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OFFICE OF INSPECTOR GENERAL

Audit of USAID/Haiti's Implementation of the President's Emergency Plan for HIV/AIDS Relief

AUDIT REPORT NO. 1-521-05-010-P

JULY 29, 2005

SAN SALVADOR, EL SALVADOR

Office of Inspector General

July 29, 2005

MEMORANDUM

TO: USAID/Haiti Director, Erna Kerst

FROM: Acting Regional Inspector General/San Salvador, Darren Roman "/s/"

SUBJECT: Audit of USAID/Haiti's Implementation of the President's Emergency Plan for HIV/AIDS Relief (Report No. 1-521-05-010-P)

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

The report contains seven recommendations intended to improve the implementation of the Emergency Plan. Based on your comments and the documentation provided, management decisions have been reached on the first six recommendations. However, no management decision has been reached concerning the last recommendation. In this regard, we request that you provide us written notice, within 30 days, of any additional information related to any action planned or taken to implement this recommendation. Determination of final action will be made by the Bureau for Management's Office of Management Planning and Innovation (M/MPI/MIC).

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

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SUMMARY OF RESULTS

As part of a worldwide audit, the Regional Inspector General/San Salvador performed this audit to answer the following questions:

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

- Did USAID/Haiti activities progress as expected towards planned outputs in their grants, cooperative agreements and contracts?

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

We concluded that USAID/Haiti was heavily involved in implementing the President's Emergency Plan for AIDS Relief (Emergency Plan) in Haiti for HIV/AIDS prevention and care, as well as playing a major supporting role for HIV/AIDS treatment; its partners were progressing towards meeting planned outputs in their contracts and agreements for some activities but outputs were not established to measure progress of other activities; and USAID/Haiti's activities contributed to the overall U.S. Government's Emergency Plan targets. (See pages 3, 5, and 14.)

This report contains recommendations that (1) USAID/Haiti make a determination whether to implement the drug management software provided by Rational Pharmaceutical Plus, and if so, set a target date for the implementation of the software and a plan for user support; (2) output goals and performance dates for completion be included in work plans; (3) a progress report template be developed and provided to partner organizations; (4) a monitoring and evaluation plan be developed; (5) new antiretroviral therapy centers not be opened unless there are adequate drugs and other supplies to treat more than a limited number of patients; (6) USAID/Haiti recommend to the Emergency Plan team that it develop an implementation plan; and (7) USAID/Haiti coordinate with Single Act auditors, in order to determine whether the audit coverage is sufficient and if not, arrange for additional coverage and conduct financial reviews for these U.S.-based organizations implementing the Emergency Plan activities. (See pages 9 - 17.)

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 speed up prevention, treatment, and care services in 15 focus countries, one of which is Haiti. 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[1] by $1 billion over five years. The worldwide goal over five years is to provide treatment to 2 million HIV-infected people, prevent 7 million HIV infections, and provide care to 10 million people affected by HIV/AIDS, including patients and orphans. In Haiti, the goal is to provide treatment to 25,000 HIV-infected people, prevent 122,307 HIV infections, and provide quality care and support services to 125,000 persons who are infected and/or affected by HIV/AIDS.

The strategy to achieve the Emergency Plan's ambitious goals focuses on improving health care system capacity to deliver effective and expanded HIV/AIDS prevention, treatment and care services. The Emergency Plan is directed by the Department of State's Global AIDS Coordinator, and it is implemented collaboratively by country teams. In Haiti, the country team is made up of staff from USAID, the Department of State, the Centers for Disease Control and Prevention, the Department of Defense, and the Peace Corps. It is important to mention that the working environment in Haiti in 2004 and 2005 was characterized by chronic instability, extreme insecurity, violence, civil unrest, limited travel within the country and a mandatory evacuation of USG personnel. This had a major impact on the implementation of the Emergency Plan. The USAID mission demonstrated considerable agility in coping with Haiti's chaotic and changing circumstances.

AUDIT OBJECTIVES

This audit was part of a worldwide audit of the President's Emergency Plan for AIDS Relief. The audit objectives were:

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

- Did USAID/Haiti activities progress as expected towards planned outputs in their grants, cooperative agreements and contracts?

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

[1] The Global Fund is a partnership among governments, civil society, the private sector and affected communities that raises money to fight AIDS, tuberculosis and malaria.

AUDIT FINDINGS

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

USAID/Haiti was heavily involved implementing the President's Emergency Plan for AIDS Relief (Emergency Plan). In the U.S. Government's Country Operational Plan for fiscal year 2004 for Haiti, USAID/Haiti was the lead agency for awards to nine organizations, for a total of $11.9 million out of a $22 million program. Haiti's program was based on four main components:

1. Improved quality of existing services to maintain adherence by continuing clients.
2. Increased number of service delivery sites to reach new clients.
3. Targeted prevention and behavior change interventions.
4. Strengthened program management and coordination to increase efficiency.

There were three broad areas that were addressed in the Emergency Plan: prevention, care, and treatment. USAID/Haiti's activities are described below.

Prevention

Prevention activities were divided into five broad categories:

- Prevention of mother-to-child transmission
- Abstinence/be faithful
- Blood safety
- Safe injections and prevention of other medical transmission
- Other prevention initiatives

USAID/Haiti had a major role in the first, second, and fifth activities

Prevention of mother-to-child transmission (PMTCT) – It was estimated that 11,800 HIV-infected Haitian women gave birth in 2000 and that there were 4,000 – 6,200 infants with HIV infections. The PMTCT activities sought to prevent transmission of HIV/AIDS from mothers to infants. PMTCT activities included supporting operating costs for PMTCT services and counseling and support for safe infant feeding practices. USAID/Haiti focused on strengthening community mobilization to recruit more pregnant women for PMTCT services and to ensure improved post-natal follow-up. Other activities included renovation of facilities where PMTCT services were provided, training of health professionals, a media campaign and development of norms and standards.

USAID/Haiti contractor Management Sciences for Health (Management Sciences) provided an integrated package of services in one location, including childhood vaccinations, treatment for diarrhea, screening for sexually transmitted infections, and screening for tuberculosis. This integrated approach was designed to encourage people to come to the centers without fear that other people would know that they had HIV/AIDS. Management Sciences also tried to co-locate the centers near food programs

because if there were a cluster of services in one area, more people would come to the clinic for voluntary counseling and testing and PMTCT services.

Abstinence/be faithful – Abstinence and be faithful activities were behavior change interventions designed to prevent new infections. Abstinence and faithfulness messages, along with training to empower responsible life decisions, were directed at youth, the largest segment of Haiti's population. Activities included training of scout leaders, labor union representatives, religious leaders, and radio disc jockeys in HIV/AIDS prevention messages and promotion of positive youth behavior as well as training staff in partner organizations in behavior change communications focused on youth.

Other prevention – Other prevention initiatives were directed at high risk clients, particularly commercial sex workers, truck drivers and at-risk youth, to discourage risky behavior as well as to encourage the consistent use of condoms. USAID/Haiti's other prevention interventions consisted of a behavior change campaign promoting the use of condoms among high risk groups.

Care

Care activities were divided into three categories:

- Voluntary counseling and testing
- Palliative care
- Care for orphans and vulnerable children

Voluntary counseling and testing (VCT) – VCT services were provided by 31 clinics and hospitals (hereinafter jointly referred to as clinics) in a network linked to Management Sciences. Existing centers were strengthened and supported under the Emergency Plan. In addition to providing services at clinics, Management Sciences trained community health agents to promote the use of VCT/PMTCT services, to provide community-based information and follow-up after testing, and to encourage referrals. The IMPACT project managed by Family Health International (Family Health) provided technical assistance to update norms and standards, developed and disseminated a VCT trainer guide, and counselor manual, published a manual on the care and treatment of people with HIV/AIDS as well as an operational handbook to support the conceptual model of VCT/PMTCT service integration.

Palliative care – Palliative care included all non-antiretroviral care and treatment, outside of clinic-based care, provided to infected individuals, from the moment of receiving VCT results through end-of-life care. Palliative care was aimed at optimizing the quality of life of HIV-infected persons and their families. Assistance also included life-extending therapy; training of caregivers and family members on health-related issues, HIV awareness, and prevention; school fees; food; and home visits by nurses and social workers.

Care for orphans and vulnerable children – Activities assist community support groups for people living with AIDS as well as orphans and vulnerable children. There were an estimated 370,000 orphans in Haiti in 2004. Funds were used to prepare guidelines and to provide technical assistance and guidance to the Ministry of Health to

develop legislation to protect the rights of HIV-affected orphans and vulnerable children as well as materials for peer education.

Treatment

Clinics in the network linked to Management Sciences provided antiretroviral treatment to some HIV/AIDS patients, but most of USAID/Haiti's efforts in the treatment area were directed to the management, purchase, and distribution of antiretroviral drugs. USAID/Haiti contractor Rational Pharmaceutical Management Plus (Rational Pharmaceutical)[2] provided logistical support as well as procuring and distributing antiretroviral drugs. Activities included developing and implementing a software program to monitor and track antiretroviral usage and stock levels, warehousing, and delivery of antiretroviral drugs to clinical sites.

Did USAID/Haiti activities progress as expected towards planned outputs in their grants, cooperative agreements and contracts?

Of the 39 activities reviewed, 15 had met or exceeded planned outputs, 7 had not met planned outputs, and 17 achieved output levels that could not be evaluated for progress because planned outputs were not established. The outputs are discussed by work area in the sections that follow.

Prevention

Prevention of mother-to-child transmission (PMTCT) – Most of the prevention activities were implemented by Management Sciences, which had established a network of 36 clinics under an existing program with USAID/Haiti. Management Sciences exceeded its planned output of supporting 12 PMTCT sites and supported 31 VCT/PMTCT sites in its network of health centers. Likewise, Management Sciences exceeded its goal of providing services to 5,300 pregnant women; 12,661 pregnant women received services. There were 893 HIV positive pregnant women, and 507 were enrolled in PMTCT.

