not be required to provide family planning services in several remote, unprofitable areas (e.g. Ixcán) that the government had now intended to cover—areas that had been served by APROFAM's mobile clinics primarily for heavily subsidized sterilizations. Thus, the new agreement with APROFAM states that CYP production should be close to FY 2004 production levels and not be below 80% of FY 2004 production (or 263,230 CYP). Negotiation of the APROFAM CYP target also took into consideration other factors: 1) USAID funds were reduced from appropriately $2.5 million per year under the previous strategy to an average of $1.9 million per year under the current strategy; 2) The MOH was increasing its coverage of family planning services provided at no cost to the client, and this expansion of MOH coverage represented a significant source of competition for APROFAM; 3) In 2005, USAID lowered the conversion factor for sterilization from 11 to 10 CYP, thus reducing by 10% the number of CYP for sterilizations that APROFAM would achieve with the same resources.

Closing the gap between urban and rural areas in family planning – The current Investing in People: Healthier, Better-Educated People strategic objective does not explicitly state that a goal of the program is to bridge the gap between urban and rural areas with respect to access to family planning services (as did the previous 1997-2004 health strategy). As outlined in the Guatemala Country Plan (attachment 3), the goal of the current strategy is to achieve national level impact through the implementation of a national-level family planning program. Neither the approved CAM PMP nor the Mission PMP establishes CYP targets for rural and urban areas. While we do want our program to help close that gap, as explained in more detail below, the costs of revamping reporting systems to measure urban versus rural CYPs on an annual basis would outweigh the benefits – therefore we have not made this a stated goal that requires annual disaggregated reporting.

CYP Reporting Should Be Improved

Discrepancies between reported and actual CYP levels – The numbers in the draft audit report are inconsistent in this section. The first bullet points out a difference of 13,482 CYP between reported levels and the CYP reported by individual partners "for the entire program" – a difference of 2.4%. The other bullets refer to subsets of the program, so are thus included in the figure used for the entire program. The statement that CYPs associated with MOH-supported NGOs were not included in the MOH figures is incorrect – we added those figures to the CYPs of MOH institutions (though we only had projections for the last quarter). The section then concludes stating that "these errors involved 30,342 CYP or 5.4 percent of the amounts verified by the auditors" but this number is inconsistent with the first bullet and the other numbers do not add up to this amount. Since the level of discrepancy for the entire program is less than the threshold level in the audit methodology, we request that the entire section be removed from the final audit report. Nonetheless, we agree that more oversight of partner CYP calculations is desirable and have taken actions to ensure such oversight.

Comments on recommendations

After careful review of the RIG draft audit report, the Mission agrees with three of the four recommendations. We hereby request, on the basis of actions already carried out, that Recommendations 1, 3, and 4 be closed upon issuance of this Audit Report and that Recommendation 2 be deleted.

Recommendation 1 - Revise targets for Couple Years of Protection

The Mission agrees with this recommendation and presents our new revised targets below. The PMP indicator tables have been modified accordingly (attachment 4).

Revised New Strategy CYP Targets

	FY 04		FY 05		FY 06	
	Actual	Baseline	Lower target	Upper target	Lower target	Upper target
Public Sector	293,487	293,487	308,161	308,161	323,569	323,569
APROFAM	263,230	210,584	210,584	263,230	210,584	263,230
Overall	**556,717**	**504,071**	**518,745**	**571,391**	**534,153**	**586,799**

As presented in the table above, the 2004 baseline has been recalculated based on the corrected 2004 actuals and calculating 100 percent of public sector production and 80 percent (lower target) of APROFAM's production. The FY 2006 targets were re-calculated using the new baseline numbers. The rule of thumb for future MOH projections is a five percent increase per year based on historical trends and anticipated resource levels. APROFAM's performance target is indeed ambitious and inspires improved performance over time considering the cooperative agreement mandate to preserve the quality and informed choice of its family planning service delivery outputs, maintain CYP production levels close to FY 2004 levels and not below 80% of FY 2004 levels, and achieve greater sustainability and reach 100% sustainability by the end of the agreement. As per USAID policy, targets for future years will be determined on the basis of actual levels from the previous year at the time of the Mission portfolio review and submission of the Annual Report.

Recommendation 2 – Disaggregate established targets between urban and rural areas for the total fertility rate, the contraceptive prevalence rate, and couple years of protection indicator.

