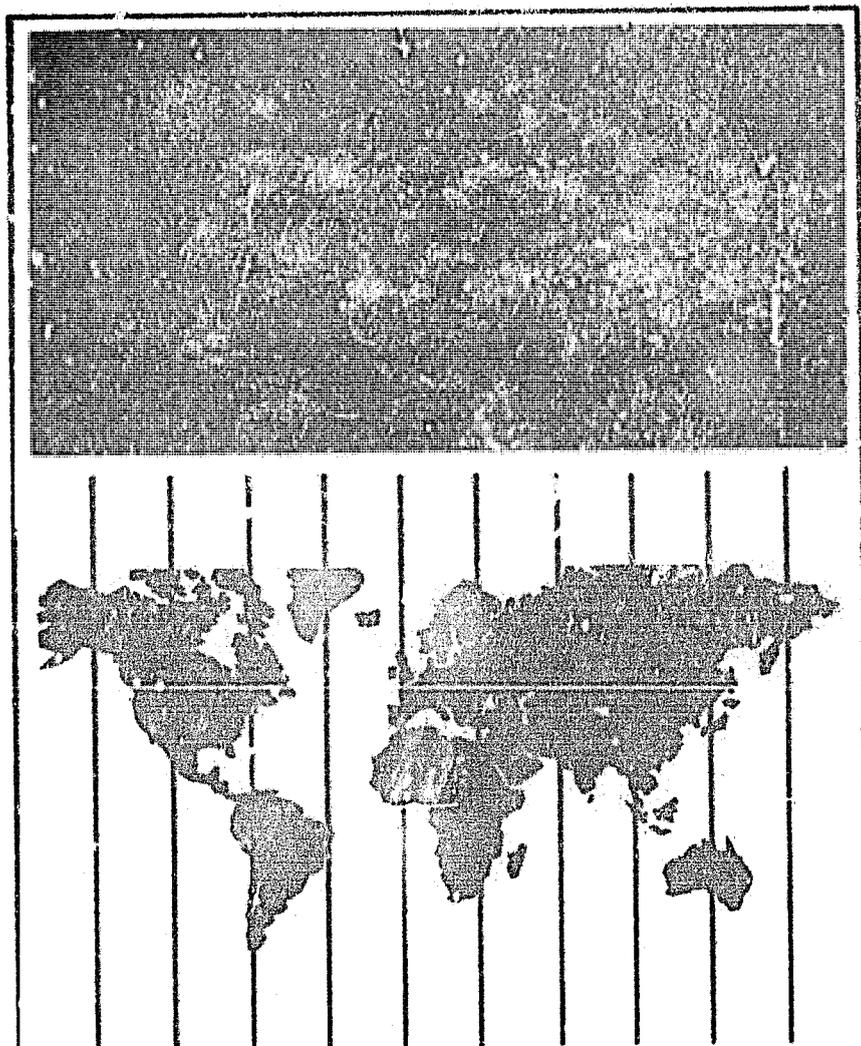


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UNITED STATES
AGENCY FOR INTERNATIONAL DEVELOPMENT

THE
INSPECTOR
GENERAL



Regional Inspector General for Audit
CAIRO

A REPORT ON
THE FIRST SEVEN YEARS OF
USAID/EGYPT'S ASSISTANCE TO
STRENGTHENING RURAL HEALTH DELIVERY
PROJECT NO. 263-0015

Audit Report No. 6-263-83-5

July 14, 1983

AID has committed \$15 million to help the Government of Egypt (GOE) upgrade the health status of Egypt's rural population. The project completion date was extended to May 1, 1986, almost 10 years after the project was approved. Project activities have been delayed. Conditions reported in February 1981 affecting project implementation have not been corrected. Project direction and objectives have changed from those initially established, and a host country contractor has not provided the technical assistance contracted for. In our view, there is no assurance that current project momentum is adequate to achieve the planned end-of-project results by 1986.

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EXECUTIVE SUMMARY

Background

Even though the Government of Egypt maintains a fairly large government operated health delivery system, health officials recognized a need to improve the health status of its poor majority. Substantial qualitative improvement in health manpower training, health education, improvement in supervision and better health planning were needed to upgrade the health status of Egypt's rural population.

In July 1975 AID provided a study team to help design an appropriate health project to assist the Egyptian Government identify and validate the principal factors limiting the productivity and outreach of rural health service. The AID assisted project authorized July 30, 1976 would evaluate and select tested cost-effective replicable strategies to improve the health delivery system for nationwide application. In addition, the project would mobilize greater support and commitment of resources to the rural health program within the Ministry of Health.

AID's grant agreement dated September 30, 1976 provided \$1.8 million to fund the first of five years of project implementation. The first year funding earmarked \$1.1 million for vehicles, \$410 thousand for a U.S. technical assistance contractor, and \$250 thousand for Egyptian technical consultation and training.

