OFFICE OF INSPECTOR GENERAL

AUDIT OF USAID/SOUTHERN AFRICA'S HIV/AIDS TREATMENT ACTIVITIES

AUDIT REPORT NO. 4-674-11-009-P
JULY 20, 2011

PRETORIA, SOUTH AFRICA

Office of Inspector General

July 20, 2011

MEMORANDUM

TO: USAID/Southern Africa Mission Director, Jeff Borns

FROM: Regional Inspector General/Pretoria, Christine M. Byrne /s/

SUBJECT: Audit of USAID/Southern Africa's HIV/AIDS Treatment Activities (Report Number 4-674-11-009-P)

This memorandum transmits our final report on the subject audit. We considered management's comments on the draft report and have incorporated them here as appropriate. Management comments have been included in their entirety in Appendix II.

The report includes six recommendations to strengthen the mission's HIV/AIDS treatment activities. Based on management's comments on the draft report and supporting documentation provided, we consider that management decisions have been reached on all six recommendations. Please provide the Office of Audit Performance and Compliance Division with the necessary documentation to achieve final action on Recommendations 1–6.

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

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CONTENTS

Abbreviations

The following abbreviations appear in this report:

ADS	Automated Directives System
AOTR	agreement officer's technical representative
CDC	Centers for Disease Control
COP	Country Operational Plan
COTR	contracting officer's technical representative
FPD	Foundation for Professional Development
FY	fiscal year
GPRA	Government Performance and Results Act
JSI	John Snow Inc.
OGAC	Office of the Global AIDS Coordinator
PEPFAR	President's Emergency Plan for AIDS Relief
RHRU	Reproductive Health & HIV Research Unit

SUMMARY OF RESULTS

In 2003, the United States launched the President's Emergency Plan for AIDS Relief (PEPFAR)[1] in response to the global HIV/AIDS pandemic. In 2008, the U.S. Congress authorized up to $48 billion to continue this effort over the next 5 years.[2] Of this amount, $39 billion is for contributions to the Global Fund to Fight AIDS, Tuberculosis and Malaria and for bilateral HIV/AIDS programs between the United States and host countries such as South Africa.[3] Through these bilateral programs, the United States works in partnership with host countries. In its HIV/AIDS activities, USAID focuses on increasing the number of persons receiving antiretroviral therapy and on building sustainable local capacity for HIV/AIDS treatment.

With 5.7 million of its 48.3 million citizens infected with HIV, South Africa has the world's largest population living with HIV/AIDS, as well as the world's largest treatment program. As of 2009, approximately 950,000 South Africans were on treatment, but that number represented less than 50 percent of those needing treatment. In recent years, the South African Government has supported the majority of treatment costs, including procurement of almost all public-sector antiretroviral drugs, with PEPFAR providing for less than 10 percent of antiretroviral drug needs.[4] However, in 2009 the United States pledged an additional $120 million in one-time funding for antiretroviral drugs in response to a direct request from South African President Jacob Zuma.

USAID/Southern Africa's HIV/AIDS treatment activities in fiscal year (FY) 2009 were designed to contribute to the overall U.S. Government goal of treating 675,000 South Africans.[5] In addition, USAID activities supported strengthening the South African health-care system and promoting the use of strategic information in health management. To achieve these goals, USAID/Southern Africa entered into agreements with 13 implementing partners. These implementing partners worked with the South African Government and communities to increase the number of patients on antiretroviral treatment while helping to develop local treatment capacity. This audit focused on the four largest agreements, as listed below.

1. Anova—a 5-year (October 1, 2007–September 30, 2012) cooperative agreement with a ceiling of $106,607,000.

2. Right to Care—a 5-year (October 1, 2007–September 30, 2012) cooperative agreement with a ceiling of $173,805,000.

[1] The United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003, Pub. L. No. 108-25 (codified as amended in scattered sections of 22 U.S.C.).
[2] Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008 (P.L. 110-293).
[3] The fiscal year (FY) 2009 PEPFAR budget for South Africa was $551 million, of which $309 million was managed by USAID. From PEPFAR's inception in 2003 through FY 2010, the United States provided more than $2.4 billion in cumulative funding for use in South Africa.
[4] Information memorandum from the Office of the U.S. Global AIDS Coordinator regarding antiretroviral drug support in South Africa in fiscal year 2009.
[5] Although USAID/Southern Africa is a regional mission overseeing programs in several countries, this audit focuses exclusively on activities conducted in the Republic of South Africa.