The Mission disagrees with this recommendation. As noted above, reducing the gap between rural and urban areas is not an explicitly stated goal under our current strategy and therefore the approved CAM PMP and the corresponding Guatemala Country Plan PMP do not disaggregate these indicators. Under the mandate of the CAM strategy, the Mission is focused on national impact of all its programs, including the family planning program. Total Fertility Rate and Contraceptive Prevalence Rate will be determined through the 2007 DHS and will be reported by the Mission as soon as the data are available. Data collection systems that are in place by the MOH and MOH NGOs and APROFAM do not permit the data to be accurately and reliably reported for urban and rural areas. We believe that the benefits to reporting annual CYP data disaggregated by rural and urban areas do not outweigh the significant cost and labor that would be required to reengineer the reporting systems, especially at this time when the Mission faces reduced funding levels for our family planning activities.

Nonetheless, we are confident that our support to the MOH and APROFAM is effectively leading to increased contraceptive security in rural and indigenous areas that will be captured by the DHS and reported in 2007. The data will be reported for national totals, but they will additionally be disaggregated for urban/rural and indigenous/non-indigenous population strata. The Mission will use this vital information for decision-making purposes and especially to inform new directions for its future family planning programs.

Recommendation 3 – Establish procedures to recalculate information on couple years of protection reported by partners.

The Mission agrees with this recommendation, and on the basis of actions already carried out, and listed below, we request that you close the recommendation.

To ensure that the information the Mission reports on CYP is accurate and reliable, the Mission has established a procedure to standardize CYP reporting among organizations and to recalculate CYP information provided by partners. The current procedure verifies quality of data, consistency of data among different reporting levels, and controls for errors that could be made while aggregating the data or applying the conversion factors to the consumption data. The new suggested process consists of the following steps:

1. Implementing partners (MOH and APROFAM) collect primary data (consumption and new users) from their service networks;
2. Implementing partners apply USAID's official conversion factors to produce and report CYP;
3. USAID/GUATEMALA obtains disaggregated data from the local reporting units (MOH's health area directorates and APROFAM's clinics, mobile units and the rural development program);
4. USAID/GUATEMALA migrates these disaggregated data onto spreadsheets that automatically calculate CYP by method and by level of reporting institutions (see attachment);
5. USAID/GUATEMALA calculates aggregated CYPs by institution and compares it with the reports submitted by implementing partners;

6. USAID/Guatemala discusses discrepancies with partners and differences are resolved;
7. USAID/Guatemala monitors consistency and accuracy of reported data by spot checks at health centers, posts, hospitals, clinics, mobile units, and community-based distribution points, and review of source documents;
8. USAID/Guatemala documents steps taken to review, recalculate and verify partners' information.

In addition to establishing the above procedure, the following actions were also undertaken to improve CYP reporting (see attached corresponding documents):

- Assessed the reporting process from MOH facilities to the MOH central level (January 2006) (attachment 5)
- Reviewed the reporting process utilized by the *Unidad Prestadora de Servicios del nivel I (UPS-1)* for contraceptive methods consumption by MOH NGOs (February 2006)
- Assessed the level of confidence of reports received by the MOH central level from decentralized and local levels (March 2006) (ATTACHMENT 6)
- Verified that all partners are aware of and are using the currently authorized conversion factors for all family planning methods (July 2006)
- Reviewed and revised the Mission's CYP Data Quality Assessment (July 2006; September 2006) (attachment 7)
- Discussed with Mission Management regarding the need to move back the SO portfolio reporting period so that partners can report actual data for September versus projections (July 2006)
- Letter sent to partners requesting that they submit cumulative FY CYP actuals in the fourth quarterly report (August 2006) (attachment 8)
- Recalculated CYP for sterilizations and natural methods reported by partners for FY 2006 3rd quarter using authorized conversion factors (August 2006)
- Negotiated with the MOH that the new Logistics Unit will integrate the distribution and consumption information from MOH NGOs into the MOH database in order to generate one consolidated MOH CYP report (August 2006) (attachment 9)
- Pilot tested CYP conversion factors spreadsheets with URC (August 2006) (attachment 10)

Recommendation 4 – Review the quantity of contraceptives on hand for the NGOs working with the MOH and transfer excess contraceptives

The Mission agrees with the recommendation and requests that the recommendation be closed due to actions already taken.

USAID/Guatemala is supporting the MOH to expand basic health services, including family planning, throughout the country. One of the key health portfolio activities is support for the MOH Coverage Extension Program to provide services for 350,000 additional persons. For a myriad of reasons, the procurement and start-up implementation of this activity was delayed for several months. Because we had anticipated an increase in the total population covered by MOH NGOs funded by USAID and the MOH, the order for additional contraceptive methods was placed. The newly ordered quantities arrived in CY 2005, but because of the delay in the USAID procurement, the new NGO service providers were not yet contracted and able to

distribute contraceptive methods. This delay caused an overstocking of contraceptive methods in the central warehouse.