In December 1977, a \$1.8 million host-country contract was awarded to Westinghouse Health Systems, a Division of Westinghouse Electric Corporation. The contractor was to provide 60 months of technical assistance to the Ministry of Health.

By February 1979 the grant agreement had been amended three times increasing AID's obligation for the project to \$7.8 million plus LE600,000. Egyptian pounds were provided to cover local costs of technical services, studies, field testing, local training program and other project operating costs.

An amendment to the project paper in January 1983 changed the project purposes and output objectives to reflect actual implementation, direction and the recommendations of AID's special evaluation team. AID extended the completion date of the Strengthening of Rural Health Delivery Project (No. 263-0015) to May 1, 1986 almost 10 years after the project was approved. The estimated project costs have reached \$44.2 million. AID's planned contribution increased to \$14.9 million and the Egyptian Government has earmarked \$29.3 million to complete project activities.

At February 28, 1983 AID had obligated \$7.8 million and disbursements had reached \$4.7 million.

Purpose and Scope

The purpose of our audit was to determine if AID's rural health project was effectively and efficiently managed, and to evaluate progress. Our audit was made in accordance with applicable U.S. Government Auditing Standards. We reviewed project documents and reports, and held discussions with responsible USAID and Egyptian health officials. We made visits to health clinics to observe contractor assisted health delivery practices. Project activities through March 31, 1983 were included in our audit. A copy of our draft report was provided to management officials. Their comments were considered in preparation of our final report.

Project Implementation Is Delayed

There have been delays in project implementation. Project activities were to be completed in five years. Currently the amended project paper projects a ten year life of project activity (1976-1986).

In February 1981 an AID special evaluation team reported that the goal and purpose as identified in the original project paper and grant agreement had not been accomplished. Originally planned tests of new health practices had not progressed as intended, and questions regarding the cost and effectiveness of new procedures remain unanswered. In addition, information relevant to newly introduced health practices had been gathered, but only a minor part had been analyzed and interpreted.

Reported conditions affecting project implementation still exist, and in our view, there is no assurance that end of project results in 1986 can be measured. To avoid further delays in project activity, we have recommended that USAID and the Ministry of Health identify all data collected by the project prior to May 1, 1982; determine what data is to be analyzed, interpreted and reported as required by the special covenant; and establish a new date for submission of this data. This information is needed to determine if new health procedures are effective and could be replicated nationwide.

Alternate Sources For Technical Assistance Should Be Explored

A \$1.8 million host country contract was awarded to Westinghouse Health Systems, a Division of Westinghouse Electric Corporation on December 27, 1977. Since that time, the project has muddled through almost two years without the benefit of a long-term technical advisor. This key person, the health services researcher, was required in Egypt for the life of the project. This person reported to work on April 5, 1978 and was considered essential to project success. The initial researcher left Egypt on June 30, 1981. Since that time, the contractor provided a health researcher in Egypt for only nine months from June 30, 1982 to April 11, 1983. In our view, the absence of a permanent technical consultant has adversely affected implementation of the project. Moreover, there is some doubt that a qualified health services researcher can be provided before the contract terminates on July 31, 1983.

The contractor's initial 18 month implementation plan submitted in July 1978 was accepted by USAID in February 1979. According to USAID project management, the plan lacked specific details in the quantity and timing of inputs, and outputs were not quantified within the timeframe required for expeditious project accomplishments. In fact the plan submitted revised the project purposes, and initiated a new project direction as more emphasis was placed on improvement of existing health services.

As of March 31, 1983, five years after the contract was signed, the contractor had not accomplished the following work:

- A project operational work plan for implementing project activities to completion was not developed.
- Testing of project data had been conducted in a few districts, but the result of these tests had not been processed or analyzed for replicability nationwide.
- An evaluation required by the contract scope of work was not made.

USAID project management believes that the contractor's performance will improve when a new health researcher is assigned to the project. The contractor had difficulty in the past recruiting a qualified person for this position. In our view, Westinghouse has failed to properly support the project in the past and there is no assurance that this will change. Moreover, it is unlikely that a qualified consultant will be located before the contract expires on July 31, 1983. We have recommended that management determine if the contractor's performance warrants an extension of the contract. Also that project management explore alternate sources of technical assistance for project completion.

Vehicle Utilization Questioned

AID-financed vehicles were being used for unauthorized purposes. We noted widespread use of vehicles to transport project employees from their residences, and five vehicles costing \$35,900 were assigned to activities outside the project. USAID's utilization plan developed in March 1979 provided guidelines for the distribution and use of vehicles for project activities. After the initial procurement of 140 vehicles, AID's special evaluation team recommended that no further vehicles be purchased. They reported that the vehicles had not had any impact on improving the rural health delivery system. Nonetheless, USAID initiated procurement of 118 additional vehicles. In their response to RIG/A/C Audit Report (No. 6-263-83-2) dated February 21, 1983, AID management said that suspension of vehicle procurement for this project was not possible or practical. Vehicles were ordered prior to our report and were scheduled to arrive in Egypt on or about April 30, 1983.

