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USAID/ZAIRE NEEDS TO DEVELOP BENCHMARKS TO MEASURE PROJECT PROGRESS, IMPROVE CASH MANAGEMENT, AND INCREASE PARTICIPANT TRAINING ON ITS BASIC RURAL HEALTH PROJECT

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USAID/ZAIRE NEEDS TO DEVELOP BENCHMARKS TO MEASURE PROJECT PROGRESS, IMPROVE CASH MANAGEMENT, AND INCREASE PARTICIPANT TRAINING ON ITS BASIC RURAL HEALTH PROJECT

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EXECUTIVE SUMMARY

Introduction

The Basic Rural Health project responds to a 1980 policy decision by the Government of Zaire (GOZ) to improve the health status of the rural population by increasing the number of residents that have access to basic health services. It is the GOZ strategy to deliver health care to all residents by the year 2000. The intermediate goal is to reduce mortality and morbidity, especially among children and mothers, by focusing on the most serious public health problems, and by making primary health care available to the entire population via a low cost delivery mechanism.

The purpose of the project is to establish a system of self-sustaining community-supported primary health care effectively offering prevention and treatment of the 10 most prevalent public health problems in 50 rural zones. The project is to assist the GOZ and Eglese du Christ au Zaire (ECZ) hospital systems with the transformation of their current curative dispensaries and health posts into full service prevention oriented health centers as designed in the GOZ national health strategy. Each health center will serve populations of 10,000 to 40,000, and is to be designed to meet the majority of the health needs of the population in each of their localities.

The project is a collaborative effort between AID, the GOZ, acting through its Department of Public Health, and the ECZ. Total project funding by all participants is $10.7 million. AID is funding $4.8 million. As of September 30, 1983 about $768 thousand of AID funds had been expended.

Purpose

The purpose of our review was to (a) determine whether project objectives were being accomplished, (b) evaluate the effectiveness of implementation and management of the project, and (c) determine that project funds were being used as planned and in conformance with project agreements and applicable laws and regulations.

Findings and Conclusions

The Basic Rural Health project was about one year behind schedule. The delay was due to the contractor's late arrival and imposition of the Brooke Amendment[1] which delayed obligation of fiscal year 1982 funds.

We were unable to measure progress toward achieving project outputs to date because project management had not established adequate interim benchmarks. Benchmarks in such areas as number of nurses and midwives trained, number of new family acceptors, active health committees, number of vaccination programs, latrines constructed, etc., would provide management with data on whether progress is adequate, including areas where additional effort is needed (pages 2 to 5).

We found that the GOZ needs to give official approval to its five year health plan. Without such approval specific boundaries and functions cannot officially be established for prospective hospitals (pages 5 to 6).

Long-term participant training was significantly behind schedule and needs increased emphasis. The training is an important input to the project because it provides the technical capability to plan, initiate and continue the work when the project terminates (pages 6 to 8).

Project funds programed for short-term training may be in excess of requirements. Accordingly the funds should be reprogramed or deobligated (pages 8 to 9).

Tighter controls are needed over counterpart funds and cash management. Adequate cash management is necessary to promote a self-financing health system (pages 9 to 12).

At the conclusion of our audit, our findings were discussed with appropriate USAID/Zaire (hereafter referred to as USAID) officials. A draft report was also provided for their written comments. Their comments during our exit conference and in response to our draft report were considered, and where pertinent, are included in this report.

1/The Brooke Amendment provides that, "No assistance shall be furnished...to any country which is in default, during a period in excess of six calendar months, in payment to the United States of principal or interest on any loan made to such country...".

BACKGROUND

The Republic of Zaire is located on the equator in Central Africa. The country is landlocked except for an important 13 mile-wide strip on the Atlantic Ocean and covers almost 905,000 square miles - about the area of the United States east of the Mississipi. It is the third largest country in Africa.

Zaire's total population is estimated at 30 million. About 700 languages and dialects are spoken. Most of the country is sparsely populated - about 20 inhabitants per square mile. The population is concentrated near the rich mineral deposits, along the main communication routes, and in the highlands. The literacy rate is about 60% and life expectancy is 47.5 years. The Gross National Product per capita is under $250 and declining.