Management Sciences reported that it trained 1,692 traditional birth attendants in PMTCT principles, exceeding its goal of 1,500; it developed management guidelines and procedures for PMTCT and voluntary counseling and testing as planned; and it trained 593 institution-based network providers of PMTCT services, exceeding its goal of 500.

Another USAID/Haiti partner, Linkages/Academy for Educational Development (Linkages), provided training regarding the options HIV positive mothers have regarding breast feeding or using formula. The goal in the work plan was to provide this training to health providers for 27 PMTCT sites, and Linkages exceeded this goal by training 85 health professionals for 30 PMTCT clinics as well as providing HIV awareness and infant feeding training to another 66 participants from various non-governmental organizations and the Ministry of Health.

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[2] Rational Pharmaceutical Management Plus is a program of Management Sciences for Health.

Photograph of an auditor from RIG/San Salvador observing a pregnant woman registering at a PMTCT clinic in Haiti, taken on April 26, 2005.

USAID/Haiti partner Family Health did renovation work at 15 PMTCT sites, exceeding the work plan output of 14. It met its goal of training 160 health professionals and counselors at PMTCT sites.

The Johns Hopkins University Health Communication Program (Johns Hopkins) designed and launched, as planned, a nationwide media campaign promoting PMTCT/VCT services, risk awareness and the importance of testing. An estimated 3.8 million people were reached through printed materials and national and community-level radio broadcasts. However, their workplan did not set a planned output for the number of people to be reached by this campaign. They also conducted training for over 400 individuals on community mobilization, abstinence and faithfulness, which included scouts and journalists and exceeded their planned output of training 100 people.

Abstinence/be faithful – Management Sciences reported reaching 127,500 youths in its abstinence/be faithful campaigns, more than double the planned level of 60,000. It also achieved its goal of reaching at least 1,500 people with behavior change messages through peer counselors. Johns Hopkins developed two media campaigns that reached 115,000 adolescents and young people. Johns Hopkins also conducted a community-outreach program on abstinence and faithfulness reaching 15,000 youths. However, the workplan did not include specific planned outputs for these activities. Family Health reached over 86,000 individuals through abstinence/be faithful messages and more than 62,000 through abstinence promotion. The work plan of Family Health did not have quantifiable planned outputs for these activities.

Population Services International through the AIDSMARK Project (Population Services) reached almost 3,000 girls through a community outreach program promoting abstinence and faithfulness exceeding the goal of 2,000. They also trained 42 youth

leaders and peer educators in how to negotiate protective behavior. The workplan did not have a quantifiable planned output for the number of individuals to be trained.

Other prevention – Population Services worked with truckers and commercial sex workers to discourage risky behavior. They reached an estimated 3.2 million people through a mass media campaign promoting condom use. Family Health also reached more than 25,000 people with other prevention strategies for high risk groups. John Hopkins conducted two media campaigns promoting other preventions strategies that reached an estimated 1.7 million people. They also provided training to almost 500 individuals in other prevention strategies. However, the work plans of these three partners did not contain quantifiable planned outputs for these activities.

Care

Voluntary counseling and testing (VCT) – VCT services were provided by 31 of the clinics that work with Management Sciences. Of these 31 VCT sites, five began providing VCT services as planned in the year ending March 2005. Two planned VCT sites in non-medical settings had not been opened. Through March 2005, over 5,000 persons had received VCT services at the clinics, exceeding the planned output of 3,000 clients. As planned, Population Services developed a mini-film for VCT promotion. They provided VCT services to almost 5,000 people but did not have a planned output for this activity.

Palliative care – USAID/Haiti planned to provide community outreach palliative care through Management Sciences to 15,000 persons infected with HIV/AIDS, but it only reported reaching 8,000 people. However, this program was on-going. Management Sciences stated that not meeting the planned output was due to time needed to develop prerequisites and standards for community-based care, development of training curriculum, and translation of materials to Creole. This was confirmed by USAID/Haiti who stated that Management Sciences had to wait for the approval of the protocol by the Ministry of Health and manage pressure from the Ministry to use a particular contractor. We are not making a recommendation at this time based on Management Science's and USAID/Haiti's explanations that the delay was due to time required to develop the curriculum, prepare the materials and get the Ministry of Health on board.

USAID/Haiti and Management Sciences also planned to provide more extensive, home-based care and life extending therapy kits to 7,500 people. This planned output was not met. At the time of the audit, Management Sciences stated that it was preparing to distribute 2,000 kits to HIV-positive persons and their families. Management Sciences stated that a delay in the procurement of the kits by Rational Pharmaceutical contributed to this missed planned output.

Population Services was to develop appropriate messages promoting positive living and compassionate care of persons living with HIV/AIDS. A total of 4.8 million people were to be reached by these messages. However, this component of the Haiti Emergency Plan was not performed because funding was not available. Population Services did not submit their workplan and budget until December 2004 because no funding mechanism had been identified with USAID. The USAID agreement was signed in January 2005 by USAID/Haiti and in February 2005 by the CTO in Washington. Consequently, Population Services has until September 2005 to complete planned project activities.

John Hopkins produced and distributed 1,000 diaries illustrated with the art works created by persons living with HIV/AIDS. They also provided technical assistance to revise the VCT norms and standards. Family Health strengthened 12 support groups and reached almost 150 persons living with the disease by providing training and guidance for organizational development to non-governmental organizations as well as psychosocial support to people with HIV/AIDS. Also, 530 Christian leaders participated in a forum for mobilization and advocacy relating to support programs. No planned outputs were defined for these activities in their work plans.

Care for orphans and vulnerable children – USAID/Haiti contractor Futures Group through the POLICY II Project (POLICY) along with Johns Hopkins developed guidelines for the care of orphans and vulnerable children (OVC), as planned. However, POLICY did not conduct an analysis of OVCs because the 2003 census data was not yet available.

Family Health provided care for orphans and vulnerable children through two programs. One program benefited more than 150 families affected by HIV-positive members that received a comprehensive package of care as well as being served by members of the community that were trained in home care. Family Health also had a program for more than 1,000 street children on prevention and care activities as well as risk reduction for HIV/AIDS. Family Health had no planned outputs for these activities in their workplan.

Treatment

Drug management software was not implemented in all centers as planned. As of the date of fieldwork, the software had only been installed at four sites. Likewise, USAID/Haiti did not provide antiretroviral therapy to as many patients as planned, treating 258 patients when the planned number of patients was 400 patients. During the period, Management Sciences tested more than 55,000 persons for HIV/AIDS of which almost 4,000 tested positive.

No Drug Management Tracking System

USAID/Haiti's contractor Rational Pharmaceutical procured, warehoused, and delivered antiretroviral drugs to clinical sites. It also developed and installed a software program to monitor and track antiretroviral drug usage and stock levels. As set forth in the Country Operational Plan, USAID/Haiti planned for the software program to be implemented throughout Haiti, but this was not achieved. Rational Pharmaceutical stated that USAID/Haiti asked it to go slow on the rollout of the software program, and USAID/Haiti stated that it was considering an alternative software program. Additionally, Rational Pharmaceutical had a limited number of staff in Haiti to implement the system in 2004 and to monitor the drug supplies in the field. According to its chief of party, only two staff were in Haiti in 2004. As a result, the software had been installed in only four sites in 2005. At one site visited where the software had been installed, the software was not generating accurate drug counts or accurate numbers of patients under treatment. The person there had been trained but did not know how to fix the problem and decided to continue maintaining the manual system.

While software installation activities were delayed, accurate inventory counts of drugs were not always available. Rational Pharmaceutical was unable to provide an accurate inventory of three antiretroviral drugs at two antiretroviral therapy centers opened under the Emergency Plan. The lack of an accurate inventory made it difficult for the Emergency Plan team to determine the amount of antiretroviral drugs to be ordered.

As a result of not implementing a software program to track drug usage and stock levels and not implementing an accurate interim tracking system, it was difficult for the Emergency Plan team to determine the amount of antiretroviral drugs to be ordered and to be able to supply all of the patients with the needed drugs. Due to the lack of a proper drug management system being in place, there was increased risk that critical drugs and commodities would not be provided in a timely manner.

Recommendation No. 1: We recommend that USAID/Haiti (a) make a determination as to whether or not to implement the drug management software provided by Rational Pharmaceutical Management Plus, and (b) if it decides to implement the software, set a schedule for the implementing the software and a plan for providing support to the users of the software.

Shortage of Antiretroviral Drugs

Management Sciences opened four antiretroviral therapy centers as planned, and the centers were treating 105 patients. The original planned output was to provide 600 patients with antiretroviral therapy, but this planned output was lowered to 250 due to drug shortage and the security situation in Haiti. Antiretroviral drugs were in short supply because USAID/Haiti had to wait for a release of funds before it could order additional antiretroviral drugs. Due to the shortage, the Emergency Plan team instructed antiretroviral therapy centers to stop adding patients.

In November 2004, the Haiti Emergency Plan team requested that the Department of State's Global AIDS Coordinator disburse its FY 2005 Emergency Plan funds early in order to enable the Emergency Plan team to order antiretroviral drugs in time to receive them in March in order to avoid drug shortages. The Global AIDS Coordinator approved this request and submitted a Congressional Notification that included these funds. The Congressional Notification was approved on December 30, 2004; however, the funds were not available to USAID/Haiti until March 25, 2005. This delay was due to discussions between USAID/Washington and the Global AIDS Coordinator regarding the wording in the agreement transferring the funds from the Global AIDS Coordinator to USAID. The language under discussion was the wording of the clauses regarding terrorism and trafficking. The wording issue was resolved, and a Memorandum of Agreement between USAID/Washington and the Global AIDS Coordinator was signed on February 28, 2005. It was then another month before the funds were made available to USAID/Haiti. As a result, funds expected by USAID/Haiti in January 2005 were not available until late March, and USAID/Haiti was not able to order antiretroviral drugs until April.