Notwithstanding, USAID had taken no action to recover five AID-financed vehicles utilized for purposes not related to the Strengthening Rural Health Delivery Project. These five vehicles were identified and reported to project management in February 1983. USAID management reported that four vehicles were returned to the project and that USAID had agreed to reassign the fifth vehicle to another project. We have recommended that the Ministry of Health provide the location and condition of the four vehicles returned to the project.

BACKGROUND

In October 1974, a United States and Egyptian Joint Working Group on Medical Cooperation identified five priority areas for cooperation. One was a health sector analysis and subsequent pilot-project for strengthening rural health services. The GOE maintains a fairly large government-operated health delivery system, and the structure closely follows the ideal for basic health services advocated by the World Health Organization. The government health delivery system employs over 150,000 professional, paraprofessional and administrative personnel; operates more than 4,000 health care, research and training facilities; and generates some 10,000 newly trained physicians and auxiliary health workers annually. Health care is delivered free, or at nominal charge, to rural areas through more than 2,000 village health units. Each unit is served by a physician and reaches an average of 8,000 inhabitants annually.

Even though the Government of Egypt (GOE) maintains a fairly large government-operated health delivery system, health officials recognized a need to improve the health status of its poor majority. In July 1975 an AID study team was provided to design an appropriate rural health project for this purpose.

The degree of improvement in the health status of the rural population would depend upon substantial qualitative improvement in health manpower training at all levels, intensive and innovative health education, marked improvement in supervision, and better health planning. Improvements in the health system would also require greatly reinforced capacity in logistical support, supervisory mobility, communication, motivation, incentive and availability of low cost methods of health delivery.

The Minister of Health identified three factors limiting the productivity of Egypt's rural health system. These factors were: the absence of a means of communication between the elements in the system; the shortcomings in training and supervision; and inadequate incentives and rewards needed to motivate staff to high levels of performance.

AID's original project paper, Improvement of Rural Health Delivery-Egypt, was approved on July 30, 1976. The project was designed to assist the GOE Ministry of Health identify and validate the principal factors limiting the productivity and outreach of rural health service, and devise replicable strategies to reduce or eliminate these factors as problems.

The approved project would also support the overall health sector goal to improve the commitment and capacity of the Ministry of Health to provide broad access to preventive and curative health services at acceptable levels of quality. It was recognized that measurements of goal achievement would focus on the adoption of new methods of approach in management and adoption of new techniques for delivery of services.

AID's project would assist the Ministry of Health conduct a number of field tests in ten selected districts. The field testing would measure the impact of improved transport and communications on services delivery and outreach, the impact of various pattern of rewards and incentives on job performance, and the impact of better supervision and training on the range, quality and quantity of services being delivered under the system. It was anticipated that the project would identify more efficient approaches to the delivery of family planning, as well as other forms of

preventive health care. Specifically, the project would enable the GOE to evaluate and select tested cost-effective replicable strategies to improve the productivity and outreach of the health system for nationwide application.

A further project purpose was to mobilize greater support and commitment of resources to the rural health program within the Ministry of Health. These areas of support included gathering of statistics for baseline information, planning, evaluation, analysis and management. The management aspect would include logistics, transportation, communication, personnel policies and manpower training.

AID's grant agreement dated September 30, 1976 provided \$1.8 million to fund the first of five years of project implementation. AID grant funds were to pay for costs of U.S. technicians in Egypt, short-term consultants, training of Egyptian technicians, and required equipment and commodities. Local currency costs not to exceed the equivalent of \$100,000 were authorized. Subsequent funding would be provided if evaluation and implementation justified continuation of project activity. The first year funding, called Phase I, earmarked the following project funds:

	<u>In Thousands</u>
Technical Assistance (U.S.)	\$.410
Technical Consultation (Egyptian)	.100
Training	.150
Vehicles, spare parts and maintenance supplies	<u>1.140</u>
TOTAL	\$1.800 =====

In cooperation with the Ministry of Health, the AID-funded technical assistance contractor would design a detailed 18-month implementation plan to include a description and schedule of testing, implementation and evaluation. The detailed plan also was to include commodity utilization and a schedule of training and consultation to be provided. The contractor's short-term consultants would be provided as needed in areas of health planning, health economics, logistics, transportation maintenance, systems analysis, management information, health training and education, communications, personnel administration, epidemiology, anthropology, environmental sanitation, family planning, nutrition education, maternal and child health, communicable diseases and other areas of expertise.