The Basic Rural Health project responds to a 1980 policy decision by the GOZ to improve the health status of the rural population by increasing the number of residents that have access to basic health services. It is the GOZ strategy to deliver health care to all residents by the year 2000. The intermediate goal is to reduce mortality and morbidity, especially among children and mothers, by focusing on the most serious public health problems, and by making primary health care available to the entire population via a low cost delivery mechanism.

A strong extensive system of indigenous Private and Voluntary Organizations (PVO's) is already established and working in the health sector. These PVO's include the major churches and social service organizations. The protestant church system called Eglise du Christ au Zaire (ECZ) is the most extensive in the rural areas and has been active in health care delivery in Zaire for over 100 years. The project agreement was signed on August 31, 1981 and has a September 30, 1986 project assistance completion date (PACD). The Basic Rural Health project is a collaborative effort between the GOZ, acting through its Ministry of Public Health, USAID, ECZ, and the Peace Corps. The amounts and types of contributions by each are presented in Exhibit 1. As of September 30, 1983, $2.158 million in AID funds had been earmarked and about $768 thousand had been spent.

The purpose of the project is to establish a system of self-sustaining community-supported primary health care offering prevention and treatment of the 10 most prevalent public health problems in 50 rural zones. The project is to assist the GOZ and ECZ hospital systems with the transformation of their current curative dispensaries and health posts into full service prevention oriented health centers as designed in the GOZ national health strategy. Each health center will

serve populations of 10,000 to 40,000, and is to be designed to meet the majority of the health needs of the population in each of their localities.

The project will assist the participating hospital systems by providing technical assistance, training, and commodities. Training will be a major aspect of the project because the health policy reorientation will require a change in attitudes, philosophy and technical skills of health care providers. Basic commodities will be provided to permit the people trained to function to the maximum level of their technical competence.

OBJECTIVES AND SCOPE

The objectives of our audit were to (a) determine whether project objectives were being accomplished, (b) determine that project funds were used as planned and in conformity with project agreements and applicable laws and regulations, and (c) evaluate the effectiveness of implementation and management of the project.

We reviewed USAID, GOZ, ECZ and contractor records, reports, and correspondence and held discussions with appropriate officials and personnel of those organizations. We visited the project headquarters in Kinshasa and made site visits to hospitals and dispensaries in the Equateur Region.

The period covered by our review was from inception in August 1981 to September 30, 1983. The audit was performed during the period September - November 1983.

Our review was made in accordance with the Controller General standards for audit of governmental programs and accordingly included such tests of the program records and internal control procedures as we considered necessary in the circumstances.

FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

Management Needs To Develop Benchmarks So Project Progress Can Be Better Measured

Adequate benchmarks had not been established to measure project progress toward outputs. As a result, we could not determine progress in meeting project objectives. Measurement of progress is an important tool to management so that corrective action can be taken when benchmarks or annual goals are not being met. End of project goals should be time phased so that interim progress can be determined. A good work plan will provide this type of strategy.

The project paper planned for a series of specific outputs that would be attained by the end of the project and would contribute to the realization of the project purpose. For example, these outputs include:

- A functioning system of training personnel in the delivery of community based health care. This system includes training objectives for 2,730 nurses, midwives, physicians, community health planners/educators, and village health workers;

- A system for collecting, organizing, and sharing experiences of all participating hospitals in the ECZ and GOZ systems. The system was to provide statistics on, for example, causes of morbidity and mortality, types of pharmaceuticals used, children vaccinated, water sources protected, and latrines constructed;

- The opening, or conversion from dispensaries, of 250 health centers focusing on preventive, promotive health practices. The health centers would in turn produce, for example, 150,000 new family planning acceptors, 3,000 active health committees, 1,000 vaccination programs, and 25,000 latrines constructed.

In order to facilitate summarization of project activities, each of the 15 participating Phase I hospitals was provided an annual report format to be used in accumulating basic data on the outputs for CY 1982. This data was to be provided by the hospitals to the contractor in the form of an annual report summarizing activities for the previous year with emphasis on experiences, lessons learned, and planned activities for the following year. The contractor was to analyze this information to determine progress in attaining life-of-project objectives.