3. Foundation for Professional Development (FPD)—a 5-year (October 1, 2007–September 30, 2012) cooperative agreement with a ceiling of $136,097,000.

4. Wits Health Consortium/Reproductive Health & HIV Research Unit (RHRU)—a 5-year (October 1, 2007–September 30, 2012) cooperative agreement with a ceiling of $115,405,000.

In addition to these agreements, the mission entered into a 5-year, $22.9 million contract with John Snow Inc. to improve data management and use in HIV/AIDS programs in South Africa. This contract is scheduled to end in July 2013.

The Regional Inspector General/Pretoria conducted this audit at USAID/Southern Africa to determine whether the mission's HIV/AIDS treatment activities were achieving their main goals. Specifically, the audit sought to determine whether those activities were increasing the number of HIV-infected individuals newly enrolled on antiretroviral treatment and the number of HIV-infected individuals currently receiving antiretroviral treatment. These two goals have been identified by the Office of the Global AIDS Coordinator (OGAC) as key steps in reducing the mortality rate of men and women infected with HIV.

Through site visits to 16 health facilities, the audit determined that USAID/Southern Africa's HIV/AIDS treatment activities have increased the number of new patients enrolled on antiretroviral treatment and of those currently receiving treatment. Specifically, those site visits verified that 43,550 patients were receiving HIV/AIDS treatment.[6] Implementing partners and USAID staff described how the program had helped improve the health of South Africans. Staff at clinics visited said that the program was helping change the social stigma associated with HIV and ensuring that patients adhere to treatment regimens. By aligning program strategy with the South African Government's strategy, USAID is helping build local capacity and sustainability for treatment activities. Finally, patients supported by USAID related how the program had improved their health and livelihoods.

Despite these positive results, the audit disclosed the following weaknesses:

- Performance indicators and targets did not facilitate program management (page 4).
- Data warehouse did not provide reliable or useful information (page 6).
- Mission did not complete required data quality assessments (page 7).
- Concentration of key duties hindered program management (page 8).
- Mission did not monitor cost-sharing contributions (page 9).

To address these issues, we make six recommendations to the mission:

1. Implement a template of the annual work plan for PEPFAR implementing partners to use to report and evaluate program performance effectively (page 6).
2. Conduct an assessment of the effectiveness of the data warehouse (page 7).

[6] Site visits verified approximately 10 percent of currently enrolled HIV/AIDS patients during 2009.

3. Draft and approve a mutually agreeable comanagement plan for the data warehouse with the Centers for Disease Control and Prevention (page 7).

4. Identify the data used for reporting externally on Agency performance, and conduct data quality assessments on that data (page 8).

5. Implement a plan to divide roles and responsibilities more evenly among the HIV/AIDS treatment team members (page 9).

6. Add to the site visit checklist an item to monitor cost-sharing requirements (page 10).

Detailed findings follow. The audit's scope and methodology are described in Appendix I and the mission's comments are included in Appendix II. Our evaluation of the mission's comments is included on page 11.

AUDIT FINDINGS

Performance Indicators and Targets Did Not Facilitate Program Management

Indicators and targets are important tools for assessing performance in USAID's results-oriented management philosophy. Indicators, which can be either quantitative or qualitative, are used to measure actual results of USAID activities, whereas targets indicate expected results. Targets orient stakeholders to the tasks to be accomplished and motivate individuals involved in a program to do their best to ensure the targets are met. Once a program is under way, targets serve as guideposts for judging whether progress is occurring as scheduled and at the levels originally envisioned. USAID's Automated Directives System (ADS) 203.3.4.2 states that a good performance indicator should be objective, useful for management, and attributable to USAID or U.S. Government efforts, while ADS 203.3.4.5 states that missions should "set performance targets that are ambitious, but can realistically be achieved within the stated timeframe and with the available resources."

Despite these requirements, USAID/Southern Africa did not establish clear, consistent, and ambitious performance targets for the four implementing partners audited. As shown in Table 1, three out of four agreements contained FY 2009 targets for the two key performance indicators; however, these targets were often significantly more than the FY 2009 targets that USAID ultimately adopted in the FY 2008 Country Operational Plan (COP). Furthermore, the mission did not establish targets for one indicator in the cooperative agreement with the FPD.