A \$1.8 million technical assistance contract was awarded to Westinghouse Health Systems, a Division of Westinghouse Electric Corporation (Westinghouse) on December 27, 1977. The contract was for 60 months effective April 5, 1978, the date of arrival of the Contractor's Chief of Party, to April 4, 1983. Because of the complexities of the project, early involvement of the contractor was required for the design of the initial 18-month implementation plan.

By February 15, 1979, the grant agreement had been amended three times increasing AID's funding up to \$7.8 million plus LE600,000. Egyptian pounds were provided to cover local costs of technical services, studies, field tests, local training programs and other project operating costs. The estimated cost for the project is shown in the table below:

Summary Cost Estimate
At February 15, 1979
(U.S. \$ 000)

	<u>AID</u>	<u>GOE</u>	<u>TOTAL</u>
Technical Assistance	\$1.500	\$ -	\$ 1.500
Vehicles and Spare Parts	2.200	-	2.200
Equipment	2.330	-	2.330
Local Currency Budget (LE Equiv.)	.620	-	.620
Training	.700	-	.700
Vehicle Operation and Maintenance	-	1.900	1.900
Miscellaneous Supplies	-	.400	.400
Project Staff	-	.800	.800
Inflation and Contingency	<u>1.140</u>	<u>-</u>	<u>1.140</u>
	\$8.490	\$3.100	\$11.590
	=====	=====	=====

The project paper was amended on January 21, 1983 to change the project name, purpose and certain output objectives. These changes were made to reflect actual implementation directions and the recommendations of a special evaluation completed in February 1981. In addition, the project completion date of the revised Strengthening Rural Health Delivery Project (No. 263-0015) was extended to May 1, 1986, almost 10 years after the project was approved. The estimated project costs have reached \$44.2 million. AID's planned contribution increased to \$14.9 million, and the GOE has earmarked \$29.3 million to complete project activities. The amended project paper revised project objectives to reflect both ongoing and future project activities, increased the number of test districts from ten to twenty, extended the original five year project life (1976-1981) to May 1, 1986, and added new funds to support project activity.

At February 28, 1983, AID had obligated \$7.8 million for the project. The tabulation below is a summary of obligations and disbursements:

Summary of Obligations and Disbursements
At February 28, 1983
(U.S. \$ 000)

	<u>Obligated</u>	<u>Total Disbursements</u>
Consulting Services	\$1.873	\$1.389
Commodities	4.177	2.349
Training	.902	.703
Miscellaneous	.683	.270
Unsubobligated	<u>.165</u>	<u>-0-</u>
	\$7.800	\$4.711
	=====	=====

PURPOSE AND SCOPE

The purpose of our audit was to determine if the USAID project (Strengthening Rural Health Delivery, Project No. 263-0015) was effectively and efficiently managed, and to evaluate progress. Our audit was made in accordance with applicable U.S. Government Auditing Standards. Accordingly, we examined project documents and reports, and held discussions with responsible officials of the Egyptian Ministry of Health, and USAID. We observed project implementation strategies at selected rural health clinics, talked with clinic health officials, and observed health delivery practices. Project activities through March 31, 1983 were included in our audit. A copy of our draft report was provided to management officials. Their written comments were considered in the preparation of our final report.

FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

PROJECT IMPLEMENTATION IS DELAYED

Slowness in the development of a detailed implementation plan and revision of the project purposes are major causes for delays in project implementation. Project activities were to be completed in five years. Currently, the amended project paper projects a ten year life of project activity (1976-1986).

There have been serious delays in most areas of project implementation. Purposes as identified in the original project paper and grant agreement have not been accomplished. Originally planned tests of new health practices have not progressed as intended, and questions regarding the cost and effectiveness of new procedures remain unanswered. Even though much information relevant to newly introduced health practices has been gathered, only a minor part of the project's data (including baseline data) has been analyzed and interpreted. These conditions were identified by an AID evaluation team in February 1981.

In their report, the evaluators stated that the project is sufficiently complicated and has undergone enough changes in its evolution from the project paper to the approved implementation plan to necessitate immediate qualification of almost any statement made on implementation status. We agree. Nonetheless, the conditions reported in February 1981 affecting project implementation still exist today, and in our view, there is no assurance that end of project results in 1986 can be measured or implemented nationwide.

The start date

The project started July 30, 1976 with the approval of the original project paper (Improvement of Rural Health Delivery). According to project planners, the project would help the Ministry of Health identify and validate the principal factors limiting the productivity and outreach of the rural health service, and devise replicable strategies to reduce or eliminate these factors as problems. The project purpose was to be achieved by conducting a series of structured tests to measure the impact of improved transportation, better communications on service delivery and outreach between rural health centers, and better supervision and training to improve the quality of services.

Important to the accomplishment of project objectives was the signing of a host-country contract with Westinghouse Health Systems, a Division of Westinghouse Electric Corporation (Westinghouse). The contract was signed December 27, 1977, but the contractor's staff did not arrive in country until April 1978. Contract personnel were considered essential to successful project implementation.