At the time of our review, this data although received for 1982, had not yet been analyzed. Even if it had been analyzed, the contractor's work plan did not always include benchmarks to which basic data accumulated and reported could be compared. Instead, it usually specified only end-of-project quantities. Accordingly, there was no way for management to determine periodically (e.g. annually when the reports are available) the status of a particular output in comparison to where it should be in relation to the end of project objective or to take any needed corrective action if outputs weren't being met.

We believe that the work plan should have included benchmarks for each specific output for each participating hospital. For example, the work plan could have projected for each participating hospital how many of the 3,000 active health committees should have been created by the end of 1983, how

many of the 25,000 latrines should be constructed by the end of 1984, etc. In this manner successful methodology could have been shared and corrective action taken for those hospitals experiencing shortfalls and difficulties.

During our site visit to the Equateur region, the contractor did obtain data on various outputs for the three hospitals visited. Subsequently, the contractor developed some tentative benchmark formulas so as to be able to calculate progress in attaining life of project objectives. USAID officials told us that data from all participating hospitals would be received at the end of CY 1983, and that this data would be analyzed.

Conclusion, USAID Comments, RIG/A/Nairobi Response and Recommendation

The contractor's work plan did not contain adequate benchmarks on project outputs. As a result, project management could not measure progress and effect corrective action if necessary. Although some effort in this direction commenced during the audit, much more remains to be done.

USAID Comments

USAID found this finding to be misleading One gets the impression that there are not 'benchmarks' in the project and that data collection which would be used in assessing progress towards purpose via outputs was not planned by the project or Mission Management. This is not the case. While the word 'benchmarks' does not appear in the project paper (PP) nor the Project Managers Guidebook or PP design guidance, AID does use outputs, magnitude of outputs and implementation plans with time frames to meet this need.

Its collection and use had been planned for in the PP and was to be used for the May 1984 in depth mid project evaluation. The other aspect of the discussion of this finding that is misleading is the timing of the project. The audit notes data from Phase I hospitals that was to have been collected in 1982. Since the project was delayed nine months, it should be modified to read "in 1983". With this modification, the finding that the data had not been analyzed takes on a different hue.

These factors were brought to the attention of the auditor. Hence, he was visiting the project in the 20th month of actual implementation.

In a larger sense, the audit seemed to find fault with the inability of project management to determine at any given point in time the status of outputs. Given the complexity of the project, and the fact that activities are spread out over

905,000 square miles, the mission does not believe this is feasible. The mission does believe that periodic evaluations and annual reports using the data that the system will be producing for CY 1983 and onward will suffice.

RIG/A/Nairobi Response

Benchmarks are a key management tool used to measure progress. Therefore, we believe they should be included in the contractor's work plan. Even if that data collected for 1982 had been analyzed, the absence of benchmarks for comparison would have resulted in management not knowing specifically where it was then or where it was going in regard to end of project objectives.

Controlling a project that covers 905,000 square miles and the complexity of managing such a project should have been a prime factor in developing such a project. We agree with USAID that periodic evaluations and annual reports using the data that the system produces will suffice to determine the level of outputs. However, we have retained our recommendation so that benchmarks will be made available so that progress can be effectively evaluated.

RECOMMENDATION NO. 1

USAID ensure that the contractor develops a work plan which contains benchmarks for each specific output for each participating hospital so that project progress can be measured.

GOZ Needs To Approve Five-Year Health Plan

The GOZ had not given official approval to the Rural Health Zone (RHZ) five year health plan covering 1982 thru 1986. Without such approval, specific boundaries and functions cannot officially be established for prospective hospitals.

Since independence the GOZ has been attempting to continue and expand the colonial health system in an effort to reach the majority of the population. This attempt resulted in the current health system reaching almost 15% of the total population with very limited hospital based curative services. In recent years the GOZ realized that the present health system will not permit further coverage of health services to the Zairian population because of lack of trained personnel, a poor transportation system, limited financial resources and a declining operating budget. As a result, the Department of Public Health studied several approaches that would permit the Zairian population to have access to at least basic health care

without substantial budget increases. The basic strategy is to do something at the local rural level where more than 70% of the population resides.