Table 1. FY 2009 Targets in Partner Agreements Differed From Targets in COP

Antiretroviral Drug Treatment Indicator	Partner	Target		Percent Change From Agreement
		Agreement	COP	
Number of currently enrolled patients	Anova	38,374	20,000	-48
	RHRU	37,400	43,540	16
	Right to Care	45,600	50,000	10
	FPD	60,000	50,000	-17
Number of newly enrolled patients	Anova	23,765	8,500	-64
	RHRU	12,999	12,350	-5
	Right to Care	24,852	11,000	-56
	FPD	Not given	25,000	N/A

Note: The numbers in this table have not been audited.

In addition, the COP targets were not ambitious and thus not useful in assessing performance. As shown in Table 2, implementing partners exceeded most targets by significant margins. For example, Right to Care reported enrolling 38,008 individuals on antiretroviral therapy in FY 2009, well over triple its COP target of 11,000 individuals.

Table 2. Comparison of FY 2009 Targets Versus Partners' Results

Antiretroviral Drug Treatment Indicator	Partner	FY 2009		Percent of Target Achieved
		Target	Reported Result	
Number of currently enrolled patients	Anova	20,000	47,275	236
	RHRU	43,540	84,155	193
	Right to Care	50,000	83,997	168
	FPD	50,000	77,269	155
Number of newly enrolled patients	Anova	8,500	18,208	214
	RHRU	12,350	32,658	264
	Right to Care	11,000	38,008	346
	FPD	25,000	32,542	130

Note: The numbers in this table have not been audited.

Two factors explain the wide differences between targets and results: the nature of the annual planning process and the incongruity between the indicators and the dynamics of the HIV/AIDS treatment program in South Africa. Regarding the annual planning process, mission officials stated that setting targets for implementing partners is not a top priority during COP preparation. Instead, technical teams focus on budgetary allocations to the various U.S. Government agencies involved in international HIV efforts. These allocations are based on the agencies' respective areas of expertise and are not tied to any specific agency targets. After a particular agency's funding level is determined, the technical teams' focus shifts to determining funding for individual partners' activities. Tellingly, guidance for the FY 2011 COP does not require USAID to report targets for implementing partners' activities.

Regarding the incongruity between indicators and program dynamics in South Africa, a U.S. Embassy Pretoria official who helps oversee the interagency process for preparing the COP noted that these indicators have limited utility because the South African Government is more involved in HIV/AIDS treatment activities than are most other PEPFAR host governments, given South Africa's relatively greater resources. As a result, most USAID implementing partners provide services in South African Government facilities, and partners' reported results encompass essentially the same patient population reported on by the South African Government. Under these circumstances, indicator results are driven more by the South African Government's scaling-up of treatment services than by partner (and, by extension, USAID) efforts, a fact that increases the difficulty of setting meaningful targets. Additionally, the use of data from South African Government facilities means that there is greater room for variability among implementing partners as to exactly what kind of treatment is provided for a patient included in their respective indicator results, introducing ambiguity as to what the indicator is measuring and limiting its usefulness for management in assessing performance.

In its HIV/AIDS program planning, USAID must meet both the requirements imposed by OGAC and those found in internal policies on performance management. While well-designed indicators with clear, ambitious, and feasible targets are a powerful tool in motivating partners and helping to ensure that U.S. Government funds are spent effectively, the benefits must not be outweighed by the costs of data collection. Without such indicators, however, the full benefit derived from USAID funding cannot be measured. Until OGAC provides additional guidance and resources, USAID should develop feasible and cost-effective ways to motivate partners and assess their performance, such as by measuring achievement against annual work plan

objectives, so that future funds are allocated as effectively as possible. As a result, we make the following recommendation.

> ***Recommendation 1.*** *We recommend that USAID/Southern Africa implement a standard annual work plan template for President's Emergency Plan for HIV/AIDS Relief treatment partners to effectively report and evaluate program performance.*

Data Warehouse Did Not Provide Reliable or Useful Information

In July 2008, USAID/Southern Africa signed a task order under an indefinite quantity contract with John Snow Inc. (JSI) to enhance the use of strategic information in the mission's HIV programs. Among other things, the task order required JSI to improve the data warehouse by developing a platform with enhanced analytical capability that would encourage the use of data in decision making.[7] The agreement also stated that "*data quality* is a fundamental dimension of this task order" (italics in the original). For its part, the USAID contracting officer's technical representative (COTR) was responsible for overseeing JSI's performance, providing verbal and written technical directions to the contractor, and inspecting all deliverables and services.