Implementation plan off target

According to the project's timed-phased schedule of events, a detailed implementation plan covering the first 18 months of project activity was to be submitted by March 1977. However, the plan was not developed until July 1978, a 16 month delay in project implementation. This delay was caused in part by a slow project start and slowness in signing of a technical assistance contract.

The contractor's implementation plan submitted and eventually accepted by USAID in February 1979 did not agree with the approved project purpose. The change in the project's purpose occurred when USAID approved the Westinghouse initial 18 month implementation plan. Prior to that point the project purpose was described to "identify and validate through field testing, duplicable methods to reduce or eliminate some of the factors limiting production of the rural health service..." (PP log frame). With the advent of the implementation plan, the basic objective was described as "...improving the status of health of Egypt's rural population through the improvement of existing health service delivery practices."

Different approaches and goals were established during the implementation of the project. The original project paper assumed that health services were adequate and that the project should concentrate on improving the managerial structure so that these services could be delivered more effectively. However, the contractor in conjunction with the GOE determined that health services were not adequate and should be strengthened before any managerial improvements could be initiated. Consequently, the project purpose was changed from improvement of the delivery of health services to the strengthening of the services itself.

In addition to changing the project purpose, USAID officials felt the implementation plan lacked specific details in the following areas: inputs and outputs were not quantified within a timeframe; implementation lacked any relationship to benchmarks; a nationwide implementation plan for the new procedures tested was not considered as an output; and benchmarks during the life of the project were not specific.

Project paper amendment delayed two years

A special evaluation of the project was completed in February 1981. The evaluators recognized that although accomplishments had been made, there were delays in most areas of project implementation including data processing and analysis. They reported major differences between stated project objectives given in the project paper and those given in the Contractor's initial implementation plan. Also, project activities were not targeted as originally approved in the project paper. In addition, originally planned tests of activities had not progressed as intended, and implementation activities as carried out would not lead to clear answers to many key questions regarding project activities proposed in the project paper.

Some of the recommendations made by the special evaluation team were not implemented by USAID. However, one major recommendation initiated a revision of the project paper. The Ministry of Health and Westinghouse were again required to develop a revised implementation plan and schedule for USAID approval. The plan was to be based on priorities noted in the evaluation. These priorities were current project information and rapid analysis and interpretation of data gathered. A revised draft implementation plan was submitted to USAID August 15, 1981. But for two years USAID management officials were involved in meetings and discussions with Ministry of Health officials and the contractor about project direction, method of implementation, project vehicles, outside technical assistance, and Ministry of Health staff capabi-

lities. In addition, AID Washington project review committee provided advise on how to put the project back on track. Nonetheless, it took two years to implement the evaluator's recommendation to amend the project paper. The amended project paper signed January 21, 1983 changed the project's purpose and certain output objectives.

The GOE had not signed the revised project grant agreement at the close of our audit fieldwork in March 1983. Subsequent to our audit, USAID project officials provided us an official copy of the fourth amendment to the grant agreement dated May 19, 1983. The amendment provides for continuation of project activities begun in 1976.

A need to process data

A large amount of data has been collected since inception of the project in 1976, but it has not been analyzed and interpreted. Thus, decisions regarding project direction were made without the benefit of analyzed data. In our view, to measure the impact of project inputs, this data must be immediately interpreted and analyzed for project use.

The AID evaluation team recommended in their February 1981 report that data collected to date be processed and analyzed by sending it to the United States under the Westinghouse contract. USAID believes the project now has the in-house capability to process and analyze this data, and has emphasized the importance of data processing, analyzing, and utilizing project generated data. The amended grant agreement dated May 19, 1983 requires the Ministry of Health to furnish USAID a schedule for reporting all analyzed and interpreted data collected after May 1, 1982. This schedule is required before disbursement of additional grant funds. In addition, a special covenant was added to assure that all data collected before May 1, 1982 would be analyzed, interpreted and reported by June 1, 1983.

In the 1983 amended project paper, USAID management remarked that because the project would be expanding into a larger area it was increasingly important that expanded "project interventions" be solely based on data results.

A Technical Advisory Committee was given the responsibility to analyze the reported data in terms of quality and validity of its collection, analyses and interpretation. In their report issued in January 1983, the committee concluded that: it was generally unable to assess the adequacy of the quality of data collection and analyses; many of the instruments used by the project were not tested for validity and reliability; in some cases it was apparent that more data analyses could have been carried out, and there is a clear-cut need for improvement in areas of management, research design, cost analysis data preparation, educational testing, and evaluation. All of the above, the committee concluded, are essential for the continued development of the project's future potential effectiveness.

Conclusions and Recommendation

USAID management needs to continue to place a high priority in the processing of all data to avoid further project implementation delays. In our view, USAID needs to require that all data collected by the project be analyzed, interpreted, and be reported immediately. Due to the late approval and signing of the amendment to the grant agreement the deadline date of June 1, 1983 for reporting data collected prior to May 1, 1982 may be premature.

