OFFICE OF INSPECTOR GENERAL

AUDIT OF USAID/GHANA'S HIV/AIDS PROGRAM

AUDIT REPORT NO. 7-641-10-006-P
JUNE 28, 2010

DAKAR, SENEGAL

Office of Inspector General

June 28, 2010

MEMORANDUM

TO: USAID/Ghana Mission Director, Cheryl Anderson

FROM: Regional Inspector General, Gerard Custer/s/

SUBJECT: Audit of USAID/Ghana's HIV/AIDS Program (Report No. 7-641-10-006-P)

This memorandum transmits our report on the subject audit. In finalizing the report, we carefully considered your comments on the draft report and have included the comments in their entirety in appendix II.

The report includes nine recommendations for your action. Based on actions taken by the mission and supporting documentation provided, final action has been taken on recommendations 1, 3, 4, and 5; and management decisions have been reached on recommendations 2, 6, 7, 8, and 9. Please provide the Audit Performance, and Compliance Division in the USAID Office of the Chief Financial Officer (M/CFO/APC) with the necessary documentation to achieve final action.

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

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CONTENTS

SUMMARY OF RESULTS

Ghana had an HIV prevalence of approximately 1.7 percent in 2009. The epidemic is concentrated among certain populations, primarily commercial sex workers, in specific geographic areas.

Under the President's Emergency Plan for AIDS Relief (PEPFAR), the U.S. Government made Ghana the focus of extensive efforts to combat HIV/AIDS through service delivery, policy reform, and coordinated financial commitments. As a continuation of PEPFAR, the U.S. Government chose to develop a 5-year (2009-2013) partnership framework with Ghana. The primary goal of the partnership framework is to reduce the number of new infections by 30 percent by 2013 through focused prevention efforts. Other goals include increasing the population covered by antiretroviral treatment from 30 to 60 percent by 2013; increasing the number of persons receiving care by 200 percent to 130,000 by 2013; strengthening the health management systems needed to achieve the prevention, treatment, and care goals; and strengthening the capacity of community-based organizations to provide information and services to most-at-risk populations and people living with HIV. The United States also supported a Global Fund[1] grant for the nationwide expansion of HIV/AIDS care and treatment services.

USAID has channeled the U.S. Government's efforts against HIV/AIDS in Ghana. Since 2004, USAID has worked closely with the Government of Ghana to strengthen prevention efforts for most-at-risk populations and link these groups with services and treatment, while promoting prevention and antistigma activities. The Agency has supported training, logistics, and performance improvement to improve the quality of care in selected sites and link these sites with community-based prevention, care, and support interventions to promote a continuum of HIV services.

To carry out these activities, USAID/Ghana entered into agreements with several implementing partners, including those shown in table 1. During fiscal year (FY) 2009, the mission obligated $3.9 million and disbursed $3.3 million for the HIV/AIDS program.

The Regional Inspector General/Dakar conducted this audit at USAID/Ghana as part of its FY 2010 audit plan to answer the following question:

Are USAID/Ghana's HIV/AIDS activities achieving their main goals?

The audit concluded that, although the prevalence rate of HIV in Ghana has decreased (peaked in 1998 at 2.4 percent and was estimated at 1.7 percent in 2009), USAID/Ghana has been only partially successful in achieving the specific goals of the five key programs.

[1] The Global Fund is a unique partnership among governments, civil society, the private sector, and affected communities dedicated to attracting and disbursing additional resources to prevent and treat HIV/AIDS, tuberculosis, and malaria. Since its creation in 2002, it has received funding of $18.7 billion for more than 572 programs in 140 countries.

Table 1. Audited Programs

Program	Partner	Objective	Estimated Budget	Program Dates
Quality Health Partners (QHP)	EngenderHealth	To improve the quality of health services through the development and implementation of innovative strategies, technical assistance, and training for quality	$20,050,000*	6/01/2004–9/30/2010
Strengthening HIV/AIDS Response Partnerships (SHARP)	Academy for Educational Development (AED)	To reduce new HIV infections and mitigate the effect of AIDS in Ghana	$15,000,000	6/10/2004–10/30/2009
DELIVER	John Snow International (Field Support)	To increase the availability of essential health supplies	$13,970,000*	9/2004–9/30/2011
HOPE	Opportunities Industrialization Centers International (OICI)	To improve care and support and provide economic opportunities for people living with HIV and orphans and vulnerable children (OVC)	$1,203,359	6/16/2004–9/30/2009
Teacher Training College HIV/AIDS Window of Hope Curriculum	Ghana's Ministry of Education, Science, and Sports	To integrate mainstream HIV/AIDS education into the curriculum of all teacher training colleges	$200,000	3/01/2008–9/30/2010

* Amount includes funding for other health activities not specifically related to HIV/AIDS.

Quality Health Partners (QHP) – Under the 5-year QHP cooperative agreement with USAID/Ghana, EngenderHealth was to help the Ghana Health Service improve family planning, reproductive health, motherhood safety, child survival, and services to reduce sexually transmitted infections and HIV/AIDS. The audit found limited improvement in the overall quality of health services, for two reasons. EngenderHealth did not (1) collaborate sufficiently with hospital management, or (2) document action plans it had helped hospitals develop, or assist in implementing the plans (pages 6-8). Furthermore, no clear link existed between EngenderHealth's QHP activities and the results reported (pages 8-10). Only limited improvement occurred because EngenderHealth did not clearly define its goals for project implementation and did not clearly communicate its plans to interested parties. Also, the program could have been more effective had EngenderHealth trained more hospital personnel in following quality assurance procedures, identifying gaps in processes, and reducing stigma. As a result of the lack of collaboration with hospital management and the inadequate implementation of action plans, hospital staff and management have lost interest in the program, limiting its effectiveness.

- We recommend that USAID/Ghana, in coordination with EngenderHealth, review and revise its implementation plan for 2010 to ensure that sufficient hospital staff is trained or retrained, and to ensure that the work plan includes sufficient followup with the hospitals to implement clearly defined action plans (page 8).

- We also recommend that USAID/Ghana, in collaboration with EngenderHealth, develop a system that more carefully measures the results of the activities performed by EngenderHealth (page 10).

Strengthening HIV/AIDS Response Partnerships Program (SHARP) – According to two of USAID's nine principles of development and reconstruction assistance (capacity building and sustainability), the Agency is to strengthen local institutions, transfer technical skills, promote appropriate policies, and design programs to ensure their impact endures. Contrary to these development principles, Academy for Educational Development (AED) did not give its SHARP subpartners enough time to implement their activities (pages 10-11). Also, because the program had ended,[2] program records documenting the project's outcomes were not available. In other words, the audit team did not receive complete documentation regarding the results that were being achieved by each subpartner. At the onset of the program, SHARP experienced delays caused by conflicts with AED management and inadequate performance by the subpartners initially selected to implement the activities. As a result, although the infection rate in Ghana has declined, the subpartners may not have achieved the capacity to sustain mitigation efforts, and the audit was unable to verify the final results that the program reported related to reducing infections and mitigating the effects of AIDS.

- We recommend that USAID/Ghana develop its new HIV/AIDS prevention activity to build the capacity of local institutions and improve the prospects for sustainability by entering into longer subagreements and improving the subpartner selection process (page 11).

DELIVER – Antiretroviral drug manufacturers typically state that their medicines should be stored at temperatures not to exceed 77 to 86 degrees Fahrenheit and should be disposed of by their expiration dates. However, the audit team observed storage temperatures at Ghana's Central Medical Store in Accra that exceeded manufacturers' established limits. Furthermore, expired drugs were not being disposed of regularly, occupying premium storage space. Medical store officials explained that they did not have sufficient funds to purchase generators and were not aware of future plans to dispose of expired drugs. Because items are exposed to temperatures that exceed their recommended limits and because expired drugs are not disposed of regularly, drugs distributed by these facilities may be ineffective or even harmful to patients (pages 11-13).