The following corrective actions, among others, were taken by USAID/Guatemala to reduce stock levels (see attached documentation):

- Reviewed expected demand for 2006 with the MOH and APROFAM (September-October 2005) (attachment 11)
- Adjusted contraceptive orders for CY 2006 (January 2006) (attachment 12):

	Original order	Corrected order
Condoms	48,000	0
Depo-Provera	60,800	18,000
Lo-Femenal	25,200	2,400

- Undertook three field visits to local warehouses to a) check stock inventory, b) train UATs (Technical Assistance Units) and NGO staff in procedures to analyze consumption trends, project needs, and use authorized forms (Balance, Requisition and Delivery of Supplies-BRES- and Integrated Information System Report 6-SIGSA 6-) and c) coordinate through UATs the transfer of excess contraceptive methods stock to MOH facilities (March 2006) (attachment 13).

While the above corrective actions were being undertaken, the MOH completed the process of contracting the MOH's Extension of Coverage NGOs to provide services in 46 new communities. The new contracts facilitated the delivery of contraceptive methods to the field and resulted in a significant decrease in the months of supply at hand for every method in the APROFAM central warehouse.

The USAID Contraceptive Procurement Guide and Product Catalog recommend a year-end stock level should generally not exceed 12 months. As of the current date, no contraceptive stock level exceeds 12 months. The APROFAM-reported inventory levels as of July 31, 2006 and August 28, 2006 for these methods whose expiration date is 2009, are the following (attachment 14):

MOH NGO Inventory

Contraceptive	Stock as of 12/31/2005	Stock as of 7/31/2006	Stock as of 8/28/2006	Monthly average consumption	Months' Supply on Hand
Oral Contraceptive: Lo-Femeral, Gragea, Ciclo 28, c/m	25,886	6,760	4,820	2,091	2.3
Injectable Contraceptive: Depo-Provera, Vial, Unit	87,118	21,200	14,599	7,116	2.1
Condom, Unit	98,577	50,884	47,434	4,887	9.7

In October, USAID will receive a new shipment of oral and injectable methods that will provide three months of stock. When USAID's contraceptive distribution agreement between the MOH and APROFAM expires in December 2006, any remaining stock of

contraceptive methods will be transferred to the MOH National Reproductive Health Program.

The Mission does not agree with the auditors' intention to claim an efficiency savings of $80,905 related to the transfer of excess stocks of contraceptives since the referred stock has been allocated to the MOH NGOs and is being distributed to users.

Although after 2006 the USAID Mission will no longer provide contraceptives to the MOH or MOH NGO service providers, the Mission will continue to assist the MOH in projecting and tracking stock levels through (a) the use and analysis of two standardized forms (BRES and SIGSA 6) for data verification purposes, as well as by b) participating in biannual workshops to review information generated by the software Pipeline to create and review Contraceptive Procurement Tables and c) participating in an annual workshop on contraceptive needs forecasting and generation of programmatic targets.

Final comments

Given the high degree of collaboration in the conduct of this audit, including considerable Mission staff time in providing information, we request our comments to date be given due consideration in the final report.

We appreciate the commitment of you and your staff to carry out such a comprehensive audit. Your work has helped us better understand the issues associated with family planning program effectiveness and efficiency.

* * *

Attachments

The attached documentation is provided as a basis for our statements and closing audit recommendations:

List of Attachments:

1. Support Documents for Targets Established for the Family Planning Program
2. URC Letter on MOH Targets
3. Regional Strategy for Central America and Mexico FY 2003-2008. Volume 2: Annex E: Guatemala Country Plan (page 20, paragraph following "Intermediate Result 3: Improved integrated management of child and reproductive health", fifth sentence) http://inside.usaid.gov/LAC/pdf/guatemala_2003.pdf
4. Revised Baseline and Targets
5. Assessment of reporting process from MOH facilities to the MOH central level (January 2006)
6. Assessment of the level of confidence of reports received by the MOH central level from decentralized and local levels (March 2006)

7. Review and revision of the Mission's CYP Data Quality Assessment (July 2006)

8. Letter sent to URC requesting that they submit as necessary a revised annual CYP actual report to USAID after final FY data are processed

9. Weekly report from URC logistics advisor on meetings with MOH regarding inclusion of NOGs data into the Reproductive Health National Program reporting system

10. Standard Form for Calculating CYPs

11. Reviewed expected demand for 2006 with the MOH and APROFAM (September-October 2005)

12. Contraceptive procurement cable 2006

13. Field visits reports to NGOs

14. APROFAM inventory reports

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