In their response to our draft report, USAID management did not concur with our audit recommendation requiring that all project data be analyzed and interpreted for project use before grant funds are disbursed under amendment no. 4. They reported that the project currently has sufficient analyzed data to proceed with the scope of work under Grant Amendment No. 4, and analysis and interpretation of the data will continue as part of the scope of work under the amended agreement. Also USAID sees no purpose in requiring more analyses at this time as it would further delay implementation of interventions. They also stated that conditions precedent to disbursement of funds made available under Amendment No. 4 of the grant agreement were met on May 30, 1983.

Notwithstanding, the amended grant agreement includes a special covenant which requires that all data collected by the project prior to May 1, 1982 to be analyzed, interpreted and reported to USAID by June 1, 1983. In our view this special covenant is important for successful completion of the project. For this reason we have revised our recommendation as follows:

Recommendation No. 1

USAID/Egypt in conjunction with the GOE Minister of Health: identify all data collected by the project prior to May 1, 1982; determine what data needs to be analyzed interpreted and reported as required by the special covenant; and establish a new date for submission of this data.

ALTERNATE SOURCES FOR TECHNICAL ASSISTANCE SHOULD BE EXPLORED

The project has muddled through almost two years without the benefit of a long-term Health Services Researcher. The initial long-term researcher left Egypt on June 30, 1981. Since that time, the contractor provided a Health Services Researcher in the capacity as Chief of Party for only nine months. This consultant was in Egypt from June 30, 1982 to April 11, 1983. AID had paid \$1.4 million to the contractor at February 28, 1983 for staff advisory services. The absence of the contractor's key person at post in Cairo in our view has impaired effective implementation of the project. Moreover, there is some doubt that a qualified health services researcher can be provided before the contract terminates on July 31, 1983. USAID should explore alternate sources to provide technical assistance for project implementation. Westinghouse has not provided the technical assistance contracted for.

Westinghouse was contracted to provide services to the Government of Egypt's Ministry of Health. A \$1.8 million host-country contract as amended was entered into on December 27, 1977. Services were to be provided over 60 months beginning April 5, 1978, the date of arrival in Egypt of the contractor's chief of party. The contractor's team of two long-term consultants was to be located in Egypt supported by the equivalent of one full-time professional back-stop in the United States. The key person,

the Health Services Researcher, was required in Egypt for the full five year life of the contract. The second long-term consultant, the Management and Training Specialist, would serve in Egypt for 18 months during the first two years of the contract. This contract team was considered essential to project success.

The contractor was to develop within three months after arrival in Egypt a detailed implementation plan covering the first 18 months of operation. The plan was to include: a detailed description including design, methodology, evaluation and schedule of test activities to be implemented; a list of commodities required for project operation; training needs and criteria for potential training candidates; identification of consultant needs; and procedures and schedules to expand and strengthen key Ministry of Health sections responsible for the rural health delivery systems. The initial implementation plan submitted on August 14, 1978 did not meet project requirements. After numerous revisions, USAID accepted the plan on February 15, 1979. In fact, the plan submitted through the Ministry of Health revised the project purposes, and USAID's approval of this plan initiated a new project direction. This new project direction, instead of eliminating some of the factors limiting production of rural health services, placed more emphasis on improvement of existing health service practices.

In February 1981, an AID special evaluation team recommended that the contractor immediately develop a new implementation plan. In their report, the evaluators recommended that a schedule be developed and followed for monitoring ongoing implementation of project activities. The contractor submitted a revised plan in August 1981. This August 1981 plan justified a three year extension of the project, expanded the project area to ten additional districts, gave priority to family planning programs, limited the number of medical interventions and stressed management interventions, deleted the communication component, and eliminated evaluation of the effectiveness of vehicles used in the project.

The Ministry of Health and USAID's project review committee concluded that the contractor's plan was too ambitious and poorly organized, therefore, developed their own implementation plan because the contractor was unable to do so.

On June 30, 1982, after a one year vacancy of the contractor's chief of party, a short-term (9 month contract) Health Services Researcher was assigned to the project as the chief of party. The reason given for the delay in filling the vacant position was that Westinghouse had problems recruiting. During the chief of party's nine months in Egypt efforts were concentrated on developing training plans for nurses and family planning outreach activities. During this period, preparation of work plans for phase II and III of the project were not developed.

In addition to the initial implementation plan, the contractor had to develop an overall project operational work plan for phasing in the following project implementation activities:

- Phase I - duration 18 months - Implement plan in four districts, develop work plan for Phases II and III and develop a training program.
- Phase II - duration 18 months - Implement plan in four more districts, continue services and testing in first four districts, continue training, phase II evaluation, revise work plan for phase III and prepare for phase III activities.