Proper storage and handling aside, the audit revealed that one-third of antiretroviral treatment drugs were unavailable, and many drugs on hand were close to their expiration dates (pages 14-15). This finding demonstrates the difficulty in achieving the goals of the USAID | DELIVER project: to strengthen Ghana's supply system, improve the availability of commodities, and increase the capacity of health personnel. Some reasons for unavailable and expiring drugs include (1) funding shortages stemming from nonreimbursement by the national insurance system, (2) a weakness in reporting drug utilization, (3) a lack of vehicles at the regional medical stores to deliver drugs to facilities, (4) a lengthy procurement process, (5) a shortage of experienced, well-trained staff in supply chain management, and (6) insufficient storage space. When drugs are unavailable, patients have no choice but to wait or rely on substitutes and suffer the health consequences.

[2] The SHARP program ended October 31, 2009.

- We recommend that USAID/Ghana advocate for improved HIV/AIDS commodity procurement and storage in a letter to the Director General of the Ghana AIDS Commission that includes this section of the audit report and points out the need for adequate equipment in warehouses to guarantee the quality of antiretroviral therapy (ART) drugs (page 13).

- Further, we recommend that USAID/Ghana work with John Snow International and revise the work plan to include preparation of a disposal plan to assist the Government of Ghana in disposing of expired drugs (page 15).

HOPE – USAID's Automated Directives System (ADS) 203.3.4.5 requires that operating units set performance targets that can optimistically but realistically be achieved. However, USAID/Ghana set performance targets for Opportunities Industrialization Centers International (OICI), its implementing partner on the HOPE project, too low, and OICI consistently exceeded them, sometimes significantly, from FY 2006 through FY 2009. Targets were too low because USAID/Ghana never adjusted them after they were originally set in 2006; the mission overlooked the need to monitor the targets and to adjust them accordingly. As a result, the performance targets used from FY 2006 to 2009 did not provide a realistic approach for measuring program performance (page16).

Although it exceeded quantitative targets in awarding scholarships, the HOPE project may not have met a qualitative target—that is, it may not have limited services to its targeted population. PEPFAR has clearly defined eligibility criteria for orphans and vulnerable children (OVC). The criteria include age, HIV status, and status of parents. However, the audit found no records for recipients of USAID-sponsored scholarships indicating that recipients met those criteria. OICI could not produce records showing eligibility of the OVC it supported because OICI relied on other organizations or government agencies to screen students for inclusion in the HOPE project's scholarship program and did not ensure that this process was adequately documented and monitored. As a result, OICI may have provided services to recipients who were not eligible for the program as defined by PEPFAR (pages 16-17). Nevertheless, individuals interviewed asserted that the program had a positive impact.

Those who received HOPE scholarships did not always receive monthly allowances according to program guidelines. Each scholarship beneficiary was entitled to a monthly allowance to cover transportation and meals. However, beneficiaries did not always receive all of these funds on time from OICI because school officials at one school retained part of the allowance and because regional offices did not consistently receive funds from OICI headquarters in a timely manner. As a result, beneficiaries faced challenges attending school and feeding themselves, challenges that could lead beneficiaries to drop out (page 18).

- We recommend that USAID/Ghana establish written procedures to regularly revise its performance targets for PEPFAR activities to reflect realistic expectations (page 16).

- We recommend that the mission implement controls requiring that OICI verify the eligibility of all students who receive scholarships and maintain documentation to support each student's eligibility (page 18).

- Finally, we recommend that USAID/Ghana, in coordination with OICI, implement adequate financial controls to ensure that scholarship recipients receive their allowances on time and in full (page 18).

Teacher Training College HIV/AIDS Window of Hope Curriculum – Ghana's Ministry of Education, Science, and Sports implemented the teacher training program, Window of Hope, which introduced teaching the basics of HIV/AIDS to teacher training colleges throughout Ghana. USAID/Ghana did not establish indicators for the program, and because of the limited funding for this activity, we performed only a limited review.

All Programs – The audit further concluded that USAID/Ghana was not meeting branding requirements. USAID's ADS 320, "Branding and Marking," requires USAID implementers to brand and mark all aspects of USAID's program assistance. However, assets such as computers funded by USAID were not marked with a USAID logo, and several individuals were not aware that the programs outlined above were funded by USAID. This lack of awareness occurred because USAID/Ghana did not ensure that the implementing partners were adhering to branding requirements. Consequently, the objectives of USAID's branding campaign, such as enhancing the visibility and value of USAID's foreign assistance, were not always achieved (pages 18-19).

- We recommend that USAID/Ghana direct all its partners to develop branding plans and monitor adherence to USAID branding guidelines (page 19).

Detailed findings appear in the following section. The audit's scope and methodology are described in appendix I.

USAID/Ghana agreed with all but one of our recommendations. Based on actions taken by the mission and supporting documentation provided, final action has been taken on recommendations 1, 3, 4, and 5, and management decisions have been reached on recommendations 2, 6, 7, 8, and 9. USAID/Ghana's comments are included in their entirety in appendix II.

AUDIT FINDINGS

EngenderHealth's Quality Health Partners Program Has Had Limited Effect

The purpose of the 5-year quality services cooperative agreement was to support the Ghana Health Service and private institutions to improve family planning, reproductive health, motherhood safety, child survival, and services to reduce sexually transmitted infections and HIV/AIDS through the development and implementation of innovative strategies, technical assistance, and training. The key program objectives were to:

1. Strengthen institutional capacity to provide services using approved standards and guidelines.

2. Improve systems for human resources capacity development (pre- and in-service training and performance management).

3. Strengthen supervision, coordination of resources, problem identification and problem-solving skills, and monitoring.

4. Raise the standard of quality in private and public health facilities and develop a franchising approach.

EngenderHealth was to achieve these objectives by helping improve Ghana's health system. Through QHP, EngenderHealth was to implement quality assurance programs and various training programs at 30 hospitals across Ghana. However, the program was not well implemented, and as a result, its impact on Ghana's health system was minimal. Two specific areas of concern that support this conclusion are discussed below.

Lack of Coordination With Hospital Administration — At all six hospitals visited, hospital administrators were not aware of the program's plans or objectives. Moreover, there were no agreements between EngenderHealth and the hospitals explicitly defining the goals of the project, how the project was to be implemented, or what responsibilities the hospitals would have to ensure program effectiveness. At Komfo Anokye Teaching Hospital in Kumasi, the director of public health, who was in charge of personnel training, noted that the program would have achieved greater results if EngenderHealth had worked with hospital management to integrate training activities. The hospitals did not have any plans to provide training to their personnel beyond what was already provided. According to hospital management, there has been turnover of staff, and new hospital staff will not receive any EngenderHealth training, thereby reducing the program's effectiveness.

According to a data quality assessment performed by an independent evaluator in FY 2008, it was unclear whether hospital management had knowledge of EngenderHealth's activities. The assessment indicated a lack of understanding of EngenderHealth's role, purpose, and jurisdiction.

Furthermore, hospital management was not aware of action plans developed by the hospital staff and EngenderHealth (described below) to improve hospital administration. Without the support and buy-in of hospital management, EngenderHealth's program was not able to achieve its desired results.