It normally takes three to four months for antiretroviral drugs to be delivered after they are ordered. Stocks of certain antiretroviral drugs were at a crisis level in April. The information available to USAID/Haiti in mid-April indicated that two drugs were out of stock, and that three more were expected to be out of stock by the end of April based on

patient loads and existing stock information. Some deliveries to Haiti's antiretroviral therapy centers were anticipated in April, but it was still estimated that four antiretroviral drugs would be out of stock. USAID/Haiti was trying to obtain the antiretroviral drugs immediately through available sources including local suppliers, but it was not certain that it would be possible to arrange immediate delivery for all drugs that were at a critically low level. USAID/Haiti worked with the Global Fund, the only other major supplier of antiretroviral drugs to Haiti, to fill some of the gaps, but the Global Fund also suffered a funding delay the first few months of 2005. The Global AIDS Coordinator and the CDC worked with the Haiti Emergency Plan team to address this crisis. Subsequent to the end of field work, we were informed that the Emergency Plan team was able to arrange the delivery of a sufficient supply of the drugs in time to avert the crisis. This was a unique situation with the language on the waivers being negotiated. Therefore, we are not making a related recommendation.

Some Outputs in Work Plans Not Defined

As noted under this objective in the sections on prevention and care, progress on 17 of the activities reviewed could not be evaluated because work plans did not contain planned output levels. Further, a review of USAID/Haiti's work plans showed that the completion dates for tasks were not always defined. The activity indicators in work plans should clearly define planned outputs. Automated Directives System (ADS) 202.3.6 states that in order to monitor the quality and timeliness of outputs produced by implementing partners, outputs should be specifically described. The guidance also states that outputs are critical to achieving results. ADS 200.3.1.2 states that performance outputs need to be established in order to assess progress. For example, the work plans for Management Sciences, Health Communication Program and Rational Pharmaceutical did not specify planned output dates for any of the planned activities. The lack of dates in work plans is attributable to a heavy workload as well as pressure for results. As a result, USAID/Haiti was without a valuable management tool to guide its partners to do the work in the desired timeframe. USAID/Haiti wanted Rational Pharmaceutical to have a system in August 2004 to track drug usage and stock levels, but there was not a deadline in the work plan. It should also be noted that it is not possible to measure the success of a program if there are no planned outputs in the work plan.

> *Recommendation No. 2: We recommend that USAID/Haiti include clearly defined planned outputs, with completion dates, for all activities in the partners' work plans.*

Progress Reports Need Improvement

Summary: Partner progress reports submitted to USAID/Haiti did not always include accurate and useful information describing progress achieved during the reporting period or about current and cumulative progress. The majority of the reports lacked clearly defined targets and sufficient information with which to validate the partner's reported achievements. As stated in ADS 202.3.6.1 assessing performance, refers to whether the outputs produced by the contractor or grantee are of acceptable quality. Shortcomings in the progress reports were due to insufficiently trained technical staff, written agreements that did not sufficiently defined the responsibilities of partner's organizations, and inadequate project monitoring and evaluation system. Consequently, USAID/Haiti could not always determine if projects were progressing towards objectives.

ADS 200.3.2.1 states that intended results should be explicit, and interactions should be organized to achieve results as effectively as possible. ADS 202.3.6.1 states that assessing performance refers to whether the outputs produced by the contractor or grantee are of acceptable quality and that the cognizant technical officer is responsible for reviewing and approving performance reports. Progress reports submitted by USAID/Haiti partners did not always include accurate and useful information about current and cumulative progress. Some partners were confused by the formats of the reports, did not understand some of the indicators, and did not know what information had to be reported. Also, management needs accurate reports to support decision-making.

A review of progress reports submitted by the various partners revealed that many of the progress reports contained data that was not accurate, and did not measure progress towards achieving the Plan's objectives. Also, the information in progress reports was sometimes too vague to be of any utility in measuring progress made toward achieving program objectives. The reports also evidenced examples of double-counting, wrongly reporting results from prior periods. For example, a partner reported training 69 people on abstinence and being faithful. The training was conducted jointly with another partner who also reported the same achievement. There was no mention in progress reports of the dates or venues for this training. Consequently, the information could not be reconciled or verified. Neither of the two partners had supporting documentation for this training that was reportedly conducted by a third organization. Both organizations said that there was a lot of pressure to report results.

For another partner as a result of the shortcomings in the annual and quarterly progress reports, we could not determine if all departments received strategic-information training. The partner's annual progress report stated that some training in certain departments had been conducted but did not include department-specific results. Consequently, we could not determine if all departments received training or validate the partner's reported achievements.

From another partner, we received two different progress reports for the same period, which included different results associated with the same indicators. For example, one progress report indicated reaching 95,000 youths through a mass media campaign while another report for the same period reported that number as 115,000. We also found that

the semi-annual progress report ending March 31, 2005 contained results from prior periods.

We reviewed progress reports from all the partners, and none contained cumulative figures that would have permitted us to measure progress towards reaching the plan's objectives. Also, the majority of the reports had no clearly defined targets or sufficient information with which to validate the partner's reported achievements.

This was the result of a lack of sufficiently trained technical staff, written agreements that did not sufficiently define the responsibilities of partner organizations, reporting formats that did not measure performance towards achieving the planned outputs, and a lack of monitoring and evaluation system. Consequently, USAID/Haiti could not always determine if projects were progressing towards objectives. Further, because the partner organizations did not always have accurate records supporting their progress reports, reported results were sometimes difficult to verify**.** Without accurate and reliable data, sound decisions cannot be made.

Recommendation No. 3: We recommend that USAID/Haiti (a) develop and disseminate to partner organizations a table or annex template that facilitates performance reporting and includes clearly-defined progress indicators; (b) provide partner organizations with training such that the partners are able to accurately report on their performance, and (c) recommend to the Emergency Plan team that this be done for all Emergency Plan partner organizations.

Monitoring and Evaluation System Needs Improvement

Summary: USAID/Haiti did not implement a system that effectively monitored Emergency Plan activities and achievements. ADS 203.3.2 states that operating units must establish systematic process of monitoring the results of activities, collecting and analyzing performance information to track progress towards planned results. This was due to civil unrest, travel restrictions and unscheduled office closings which adversely impacted the ability of USAID/Haiti to monitor Emergency Plan activities. Consequently, the Mission could not measure the efficiency and effectiveness of the program, and apply measurements to improving program implementation.

ADS 203.3.2 states that operating units must establish a systematic process for monitoring the results of activities; collecting and analyzing performance information to track progress towards planned results; using performance information to influence program decision making; and communicating results achieved or not attained. USAID/Haiti cognizant technical officers are responsible for monitoring the progress of activities.

USAID/Haiti did not implement an effective system to monitor its Emergency Plan activities and record program achievements. A monitoring and evaluation plan was not developed to determine which activities should be monitored and how the activities would be monitored, including the number and frequency of site visits to be performed by USAID/Haiti. Available records showed that during FY 2004 USAID/Haiti only made a few site visits, and those site visits were not documented. We were informed that some Emergency Plan site visits focused only on the area of the person or organization

conducting the site visits. Site visits should include a review all Emergency Plan activities at a site. While everyone was not an expert in every area, there are basic review procedures that could have been performed by persons not trained in a specific area. Well-planned, documented visits would have assisted USAID/Haiti in identifying implementation problems and taking remedial action. For example, the data reported in terms of individuals tested for HIV/AIDS for two sites were not accurate, and in one site, the individuals tested from the satellite clinics were not reported. These report deficiencies could have been detected and corrected with proper monitoring visits.

Civil unrest forced the evacuation of the all U.S. direct hire employees and U.S. private service contractors (collectively referred to as employees) in February 2004. Some employees were permitted to return to Haiti after six weeks, but some employees did not return for four months.[3] Even when in Haiti, travel restrictions and unscheduled office closings adversely impacted the ability of USAID/Haiti to monitor Emergency Plan activities. This resulted in the program having abrupt starts and stops, programming uncertainties, and a disruption in normal working hours. Likewise, the lack of an implementation plan for Emergency Plan activities prevented the Mission from establishing a monitoring plan to ensure that partners were progressing as expected to achieve intended results.

Without a monitoring and evaluation plan with which USAID/Haiti could monitor program implementation data received from the partners on a regular basis, the Mission could not measure the efficiency and effectiveness of the program and improve implementation, and it could not ensure that the partner progress reports were credible and useful. As a result, USAID/Haiti could not reliably determine if the Emergency Plan program was meeting its objectives or if part of the program would become sustainable.

A monitoring and evaluation plan should include well-defined performance indicators (including baselines and targets), and it should assign responsibility to personnel to periodically assess the quality of data reported by the partners. USAID/Haiti should verify and validate performance data to ensure that the information is accurate by (1) reviewing partner reports; (2) making site visits and conducting spot checks; and (3) holding discussions with partners on the importance of quality data. The monitoring plan should ensure that progress reports submitted by the partners are complete, accurate, and consistent.

> *Recommendation No. 4: We recommend that USAID/Haiti (a) develop a monitoring and evaluation plan that includes evaluating each partner's progress towards meeting Emergency Plan objectives such that accurate and complete program implementation information is ensured and to facilitate timely interventions to improve program results, and (b) recommend to the Emergency Plan team that it develop a similar monitoring and evaluation plan for all Emergency Plan partners.*

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[3] CDC/Haiti members of the Emergency Plan team were also covered by the evacuation order, and they did not all return to Haiti for a few months.

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

USAID/Haiti's HIV/AIDS activities contributed to the overall U.S. Government's Emergency Plan targets. However, since results are tracked at the country team level and not at the implementing agency level, isolating USAID/Haiti's contribution to the U.S Government's Emergency Plan achievements to-date at an individual activity level was not practical.