Despite these requirements, the audit found a number of errors in reports generated by the data warehouse. For example, partner targets displayed in data warehouse reports did not correspond with the supporting documentation used to populate the data warehouse. As shown in Appendix III, Tables III-1 and III-2, the FY 2009 targets for Right to Care and RHRU taken from data warehouse reports did not agree with the FY 2009 targets in the FY 2008 Country Operational Plan. These discrepancies were caused by several factors. For example, faulty formulas in the database double counted patient age subgroups, producing incorrect and inflated indicator target totals. In addition to faulty formulas, subgroup values did not match with supporting documentation.

Errors in data warehouse reports were not restricted to targets. As shown in Appendix III, Table III-3, results generated by the data warehouse were not always consistent with those originally reported by implementing partners.

JSI officials could not explain why these discrepancies occurred. The officials noted that their work required constant adjustment to the system formulas to accommodate ongoing requirements imposed by OGAC. In this case, they could not explain why the formulas did not provide the correct results but believed that this was a result of recent design changes mandated by the mission during FY 2010 to accommodate new patient age subgroups. Furthermore, although JSI officials stated that changes in subgroup values could be a result of target revisions, no documentation was available to support this theory.

The USAID COTR for JSI, a member of the HIV/AIDS treatment team, was aware of systematic problems with the data warehouse. The COTR stated that the original design of the data warehouse by JSI's predecessor was poor and did not have the capability to adjust to changing OGAC requirements. While the USAID COTR and the activity manager concurrently managed the JSI contract, they stated that management of the JSI contract was complicated because it is managed with the U.S. Centers for Disease Control (CDC). While the contract has been

[7] The data warehouse is a database created under a previous USAID agreement.

managed in this fashion, there is no written agreement between USAID and CDC to define responsibilities.

As a result, as of December 31, 2010, USAID had spent over $4.6 million developing and maintaining a data warehouse that has not provided consistently reliable or useful information. For example, the database is not currently a useful platform for decision making. Implementing partner officials voiced their discontent with the data warehouse, saying it was not designed to meet their needs. Moreover, partner officials also complained about the unreliability of reports generated by the data warehouse, which affects the reliability of data reported to Washington stakeholders. Yet mission officials believe that the data warehouse has indeed enhanced the monitoring and evaluation of treatment activities in that it drives the behavior and discipline of implementing partners to manage their programs more effectively.

Given the range of problems with the system and the depth of users' dissatisfaction, future improvements appear unlikely without identifying and fixing underlying technical causes of errors in the database. In addition, USAID and CDC need to clarify their day-to-day management responsibilities. Consequently, we make the following recommendations.

Recommendation 2. *We recommend that USAID/Southern Africa conduct an assessment of the effectiveness of the data warehouse.*

Recommendation 3. *We recommend that USAID/Southern Africa draft and approve a mutually agreeable comanagement plan for the data warehouse with the Centers for Disease Control and Prevention.*

Mission Did Not Complete Required Data Quality Assessments

ADS 203.3.5.2 states that data reported to Washington for Government Performance and Results Act (GPRA) reporting purposes or for reporting externally on Agency performance must have had a data quality assessment at some time within the 3 years before submission. A data quality assessment determines the strengths and weaknesses of the data and the extent to which the data can be trusted for making programmatic decisions.

Data from USAID, including that reported by the mission in South Africa, was included in the indicator *Number of people receiving HIV/AIDS treatment in the 15 focus countries* reported in the Department of State-USAID *Joint Summary of Performance and Financial Information for Fiscal Year 2009*. In addition, similar data was included in the *FY 2009 Foreign Operations Performance Report*. Consequently, data included in those reports should have had a data quality assessment done in accordance with ADS 203.3.5.2 and GPRA.

Despite this requirement, however, the mission has not completed data quality assessments within the past 3 years for indicators reported by three of the four implementing partners under review. For those three implementing partners, data quality assessments were omitted for key performance indicators in USAID's HIV/AIDS treatment program, including the indicator measuring the number of individuals currently receiving antiretroviral treatment. The latest data quality assessments for these partners were performed in 2005. As a result, potential data problems, limitations, or weaknesses were not identified.

According to mission officials, they were unable to comply with the ADS requirement because data quality assessments were costly and would diminish the funding available for program activities. Although the mission has since hired a contractor to perform these tasks, assessments are done only at the request of activity managers, and data quality assessments have yet to be performed for three of the four partners under review.