Action Plans Not Implemented – After conducting training sessions for hospital staff, EngenderHealth worked with selected individuals to identify quality assurance problems and assisted the hospitals in developing action plans to resolve the problems. At the five hospitals visited where QHP quality assurance programs were implemented, we found no evidence of action plans developed by the hospitals with EngenderHealth's assistance. The hospital staff did not know where they were maintained or how these plans were to be implemented. The staff noted, in some cases, that EngenderHealth had not returned to follow up on the action plans, to monitor their progress, or to resolve problems. Two months after the end of our fieldwork, the mission reported receiving two action plans from the Korle Bu Teaching Hospital.

Also, the program could have been more effective had EngenderHealth trained more hospital personnel in following quality assurance procedures, identifying gaps in processes, and reducing stigma. One hospital administrator admitted that the total number of personnel trained at her hospital was insufficient to bring about the desired effect either in stigma reduction or in improvement in overall patient experience. For example, at Komfo Anokye Teaching Hospital in Kumasi, although the hospital and EngenderHealth could not confirm the total number of personnel trained because of poor record keeping, the hospital estimated that 70 out of a total of 2,500 personnel (3 percent) received stigma reduction training. At 37 Military Hospital in Accra, where both the quality assurance and stigma reduction trainings took place, hospital officials estimated that 70 out of 2,000 personnel (4 percent) received training.

In an effort to train more personnel, EngenderHealth trained selected hospital staff as trainers who could in turn train their colleagues. However, at hospitals visited during the audit, none of the 25 trained trainers had used their acquired skills to train other hospital personnel in quality assurance, stigma reduction, or any other subjects.

The mission agreed that antistigma activities, which had limited impact at three large facilities, may require additional efforts in training. However, the mission pointed out that high training coverage is not a measure of a quality assurance program. The mission stated that the goal of quality assurance is to establish a quality assurance team at the facility and that establishing a team does not require a large number of trainees.

Furthermore, although the need for refresher training courses was often expressed during our site visits by previously trained hospital personnel, EngenderHealth did not have plans to provide these courses. Some personnel attended the training from 1 to 3 years ago and required refresher courses to stay current with the knowledge or skill acquired from the training. None of the three individuals interviewed who had received the training could recall the principal elements of the training. Finally, all staff interviewed noted that they had not been contacted by EngenderHealth about training for new staff or about additional trainings. Although many individuals noted that the training materials and delivery were effective, the inability to reach more personnel hampered the program's overall effectiveness.

Furthermore, the lack of coordination with hospital staff and the inadequate implementation of action plans occurred because EngenderHealth had not clearly defined its goals for project implementation and had not clearly communicated its plans to interested parties. The weaknesses in project implementation that a 2008 data quality assessment identified still existed at the time of the audit. Because of EngenderHealth's inability to promote the program objectives, hospital staff and management have lost interest in the program. As a result, the QHP program in Ghana has had limited effect.

Recommendation 1: We recommend that USAID/Ghana, in coordination with EngenderHealth, review and revise its implementation plan for 2010 to ensure that sufficient hospital staff is trained or retrained, and to ensure that the work plan includes sufficient followup with the hospitals to implement clearly defined action plans.

EngenderHealth Claimed Too Much Credit for the Results Achieved

According to ADS 203.3.4.2, performance indicators should be useful for the relevant level of decision making for which they are intended; they should be unambiguous and closely track the results they are intended to measure. In addition, performance indicators selected for inclusion in the performance management plan should measure changes that are clearly and reasonably attributable to USAID efforts. In the context of performance indicators and reporting, changes are attributable when the outputs of USAID-financed activities have a logical and causal effect on the result(s) being measured by a given performance indicator. One way to assess attribution is to ask, "If there had been no USAID project or activity, would the measured change have been different?" If the answer is no, there likely is an attribution problem, and the team should look for a more suitable performance indicator. If more than one agency or government is involved in achieving a result, USAID should describe exactly what role each played in achieving the result.

EngenderHealth entered into an agreement with USAID from 2004 to 2010 for a total of $20 million to support the Ghana Health Service and private institutions to improve family planning, reproductive health, motherhood safety, child survival, and services to reduce sexually transmitted infections and HIV/AIDS through the development and implementation of innovative strategies, technical assistance, and training. EngenderHealth reported on 16 indicators related to HIV/AIDS, and it reported that it met or exceeded most of the 16 indicator targets in 2009.

However, EngenderHealth has claimed too much credit for care and treatment results that cannot be attributed to its activities. For example, although QHP activities were implemented on a limited basis at the Komfo Anokye Teaching Hospital, EngenderHealth claimed full credit for all the care and treatment results reported for the hospital. There is no clear link between the activities undertaken by EngenderHealth and what was reported. Of the 16 indicators EngenderHealth reported on, the audit determined that 14 (shown in table 2) were only indirectly related to the activities of the QHP program, especially at hospitals where the QHP program was implemented only partially. In fact, the first indicator in the table—the number of service outlets providing HIV-related palliative care—should not be attributed to EngenderHealth at all. A service

outlet, such as a hospital or clinic, would have provided the HIV-related palliative care regardless of EngenderHealth's involvement.

Table 2. Selected Indicators and Results Reported by EngenderHealth for FY 2009

Indicator	FY 2009 Target	FY 2009 Actual
Number of service outlets providing HIV-related palliative care	30	30
Number of individuals provided with palliative care	14,500	30,384
Number of service outlets providing clinical prophylaxis or treatment for TB to HIV infected individuals	30	30
Number of HIV infected clients attending care/treatment services that are receiving treatment for TB	4,500	403
Number of individuals trained to provide clinical prophylaxis or treatment for TB infected individuals	560	885
Number of registered TB patients who received counseling and testing for HIV and received their test results as a U.S. Government-supported TB service outlet	1,400	2,509
Number of service outlets providing counseling and testing according to national guidelines	30	30
Number of individuals who received counseling and testing for HIV and received their test results	15,000	25,461
Number of service outlets providing ART according to national and international guidelines	30	30
Number of individuals newly initiating ART therapy	1,400	5,704
Number of pregnant women newly initiating ART therapy	No target	359
Number of individuals receiving ART at the end of the reporting period	7,500	17,138
Number of pregnant women receiving ART during the reporting period	No target	658
Number of health workers trained to deliver ART according to national guidelines	900	968

Note: The results above are reported by the hospitals. Because of poor record keeping, we were not able to verify the reported results.

Furthermore, EngenderHealth is taking full credit, rather than partial, for the clinical outputs. Moreover, EngenderHealth's results are not based on a carefully developed measurement system—one that uses a baseline metric prior to the start of the activities; instead, the organization attributes to project activities all increases in service outputs that occurred after project start.

The audit team's opinion is further supported by the 2008 data quality assessment, which noted that managers at some QHP-supported facilities reported on the indicators in table 2 only reluctantly; the managers did not see the need to report on clinical data indicators that were not influenced by EngenderHealth's actions. The managers noted that the results reported in table 2 would have occurred even without EngenderHealth's program.

The mission countered that QHP complements the Global Fund's clinical care and treatment program through quality assurance to strengthen services and improve operations—e.g., reducing stigma, improving client flows, ensuring confidentiality, improving laboratory functions, strengthening strategic information systems, and creating linkages with community-based programming. In prevention, it develops materials and supports supervisory systems for peer-education programs, strengthens programmatic

and management skills of local implementing partners, and builds government staff capacity to manage programs. These initiatives improve the quality of prevention and treatment activities. When quality improves, more people seek services, and facilities are able to handle more clients. USAID/Ghana believes that at hospitals where QHP has been successfully implemented, the care and treatment indicators can be attributed to its activities, but agrees that results from other sites should not be attributed to QHP. It also noted that similar programs were reporting their progress by using the same PEPFAR indicators throughout the world.