As of March 2005, 15 antiretroviral sites had been established by CDC and USAID/Haiti, and more than 3,900 patients including 212 pregnant women had received antiretroviral therapy services. The target was 4,000 patients treated by June 2005. Despite a drug supply crisis, the target was reached. Through a network of VCT/PMTCT services, 135,274 persons and 54,743 pregnant women have received the HIV tests. More than 2,000 heath workers had received training in PMTCT related services. Almost 35,000 people received palliative care. More than 900 people were trained to provide palliative care and over almost 1,500 trained on counseling and testing. Behavior change communications, including abstinence/be faithful messages through community outreach program or mass media reached over 900,000 people and another 6.8 million people were reached on other prevention strategies. Over 8,000 persons were trained on providing prevention services and over 2,000 orphans or vulnerable children received services.

In Haiti, both USAID and CDC play large, complimentary roles in the implementation of the Emergency Plan wherein their individual roles are geared towards their comparative advantages. It is not possible to disaggregate the results achieved by each without redirecting considerable effort and resources away from the Emergency Plan team's other implementation activities. The Country Operational Plan combines both USAID and CDC-financed activities. For example, in establishing "CDC" antiretroviral treatment centers, CDC finances the laboratory equipment, the medical expertise and the training of lab technicians while USAID builds or renovates the infrastructure, supports demand generation through social mobilization, and provides community-based wraparound services such as food or other reproductive health activities. So even though the center is considered a "CDC" center, USAID/Haiti contributed largely to the establishment of the center.

We did not compare the partners' results to the results described in the annual report to Congress on the Emergency Plan because often the partners did not distinguish between USAID- and CDC-funded activities in their reports.

Other Matters with Recommendations

Pressure for Immediate Results

ADS 300.2.1 states that accountability for results includes responding effectively to changes in the development and policy environment that affect the feasibility of results. The Emergency Plan is a goal-driven program that demands immediate results, and the Emergency Plan team went immediately from planning its programs to implementation. In order to meet the Emergency Plan targets, there was strong pressure to open antiretroviral therapy centers and put patients on antiretroviral drugs. Meeting targets

drove the Emergency Plan program without responding to changes in the field that affected the feasibility of results.

The supply of antiretroviral drugs did not keep pace with the opening of new antiretroviral therapy centers and the enrollment of new antiretroviral therapy patients. As was mentioned above, the in-country supply of antiretroviral drugs was at a crisis level in 2005. The Emergency Plan team knew that the antiretroviral drug supply was a problem, and yet it continued opening five new antiretroviral therapy centers in January, February, and March 2005 in St-Antoine Hospital/Jeremie, Grace Children's Hospital/Port au Prince, St-Michel Hospital/Jacmel, Hospital de Mirebalais, and Beraca Clinic/Port de Paix. Because of the antiretroviral drug crisis, all existing U.S. government-supplied antiretroviral therapy centers were told in March 2005 not to enroll new patients, and the antiretroviral therapy centers that were opened in 2005 were told to place only a limited number of new patients on antiretroviral drug therapy.

In addition to the drug crisis, the Emergency Plan team did not have a sufficient supply of HIV rapid tests due to the lack of a proper drug management and distribution system. At least two PMTCT/VCT centers did not have enough HIV rapid tests to provide pregnant women or the general population with HIV/AIDS testing. Rational Pharmaceutical had 200 Capilus tests in stock at the time of the audit, and therefore, PMTCT and VCT centers would not be able to continue to provide services unless more rapid tests were purchased. The Emergency Plan involves a large amount of money and accountability. The Emergency Plan team did not, however, have the commensurate flexibility to respond to demand. USAID/Haiti had to comply with USAID regulations and Federal laws and regulations regarding the hiring of employees, procurement, and contracting. These actions could not happen overnight, yet the Emergency Plan targets drove the program forward at a rapid pace.

The opening of new antiretroviral therapy centers was accompanied by a community awareness campaign to promote the new centers and their services. By opening and publicizing a new center that could treat only a severely limited number of patients, false expectations were created which were then deflated when the new antiretroviral therapy centers could not provide antiretroviral drugs to patients who qualified for treatment. This occurred because of the pressure to meet the Emergency Plan target of opening 11 antiretroviral therapy centers. Meeting targets by opening antiretroviral therapy centers was a hollow achievement when the new antiretroviral therapy centers could only provide antiretroviral drugs to an extremely limited number of patients.

> *Recommendation No. 5: We recommend that USAID/Haiti recommend to the Emergency Plan team that new antiretroviral therapy centers not be opened unless there are adequate drugs and other supplies available to enable a new antiretroviral therapy center to provide treatment to more than a limited number of patients.*

Lack of an Implementation Plan

ADS 200.3.2.1 states that managing for results means to define and organize work around end results USAID seeks to accomplish. This means making intended results explicit; ensuring agreement among partners and stakeholders that proposed results are worthwhile; and organizing day-to-day work and interactions to achieve results as

effectively as possible. Management Sciences developed an implementation plan for the four antiretroviral sites in its network. However, implementation plans ensuring a standard, complete implementation timeline were not prepared by the Emergency Plan team for all Emergency Plan antiretroviral sites to ensure that personnel would be trained prior to launching of new sites and to ensure that other pre-launch tasks were performed in an orderly, sequenced manner. For example, Hospital St. Antoine's antiretroviral site was launched on February 1, 2005, but the statistician and the site manager were not trained until March 2005. Further, the PMTCT counselor had not been provided training as of April.

Without an implementation plan, the risk that objectives might not be accomplished efficiently increased. There were efforts to coordinate the work of all partner organizations, but there was not a comprehensive implementation plan for the Emergency Plan that would have guided the team and all concerned agencies and donors and that would have facilitated the monitoring and evaluation of program implementation. This issue was reported not only by six partners but also by the HIV Coordinating Committee of the Ministry of Health.

An implementation plan was not developed due to a lack of staff, an extremely heavy workload due to Emergency Plan activities, a difficult operating environment that included a mandatory evacuation, the pressure to implement the Emergency Plan program immediately, and the pressure to produce immediate results. Without a well-defined implementation plan, however, the Mission was not able to clearly plan, coordinate, and monitor the implementation of the Emergency Plan program by the various partner organizations. Due to a lack of an implementation plan, communication with the partners often lacked clarity, and activities were not coordinated.

> *Recommendation No. 6: We recommend that USAID/Haiti recommend to the Emergency Plan team that it develop an implementation plan that takes into account all the key participants, identifies risks and constraints, and puts forward a complete program implementation timeline, including site assessments, facility preparation, delivery and installation of equipment, sensitization campaigns, training of site personnel, monitoring, and evaluation.*

Improved Fund Accountability

ADS 596.3.1 states that USAID managers and staff must develop and implement appropriate, cost-effective management controls to ensure that assets are safeguarded and revenues and expenditures are properly recorded and accounted for. In this regard, the USAID/Haiti financial management office did not have adequate financial information on the centrally funded (also known as Field Support) Emergency Plan projects implemented in Haiti. More specifically, even though USAID/Haiti was responsible for monitoring and implementing the Emergency Plan, the Mission did not have adequate financial information on U.S.-based organizations to ensure that the funds were used for intended purposes only and properly accounted for. The mission should coordinate with Single Act auditors, in order to determine whether the audit coverage is sufficient and if not, arrange for additional coverage and conduct financial reviews for these U.S.-based organizations implementing the Emergency Plan activities.

During FY 2004, the financial management office oversaw financial audits and performed, with the assistance of private accounting firms, financial reviews of the locally funded Emergency Plan partner organizations. However, the U.S.-based partner organizations that were centrally funded were not included in these financial reviews because USAID/Haiti was under the misconception that it could not conduct financial reviews of centrally funded partner organizations. As a result, the risk of loss was increased and the Mission could not ensure that funds were spent for intended purposes only.

Our review of some of these organizations' documentation, including audit reports on two centrally funded organizations prepared by local accounting firms, identified several internal control and compliance deficiencies: 1) an unreconciled difference between the balance stated on the fund accountability statement and the actual cash on hand; (2) a lack of compliance with the agreements' terms concerning the method of allocating commodities and indirect costs; and (3) a lack of supporting documentation in support of travel and salary expenses. These same organizations received funding from USAID and CDC as well as other donors to implement similar program activities under the Emergency Plan and we were unable to obtain reasonable assurance that USAID funds were used for intended purposes only and properly accounted for.

In order to ensure adequate fund oversight and accountability, we recommend that the Financial Management office develop a plan to conduct financial reviews to ensure that these organizations have acceptable financial management systems that control and account for USAID funds.

> *Recommendation No. 7: We recommend that USAID/Haiti coordinate with Single Act auditors, in order to determine whether the audit coverage is sufficient and if not, arrange for additional coverage and conduct financial reviews for these U.S.-based organizations implementing the Emergency Plan activities.*

Other Matters without Recommendations

The following information is provided for informational purposes only. We are not making any recommendations.

Sustainability – While the emergency plan focuses on treatment and care, attention to prevention would reduce the need for expensive treatment in the future and likely enhance the program's sustainability. USAID is concerned with sustainable interventions being put in Haiti and can leverage investments in primary health care and food programs to address the important health problems facing the country. More than 70 percent of the population lives below the poverty level and does not have enough food or access to safe water and other health programs. Treatment interventions would need to address these needs in order to be effective and would require enormous resources. It would be important for the Presidential plan program elements to be better integrated with USAID's other health and food components to strengthen performance and improve health outcomes.

The Emergency Plan program addressed sustainability issues by providing training to counselors, pharmacists, nurses, and doctors. The Emergency Plan also supported training of home health aides to perform routine follow-up and patient counseling for adherence to drug regimens. Sustainability was also addressed through the

strengthening of physical infrastructure including building renovations, water and electricity connections. The Emergency Plan also equipped laboratories and trained lab technicians.

Because HIV/AIDS activities are more likely to be sustainable if they are integrated with other services, USAID/Haiti co-located many PMTCT centers and four antiretroviral therapy centers in clinics in Management Sciences' network that provided general health services. The new HIV/AIDS services were integrated with the clinics' other programs.

While building up a trained work force reinforced sustainability, Management Sciences and others providing training noted that there was a large turnover of trained personnel at clinics. It was therefore necessary to provide on-going training for the new personnel. Linkages stated that it paid for the transportation and lodging for people that attended its training because not all the clinics could afford to pay these expenses.