Data reported to the American public must be as complete and accurate as possible. To this end, USAID policies have been established to help ensure that data are assessed against standards of validity, integrity, precision, reliability, and timeliness—particularly for data reported externally. Consequently, auditors believe that because the South African program is USAID's largest treatment program in the world, ensuring the quality of data for the program is essential to maintaining USAID's credibility in reporting accurate and reliable data. As a result, this audit makes the following recommendation.

Recommendation 4. *We recommend that USAID/Southern Africa identify the data used for reporting externally on Agency performance, and conduct data quality assessments on that data.*

Concentration of Key Duties Hindered Program Management

The U.S. Government Accountability Office's *Standards for Internal Control in the Federal Government* requires federal agencies to conduct top-level reviews and ensure adequate segregation of duties. Additionally, ADS 596, "Management's Responsibility for Internal Control," requires USAID operating units to establish systems of internal control that segregate key duties and responsibilities among different staff. These duties include authorizing, processing, recording, and reviewing transactions. Further, ADS 102.3.3.2 requires the team leader to balance tasks and workload among team members. Despite these requirements, key duties have been concentrated in the HIV/AIDS treatment team leader, who also serves as the agreement officer's technical representative (AOTR) on the treatment program's four largest agreements.

As shown in Table 3, the treatment team leader managed 75 percent of the FY 2009 budget as an AOTR. AOTR responsibilities include regularly monitoring the financial status of the award to ensure that the funding level is the minimum necessary and monitoring the recipient's progress in meeting agreement objectives. In addition, the treatment team leader is responsible for managing budget planning and allocation for the treatment portfolio. The treatment team leader also plays a key role in project development, analyzing and reporting on best practices in antiretroviral treatment that can be applied elsewhere.

Table 3. Budgeted Treatment Funds Managed by Treatment Team Members While They Were Serving as AOTR

Treatment Team Staff	FY 2009 Budgeted Treatment Funds Managed as AOTR ($)	Percent of FY 2009 Budgeted Treatment Funds Managed as AOTR
Treatment Team Leader	70,542,394	75
Employee A	16,492,175	18
Employee B	639,817	1
Employee C	2,850,239	3
Employee D	776,724	1
Employee E	2,489,263	3
Employee F	124,997	0
Total	**93,915,609**	**100**

Note: Percentages were rounded to the nearest whole value. The numbers in this table have not been audited.

The treatment team's managerial structure, as shown in Table 3, resulted from rapid program expansion without a corresponding increase in staff. While the team leader assigned tasks to other team members when possible, this management structure led to both actual and potential problems. First, the sheer number of responsibilities in the dual roles of treatment team leader and AOTR led to managerial deficiencies described elsewhere in this report, such as not monitoring cost-sharing contributions. Second, the scope of the treatment team leader's responsibilities, when combined with AOTR duties over such a large portion of the mission's treatment program, created the opportunity for errors in oversight and incomplete adherence to Agency regulations due to competing priorities and time constraints.

Good internal control and good management practice dictate that these duties should be separated to a greater degree than they have been. As a result, this audit makes the following recommendation.

Recommendation 5*. We recommend that USAID/Southern Africa implement a plan to divide roles and responsibilities more evenly among the HIV/AIDS treatment team members.*

Mission Did Not Monitor Cost-Sharing Contributions

According to ADS 302.2, an AOTR is required to ensure that USAID exercises prudent management of its awarded assistance and facilitates the achievement of program objectives by monitoring recipient performance. Specifically, ADS requires the AOTR to monitor financial records to ensure that the recipient is making the required cost-sharing contributions.

"Cost-sharing" refers to amounts expended by an implementing partner—which are typically in-kind contributions of goods or services—in furtherance of an agreement's objectives. As shown in Table 4, the selected HIV/AIDS treatment program agreements required the implementing partners to provide $207 million in cost-sharing contributions over 2 years.

Table 4. Required Cost-Sharing Contributions ($)

Partner	FY 2008	FY 2009
Anova	42,083,537	66,381,347
Right to Care	19,778,000	26,700,300
RHRU	13,720,285	24,608,553
FDP	5,139,969	8,658,278
Subtotal	80,721,791	126,348,478
Total		**207,070,269**

Note: The numbers in this table have not been audited.