USAID/Ghana and EngenderHealth did not agree on indicators that would better reflect the activities and performance of the QHP program, and as a result, the achievement reported by EngenderHealth may be misleading and not useful to USAID/Ghana and other stakeholders.

Recommendation 2: We recommend that USAID/Ghana, in collaboration with EngenderHealth, develop a system that more carefully measures the results of the activities performed by EngenderHealth.

SHARP Subpartners Did Not Have Enough Implementation Time

USAID has developed nine principles of development and reconstruction assistance. Under the area of capacity building, USAID aims to "strengthen local institutions, transfer technical skills, and promote appropriate policies." Under sustainability, it aims to "design programs to ensure their impact endures." The Agency's policy guidance on *Mitigating the Development Impacts of HIV/AIDS* adds that USAID must "demonstrate how successful mitigation programs can be achieved and build capacity to sustain the efforts." It should "strengthen country capacity to improve development program performance and thereby reinforce the global effort to combat the spread of HIV/AIDS."

Although SHARP was a 5-year project with the goal of reducing new HIV infections, particularly for the most-at-risk population, only 1 of the 23 subpartners was given more than 2 years for project implementation. In fact, several were given a year or less to implement their activities. The short timeframe given to SHARP's subpartners hampered the program's effectiveness and limited the benefits of SHARP's technical and financial management training. Although all five subpartners interviewed expressed satisfaction with the program, they unanimously agreed that the program would have been much more effective if they had been given at least 2 years to implement their activities. A SHARP assessment conducted by Washington officials in late 2008 further alluded to this shortcoming. Table 3 shows the timeframe given to each of the five subpartners visited.

Table 3. Implementation Timeframe Given to SHARP Subpartners

SHARP Subpartner	Implementation Dates	No. of Months
4-H Ghana	1/2008-6/2009	18
MICDAK Charity Foundation	7/2007-9/2008 4-7/2009	19
OICI	12/2008-6/2009	7
Pro-link	9/2008-6/2009	10
Society of Women Against AIDS in Africa	2/2008-6/2009	17

The mission explained that SHARP's startup was particularly onerous because working directly with female sex workers, their nonpaying partners, and men who have sex with men required different skills and innovative approaches that were foreign to these organizations. AED's management problems, which resulted in the replacement of its chief of party, also contributed to delays in implementation. More importantly, all eight subpartners that started with SHARP before 2006 had management and performance problems. In addition, a key subpartner, West Africa Program to Combat AIDS and STI in Ghana (WAPCAS), was originally selected to work in 21 sites nationwide. However, its activities were drastically reduced because of unfavorable audit findings, and it later chose to leave the program. Similarly, the Center for Popular Education and Human Rights in Ghana (CEPEHRG), another key subpartner that supported the development of the intervention for men who have sex with men, left SHARP. These setbacks required the identification, training, and awarding of grants to several new subpartners, a challenging process that consumed a great deal of time and effort.

Because SHARP has ended and there was a delay in replacing the program, some of the knowledge and skills obtained under SHARP were lost or forgotten. Also, without any oversight, reporting requirements, salaries, or monthly transportation allowances for its peer educators, the subpartners' attempts to continue this work have not been effective.

Finally, USAID/Ghana expected to continue SHARP's prevention activities under a new award. Despite a recommendation from an assessment team to "ensure that there are no major funding gaps between the current and next PEPFAR agreement(s) or contract(s)," USAID's follow-on activity has been delayed because of a lengthier-than-anticipated procurement process. Although SHARP has ended, we are making a recommendation to ensure that the follow-on HIV/AIDS prevention activity awarded on February 26, 2010, does not encounter the same problem.

> *Recommendation 3: We recommend that USAID/Ghana develop its new HIV/AIDS prevention activity to build the capacity of local institutions and improve the prospects for sustainability by entering into longer subagreements and improving the subpartner selection process.*

Commodity Storage Conditions Were Inadequate

The USAID | DELIVER project aims to strengthen the integrated supply chain system and enhance commodity security. One of its FY 2009 objectives was to provide supervision to improve management of antiretroviral drugs, lab supplies including test kits, and family planning commodities.

Commodities Were Exposed to High Temperatures – Labels on antiretroviral drugs generally require storage at room temperature or at temperatures not to exceed 77 to 86 degrees Fahrenheit. However, storage temperatures observed at Ghana's Central Medical Store in Accra exceeded these established limits because the store's air-conditioner was not operational for over 2 years. Therefore, despite being well designed and ventilated, the storage facility had a temperature of about 88 degrees Fahrenheit in December 2009. The air-conditioner was finally repaired in February 2010 (after completion of audit fieldwork), and the Central Medical Store blamed the delay on a

negligent subcontractor. In the northern regions of Ghana, temperatures are about 11 degrees higher than those in Accra, potentially exposing the items to even greater heat.

The Central Medical Store supplies 10 regional medical stores, which in turn supply many other medical facilities in each region. Although the three regional medical stores visited were air-conditioned, they, along with the Central Medical Store, did not have generators or other contingency plans to protect commodities during power outages. Therefore, items at the regional medical stores were periodically subjected to heat that exceeded the recommended storage temperatures. In Ghana, power outages have been estimated to occur three times per month for up to 8 hours at a time. All medical stores visited further rely on electric freezers and refrigerators that hold expensive items such as insulin, vaccines, and other temperature-sensitive items.

Medical store officials explained that they did not have the authority to purchase generators, and funds were unavailable to purchase generators. In February 2010, after audit fieldwork was completed, the Central Medical Store was reportedly in the process of installing a generator.

Storerooms Were Overcrowded – Officials at the three regional medical stores visited complained that there was inadequate storage space. Particularly at the Ashanti and Greater Accra regional medical stores, storage rooms were overcrowded with boxes scattered along the floor, making it difficult to walk or retrieve certain items. Because of lack of space, many items were stored outside with excessive exposure to dust, sunlight, heat, and rain. As the following picture shows, it was difficult to determine the contents of the commodities and whether the commodities were adequate for distribution or set for disposal. The inadequate storage conditions occurred because of a lack of funding to provide additional space.

Pictured above in January 2010, supplies that would not fit in storage rooms at the Greater Accra Regional Medical Store are piled outdoors. (Photo by OIG)

Disposition of Expired Drugs Needed - Each store visited had a separate section for storing boxes of expired drugs, as shown in the picture below. Although store officials explained that the disposal process was carefully controlled, the regional medical stores in Ashanti and Greater Accra have not disposed of expired drugs within the past 3 years. The policy at the medical store in the Eastern region was to send expired drugs to the Central Medical Store for disposal, although this was not being done regularly. Officials at the stores visited were not aware of when the next drug disposal was scheduled or when the expired drugs would be returned to the Central Medical Store.

Shown above in January 2010, the entire top shelf of the storeroom at the Ashanti Regional Medical Store is stocked with expired drugs for disposal. (Photo by OIG)

Items that are improperly stored and exposed to temperatures that exceed their recommended limits may be ineffective or even harmful to patients. Also regularly disposing of expired drugs would provide additional shelf space and eliminate the possibility of misusing them. The mission has great concerns regarding these conditions but believes that USAID | DELIVER should not be held accountable because the project requires work with country counterparts through technical assistance only rather than through direct management of the stores. We agree with the mission that storage conditions and the disposal of expired drugs may be outside of its direct, manageable interest, but we believe that the situation is serious and should be conveyed in writing to the Government of Ghana. Therefore, we are making the following recommendation.

Recommendation 4: We recommend that USAID/Ghana advocate for improved HIV/AIDS commodity procurement and storage in a letter to the Director General of the Ghana AIDS Commission that includes this section of the audit report and points out the need for adequate equipment in warehouses to guarantee quality of antiretroviral therapy drugs.