The Emergency Plan is a five-year program, and it is intended to create a sustainable HIV/AIDS treatment program in the targeted countries. Everyone to whom we spoke told us that antiretroviral therapy is not sustainable in Haiti without outside assistance. Haiti is the poorest country in the Western Hemisphere, and the patients cannot begin to afford to pay for antiretroviral therapy. Virtually all the antiretroviral therapy being provided in Haiti is provided by foreign governments and organizations from outside Haiti. Given the depth of poverty in Haiti, it is not realistic to expect large-scale antiretroviral therapy to continue without outside assistance.

Contract Ceilings – Contract ceilings were placing an additional burden on USAID/Haiti. In FY 2004, USAID/Haiti bought into nine centrally-awarded contracts and/or grants to support the Emergency Plan program. These centrally-awarded contracts enabled USAID/Haiti to obtain services quicker than awarding a contract at the mission level. At the time of our audit, the contracts with Population Services and Family Health were at or near their contract ceilings, and the ceilings were not being increased. Even though the Mission was satisfied with the services of these partners, due to the contract ceiling, the Mission will have to spend valuable time and energy going through the procurement process in order to award contracts itself. Without the limitation of the contract ceilings, the Mission would be able to continue buying into the centrally-funded contracts and/or grants.

The contract with Rational Pharmaceutical was also centrally-awarded, and it was also subject to a contract ceiling. USAID/Haiti was purchasing drugs through Rational Pharmaceutical, and this contract ceiling would have presented a problem in January 2005 if USAID/Haiti had obtained the early release of FY 2005 funds for the purchase of drugs. As discussed elsewhere in this report, USAID/Haiti did not receive the FY 2005 funds until April 2005. In the same month, the contract ceiling for Rational Pharmaceutical was increased thereby allowing USAID/Haiti to purchase drugs through Rational Pharmaceutical.

Staffing and Transportation – The USAID/Haiti Population, Health and Nutrition (PHN) team is operating under a great amount of stress. As shown in Table No. 1, the funds managed by the PHN team, including Emergency Plan funds, increased from $22.1 million in 2002 to $53.7 million in 2005. Excluding the Emergency Plan, the PHN program grew by 52 percent in three years, and including the Emergency Plan, it increased by 143 percent. While PHN's workload multiplied, the professional staff only

increased by 3 to a total of 10, with only two direct hires creating enormous pressures on both the professional and administrative staff.

Table No. 1: Funds Managed by PHN

Year	PHN Budget	Emergency Plan Funds	Total Funds Managed by PHN
FY 2002	$22.1 million		$22.1 million
FY 2003	$26.4 million		$26.4 million
FY 2004	$31.5 million	$12.2 million	$43.7 million
FY 2005	$33.6 million	$20.1 million	$53.7 million

The demands of the Emergency Plan stretched the PHN staff thin, leaving little time to manage and monitor the programs. The Emergency Plan is a massive program that the team had to implement immediately, and it therefore added a tremendous burden in FY 2004. The staff worked long hours for over a year, including weekends, in order to implement the program and to meet the Emergency Plan targets. While the Emergency Plan involved a tremendous amount of work, at the same time the USAID/Haiti PHN team also had to manage its other population, health, and nutrition programs. Burnout was a real danger at the current work level.

To complicate matters further, there was an ordered evacuation of all USDH and USPSC employees in February 2004. The USAID/Haiti PHN Director returned after approximately six weeks; the other USDH employee did not return until May 2004.

USAID/Haiti was addressing the staffing issue in PHN. In addition to the three positions added to PHN in FY 2004, USAID/Haiti was in the process of adding four more positions in PHN. These positions were (1) a senior USPSC for monitoring and evaluation, (2) a senior USPSC for HIV/AIDS and infectious diseases coordination, (3) an FSN for the behavior change communication program, and (4) a technical writer working only on the Emergency Plan and other PHN programs. Additionally, at the time of field work, there was a vacant FSN financial program assistant position which PHN planned to filled.

Getting to the sites to monitor activities was also a problem. Because of the security situation in Haiti, trips outside the Port-au-Prince area were required to include at least two lightly armored vehicles. Lightly armored vehicles were also required when going to and from the USAID/Haiti office. PHN only had two vehicles, and when a PHN team member went to a site, PHN had to rely on the availability of other vehicles in USAID/Haiti's motor pool. Other vehicles were not always available, thereby restricting the ability of PHN team members to monitor activities and to attend meetings outside USAID/Haiti's office. PHN was in the process of issuing a purchase order for two lightly armored vehicles. One of the current PHN vehicles was being replaced, so there will be a net increase of one vehicle. PHN was considering the purchase of another vehicle to increase the PHN motor pool to four vehicles.

Marking – USAID/Haiti and CDC Haiti were the primary implementers of the Emergency Plan program in Haiti. Each agency had its own marking requirements and its own logo. The Global AIDS Coordinator also had a logo and was encouraging the use of its logo on equipment provided with Emergency Plan funds and at institutions receiving Emergency Plan funds. To add to the multiplicity of logos, partner organizations added

their logos to materials that they developed, and materials produced for the Ministry of Health also carried its logo. The Emergency Plan is an inter-agency program, and there needed to be consistency in marking policies in order to avoid confusion. A protocol needed to be developed that clearly set forth a marking policy.

Emergency Plan Fiscal Year – The Emergency Plan fiscal year runs for performance measurement from April 1 to March 31, whereas the Emergency Plan fiscal year for financial management runs from October 1 to September 30. Having different fiscal years was confusing to partner organizations, and it added needless complication to the Emergency Plan program.

Indicator Overload – The Global AIDS Coordinator indicators for Emergency Plan were described in 94 pages. The number of indicators to be reported on, as well as the number of reports to be submitted, created confusion, increased the workload, and reduced program efficiency. Efforts should be made to reduce and simplify data collection instruments and the number of indicators and to periodically evaluate Emergency Plan performance indicators in order to ensure that all indicators are necessary, relevant, and easily understood by all concerned.

EVALUATION OF MANAGEMENT COMMENTS

USAID/Haiti comments described some of the exceptional conditions in Haiti that made it difficult to implement the Emergency Plan and also provided some suggestions for future audits of Emergency Plan activities. USAID management concurred with the first six of seven recommendations that are included in this report and decided to take corrective measures in order to resolve the findings reported as well as to provide a plan to address the recommendations. Accordingly, we consider management decisions to have been reached on six of the seven recommendations.

With regard to the seventh recommendation, no management decision has been reached while the recommendation has undergone minor modifications to better reflect management's views. Accordingly, we have restricted our recommendation to the mission conducting financial reviews of some U.S.-based organizations if audit coverage is not sufficient under the Single Act.

SCOPE AND METHODOLOGY

Scope

The Regional Inspector General/San Salvador conducted this audit in accordance with generally accepted government auditing standards. Fieldwork for this audit was performed in Haiti from April 4 to 29, 2005, at USAID/Haiti and at various Emergency Plan partner organization offices as well as at program sites.

This audit is one of a series of worldwide audits, and it was designed to answer the following audit objectives: (1) How has USAID/Haiti participated in the President's Emergency Plan for AIDS Relief activities? (2) Did USAID/Haiti's HIV/AIDS activities progress as expected towards planned outputs in their grants, cooperative agreements and contracts? (3) Are USAID/Haiti's HIV/AIDS activities contributing to the overall U.S. Government's Emergency Plan targets?

In planning and performing the audit, we reviewed and assessed the effectiveness of USAID/Haiti's management controls related to the Emergency Plan. The USAID/Haiti management controls identified included the mission performance monitoring plan, the Country Operational Plan, the Mission's self assessment of management controls through its Annual Federal Managers Financial Integrity Act, the Financial Management Office Audit and Financial Review Plan, and the Portfolio Review. Interviews were conducted with Mission officials, cognizant technical officers, and implementing partners. A total of eight field visits to partner offices were conducted, five visits to antiretroviral treatment centers and eight visits to Voluntary counseling testing/Prevention of mother to child transmission/Orphans and vulnerable children clinics. In this regard, it should be noted that USAID/Haiti awarded $4.8 million to an umbrella organization working with more than 20 local partners as well as $6.1 million through centrally-funded awards.

We did not compare the partners' results to the results described in the annual report to Congress on the Emergency Plan because often the partners did not distinguish in their reports between activities funded by USAID and activities funded by the U.S. Centers for Disease Control and Prevention (CDC). Disaggregating the USAID-funded activities from CDC-funded activities as reported in the partner progress reports was not possible.

Methodology

To answer audit objective one, we reviewed USAID/Haiti's Country Operational Plan, and interviewed Mission officials, managers, technical officers and implementing partners. We interviewed representatives of the Global Fund, CDC, the Ministry of Health, the HIV/AIDS Coordinating office, and the Peace Corps.

To answer audit objective two, 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, observed the project's operations and tested data described in the progress reports. Testing consisted of reviewing the supporting documentation for selected months for selected activities. For example, for selected training activities, we reviewed the attendance lists

signed by the participants. Additionally, for selected months, we reviewed, among other items, the number of persons reported as being tested for HIV/AIDS, the number that were reported as testing positive, and the number of HIV-positive pregnant women receiving treatment to prevent the transmission of the HIV virus to their babies. This review consisted of comparing the monthly data reports submitted by clinics to Management Sciences for Health to the information report to USAID/Haiti and testing certain parts of this data during site visits to selected clinics. With regard to other partners, during our field visits we verified the accuracy of the reported data by comparing the laboratory register to the VCT/MTCT registers with respect to the number of individuals tested and the number of individuals testing HIV+. We also compared the number of tests performed by the laboratory to the monthly reports produced for the Emergency Plan.

To answer audit objective three, we reviewed the Emergency Plan Team's annual report, and reviewed the progress reports of implementing partners to compare planned outputs with progress. We conducted 13 site visits to meet with partners and beneficiaries involved in prevention, care, and treatment. We also observed the operation of facilities.