In January, 1982, the GOZ completed a revision and updating of its National Health Strategy. In the strategy statement, the GOZ elaborated its goals for the next ten years (1982-1991) and major program objectives for the next five years (1982-1986). The strategy included the establishment of 140 functioning RHZs by 1986 and an additional 140 RHZs by 1991. Fifty of the former RHZs are included in the Basic Rural Health project which supports this strategy.

A rural health zone consists of a general hospital facility which serves a population approximating 105,000 and supervises 3-12 health centers. Each health center serves approximately 25,000 persons in about 30 villages. Each village has a health worker who serves about 700 persons.

Since the revision and updating of its National Health Strategy, the GOZ had yet to officially adopt measures (e.g. proposals for specific boundaries and functions for each RHZ) to implement the RHZ plan. The failure to adopt such measures impacted on the project by delaying the development of RHZs. The official recognition of the plan would increase the RHZ chance of success because it requires initial collaboration among the various RHZs and GOZ ministries. The GOZ representative to the project told us that the approval must be made by the GOZ Executive Council, and further, that approval was expected by the end of 1983.

Conclusion and Recommendation

We believe that official recognition of the RHZ plan would facilitate and promote project implementation. Also, we believe that USAID should follow up to see that the GOZ provides this recognition and approval.

RECOMMENDATION NO. 2

USAID follow up with the GOZ (Executive Council) to see that the five-year health plan gets approved.

Long-Term Participant Training Needs To Be Emphasized

Project long-term training for participants is significantly behind schedule. As a result, it is questionable whether the long-term participant training objective can be accomplished. In our opinion, this had resulted because participants have not

been selected and processed in a timely manner or in sufficient numbers.

The project paper specified that a total of 360 person months of long-term participant training out of country was to be accomplished by project completion. Specifically, 30 participants (primarily medical officers) were to receive Master's Degree training in health education or health administration. The project agreement planned for 168 person months of training in 1982, 120 in 1983, and 72 in 1984.

The project agreement stated that one of the critical needs in the development of a public health program is functional, relevant training for nationals who will plan, initiate and continue the work after expatriates have terminated their services. A total of $648,000 had been budgeted for this training. As of September 30, 1983, about $90,000 had been earmarked and $16,000 expended.

We found that as of September 30, 1983 four participants had been in training a total of eight months (four times two months). This represents about five percent of the 168 person months of training that should have been completed in 1983 (the training was actually planned for 1982 in the project paper but the project is almost nine months behind schedule so the schedule has slipped almost a year). USAID officials stated they were unable to send the first group of (four) participants due to the Brooke Amendment's freezing project obligations in FY 1982. As a result, the first group of participants was not sent until August 13, 1983. Further, USAID officials stated that the project has identified 12 qualified participants for 1984 and has begun their processing. Even so, this represents only 53% of the long-term training objective of 30 participants.

In addition, USAID officials expressed confidence that the establishment in 1984 of a Graduate School of Public Health (GSPH) in Zaire will achieve the long term training objectives as the remaining participants will be sent to the GSPH in the 1984 and 1985 school years[1/]. We doubt that this will happen because the GSPH has not been established. Should the GSPH be established, a realistic amount of time will be needed to staff the school, accomplish a full curriculum, and operate on a full schedule.

1/At the time of our audit, Project 660-0101, School of Public Health, was being formulated. Under this project, USAID proposes to fund the establishment of a Graduate School of Public Health at Kinshasa University in Zaire. AID/W had approved the Project Implementation Document in October, 1983. We were advised by USAID officials that they had approved the project paper and a final review by GOZ is in process with final approval/authorization planned for March 1984.

Conclusion, USAID Comments, RIG/A/Nairobi Response and Recommendation

The project is not meeting one of the critical needs in the development of the public health program -- that of providing functional and relevant training. Such training is necessary for nationals because the project requires a change in attitude, philopsophy, and technical skills of health care administrators and advisors. The training is also required to plan, initiate and continue the work after expatriates have terminated their services. We do not believe the GSPH will be ready to provide training to project participants, accordingly, we believe that USAID needs to schedule training in third countries or the U.S. to ensure that participant training objectives are met by the PACD.

USAID Comments

USAID concurred with the fact that participant training was behind schedule at least nine months, but believed that all long-term training will be achieved irrespective of the establishment of the School of Public Health.