Antiretroviral Drugs Were Unavailable or Expiring

According to the USAID | DELIVER FY 2010 work plan, the project aims to strengthen Ghana's supply system, improve the availability of commodities, and build up the capacity of health personnel. A specific objective listed in the FY 2010 and FY 2009 work plans is to improve the capacity of local personnel to undertake forecasting, quantification, procurement planning, and regular reviews of the pipeline of antiretroviral drugs, test kits, tuberculosis medicines, and family planning commodities. Although much progress has been made, our observations confirmed the mission's belief that "the national system for commodity procurement and distribution continues to under-perform."

During visits to the Central Medical Store and 3 of Ghana's 10 regional medical stores, several antiretroviral drugs were not available on demand, as shown in table 4. Based on input provided by store employees, each store received requests for 17 to 21 drugs.

Table 4. Availability of Antiretroviral Drugs at Medical Stores Visited

Location of Store	Drugs Available	Drugs Not Available	Percent Unavailable
Central Medical Store	13	8	38
Eastern Regional Medical Store	11	8	42
Ashanti Regional Medical Store	12	5	29
Greater Accra Regional Medical Store	13	8	38
Total	**49**	**29**	**37**

In addition, supplies of 5 of the 49 antiretroviral drugs observed were to expire within 2 months, and as noted previously, each store had large sections of expired drugs. An official explained that when the Central Medical Store receives requests for drugs that are found to expire within 2 months, staff members there often decide to put the drugs in the expired drugs section of the store rather than send them to the requesting regional medical store. Another official complained that the store's large inventory of expired drugs is a result of receiving drugs from the Central Medical Store that cannot be used by the expiration date. A Central Medical Store official denied that expiring drugs were a problem and cited a favorable review performed in 2008. In general, officials noted improvements regarding drug availability and the number of expired drugs, but all acknowledge that there is room for further improvement.

Problems that contribute to the unavailability and high percentage of expired drugs include the following.

- Weaknesses in reporting drug utilization – To properly forecast demand, facilities are required to report drug consumption statistics by the fifth day of the following month. However, one study conducted about a year ago in the Ashanti region showed that more than 50 percent of its facilities were unable to meet this deadline. Some facilities were also reporting incomplete or incorrect information. As a result, regional medical stores were not able to provide stock status reports by the 12th of the following month as required by the National AIDS Control Program. During visits to

the Ashanti, Eastern, and Greater Accra regional medical stores in mid-January 2010, the most recent stock status reports were for November, September, and June 2009. These medical stores were more than 1, 3, and 6 months late, respectively, in reporting their monthly drug balances, yet nobody had reminded the Greater Accra Regional Medical Store about the need to submit these overdue reports.

- Lack of funds – All levels of the supply chain must deal with funding shortages. One official explained that the national insurance system has not been reimbursing medical facilities in a timely manner, preventing facilities from purchasing additional supplies. A January 2010 newspaper article reported that some health providers in the Ashanti region had not been reimbursed since May 2009, hampering their ability to pay the regional medical store.

- Lack of vehicles – The regional medical stores in the Eastern and Ashanti regions cited the lack of transport vehicles as a cause for delays in meeting the needs of the medical facilities.

- A lengthy procurement process – One official complained that procurement laws were inflexible and the process was too lengthy, and another remarked that the process relied excessively on collaboration and coordination between government officials and foreign donors.

- Shortage of qualified staff – Despite the training provided by the project, there was a shortage of well-qualified and well-trained technical staff. Each store had many new, entry-level personnel, but they were not always trained or capable of performing their assigned duties.

- Space limitations – One pharmacist explained that space limitations often lead to ordering a 3-month supply of drugs instead of a 6-month supply.

Because of the unavailability of antiretroviral drugs, patients have no choice but to wait or to rely on substitutes. Taking medication regularly is a matter of life and death for these patients. In a country that has a shortage of medical supplies, to have large quantities of expensive drugs expire is unacceptable. Aside from being wasteful, it directly reduces the number of people that have access to drugs and causes the potential death of patients who cannot receive timely treatment. In December 2009, the Acting Director General of the Ghana AIDS Commission estimated that treatment covers only 37 percent of people living with HIV in Ghana. To some extent, the mission has already been informed about these problems, and the mission believes that many of the issues are outside its controllable interest (as previously noted). Nonetheless, we recommend that the mission take the following action.

Recommendation 5: We recommend that USAID/Ghana work with John Snow International and revise the DELIVER work plan to include preparation of a disposal plan to assist the Government of Ghana in the disposal of expired goods.

USAID/Ghana Set Performance Targets for OICI Too Low

USAID's ADS 203.3.4.5 states that, for each indicator in a performance management plan, the operating unit should set performance baselines and set targets that can be optimistically but realistically achieved within the stated timeframe and with the available resources. Targets should be ambitious but achievable given USAID inputs. Performance targets that are set too low are not useful for management or for reporting results to PEPFAR and other stakeholders.

Targets for some of OICI's annual performance indicators were set too low from FY 2006 to FY 2009. As a result, as shown in Table 5, OICI consistently exceeded them, sometimes by significant margins. For example, in 2009, OICI reached 1,369 individuals with abstinence messages, far more than its target of 300 individuals.

Table 5. OICI Targets Versus Reported Results

Indicators	2009 Target	2009 Actual	Percent Achieved	2008 Target	2008 Actual	Percent Achieved
Individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence	300	1,369	456	200	697	349
Individuals trained to promote HIV/AIDS prevention programs through abstinence or being faithful	400	1,705	426	400	584	146
Individuals trained to promote HIV/AIDS prevention through other behavior change beyond abstinence or being faithful	400	1,705	426	400	584	146
Total individuals trained to provide HIV palliative care	400	1,705	426	400	584	146

The disparity between target and actual results occurred because USAID/Ghana's HIV/AIDS team overlooked the need to adjust indicators as required. Adjusting targets will help keep them relevant and may improve results. Targets that are set too low are not useful for management or reporting purposes. We are making the following recommendation to ensure that USAID/Ghana revises targets to reflect realistic expectations, enabling management to measure program performance accurately.

Recommendation 6: We recommend that USAID/Ghana's HIV/AIDS team establish written procedures to revise its performance targets for the President's Emergency Plan for AIDS Relief activities to reflect realistic expectations.

OICI Did Not Document Eligibility of Orphans or Vulnerable Children

The HOPE program implemented by OICI provided scholarships to OVC in 4 of Ghana's 10 regions. At the time of the audit, the program was sponsoring 556 scholarship recipients, and since inception the program had reached 1,302 students. PEPFAR clearly defines an OVC as a "child, 0-17 years old, who is either orphaned or made more

vulnerable because of HIV/AIDS." An orphan has "lost one or both parents to HIV/AIDS," and a vulnerable child is one who meets any of the following requirements:

- Is HIV-positive.

- Lives without adequate adult support (e.g., in a household with chronically ill parents, a household that has experienced a recent death from chronic illness, a household headed by a grandparent, or a household headed by a child).

- Lives outside of family care (e.g., in residential care or on the streets).

- Is marginalized, stigmatized, or discriminated against.

However, during visits to 12 vocational training centers in 3 of the 4 regions, attempts to verify the eligibility of the recipients were unsuccessful because the centers did not maintain records documenting how or why children had been admitted to the program. Although the centers and OICI maintained a spreadsheet containing the names of the students, OICI did not maintain files or records to support children's ages, the presence or health status of parents, or other eligibility requirements. Moreover, we noted that OICI personnel in charge of reviewing eligibility of scholarship recipients were not familiar with PEPFAR's eligibility criteria. USAID/Ghana provided us with eligibility criteria that OICI was theoretically required to use, but these criteria were not the same as those issued by PEPFAR.