A materiality threshold was not established for this audit, as it was not considered to be applicable given the qualitative nature of the audit objectives, which focused on USAID/Haiti's participation, progress and contribution to the overall U.S. Government's Emergency Plan targets.

MANAGEMENT COMMENTS

July 15, 2005

Pamela Callen, Acting Mission Director USAID/Haiti

Management Comments on the RIG Draft Audit Report No. 1-521-05-0XX-P.

Timothy E. Cox, Regional Inspector General (RIG/San Salvador)

I am pleased to send you the USAID/Haiti response to the recent audit of the Mission's contribution to the PEPFAR/Haiti program. I realize this was a very labor-intensive and time-consuming effort for your auditors and my own staff. We appreciated their openness and collaborative working style during the exercise.

I might make one suggestion to the RIG for future audits. The audit team did their best to review the kilos of background documents the Mission sent in advance of the trip and become familiar with the complex PEPFAR program. This continued to take up a great deal of time and effort of the audit team itself and the Haiti PHN office, and several days of potential field visits were spent learning about basic PEPFAR issues. Soon after arriving in Haiti they realized that PEPFAR is much more complicated and intricate than they had understood, and the RIG was forced to both extend their stay in Haiti and add a third auditor to their team to manage the volume and complexity of the audit. Given that the IG had already audited other PEPFAR countries and several IG auditors had become familiar with the details of the worldwide PEPFAR program, it would have been very helpful to have at least one IG staff member who had already participated in at least one of these audits participate as a member of the PEPFAR/Haiti audit team.

After working with the PEPFAR program for two years it has become apparent to us that the high degree of integration and interdependence of the several USG agency interventions under PEPFAR call for a program-wide assessment, rather than single-agency audits, to provide truly meaningful information for improving strategic management of the overall USG response to the epidemic. At many times during the Haiti audit it was clear that key pieces of the program, those under the responsibility of CDC, were missing and would have completed the picture if included in the same overall report. I will look forward to this more holistic view in the future.

This memorandum constitutes USAID/Haiti's response to the Regional Inspector General (RIG) Draft Audit on USAID/Haiti's Implementation of the President's Emergency Plan for HIV/AIDS Relief (Report No. 1-521-05-0XX-P)

General Comments:

After completing the review of the Draft Audit Report, the Mission has some specific comments to make regarding the Background and Environment section of the report which are summarized as follows:

It is critical to provide a complete picture of the overall PEPFAR initiative, management structure, and approach to technical direction. It is also critical to understanding the PEPFAR/Haiti program that the reader understands the integrated nature of the initiative as a consolidated USG program. Following the strong directive from the White House, results are defined by country program, not by individual agency. And targets are not disaggregated by agency contribution. Focusing on these types of divisions undermines the unified program PEPFAR/Haiti is working hard to create. It is also important to fully understand the security and working environment in Haiti during 2004 and 2005. Chronic instability and violence had a major impact on the ability of the USG and partners to accomplish even basic tasks.

PEPFAR worldwide overview. The President's Emergency Plan for AIDS Relief (PEPFAR) is a $15 billion, five-year program to combat HIV/AIDS worldwide, with emphasis on 15 focus countries. It provides $9 billion in new funding to speed up prevention, treatment and care services. PEPFAR 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 for AIDS Tuberculosis and Malaria[4] (GFATM) by $1 billion over five years. The worldwide goal over five years is to provide treatment to 2 million HIV-infected people, prevent 7 million new HIV infections, and provide care and support to 10 million people affected by HIV/AIDS, including patients and orphans. In Haiti, the goal is to provide treatment to 25,000 HIV-infected people, prevent 122,307 HIV infections, and provide quality care and support services to 125,000 persons who are infected and/or affected by HIV/AIDS. Haiti's 2004 PEPFAR budget was roughly $22 million and was shared evenly between USAID and the Department of Health and Human Services (HSS), mostly to CDC. The ambitious short-term PEPFAR program goals present specific challenges to creating sustainable in-country implementation capacity and leadership, objectives normally requiring longer-term engagement.

The Administration has made clear to all participating U.S. Government (USG) agencies that PEPFAR shall be implemented, managed, and evaluated as a single unified program, and that employees from specific agencies are to "leave your uniforms at the door" when discussing the program. Isolated, agency-specific strategies, 'branding' of activities, or reporting have been strongly discouraged by PEPFAR senior leadership, and all program interventions are referred to simply as PEPFAR. PEPFAR/Haiti is implemented jointly by USAID and CDC and supports Haiti's national response to the epidemic. The comprehensive program depends on both USG agencies planning, designing, implementing, monitoring and reporting on joint results. This combined technical group is commonly referred to by partners simply as the USG Team. While each agency manages separate resource streams for tracking funds to awardees, the program components are completely interdependent. The only reportable targets are consolidated country-level results, so that if one agency fails to produce critical inputs, the other will

[4] The Global Fund is a partnership among governments, civil society, the private sector and affected communities that raises money to fight AIDS, tuberculosis and malaria.

also not succeed. The key to PEPFAR's success or failure as a USG program will be the effectiveness of coordination among USG agencies for unified response. Therefore, since this audit covered performance by USAID only, it provides a distinctly incomplete picture of PEPFAR program and its impact in Haiti. In order to generate a meaningful assessment of results achieved in Haiti's increasingly insecure environment it will be necessary to audit the entire program and the coordinated inputs of all participating agencies.

PEPFAR planning and direction is highly centralized in the newly created Office of the Global AIDS Coordinator (OGAC) in Washington. Specific technical program areas, budgets, performance measures and reporting systems and to a large extent, choice of implementing partners, are strongly guided by OGAC. OGAC has mandated a standardized annual country operational plan (COP) from each of the 15 focus countries as a perquisite for annual funding. The annual funding request is submitted to OGAC according to a fixed schedule through the COP, describing activities to be carried out and results to be achieved for the funds available for that country. Annual schedules for the COP, actual funds disbursements and reporting cycles do not allow for lengthy implementation periods or drawing lessons learned from one year's programming before the plan for the next year must be developed and submitted. The submission deadline for COP for 2004 to OGAC was June 2004, with funds disbursed to USAID/Haiti in August 2004. Some implementing partners received their 2004 funds in September 2004, while USAID and the USG/Haiti team was required to submit their semi-annual progress report for 2004 in October for the period ending September. The annual report for 2004 was required in March 2005. Literally weeks after many partners began implementing activities for 2004, USAID and CDC were required to submit the COP for 2005 in November 2004. This will not allow for highly informed improvements in program design or monitoring from one year to the next, and kept the USG team very busy in an extended and labor-intensive planning exercise for much of the year.

The PEPFAR program also receives an extreme degree of scrutiny from Congress and OGAC, and has required regular reporting against an extensive list of over 120 specific performance indicators for standardized reporting from each PEPFAR country. This 96-page list of indicators, definitions of key measurement issues, and reporting formats have continued to evolve over the first 24 months of the PEPFAR initiative. Some of these indicators represent special interest areas for Congress or the US Government as a whole, and are not immediately relevant decision-making for PEPFAR to field operations. This has presented challenges to focus countries to establish reliable data gathering and analysis structures for the level of detail required. PEPFAR results are measured for the country level across all agencies, and as a single USG program, and it is therefore not relevant to disaggregate these targets by USG agency.

Haiti environment: The working environment in Haiti in 2004 and 2005 was characterized by chronic and extreme insecurity, civil unrest, and limited travel within the country. Haiti's elected president was forced from office in early 2004 and Haiti became progressively more unstable due to gang violence and threats from various armed para-military factions. Most American staff from USAID and CDC were evacuated from Haiti in February 2004 and remained outside the country at least two months. The now far-

flung USG Haiti team continued to develop the 2004 COP by email and telephone, with only one specially arranged face-to-face working session in Washington with OGAC colleagues and staff in Haiti participating by phone. The USG team eventually submitted the 2004 COP on time to OGAC, with no allowances or special consideration fro the extreme difficulty of operating in Haiti during this time.

For the remainder of this year, routine work in the USAID offices was frequently disrupted by violence in surrounding streets and inability to move freely about the city. Important meetings and working sessions dealing with PEPFAR often needed to be moved to safer locations in the capital, including certain partner offices and larger hotels, to ensure key participants would be able to attend and the discussions would not be curtailed by orders to leave the building due to rumors of further violence. For several weeks, the combined USG team held technical PEPFAR COP design meetings in rented hotel space to ensure uninterrupted working sessions. A critical PEPAFR planning meeting with the MOH and over 30 key Haitian partners was moved from Haiti to Miami due to rising insecurity and potential for disruption in Port au Prince. Several USAID staff have been attacked or car-jacked en route to and from the USAID office. All of this was extremely disruptive to program design and management, and severely hampered the ability of the team to develop a seamless and coherent program for 2005 and effectively manage the ongoing program. As this report goes to press, violence and insecurity continues to worsen in Haiti and working conditions for USG and other partners are becoming progressively more difficult. Many Haitian professionals have already left Haiti for more stable lives elsewhere.

Prior USAID investments in the health sector. It is important to note that PEPFAR arrived in Haiti after many years of investment by USAID in health and other sectors. The narrow parameters of allowable PEPFAR activities therefore are constructed on this base of essential health services and management capacity. Basic services upon which PEPFAR activities are designed include prenatal care and reproductive health services, all basic clinical care and laboratory capacity (much of USAID's prior investment was geared toward malaria and tuberculosis control), and an extensive network of community-based and outreach services for child health and family health promotion. USAID had also invested significant resources in management and other public health skills training for NGO and MOH staff. The ongoing USAID non-PEPFAR health portfolio in 2004 amounted to roughly $20 million, and provided direct services through over 100 clinics nationwide, plus targeted institutional capacity building to the MOH and NGOs. Without these extensive and ongoing investments, PEPFAR would have been required to expend considerable additional resources to accomplish the results from the 2004 COP.