Despite the requirement in ADS 303.2 to monitor cost-sharing contributions, the AOTR for these agreements did not do so because she was not aware of this requirement. The original AOTR designation letter for these agreements did not list the requirement to monitor cost sharing. Furthermore, the checklist used by the mission's health team during routine site visits did not contain a reminder to monitor cost-sharing contributions. The AOTR added that since the cost-sharing contributions were primarily drugs provided by the South African Government, she assumed that partners were meeting their required cost-sharing amounts because without the drugs the clinics would not be able to operate. While the AOTR and other mission HIV/AIDS treatment personnel believed that recipients were meeting their obligations, personnel did not have documentation illustrating how those obligations were met.

Although recipients' required financial audits do disclose cost-sharing requirements and contributions, cost-sharing contribution schedules are subject to review only by a recipient's independent auditors. These reviews are substantially more limited in scope than an audit and occur months after the period under review.[8] Thus, AOTRs are better placed to monitor such contributions during the course of a fiscal year. It is clear, however, that without proper monitoring of cost-sharing contributions, USAID lacks assurance that recipients are fulfilling their obligations, and program beneficiaries may not be benefitting from required cost-sharing contributions.

As a result, this audit makes the following recommendation.

> ***Recommendation 6.*** *We recommend that USAID/Southern Africa add to its site visit checklist an item to monitor cost-sharing requirements.*

[8] For example, a recent financial audit of one of the above agreements found that the recipient's senior management was not adequately monitoring its cost-sharing contributions, underscoring the importance of ongoing monitoring by USAID officials.

EVALUATION OF MANAGEMENT COMMENTS

USAID/Southern Africa agreed with all six recommendations in the draft report. On the basis of the response from the mission, management decisions have been reached on all six recommendations. Management comments are summarized below, followed by the audit team's evaluation of management comments.

Recommendation 1. USAID/Southern Africa agreed with the recommendation to implement a standard annual work plan template for PEPFAR treatment partners. The mission noted that it is developing a standard work plan that will be used in a pilot for activities funded under the FY 2011 COP. In subsequent correspondence, the mission noted it expects to implement the standard work plan by September 30, 2011. Consequently, we consider that a management decision has been reached on Recommendation 1.

Recommendation 2. USAID/Southern Africa agreed with the recommendation to conduct an assessment of the effectiveness of the data warehouse. The mission noted that it will include this assessment as part of its upcoming evaluation of the project implemented by John Snow Inc. In subsequent correspondence, the mission noted it expects this evaluation to be completed by July 1, 2012. Consequently, we consider that a management decision has been reached on Recommendation 2.

Recommendation 3. USAID/Southern Africa agreed with the recommendation to draft and approve a mutually agreeable comanagement plan for the data warehouse with CDC. The mission noted that the plan will be based on the memorandum of understanding with CDC to monitor the South Africa PEPFAR Partner Performance Assessment (SAPPPA) contract. In subsequent correspondence, the mission indicated it expects this memorandum to be completed by September 30, 2011. Consequently, we consider that a management decision has been reached on Recommendation 3.

Recommendation 4. USAID/Southern Africa agreed with the recommendation to identify the data used for reporting externally and conduct data quality assessments on that data. In subsequent correspondence, the mission noted that data quality assessments will be completed by August 1, 2012. Consequently, we consider that a management decision has been reached on Recommendation 4.

Recommendation 5. USAID/Southern Africa agreed with the recommendation to implement a plan to divide roles and responsibilities more evenly and noted it had already reassigned two projects and recruited two new senior health technical advisors that will be assigned specific project management roles and responsibilities. In subsequent correspondence, the mission estimated that these newly recruited individuals would be assigned their specific roles and responsibilities by January 1, 2012. Consequently, we consider that a management decision has been reached on Recommendation 5.

Recommendation 6. USAID/Southern Africa agreed with the recommendation to add an item to monitor cost-sharing requirements to its site visit checklist. In subsequent correspondence, the mission indicated it will add this item to the checklist by August 1, 2011. In addition, the

mission proposed ensuring that cost sharing is reported at quarterly Joint Planning and Performance Monitoring discussions. We support this proposal, although we consider that a management decision has been reached on Recommendation 6 based on the inclusion of monitoring the cost-sharing requirement in the site visit checklist.