OICI regional personnel in charge of ensuring beneficiary eligibility did not verify critical information—such as the age of the beneficiary, HIV/AIDS status, and other PEPFAR requirements—because they relied on third parties such as the Red Cross, hospital officials, and others. The lack of student files can be attributed to inadequate oversight of the program.

As a result, the program may have assisted beneficiaries who were not eligible for the program. The audit team interviewed the students,[3] asking general questions to determine whether these children were eligible for the program, but specifically avoided questions related to HIV/AIDS because of concerns over beneficiary confidentiality. Of 44 students interviewed, 10 students were 18 or older.[4] Most students mentioned that their parents were ill, dead, or living at unknown locations, but 18 students mentioned that both of their parents were still alive and well. When asked how she was admitted to the program, one student mentioned that a friend at her church who liked her singing got her in. Another student mentioned that the person who recruited him was impressed with his play during a soccer match and offered him the scholarship. Because of the lack of documentation and concerns regarding confidentiality, we could not conclusively determine whether a particular child was eligible to participate in the program. To ensure the eligibility of future scholarship recipients, we are making the following recommendation.

[3] Our conclusion was not based solely on the interviews (those interviewed may not be representative of the entire population, and students' statements may or may not be true), but we are including them because they demonstrate the need to document program eligibility.

[4] Because this is a 2-year program, some children may have met age requirements when they entered the program, but there was no support to determine their ages.

Recommendation 7: We recommend that USAID/Ghana implement controls requiring that Opportunities Industrialization Centers International (1) use the President's Emergency Plan for AIDS Relief guidelines to verify the eligibility of all students who receive scholarships as part of the HOPE program and (2) document and maintain each student's personal file at Opportunities Industrialization Centers International offices.

Distribution of Program Allowances Lacked Controls

Under the HOPE program, beneficiaries are entitled to receive 80 Ghanaian pesewas (1 cedi is divided into 100 pesewas; 80 pesewas is equivalent to $0.56) for daily food and transportation expenses. Although these payments are to be made in full each month, the audit team noted some exceptions.

At one vocational school visited, records showed that all five students had received less money than they were entitled to. The students reported that the administrator of the school and a teacher were retaining 25 percent of the monthly allowances without student consent or permission from OICI. OICI representatives were unaware of the situation and pledged to take immediate action by having the OICI regional representatives pay the monthly allowances directly to the students.

In addition, all 44 students interviewed reported that they did not always receive their allowances on time or in full. Of the 44 students, 18 students did not receive any allowance during October and November 2009 but received a lump-sum payment in December for the 3 months. This delay occurred because regional personnel did not receive funding from OICI headquarters on time. Furthermore, OICI was not adequately supervising distribution of allowances.

Although the amount of money withheld from the students is not significant, these acts of wrongdoing and possible fraud committed by the administrators and teachers should be addressed. A reduced allowance or delay in payment can cause undue hardship to students who are already struggling financially. In extreme cases, allowance problems could lead to school dropouts. We are making the following recommendation to ensure that each beneficiary receives the full allowance on time.

Recommendation 8: We recommend that USAID/Ghana require Opportunities Industrialization Centers International to develop and implement financial controls to confirm that the scholarship recipients receive their allowances on time and in full.

USAID/Ghana Should Adhere to Branding Requirements

ADS 320, "Branding and Marking," generally requires "that all USAID-funded foreign assistance must be branded through the use of a 'Branding Strategy' and marked through the use of a 'Marking Plan.'" USAID programs, projects, activities, public communications, and commodities with USAID funding are generally required to be branded with a standard graphic identity.

The audit team observed the following instances of noncompliance with USAID's branding requirements:

- At the offices of all five SHARP subpartners visited, none of the USAID-funded fixed assets—air-conditioners, chairs, TVs, computers, etc.—were branded with the appropriate USAID logo. This lack of branding occurred because the subpartners either were unaware of the requirement or were awaiting further instruction from AED.

- None of the computers, chairs, or tables at the QHP office were appropriately branded, and neither of the two external computer hard drives donated to the Korle Bu Teaching Hospital in Accra were branded.

- Personnel at a hospital visited in Nsawam in the Eastern region did not know that USAID was the sponsor of the training they received.

- None of the 18 computers and printers donated by USAID/Ghana to the OICI vocational school in Kumasi were branded with the appropriate USAID logo. Instead, all of them were inappropriately branded with OICI logos and markings.

- Although administrators, teachers, and students interviewed were all very excited about the HOPE scholarship program and wished for it to continue, 29 out of 44 students interviewed were unable to identify USAID or the American people as the sponsor.

- At one of the three regional medical stores visited, the head pharmacist in charge of managing program drugs was not aware of USAID's contributions. She believed that the National AIDS Control Program provided most of the support to the store and was uncertain about whether funding came from the Global Fund, USAID, the Government of Ghana, or another source. At the Central Medical Store, another USAID trainee was unable to identify USAID as the donor.

- None of the six vehicles used by OICI, EngenderHealth, and John Snow International were appropriately branded. The mission explained that the Regional Security Office opposed branding vehicles. However, no waivers were obtained.

For AED, the lack of an approved branding implementation plan contributed to the problem, and for EngenderHealth and OICI, the branding plan was not followed. More importantly, USAID/Ghana failed to identify and correct the deficiencies. The risk exists that neither the U.S. Government nor the American people will receive the credit they deserve for their HIV/AIDS efforts in Ghana, and the objectives of furthering U.S foreign policy in Ghana will not be achieved. To ensure that the people of Ghana know about USAID's contributions, this audit makes the following recommendation.

Recommendation 9: We recommend that USAID/Ghana direct all partners in writing to develop branding plans to ensure adherence to USAID branding guidelines (which may include obtaining waivers).

EVALUATION OF MANAGEMENT COMMENTS

USAID/Ghana agreed with eight of the nine recommendations in the draft report. In preparing the final report, the Regional Inspector General/Dakar (RIG/Dakar) considered management's comments and clarified its position on the one recommendation with which the mission did not agree. The evaluation of management comments is shown below.

For recommendation 1, USAID/Ghana disagreed with some of the content in the finding, but concurred with the recommendation. Specifically, the mission thought that our audit sample was small and skewed—selecting only 6 of 30 facilities and including facilities where activities were limited. However, we have documented in our scope and methodology section that, although the results from the sample cannot be projected to the universe of all activities, we believe that our work provides a reasonable basis for our conclusions. Nevertheless, the mission submitted a revised QHP work plan, which includes training and followup, which RIG/Dakar has reviewed. This action constitutes final action for this recommendation.

For recommendation 2, USAID/Ghana agreed with the recommendation and will develop, in coordination with QHP, a system that measures increases in service outputs by September 7, 2010. Accordingly, a management decision has been reached for this recommendation.

For recommendation 3, USAID/Ghana agreed with the recommendation and has sent a letter to Family Health International, the implementing partner on the 4-year follow-on project SHARPER, to inform Family Health International of the audit findings and ask it to improve on the selection process, paying particular attention to ensuring that subagreements span longer periods. RIG/Dakar reviewed this letter, and it adequately addresses the recommendation. This action constitutes final action for this recommendation.

For recommendation 4, USAID/Ghana agreed with the recommendation and has sent a letter to the Acting Director-General of the Ghana AIDS Commission regarding storage conditions and the need to have adequate equipment. RIG/Dakar reviewed this letter, and it adequately addresses the recommendation. This action constitutes final action for this recommendation.