Within this program, over 30 USAID-funded NGOs were mandated to initiate HIV testing and counseling services, along with activities to prevent mother to child transmission of HIV, beginning in late fiscal year 2003. The PEPFAR 2004 COP continued the approach to integrate these activities into routine health services. Other HIV prevention and behavior change activities had been ongoing through the USAID program for over 10 years. Since HIV testing and clinical care only began in earnest in Haiti in 2003. USAID's community health program provided an integrated package of

services in one location, including childhood vaccinations, treatment for diarrhea, screening for sexually transmitted infections, and screening for tuberculosis. This integrated approach was designed to encourage people to come to the centers without fear that other people would know that they had HIV/AIDS. MSH also tried to co-locate the centers near food programs because if there were a cluster of services in one area, more people would come to the clinic for voluntary counseling and testing and PMTCT services.

In addition, the USAID/Haiti Title II food security program provides critical nutritional inputs to address malnutrition and poverty among Haiti's most vulnerable groups—pregnant women and their children. There are over 800 food distribution points around the country that serve as a magnet for identifying and integrating health services. As with other basic development interventions, years of USAID/Haiti investment and support to Haiti's fragile social sector are now strongly supporting the success of PEPFAR to exceed most of its targets.

PEPFAR is a five-year program, and it is intended to rapidly create HIV/AIDS treatment programs in focus countries. All people interviewed in Haiti felt that antiretroviral therapy is not sustainable in Haiti without outside assistance. Haiti is the poorest country in the Western Hemisphere, and the patients cannot begin to afford to pay for antiretroviral therapy. Virtually all the antiretroviral therapy being provided in Haiti is provided by foreign governments and organizations from outside Haiti. Given the depth of poverty in Haiti, it is not realistic to expect large-scale antiretroviral therapy to continue without outside assistance.

Specific PEPFAR/Haiti background. USAID and CDC are the primary USG agencies implementing PEPFAR in Haiti, and coordinate closely on action planning and overall program decisions. But the two agencies follow distinctly different program management approaches. USAID is an overseas sustainable development agency, and conducts long-term integrated programs, usually through host country and international NGO implementers. Procurement and program management are highly decentralized in country missions. CDC is a primarily a domestic agency and conducts its work through a large cadre of direct-hire technical staff. Procurement and grant-making are centralized in Atlanta.

These different organizational cultures presented continuing challenges for the USG team to capitalize on the relative strengths and comparative advantages of each agency. By agreement of the joint USG team, USAID was the lead agency for orphans and vulnerable children (OVCs), palliative care, prevention, and drug logistics. CDC was the lead agency for data management, laboratory services and clinical transmission (blood safety and injection safety). Both agencies jointly managed ARV clinical care. Both funded the same implementing agencies to carry out similar activities under the COP 2004. This caused confusion among those partners and did not noticeably increase the quality or speed of implementation. Overall in-country leadership and coordination of PEPFAR rests with the USG Chief of Mission. Unfortunately, the embassy staff was completely absorbed by the worsening political and security crisis in Haiti throughout 2004. CDC and USAID were largely left to design and manage the program on their own.

Several other PEPFAR focus countries have assigned a senior-level PEPFAR Country Coordinator to oversee and arbitrate between agencies when consensus cannot be reached. The USG Haiti team had not opted for this staffing strategy as of this audit.

USAID specific management background:

Contract ceilings on USAID implementing mechanisms also placed an unnecessary additional burden on USAID/Haiti. In FY 2004, USAID/Haiti bought into nine centrally-awarded contracts to support the PEPFAR program. These centrally-awarded contracts enabled USAID/Haiti to obtain services more quickly and easily than awarding a contract at the mission level. At the time of our audit, the contracts with PSI and FHI were at or near their contract ceilings, and the ceilings were not being increased. Even though the Mission was satisfied with the services of these partners, due to the contract ceiling, the Mission will have to spend valuable time and energy going through the procurement process in order to award contracts itself. Without the limitation of the contract ceilings, the Mission would be able to continue buying into the centrally-funded contracts.

Staffing and Transportation – The USAID/Haiti Population, Health and Nutrition (PHN) team is operating under a great amount of stress. The funds managed by the PHN team, including PEPFAR funds, increased from $22.1 million in 2002 to $53.7 million in 2005. Excluding PEPFAR, the PHN program grew by 52 percent in three years, and including the PEPFAR, it increased by 143 percent. While PHN's workload multiplied, the professional staff only increased by 3 to a total of 10, with only two direct hires creating enormous pressures on both the professional and administrative staff.

The demands of PEPFAR stretched the PHN staff thin, leaving little time to manage and monitor the programs. The PEPFAR is a massive program that the team had to implement immediately, and it therefore added a tremendous management burden in FY 2004. The staff worked long hours for over a year, including weekends, in order to implement the program and to meet the PEPFAR targets. While the PEPFAR involved a tremendous amount of work, at the same time the USAID/Haiti PHN team also had to manage its other population, health, and nutrition programs. Burnout is a real danger at the current work level.

USAID/Haiti was addressing the staffing issue in PHN. In addition to the three positions added to PHN in FY 2004, USAID/Haiti was in the process of adding four more positions in PHN. These positions were (1) a senior USPSC for monitoring and evaluation, (2) a senior USPSC for HIV/AIDS and infectious diseases coordination, (3) an FSN for the behavior change communication program, and (4) a technical writer working only on the PEPFAR and other PHN programs. Additionally, at the time of field work, there was a vacant FSN financial program assistant position which PHN planned to fill.

Travel to PEPFAR sites to monitor activities was a problem. Because of the security situation in Haiti, trips outside the Port-au-Prince area were required to include at least two lightly armored vehicles. Lightly armored vehicles were also required when going to and from the USAID/Haiti office. PHN only had two vehicles, and when a PHN team member went to a site, PHN had to rely on the availability of other vehicles in

USAID/Haiti's motor pool. Other vehicles were not always available, thereby restricting the ability of PHN team members to monitor activities and to attend meetings outside USAID/Haiti's office. PHN was in the process of issuing a purchase order for two lightly armored vehicles. One of the current PHN vehicles was being replaced, so there will be a net increase of one vehicle. PHN was considering the purchase of another vehicle to increase the PHN motor pool to four vehicles.

USAID/Haiti Responses to Specific Recommendations:

Recommendation No. 1: We recommend that USAID/Haiti (a) make a determination as to whether or not to implement the drug management software provided by Rational Pharmaceutical Management Plus, and (b) if it decides to implement the software, set a schedule for the implementing the software and a plan for providing support to the users of the software.

Mission response to recommendation No. 1:

USAID/Haiti has decided to continue implementation of the RPM+ drug management software. Specific deliverables and performance schedule are being updated in the 2005 PEPFAR detailed action plan.

ARV Drug management issues:

USAID was charged with procurement and management of ARV drugs for all PEPFAR sites, as well as direct operational support to four ARV treatment sites. In early 2005, the PEPFAR program was faced with an ARV drug crisis, though this later became apparent as an artificially generated situation.

ARV drugs were budgeted in sufficient quantities in 2004 by PEPFAR/Haiti, the Global Fund and sub-recipients, and Haiti Track 1.0 recipient CRS Consortium to ensure uninterrupted care for more patients than the annual PEPFAR target of 3,800 by March 2005. Global Fund counterparts repeatedly assured USAID/Haiti staff that ARV supply was not a problem, as Haiti's Global Fund budget included ARVs for 3,650 patients that year through GHESKIO, Partners in Health (PIH) and the Albert Schweitzer Hospital (HAS in French). In addition, PEPFAR/Haiti had purchased drugs for 1,500 patients and the CRS Consortium had received funds from OGAC to directly treat 900 ARV patients.

In February 2004, GHESKIO made an emergency request to PEPFAR for ARV drugs, not stating that the organization had sufficient budget from the Global Fund to purchase drugs for all the patients they would treat that year (up to 1,500 patients), and that their stock crisis was a result of administrative process, rather than a permanent obstacle. The USG Team acted quickly to assist GHESKIO based on information available, but soon learned that this initial crisis was in fact artificial. By November 2004, it was clear that these other sources of ARV drugs were not fulfilling their engagements and ARV stocks actually delivered by all partners would not cover the caseload. There would be serious stock-outs by April 2005.

In December 2004, USAID/Haiti received approval from OGAC for early disbursement of COP 2005 funds to initiate ARV purchases in January 2005, and ensure delivery in Haiti before in-country stocks would expire in April 2005. While waiting for these funds to be released from OGAC to USAID and the drugs to be ordered, GHESKIO and other treatment sites slowed recruitment of new patients considerably to remain within available drug supplies.

As time passed, USAID/Haiti discovered that other partners funding ARVs had not completely fulfilled their procurement engagements, and PEPFAR/Haiti supplies were being expended much faster than anticipated. The USG team has taken steps to ensure more transparent inventory management and procurement collaboration to improve the collective efficiency of the ARV program in the future. The USG will soon sign an MOU with the Global Fund and MOH to formalize this cooperation.

Logistics and tracking. The forecasting and distribution of HIV rapid tests, lab equipment and other materials under the responsibility of CDC were not included in the scope of work of the drug management partner RPM+. RPM+ attempted to assist the CDC in storage and delivery of large amounts of non-expendable property on an ad hoc basis to prepare sites for service launch. No clear and concrete procurement or distribution plan for these materials was available in advance of delivery requirements, and requests generally arrived to RPM+ at the last minute for urgent action, requiring re-programming of staff and assets. Attempts by RPM+ to help with management of these stocks and other ad hoc materials delivery for the CDC proved problematic and seriously detracted from their ability to focus on their primary tasks and program deliverables, notably the roll-out of the computerized drug tracking system.

Recommendation No. 2: We recommend that USAID/Haiti include clearly defined planned outputs, with completion dates, for all activities in the partners' work plans.