- Phase III - duration 15 months - Continue implementation in all eight districts, study issues for replicability, start training personnel for other districts, and prepare and submit final report.

All of these work requirements were to be completed during the contractor's initial 60-month contract.

As of March 31, 1983 five years after the contract was signed, the tasks outlined below had not been accomplished by the contractor:

- A specific implementation plan had not been prepared by the contractor;
- Testing had been conducted in only a few districts, but results of these tests had not been processed nor evaluated;
- A detailed work plan had not been developed for Phase II or III; and
- The contractor did not conduct an evaluation as required by the contract scope of work. The Phase I evaluation was conducted by AID/W in February 1981. As a result of this evaluation USAID/E and the MOH decided to change the thrust of project objectives to comply with the special evaluation recommendation.

Since inception of the contract, disbursements for short-term consultants have reached \$250,000. For this amount, short-term consultants furnished twelve reports to the Ministry of Health covering periods from August 1978 through December 1981. Since the contract did not prepare a life of project operational plan, specific tasks, priorities, sequence, timetable, and short-term assignments were not identified. As a result, there are no benchmarks or data to evaluate short-term technical assistance. In our view, these reports did not meet the needs of the revised project objectives. Reports submitted dealt with the original project objectives of improving the managerial capabilities of the Ministry of Health. Therefore, report recommendations were not implemented. One short-term consultant report was titled "Results of the Supervisory Feedback Survey Instrument for 1980 and 3rd Quarter of 1981." In their transmittal of this report to USAID, Ministry of Health Officials stated they had reservations on the content of this report.

Another area of concern is the contractor's monthly and quarterly progress reports. As required by their contract, Westinghouse was to submit monthly reports showing field personnel arrivals and departures, activities including information available on progress and training (initiated, continuing, completed), constraints and problems encountered during implementation of project activities, and corrective recommendations to overcome these problems. Contractor reports submitted did not provide substantive information in terms of meeting contract objectives, constraints or problems encountered, and the reports contained no recommendations for corrective actions.

Conclusions and Recommendations

Westinghouse has not provided the services contracted for. The contractor did not prepare an implementation plan acceptable to USAID and the Ministry of Health, and as a result, efforts were not properly focused to carry out project purpose. Project accomplishments could not be measured against established objectives because project data had not been analyzed and interpreted for project use. Consequently, the project was not managed to reach specific purposes but was implemented in a manner to reach general objectives.

In addition, key personnel were not assigned to the project as required by the contract. A chief of party position (Health Services Researcher) was not filled for almost two years. Also there is some doubt that short-term consultants assigned to the project were used effectively in that recommendations submitted by these individuals were not fully implemented. Moreover, progress reports submitted by the contractor lacked substance, performance was not measured against specific benchmarks, and implementation problems or recommendations for corrective actions were missing.

We were informed by USAID/E that the contractor's performance will improve when a new Health Researcher is assigned to the project. Since the contractor had difficulty in the past recruiting a qualified person for this position, we believed it is unlikely that a qualified Health Services Researcher will be located before the contract expires on July 31, 1983. In our view, Westinghouse has failed to properly support the project in the past and there is no assurance that this will change in the future.

In response to our draft report, USAID agreed that the Contractor's performance had fallen short of expectations, but believes that both the Ministry of Health and USAID has the responsibility to assess the contractor's performance. We agree. In this regard, we make the following recommendation.

Recommendation No. 2

USAID/Egypt in coordination with the GOE Ministry of Health determine whether the contractor's performance warrants an extension of the contract beyond its current expiration date of July 31, 1983; and if necessary, explore alternate sources to provide technical assistance for project completion.

VEHICLE UTILIZATION QUESTIONED

AID-financed vehicles were being used for purposes not authorized by project documents. We noted widespread use of vehicles to transport project employees from their residences, and five vehicles costing \$35,900 were assigned to activities outside the project. AID's special evaluation team concluded there was no evidence that project funded vehicles have had an impact on health center service delivery functions.

One of the project purposes was to test transportation as an element of strengthening the service support system. The Ministry of Health had a policy objective to provide each rural health facility with a vehicle, and project designers determined that 280 vehicles would be required for the project's ten districts. Vehicles were to be purchased in two increments of 140 each. The first increment of 140 vehicles arrived in Egypt in early 1979 and were distributed to 10 project districts located in the governorates of Cairo, Dakahlia, Beheira, Fayoum and Assyut.

Because of the large number of vehicles procured for this project, USAID prepared a vehicle utilization plan in March 1979. The purpose of the plan was to provide Ministry of Health officials with guidelines for the distribution and use of vehicles. In accordance with the utilization plan vehicles were to be used for project purposes only, and detailed instructions were issued for vehicle operation and maintenance.