SCOPE AND METHODOLOGY

Scope

The Regional Inspector General/Pretoria conducted this performance audit in accordance with generally accepted government auditing standards.[9] Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions in accordance with our audit objective. We believe that the evidence obtained provides that reasonable basis.

The objective of this audit was to determine whether USAID/Southern Africa's HIV/AIDS treatment program was achieving its main goals. Specifically, the audit sought to determine whether those activities were increasing the number of HIV-infected individuals newly enrolled on antiretroviral drug treatment and the number of HIV-infected individuals currently receiving such treatment. Audit fieldwork was conducted intermittently from July 8, 2010, to March 7, 2011, and covered FY 2009. In FY 2009, the treatment program had a total budget of about $104 million, which comprised over $94 million for adult treatment and about $10 million for antiretroviral drugs.

In planning and performing the audit, the audit team assessed internal controls related to management review, proper execution of transactions and events, and reviews of performance measures and indicators. Specifically, we studied and assessed the following:

- PEPFAR Country Operational Plans
- Implementing partners' agreements
- Implementing partners' quarterly and annual progress reports
- USAID/South Africa PEPFAR data warehouse and reports
- Performance measures
- Target and actual performance results

We also interviewed key USAID/Southern Africa personnel, implementing partners, beneficiaries, and South African Government clinic staff. We conducted the audit at USAID/Southern Africa and at the treatment activity sites of the four major implementing partners.

As of September 2010, USAID/Southern Africa had agreements with 13 implementing partners working on treatment activities, with a total treatment budget of almost $104 million in FY 2009. Of these agreements, the audit focused on the four largest agreements in the treatment portfolio. These four agreements had a budget of almost $65 million in FY 2009, approximately 62 percent of the total treatment portfolio.

[9] *Government Auditing Standards*, July 2007 Revision (GAO-07-731G).

Methodology

To answer the objective, the Regional Inspector General/Pretoria interviewed officials representing USAID/Southern Africa, the South African Government, and implementing partners to gain an understanding of the mission's HIV/AIDS treatment activities as well as to identify the key performance indicators used to measure the contribution of those activities to meeting the main goals of the program.

At the beginning of fieldwork, USAID/Southern Africa specified 5 of its 16 PEPFAR-reported indicators as key for measuring project success. However, three of these indicators were new and were not reported on in 2009. Therefore, the audit team focused on verifying the remaining two indicators during fieldwork: *Number of patients currently enrolled on antiretroviral treatment* and *Number of patients newly enrolled on antiretroviral treatment*. Where possible, auditors compared target values with actual results for FY 2009.

Auditors performed site visits at 16 treatment clinics in Gauteng Province (4 clinics per partner). Visits were limited to Gauteng Province because all partners under review had extensive projects in this area. Auditors classified clinics as small, medium, or large and then judgmentally selected at least one small, one medium, and one large clinic to visit for each partner. At the clinics, auditors interviewed implementing partner and South African Government personnel, performed a walk-through of the facilities, and verified supporting documentation for key indicator results reported to USAID/Southern Africa in 2009. For three of the agreements audited, results reported came from the data warehouse. For one agreement, the results reported came from the implementing partner. Due to the judgmental selection of clinics visited, site visit results cannot be projected to the entire universe of clinics in South Africa.

We also reviewed the following documents: the South Africa 2009 Country Operational Plan, partners' agreements and related modifications, multiple sections of USAID's ADS, and Federal Acquisition Regulations.

We established two materiality thresholds to determine success. If the number of HIV-infected individuals newly enrolled on antiretroviral drugs and the number of HIV-infected individuals currently receiving such drugs did not reach 80 percent of the stated target goal, we stated that the program had not achieved its goals. If the number of HIV-infected individuals newly enrolled on antiretrovirals and the number of HIV-infected individuals currently receiving the drugs met more than 80 percent of the stated target goal, we stated that the program had succeeded.

Appendix II

MANAGEMENT COMMENTS

June 30, 2011

Memorandum

From: Jeff Borns, Mission Director /s/

To: Regional Inspector General/Pretoria: Christine M Byrne

Subject: Audit of USAID/Southern Africa's HIV/AIDS treatment activities (Report Number 4-674-11-XXX-P)

This memo transmits USAID/Southern Africa's written comments on the recommendations made under the subject audit.