Mission response to recommendation No. 2:

USAID/Haiti agrees completely with this recommendation, and had already developed a new planning and monitoring approach based on experiences from 2004 by the time of the audit. The Mission has developed a simple action planning template and monitoring methodology to greatly improve and simplify program monitoring for specific contractors and grantees, as well as tracking of progress towards program results, for 2005. The template closely resembles action plans previously developed by PEPFAR partners and is simple to complete. The Excel-based format includes basic information on each activity to identify the geographic location, estimated cost and expended funds, specific deliverable expected for that activity (for example, 100 nurses trained in HIV counseling), the date by which the activity is to be completed, the PEPFAR results indicator to which the activity contributes and quantitative contribution (if this direct link is feasible), and the persons responsible for that activity within the contractor/grantee organization and on the USAID/CDC team.

The USG team, lead by USAID, has conducted several technical workshops with all PEPFAR partners and MOH counterparts to introduce this planning and monitoring format, and has held separate working sessions with each partner to ensure they fully understand the exercise and complete the form correctly. All partners have submitted their COP2005 action plans in this format as of July 2005. Due to continued extreme insecurity in Haiti and implementation difficulties, all these plans are being updated for contingencies and activities prioritized together with USG staff. USAID and CDC technical staff will conduct a rapid review of all planned activities for each partner each month, noting which activities planned for that month are completed, estimated funds actually expended on each activity, and actual achievement against planned deliverables (20 nurses trained in counseling compared to 25 planned, for example). Reporting data will be verified by field visits to the extent possible. This system will help USAID and CDC remain focused on essential program elements and provide a clear and unambiguous reporting exercise for partners.

Because the template is Excel based, the action plans are easily aggregated into a single consolidated PEPFAR plan for Haiti. This overall plan can be quickly analyzed and generate reports on funds budgeted and expended for any category of activities for any given time during the year (extract an overall training plan and budget, with fund pipeline, for example). If the simple information is correctly updated each month, the template will easily generate reports on achievement of deliverables for each contractor or grantee, greatly facilitating more focused and concrete performance monitoring.

USAID/Haiti is confident this simple system will help keep technical staff and partners focused on essential program monitoring elements and provide a formal, completely transparent performance record of the PEPFAR program. Partners and Ministry of Health counterparts are enthusiastic about this new approach.

Recommendation No. 3: We recommend that USAID/Haiti (a) develop and disseminate to partner organizations a table or annex template that facilitates performance reporting and includes clearly-defined progress indicators; (b) provide partner organizations with training such that the partners are able to accurately report on their performance, and (c) recommend to the Emergency Plan team that this be done for all Emergency Plan partner organizations.

Mission response to recommendation No. 3:

USAID/Haiti agrees with this recommendation, though wishes to point out that by agreement of the joint USG team; the CDC was given primary responsibility for developing and managing the overall monitoring and evaluation component of the PEPFAR/Haiti program. All resources and level of effort for M&E were budgeted under CDC for 2004 and 2005. That said, this issue is partly resolved by implementation of the new action planning and monitoring system described under Recommendation No 2.

Recommendation No. 4: We recommend that USAID/Haiti (a) develop a monitoring and evaluation plan that includes evaluating each partner's progress towards meeting Emergency Plan objectives such that accurate and complete program implementation information is ensured and to facilitate timely interventions to improve program results, and (b) recommend to the Emergency Plan team that it develop a similar monitoring and evaluation plan for all Emergency Plan partners.

Mission response to recommendation No. 4:

As with recommendation No. 3, the M&E component was the task of CDC under the PEPFAR/Haiti program.

For process measures, the Mission agrees with the need to monitor performance of each contractor, and measure progress against deliverables and indicators. Achievement of planned deliverables is tracked in the systems described under Recommendation No. 2. Those partner activities that can be directly linked to overall PEPFAR country-level indicators are linked to those indicators in this same action planning template, and quantifiable progress can be easily tracked. For example, a specific activity to train health workers in prevention of mother to child transmission will directly support the official indicator "Number of health workers newly trained or retrained in the provision of PMTCT services". However, most PEPFAR indicators measure higher-level achievements like numbers of people actually receiving a specific type of treatment. These results require multiple inputs (staff trained, equipment installed, drugs delivered, community education completed, etc) and it is misleading to try to quantify the contribution towards this indicator of any one of these sub-activities, which are carried out by different partners.

Recommendation No. 5: We recommend that USAID/Haiti recommend to the Emergency Plan team that new antiretroviral therapy centers not be opened unless there are adequate drugs and other supplies available to enable a new antiretroviral therapy center to provide treatment to more than a limited number of patients.

Mission comments to recommendation No. 5:

USAID/Haiti agrees that scale-up of services must not move faster than the ability of the program to ensure that those services will be delivered at an acceptable quality standard, and without interruption. Placing new patients on anti-retroviral drugs certainly requires a stable and uninterrupted supply of medication for each new patient recruited. However, the supply and clinical service situation in 2004 was much more complicated than the drug supply chain only. USAID and CDC had obtained assurances that drugs would be available in sufficient quantities to continue expanding services, both from PEPFAR and the Global Fund, and so continued to open planned new sites with limited patient numbers until March 2005. No patients missed a day of treatment during this time. Critical factors for placing new patients on treatment include ARV drug supply, the fixed investment in establishing clinical treatment and laboratory capacity, and clinical skills and experience of health workers.

First, ARV drugs were budgeted in sufficient quantities in 2004 by PEPFAR/Haiti, the Global Fund and sub-recipients, and Haiti Track 1.0 recipient CRS Consortium to ensure uninterrupted care for more patients than the annual PEPFAR target of 3,800 by March 2005. Global Fund counterparts repeatedly assured USAID/Haiti staff that ARV supply was not a problem, as Haiti's Global Fund budget included ARVs for 3,650 patients that year through GHESKIO, Partners in Health (PIH) and the Albert Schweitzer Hospital (HAS in French). In addition, PEPFAR/Haiti had purchased drugs for 1,500 patients and the CRS Consortium had received funds from OGAC to directly treat 900 ARV patients. By November 2004, it was clear that these other sources of ARV drugs were not fulfilling their engagements and ARV stocks actually delivered by all partners would not cover the caseload. There would be serious stock-outs by April 2005. In December 2004, USAID/Haiti received approval from OGAC for early disbursement of COP 2005 funds to initiate ARV purchases in January 2005, and ensure delivery in Haiti before in-country stocks would expire in April 2005. While waiting for these funds to be released from OGAC to USAID and the drugs to be ordered, GHESKIO and other treatment sites slowed recruitment of new patients considerably to remain within available drug supplies. As time passed, USAID/Haiti discovered that other partners funding ARVs had not completely fulfilled their procurement engagements, and PEPFAR/Haiti supplies were being expended much faster than anticipated.

Second, a major element in the decision to launch new sites, despite limited availability of ARV drugs, was he fixed investment and considerable required to prepare a new site, regardless of the initial patient load. Launching ARV services at a new clinical site requires roughly the same level of time, effort and infrastructure whether the clinic will initially treat 10 patients or 100. Clinical and other staff must be trained Minimum equipment and furniture must be installed for laboratory and clinical services, and at least some degree of minor renovations is usually necessary to establish confidential counseling and treatment spaces. Even beginning with a small number of patients, these new sites would be positioned to rapidly expand their caseload once drugs were more available. The clinicians at these sites would have improved their new clinical skills and familiarity with the treatment regimens and patient management. Other support staff in the clinic will have become more familiar managing drug supplies, reporting and patient records, outreach and adherence monitoring, and other key services. Waiting until all drugs were available for the ultimate target patient numbers would have caused unnecessary delays at that later date.

As noted elsewhere in the audit report, there is enormous pressure from the Administration and OGAC for PEPFAR focus countries to reach their centrally imposed country targets. This pressure serves as the backdrop for virtually everything that happens in the Haiti program. Were this period in PEPFAR/Haiti's history to be repeated, the team would probably decide again to open these new treatment sites in order to position them for rapid scale-up upon delivery of additional ARV drugs. USAID/Haiti staff would ensure more active forecasting of needs and projected ARV deliveries by all partners to apply pressure to respect procurement engagements.

Recommendation No. 6: We recommend that USAID/Haiti recommend to the Emergency Plan team that it develop an implementation plan that takes into account all the key participants, identifies risks and constraints, and puts forward a complete program implementation timeline, including site assessments, facility preparation, delivery and installation of equipment, sensitization campaigns, training of site personnel, monitoring, and evaluation.

Mission comments to recommendation No. 6:

Mission agrees with this recommendation. All of these elements are included in the action planning exercise described under Recommendation No. 2.

That the USAID/Haiti PEPFAR audit is unable to make recommendations directly to the overall PEPFAR/Haiti program, as in recommendations No. 5 and No. 6, supports USAID's opinion that an audit or evaluation of only one agency under the integrated USG PEPFAR/Haiti program does not generate complete and meaningful management recommendations for decision-making.

Recommendation No. 7: We recommend that USAID/Haiti include centrally-funded partner organizations in its monitoring plans and develop a plan to conduct financial reviews of these organizations to ensure that their offices in Haiti have acceptable financial management systems that control and account for USAID funds.

Mission comments to recommendation No. 7:

The USAID/Washington Office of Procurement has made very clear to country missions that no reporting or performance requirements shall be imposed on centrally funded and managed contracts or agreements in addition to those already negotiated in their legal agreements with USAID. The Cognizant Technical Officers (CTOs) for these agreements are based in USAID/Washington, and country mission technical officers have no authority to make direct requests or give directives to these partners. USAID/Haiti is therefore not authorized to require any special financial review or reporting from any of these centrally-managed partners. However, the Haiti PHN office has begun to receive minimal quarterly financial updates from all field support partners. This report shows only three numbers; the total amount received from USAID/Haiti, the estimated expenditures from the quarter, and estimated expenditures for the following quarter. The Mission will not ask for more information than this, and any partner may choose not to furnish this report. This information provides a rough informal quarterly pipeline for the overall PHN portfolio. The Mission will place more emphasis on the action plan and monitoring tool described under Recommendation No. 2 above for program management.

In closing, USAID/Haiti would again like to express its appreciation for the manner in which the audit was conducted and the usefulness of some of the recommendations contained therein.

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