For recommendation 5, USAID/Ghana agreed with the recommendation and has included a step to ensure "proper disposal of expired/damaged ARV" in the current John Snow International work plan. RIG/Dakar reviewed this work plan, and it adequately addresses the recommendation. This action constitutes final action for this recommendation.

For recommendation 6, USAID/Ghana agreed with the recommendation and added that procedures to revise performance targets will be included as part of the next country operational plan, which will be completed by October 15, 2010. Accordingly, a management decision has been reached for this recommendation.

For recommendation 7, USAID/Ghana did not agree with the recommendation. According to the mission, with regard to the type of documentation required for confirming eligibility, HIV test results for the parents of affected children are not necessary for Orphans and Vulnerable Children (OVC) to receive service. The mission considers that participation of the child's parent(s) in a support group for People Living with HIV/AIDS is sufficient evidence of the child's eligibility for the OVC program based on a presentation made by the Senior Technical Advisor for OVC at the Office of the Global AIDS Coordinator in September 2007, which stated, "a child does not need to be infected, or an orphan, and does not need proof, but only possibility of parent being chronically ill to be considered an OVC."

However, we would like to point out that PEPFAR guidance (http://www.pepfar.gov/guidance/78164.htm) states:

> Conceptually, a vulnerable child is one who is living in circumstances with high risks and whose prospects for continued growth and development are seriously impaired. In the international community, the term 'Orphans and other Vulnerable Children,' or 'OVCs,' sometimes refers only to children with increased vulnerabilities because of HIV/AIDS, and at other times refers to all vulnerable children, regardless of the cause (e.g., chronic poverty, armed conflict, famine). Since the Emergency Plan focuses on those with increased vulnerabilities from HIV/AIDS, this guidance defines 'OVC' in the following way:
>
> A child, 0-17 years old, who is either orphaned or made more vulnerable because of HIV/AIDS.
>
> [An orphan] Has lost one or both parents to HIV/AIDS
>
> [and a vulnerable child] Is more vulnerable because of any or all of the following factors that result from HIV/AIDS:
>
> - Is HIV-positive.
> - Lives without adequate adult support (e.g., in a household with chronically ill parents, a household that has experienced a recent death from chronic illness, a household headed by a grandparent, and/or a household headed by a child).
> - Lives outside of family care (e.g., in residential care or on the streets).
> - Is marginalized, stigmatized, or discriminated against.

Our recommendation was intended to establish adequate controls to ensure that only eligible beneficiaries participate in the program. According to the mission's response, the mere possibility of a parent being chronically ill is sufficient. The mission is implying that documentation of a link to HIV/AIDS is not necessary, which is contrary to PEPFAR's guidance. We contacted the Sr. Technical Advisor for Orphans and Vulnerable Children Technical Working Group Co-Chair for further guidance. She

confirmed that there have been some changes to the definition (for a more vague definition), however, she stated that unfortunately the new definition has not been formally updated on the website. According to the advisor, the definition was changed to protect the children from stigmatism, but she agreed that in the case of Ghana, increased controls over the eligibility of the child were necessary. Nevertheless, although there is disagreement about the criteria used for program eligibility, there is agreement that the age of entrance into the program should be properly documented and will be implemented by September 30, 2010. Accordingly, a management decision has been reached for this recommendation.

For recommendation 8, USAID/Ghana agreed with the recommendation and expects that new controls will be in place before September 30, 2010. Accordingly, a management decision has been reached for this recommendation.

For recommendation 9, USAID/Ghana agreed with the recommendation and will require all implementing partners to have branding and marking plans in place before September 30, 2010. A memo requesting the submission of marking and branding plans was sent to all implementing partners and reviewed by RIG/Dakar. Accordingly, a management decision has been reached for this recommendation.

SCOPE AND METHODOLOGY

Scope

The Regional Inspector General/Dakar conducted this performance audit in accordance with generally accepted government auditing standards. 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, based on our audit objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective. The objective of the audit was to determine whether USAID/Ghana's HIV/AIDS activities achieved their main goals.

In planning and performing the audit, the audit team assessed management controls related to management review, proper execution of transactions and events, and performance targets and indicators. Specifically, we reviewed and evaluated the following:

- FY 2009 and FY 2010 country operational plans
- Performance management plans
- Certification required under the Federal Managers' Financial Integrity Act of 1982 (as codified in 31 U.S.C. 1105, 1113, and 3512)
- Implementing partner agreements
- Actual performance results
- Data quality assessments
- Financial reports

We interviewed key USAID/Ghana personnel, implementing partner staff, volunteers, beneficiaries, and Ghanaian Government health and education officials. We conducted the audit at USAID/Ghana and at the activity sites of implementing partners in 3 of Ghana's 10 regions (Greater Accra, Eastern, and Ashanti). Audit fieldwork was conducted at USAID/Ghana December 7-11, 2009, and January 11-22, 2010, and covered selected activities that took place from FY 2004 through FY 2009.

During FY 2009, USAID/Ghana's HIV/AIDS program had agreements with several partners. As shown in the table on the following page, we focused on five agreements, including the three that were responsible for nearly all the results required by PEPFAR's reporting guidelines (QHP, SHARP, and HOPE).

HIV/AIDS Program Agreements

Activity Name/ Partner Name	Estimated Budget	Program Start Date	Program End Date
QHP / EngenderHealth	$20,050,000	6/01/2004	9/30/2010
SHARP / Academy for Educational Development (AED)	$15,000,000	6/10/2004	10/30/2009
USAID | DELIVER / John Snow International (Field Support)	$13,970,000	9/2004	9/30/2011
HOPE / Opportunities Industrialization Centers International (OICI)	$1,203,359	6/16/2004	9/30/2009
Teacher Training College HIV/AIDS Window of Hope Curriculum / Ghana's Ministry of Education, Science, and Sports	$200,000	3/01/2008	9/30/2010

During FY 2009, $3.9 million was obligated and $3.3 million was disbursed for USAID/Ghana's HIV/AIDS program.

Methodology

To answer the audit objective, we reviewed activities implemented by the five selected implementing partners as well as the PEPFAR indicators reported by USAID/Ghana in FY 2009. We also reviewed available agreements, progress reports, and work plans of the five implementing partners. We reviewed applicable laws and regulations and USAID policies and procedures pertaining to USAID/Ghana's HIV/AIDS program, including the Federal Managers' Financial Integrity Act of 1982 certification, ADS chapters 202 and 203, and supplemental ADS guidance.

We performed site visits at the following:

- 3 of 10 regional medical stores and the Central Medical Store to observe the process of storing and distributing antiretroviral drugs
- Offices of 5 of 14 subpartners that implemented SHARP's prevention activities during FY 2009
- 6 of 30 hospitals that participated in USAID/Ghana's quality improvement program
- 12 of 56 vocational training centers for OICI students

The sample consisted of sites that (1) were located in the Greater Accra, Eastern, and Ashanti regions where the five audited programs were being implemented, (2) included both large and small hospitals, and (3) involved large, medium, and small numbers of student participants. The results from the sample cannot be projected to the universe of all activities on a statistical basis. However, we believe that our work provides a reasonable basis for our conclusions.

In addition, we visited a piggery and a cassava farm managed by people living with HIV, an orphanage, a Presbyterian teacher training college, and an HIV/AIDS support group session.

During these visits, we interviewed implementing partner staff, service providers, volunteers, beneficiaries, and Ghanaian Government health and education officials. Among other things, the purpose of the visits was to verify reported results, ensure that activities were being monitored and evaluated, and ascertain the effectiveness and efficiency of the programs.