In our RIG/A/C Audit Report No. 6-263-83-2 (AID-Financed Project Vehicles In Egypt) dated February 21, 1983 we reported several instances of nonutilization, underutilization and misuse of project vehicles. Also the report showed deficiencies in vehicle operation and maintenance resulting in inefficient use of project-funded vehicles.

In February 1981, two years earlier, AID's evaluation team reported similar deficiencies. The evaluators concluded that these vehicles were not fully used. They also reported vehicle usage below the district level was ill defined and most likely not needed. In addition, transportation did not appear to be a key to effective administration and supervision at the district level, and vehicle maintenance plans had not been implemented. To sum it up, there was no evidence that vehicles had an impact on health center service delivery functions and there had been no attempt to measure the benefits received from the procurement of vehicles and spare parts costing \$2.2 million. The special evaluation team recommended that no further vehicles be supplied to this project.

USAID did not accept the evaluators recommendation, and in mid-1982 approved the procurement of an additional 118 vehicles. USAID's rationale for approving this procurement was their commitment in principle to expand the project testing area from 10 to 20 districts, and the Ministry of Health's desire to establish a single patient evacuation system in the project area.

In our Audit Report (6-263-83-2) issued February 21, 1983 we recommended suspension of procurement of additional vehicles for the Strengthening Rural Health Delivery project until the project demonstrates convincingly a capability to effectively and efficiently utilize additional vehicles.

In their response to our February 21, 1983 report recommendation, USAID management said that suspension of vehicle procurement for this project was not possible or practical. Project vehicles had been ordered prior to the audit, were in transit, and scheduled to arrive in Egypt on or about April 30, 1983. Therefore, we are not repeating this recommendation in our current report because USAID is required to implement a control and monitoring system to assure the proper utilization and disposition of AID-financed project vehicles.

Notwithstanding, we are concerned that USAID had not taken action to recover the five project-funded vehicles utilized for purposes not related to the Strengthening Rural Health Delivery Project. The five vehicles listed below were identified and reported to project management in February 1983.

- A Chevrolet van assigned to a Belharzia Research Institute at Kalyoub near Mansoura.
- A Ford Clubwagon utilized by a British team engaged in a Ministry of Health project sponsored by the British Government in Abbassia.
- Two Ford vans at Beheira governorate assigned to a local pharmaceutical company and a government medical unit for their internal use.
- A Ford van in Fayoum assigned to the local national health insurance office.

As of April 30, 1983, the USAID project officer reported these vehicles had not been returned to the project. Subsequent reporting from USAID however states that four of the five vehicles have been returned to the project. The fifth vehicle, the Chevrolet van, was assigned to the Belharzia Research Institute at Kayoub with USAID concurrence. Notwithstanding, we are making the following recommendation to officially document the return of the four vehicles to the project.

Recommendation No. 3

USAID/Egypt obtain a certification from the Ministry of Health giving the project location and condition of the four vehicles returned to the project.

LIST OF REPORT RECOMMENDATIONS

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<u>Recommendation No. 1</u>	8
USAID/Egypt in conjunction with the GOE Minister of Health: identify all data collected by the project prior to May 1, 1982; determine what data needs to be analyzed interpreted and reported as required by the special covenant; and establish a new date for submission of this data.	
<u>Recommendation No. 2</u>	11
USAID/Egypt in coordination with the GOE Ministry of Health determine whether the contractor's performance warrants an extension of the contract beyond its current expiration date of July 31, 1983; and if necessary, explore alternate sources to provide technical assistance for project completion.	
<u>Recommendation No. 3</u>	13
USAID/Egypt obtain a certification from the Ministry of Health giving the project location and condition of the four vehicles returned to the project.	

LIST OF REPORT RECIPIENTS

Assistant To The Administrator For Management (AA/M)	1
Assistant Administrator/Bureau For Near East (AA/NE)	5
Director, USAID/Egypt	5
Audit Liaison Office (AA/NE)	1
Office Of Egypt Affairs (NE/E)	1
Office Of Financial Management (M/FM/ASD)	2
Directorate For Program And Management Services (M/DAA/SER)	6
Bureau For Program And Policy Coordination (PPC/PDPR/PDI)	1
General Counsel (GC)	1
Office Of Legislative Affairs (LEG)	1
Office Of Public Affairs (OPA)	2
Office Of Evaluation (PPC/E)	1
Office Of Development Information And Utilization (S&T/DIU)	4
Inspector General (IG)	1
RIG/A/Abidjan	1
RIG/A/Karachi	1
AAP--New Delhi	1
RIG/A/Latin America/W	1
RIG/A/Manila	1
RIG/A/Nairobi	1
RIG/A/Washington	1
Office Of Policy, Plans And Programs (IG/PPP)	1
Executive Management Staff (IG/EMS)	12
Assistant Inspector General For Investigations And Inspections (AIG/II/W)	1
Regional Inspector General For Investigations And Inspections (RIG/II/Cairo)	1