Recommendation 1. *We recommend that USAID/Southern Africa implement a standard annual work plan template for President's Emergency Plan for HIV/AIDS Relief treatment partners to effectively report and evaluate program performance.*

We accept this recommendation. A standard work plan for treatment partners is now under development. This work plan will be piloted for activities funded under the FY 2011 country operational plan (COP). We intend to collaborate and consult with CDC in developing this work plan, and will attempt to standardize across agencies.

Recommendation 2. *We recommend that USAID/Southern Africa conduct an assessment of the effectiveness of the data warehouse.*

We accept this recommendation. An assessment of the data warehouse will be included as part of the upcoming evaluation of the project implemented by John Snow Inc., Expanded Strategic Information (ESI), where the data warehouse is housed.

Recommendation 3. *We recommend that USAID/Southern Africa draft and approve a mutually agreeable co management plan for the data warehouse with the Center for Disease Control and Prevention.*

We accept this recommendation for management of the existing data warehouse. This co management plan will be based on the Memorandum of Understanding with CDC to monitor the South Africa PEPFAR Partner Performance Assessment (SAPPPA) contract.

Recommendation 4. *We recommend that USAID/Southern Africa identify the data used for reporting externally on Agency performance, and conduct data quality assessments on that data.*

We accept this recommendation and are already moving forward with plans to conduct data quality assessments of all prime partners. This will be done through the South Africa PEPFAR Partner Performance Assessment (SAPPPA) process, where the current data assessment areas are being enhanced to assure that the assessment meets the

requirements of ADS 203.3.5.2.The tool will specifically verify that data are of reasonable quality, based on the five data quality standards provided in the ADS.

Recommendation 5*. We recommend that USAID/Southern Africa implement a plan to divide roles and responsibilities more evenly among the HIV/AIDS treatment team members.*

We accept the recommendation. We are in the process of dividing roles and responsibilities more evenly, and have already reassigned two projects. Unfortunately, USDH vacancies may slow down the implementation of this recommendation. The positions of Deputy Director, and the Medical Officer, will both be vacant in August. Both have been advertised but no appropriate candidates have been identified. However two new senior technical advisors, an FSN 12 treatment advisor and a senior USPSC care advisor have been recruited and will join the Health Office within the next two months. They will soon be trained as A/COTRs and and assigned specific project management roles and responsibilities.

Recommendation 6. *We recommend that USAID/Southern Africa add to its site visit checklist an item to monitor cost-sharing requirements.*

We accept this recommendation and will add this item to the checklist. Nonetheless we think it will be difficult to monitor cost sharing effectively during site visits. Thus, in addition to amending the checklist to add this item, we propose to ensure that cost sharing is reported at quarterly Joint Planning and Performance Monitoring discussions, and will be included in project officer (COTR/AOTR) files.

Finally, I would like to thank you and your staff for the collaborative way in which this audit was conducted, and the useful nature of the recommendations.

Tables III-1 and III-2. FY 2009 Targets: Data Warehouse Records Versus Country Operational Plan (Unaudited)

Right to Care Targets - Number of individuals receiving antiretroviral therapy at the end of the reporting period (current clients) (by ages 0-5, 0-14, and 15+) for 2009 (Oct. 2008 – Sept. 2009)

Age Groups	Per Data Warehouse	Per Partner's Approved COP	Difference
0 - 14 Years	3,500	1,815	1,685
< 5 years	8,000	750	7,250
5 - 14 Years	No data given	No data given	N/A
15 Years +	46,500	48,185	-1,685
Total	**58,000***	**50,000**	**8,000**

RHRU Targets - Number of individuals receiving antiretroviral therapy at the end of the reporting period (current clients) (by ages 0-5, 0-14, and 15+) for 2009 (Oct 2008 - Sept 2009)

Age Groups	Per Data Warehouse	Per Partner's Approved COP	Difference
0 - 14 Years	6,543	5,163	1,380
< 5 years	2,582	2,582	0
5 - 14 Years	No data given	No data given	N/A
15 Years +	36,997	38,377	- 1,380
Total	**46,122***	**43,540**	**2,582**

*Note that the data warehouse totals are incorrect, as explained on page 6.

Table III-3. FY 2009 Results: Data Warehouse Versus Partner Records (Unaudited)

Antiretroviral Drug Treatment Indicator	Partner	FY 2009 Results		Difference
		Data Warehouse	Partner's Reported Result	
Number of currently enrolled patients	Anova	47,275	47,275	0
	RHRU	83,797	84,155	-358
	Right to Care	83,997	83,997	0
	FPD	79,114	77,269	1,845

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