RIG/A/Nairobi Response

We believe that having only four of 30 participants in training a year after the Brooks amendment was no longer applicable is a poor track record and reason for concern and stepped up emphasis. In addition, the longer the training is delayed the less technical resources the project will have during implementation. Having ten or more participants in training the last year of the project does the project little good. The project agreement planned for participant training to be completed in 1984, therefore, with the delay, training should be completed in 1985. We therefore have retained our recommendation.

RECOMMENDATION NO. 3

USAID develop a long-term training schedule for participants so that training will be completed by the project completion date.

Short-Term Training Is Overfunded

Project funds programmed for short-term training may be in excess of requirements.

The project paper called for $385,000 in project funds to be used for short-term academic training during the project's life. At the end of year three (September 30, 1983), $245,000

had been earmarked. However, we found at that time only $2,470 had been expended for short-term training. USAID officials told us that several centrally funded intermediaries had been eager to fund this training and that 27 person months of training had been provided. USAID officials further told us that they plan to review this lower than planned expenditure with an eye to reprogramming part of it at the mid-project evaluation in May, 1984.

Conclusion and Recommendation

The use of centrally-funded intermediaries to accomplish short-term training requirements has resulted in excess funds which should be reprogramed or deobligated.

RECOMMENDATION NO. 4

USAID review short-term training requirements and reprogram or deobligate those funds considered excess to requirements.

ECZ Needs To Tighten Controls Over Counterpart Funds And Improve Cash Management

Records relative to project funds do not provide adequate cash management and control.

Prudent cash management dictates that records adequately support the use of funds and provide the basis for timely financial information. Likewise, cash collected should be adequately protected, and supported by prenumbered receipts so that the cash can be controlled and accounted for.

We reviewed recordkeeping procedures and controls at the ECZ's Medical Bureau which is responsible for project implementation. Approximately $2.2 million in counterpart funds will flow through this bureau during the life of the project. We also tested controls over cash receipts at two dispensaries visited in the Equateur Region. These receipts represent cash received from patients who had obtained medicines. The proceeds are to be used to replenish medical stocks and other expendable supplies. Pharmaceuticals are also being provided by AID as a first stock of the self-financing system. Accordingly, proper control over cash is of primary importance in the success of this activity, if stocks are to be replenished.

We found no evidence at the ECZ medical bureau that the bank statements had been reconciled. The most current bank statement, dated August 31, 1983, showed a balance of Z703,488 (about $120,000). We noted incomplete data on some check stubs

such as no date, amount, payee, balance forward or bank transfer/charge amounts. Several checks had been made payable to the contractor, ECZ employees, and "cash". We also noted on hand a petty cash amount of Z9,634 (about $316) but due to lack of records, the correctness of this amount could not be ascertained. USAID officials told us that the bookkeeper had been absent from the project due to a medical problem and that his absence hampered the normal operation of the bookkeeping/ accounting section of the ECZ medical office. Further, USAID officials told us that the reason checks were drawn to members of the bureau's staff and to the contractor was because of difficulty in getting cash from banks and the unwillingness of vendors/employees to accept checks.

At one of the two dispensaries visited during our trip to the Equateur Region we noted an undetermined amount of cash in a desk and in a locked cabinet. No receipts had been issued. Responsible dispensary officials told us that because the previous treasurer had not been replaced (due to his release after absconding with receipts) no one knew how to handle the money received from patients. A written policy or procedure on cash management would alleviate this problem.

A recent review of counterpart fund control by the USAID controller confirmed our findings with regard to project accounting records. Furthermore, we were told that the controller had verbally suggested that the system be changed by organizing records in a manner so that totals in project management reports will agree with accounting records. At the time of our review, this had not been done.

Conclusion, USAID/Zaire Comments, RIG/A/Nairobi Response and Recommendation

Control over project funds need to be improved. Sound recordkeeping procedures relative to cash management and cash controls are needed to strengthen project management and facilitate accomplishment of project objectives.

USAID Comments

USAID indicated that it should be acknowledged that prudent record keeping systems exist at the ECZ project office and under the various PVO churches that participate in the project. However they all could use improvement. Before the audit was announced in September 1983, the USAID controller had already visited the ECZ/Project office and confirmed that the bookkeeping and accounting systems were in place and being maintained by responsible personnel. He noted that financial reports provided to mission did not tie into any totals in accounting records and that filing of invoices could be improved to facilitate audit. Controller therefore listed this

project on the mission work plan of counterpart accounting, as one that needed some modification.