MANAGEMENT COMMENTS

USAID | GHANA
FROM THE AMERICAN PEOPLE

To: Gerard Custer, Regional Inspector General

From: Cheryl Anderson, Mission Director, USAID/Ghana /s/

Date: June 28, 2010

Subject: Audit of USAID/Ghana's HIV/AIDS program (report 7-641-10-00X-P)

This memorandum transmits USAID/Ghana's management response on the above audit report. The Mission thanks the audit team for their work on data collection and write-up of the report. The report documents and identifies nine weaknesses, for which recommendations are proposed for improvement. The Mission concurs with seven of them without major comments, and proposes measures to close the recommendations.

The Mission has fundamental reservations with two of the perceived weaknesses. The first is related to the QHP program implemented by EngenderHealth, where we disagree with the findings presented in the text. However, we will still follow-up on your recommendation (No. 1). Another recommendation, No. 7, on OVC eligibility for the scholarship programs, appears surpassed by recent guidance by OVC policy makers.

The Mission's main reservation concerns the findings that states "EngenderHealth's QHP program has had limited effect." The Mission provided written and verbal comments on at least six occasions and, again, draws your attention to the fact that the sample of the audit was small and skewed. The auditors visited six facilities out of a total of 30 facilities where the program is active. Two of the facilities visited had limited programs, being 37 Military Hospital and Komfo Anokye Teaching Hospital (KATH). While high-service volume sites, 37 Military and KATH hospitals are atypical since they had limited program activities. It appears that the conclusions of the audit representationally skewed by the experiences in these two hospitals, especially KATH.

After six rounds of written and verbal comments, the Mission notes with some concern that both Its Health Team and the implementer do not feel that this section accurately describes the situation, and we have not come to a common understanding with the audit team of the strengths and weaknesses of the program. There are also still inaccuracies in the text, e.g. "EngenderHealth did not have plans to provide [refresher training courses]", even though The Mission has stated many times that these are part of the currently implemented work plan. There are also still sweeping statements that in our opinion cannot be justified from the audit's limited and unrepresentative sample, e.g. "Because of EngenderHealth's inability to promote the program objectives, hospital staff and management have lost interest in the program".

The Mission concludes that the audit team has not been able to produce a fair, representative and balanced account of this particular program. Nevertheless, we are prepared to respond to the report's recommendation.

Recommendation No. 1: *We recommend that USAID/Ghana, in coordination with EngenderHealth, review and revise its implementation plan to ensure that the work plan includes sufficient staff is trained or retrained, and to ensure that work plan includes sufficient follow-up with the hospitals to implement clearly defined action plans.*

Management Response: The Mission concurs with the recommendation. Attached is the latest QHP work plan which in our opinion addresses the issues raised in the recommendation (attachment 1).

Recommendation No. 2: *We recommend that USAID/Ghana, in collaboration with EngenderHealth develop a metric system that more carefully measures the activities performed by EngenderHealth.*

Management Response: The Mission concurs with the recommendation. USAID/Ghana appreciates that our opinions and comments have been included in the text. We thank the auditors for pointing out that the results from less successful QHP sites should not be included in their results, and we will develop with QHP a system that measures increases in service outputs within the next three months.

Recommendation No. 3 *We recommend that USAID/Ghana develops its new HIV/AIDS prevention activity to build the capacity of local institutions and improve the prospects for sustainability by entering into longer sub-agreements and improving the sub-partner selection process.*

Management Response*:* The Mission concurs with the recommendation. We have written a letter to the 4-year follow-on project, Family Health International/SHARPER, to inform them of the audit findings and have requested them to improve upon the selection process and pay particular attention to ensuring that sub-agreements span longer periods of time. The letter is reproduced as attachment 2.

Recommendation No 4: *We recommend that USAID/Ghana advocate for improved HIV/AIDS commodity procurement and storage in a letter to the Director General of the Ghana AIDS Commission, that includes this section of the audit report and points out the need for adequate equipment in warehouses to guarantee quality of anti-retroviral therapy (ART) drugs.*

Management Response: The Mission concurs with the recommendation. A letter has been sent to the Acting Director-General of the Ghana AIDS Commission and is reproduced as attachment 3.

Recommendation No. 5: *We recommend that USAID/Ghana work with John Snow International and revise the work plan to include preparation of a disposal*

plan to assist the Government of Ghana in the disposal of expired goods.

Management Response: The Mission concurs with the recommendation. However, as previously stated in communications with the audit team, these are serious concerns regarding GOG products that are shared by USAID and the entire donor community and which USAID has been working to address for some time. John Snow has included this activity in the current work plan (attachment 5, activity 1.4.1. c and d; and footnotes on the last 2 pages "steps to proper disposal of expired/damaged ARV").

Recommendation 6*: We recommend that USAID/Ghana's HIV/AIDS team establish written procedures to revise its performance targets for Emergency Plan activities to reflect realistic exceptions.*

Management Response: We agree with the recommendation. A document outlining such procedures will be included as part of the next Country Operational Plan.

Recommendation No. 7: *We recommend that USAID/Ghana implement adequate controls to ensure that OICI (1) verifies the eligibility of all students who receive scholarships as part of the HOPE program using PEPFAR guidelines and (2) documents and maintains each student's personal file at the vocational centers and at OICI offices.*

Management Response: The Mission does not concur with the recommendation. Some of the findings cited by the audit team to support the recommendation concerning validity of source documentation are not consistent with recent PEPFAR guidance. Specifically, in regards to the type of documentation required for confirming the accuracy of results reported, the presence of HIV test results for the parent of affected children are not necessary for Orphan or Vulnerable Child (OVC) to receive service. In a presentation made by the Sr. Technical Advisor for OVC at the Office of the Global AIDS Coordinator (O/GAC) in September 2007 to clarify this issue, a slide stated, "a child does not need to be infected, or an orphan, and does not need proof, but only possibility of parent being chronically ill to be considered an OVC". Therefore, participation of the child's parent(s) in the support group for People Living with HIV/AIDS is sufficient evidence for eligibility of the child into the OICI program. This broader definition of "OVC" is also a matter of Public Law. Public Law 110-293, which reauthorized the PEPFAR program in 2008, states: "orphans and children who are vulnerable to, or affected by, HIV/AIDS." Citation: The Tom Lantos and Henry J. Hyde Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008, PL 110–293, 122 STAT. 2918, (2008).

The current data collection system being employed by USAID and its partner OICI – with emphasis on record keeping at the Regional OICI Offices (and thus away from possible unauthorized observers at the schools) is in our opinion appropriate. The methods used by OICI to determine eligibility are widely accepted in other programs and are considered appropriate to protect the privacy of clients seeking HIV related services that are still highly stigmatized in Ghana. We will however, make sure that the age of entrance into the program is properly documented.

In formulating this response we were supported by Gretchen Bachman, Sr. Technical Advisor, Orphans and Vulnerable Children, PEPFAR OVC Technical Working Group Co-Chair, Office of HIV/AIDS, Global Health, USAID, WDC, Email: gbachman@usaid.gov, Telephone: 202 684-9946

Recommendation No. 8*: We recommend that USAID/Ghana require Opportunities Industrialization Centers International to develop and implement financial controls to confirm that the scholarship recipients receive their allowances on time and in full.*

Management Response: The Mission concurs with the recommendation. We expect the new controls to be in place before the end of the fiscal year.

Recommendation No. 9: *We recommend that USAID/Ghana direct all partners in writing to develop branding plans to ensure adherence to USAID branding guidelines.*

Management Response: The Mission concurs with the recommendation and will require all implementing partners to have branding and marking plans in place before the end of the fiscal year. Please note that the Regional Security Officer is against the branding of vehicles for security reasons. A memo requesting submission of marking and branding plans is reproduced as attachment 4. Branding and marking plans should be in place within the next three months.

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