Totals in reports do now agree with accounting records. As for the reconciliation of bank statements, the appropriate records have been generally available but had not been kept up to date because of the medical evacuation of the project accountant. Mission agrees with the need for accurate and up to date financial records. However, this must be balanced with the cost of designing and operating the system. The Basic Rural Health project for reasons of sustainability has kept a very lean staff; one long-term project technician and two counterpart funded secretarial assistants. The project has relied on, and received good accounting/recordkeeping service at no cost from an ECZ full time expatriate employee. The negative aspect of this staffing mode is a less than optimum functioning when the one accountant is absent or ill. It should be noted also that concerns about good record keeping to facilitate accomplishment of project objectives have always been passed to all levels of project supervision. However, it is left up to individual hospitals participating in the project to adopt a system that fits their operational scheme in their particular area of the country. It should be acknowledged also that all of the dispensaries visited in the Equateur Region had evidence that a financial accounting system existed. However, they were not in a written form that the auditor could see in order to test the system.

As for the loose, unaccounted for cash in the drawer noted on the auditor's health center visit, it amounted to not more than $5.00. Note also that the strength of this project is that it works through existing PVO hospital systems that have a good track record for, inter alia, financial management. Mission thinks it is inappropriate to attempt to impose one system in the entire 50 hospitals. However, technical guidance will be made available to the hospitals and suggestions for improvement made. In this connection the Mission controller intends to return to the project office in the next three months to review current status of accounting records and to suggest any appropriate changes. Mission also intends to have counterpart funds provided to the project audited sometime in 1984.

RIG/A/Nairobi Response

We agree that unformity is not practical, but cash management and control requires certain documentation and record keeping norms. If the systems provide adequate control that is all that can be expected. We do not believe the current controls are adequate therefore improvements have to be made if funds are to be controlled and accounted for.

We agree with USAID's intent to make technical guidance available to the hospitals as well as to have project counterpart funds audited in 1984. We believe these are steps in the right direction for tightening cash management and control. However, we have retained our recommendation until USAID has had an opportunity to implement their program and provide us with a statement that the program is working.

RECOMMENDATION NO. 5

USAID implement a program of technical guidance and audits of counterpart funds to develop control over cash receipts and disbursements at the funding sources.

EXHIBIT 1

Project Financial Plan
($000)

PROJECT INPUTS	CONTRIBUTORS				
	USAID	GOZ	ECZ	PEACE CORP	TOTAL
Technical Assistance	$ 936	$ 836	$ 190	$350	$ 2,312
Training	1,033	618			1,651
Commodities	2,775	235			3,010
Other Costs	120	1,002	2,605		3,727
TOTALS	$4,864	$2,691	$2,795	$350	$10,700
(Percent of Contribution)	(45.5)	(25.1)	(26.1)	(3.3)	(100)

APPENDIX A

List of Recommendations

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USAID ensure that the contractor develops a work plan which contains benchmarks for each specific output for each participating hospital so that project progress can be measured.	5
RECOMMENDATION NO. 2	
USAID follow up with the GOZ (Executive Council) to see that the five-year health plan gets approved.	6
RECOMMENDATION NO. 3	
USAID develop a long-term training schedule for participants so that training will be completed by the project completion date.	8
RECOMMENDATION NO. 4	
USAID review short-term training requirements and reprogram or deobligate those funds considered excess to requirements.	9
RECOMMENDATION NO. 5	
USAID implement a program of technical guidance and audits of counterpart funds to develop control over cash receipts and disbursements at the funding sources.	12

APPENDIX B

List of Report Recipients

	No. of Copies
Field Offices	
USAID/Zaire	5
REDSO/WCA	2
AID/Washington	
AA/M	1
AA/AFR	5
AA/PPC	1
LEG	1
GC	1
OPA	1
IG	1
AFR/CA	2
PPC/PDPR	2
M/FM/ASD	2
PPC/E	1
PPC/E/DIU	4
S&T/IT	1