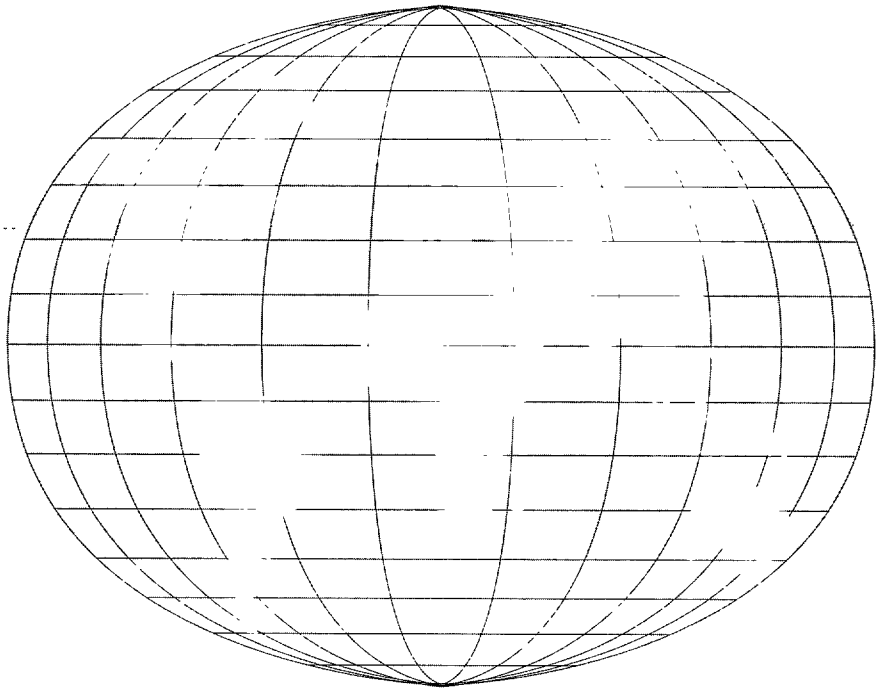
Report of Audit

Audit of USAID/Bangladesh's Child Survival Activities

Audit Report No. 5-388-01-001-P
December 22, 2000



Manila, Philippines

OFFICE OF INSPECTOR GENERAL
U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT

Regional Inspector General for Audit
Manila

AUDIT OF USAID/BANGLADESH'S CHILD SURVIVAL ACTIVITIES

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December 22, 2000

MEMORANDUM

TO: Director, USAID/Bangladesh, Gordon H. West

FROM: RIG/Manila, Paul E. Armstrong

SUBJECT: Audit of USAID/Bangladesh's Child Survival Activities, Report No. 5-388-01-001-P

This is our final report on the subject audit. We reviewed your comments to the draft report, made some revisions based on them and included the comments in their entirety as Appendix II.

This report contains five recommendations addressed to USAID/Bangladesh. Based on your comments to the draft report, Recommendation Nos. 4.1 and 5 are closed upon issuance of this report. Recommendation Nos. 1, 3 and 4.2 have had a management decision and may be closed when the cognizant responding office provides evidence to USAID's Office of Management Planning and Innovation that it has implemented its planned actions. A management decision is pending on Recommendation No. 2 until there is a clear agreement on the planned course of action. Please advise us within 30 days on any actions planned or taken to implement Recommendation No. 2.

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

EXECUTIVE SUMMARY

Background

The U.S. Congress has included specific authorizing language in the Foreign Assistance Act (FAA) of 1961, as amended, to address the special health needs of children and mothers. Section 104 (c) (2) (A) of the FAA states that *"In carrying out the purposes of this subsection, the President shall promote, encourage, and undertake activities designed to deal directly with the special health needs of children and mothers. Such activities should utilize simple, available technologies which can significantly reduce childhood mortality, such as improved and expanded immunization programs, oral rehydration to combat diarrhoeal diseases, and education programs aimed at improving nutrition and sanitation and at promoting child spacing."*

In addition, since 1997, the U.S. Congress established a separate appropriation account called Child Survival and Disease (CSD) Programs Fund in the annual FAA appropriation legislation. The annual CSD appropriations provide the minimum amount of funds that are to be used for child survival and disease activities. In fiscal year 2000, $715,000,000 was appropriated for this purpose.

To help ensure that missions comply with the CSD appropriation, USAID has issued periodic guidance on allowable uses of CSD funds. For example, USAID's fiscal year 1998 guidance states that allowable activities are those that contribute directly to the strategic objective of improving infant/child health and nutrition and reducing infant/child mortality. At the time of the audit, USAID's Bureau for Policy and Program Coordination issued additional CSD guidance. USAID officials believe that the new guidance will further help preserve the integrity of the CSD account.

USAID/Bangladesh has obligated and expended approximately $46.6 million and $16.4 million, respectively, in CSD funds during fiscal years 1997 through 1999.

Audit Objectives

The Office of the Regional Inspector General, Manila, audited USAID/Bangladesh to answer the following audit objectives:

- How were USAID/Bangladesh's child survival funds expended?
- Has USAID/Bangladesh achieved the intended results of its child survival activities?

Results of Audit

USAID/Bangladesh has obligated and expended CSD funds under two mission strategic objectives. First, the Mission uses CSD funding along with development assistance (DA) funding under the Mission's Strategic Objective (SO) No. 1 – *"Fertility Reduced and Family Health Improved."* Second, the Mission used CSD funding along with DA funding and Public Law 480, Title II commodities under SO 2 – *"Enhanced Household Income and Food-Based Nutrition."* (page 3)

The audit found that $7.8 million of the $9 million in CSD funds obligated for mission SO 2 went to activities that do not directly contribute to improving infant/child health and nutrition and reducing infant/child mortality. Section 104 of the Foreign Assistance Act (FAA) directs that the activities be "designed to ***deal directly*** with the special health needs of children and mothers." (Emphasis supplied). We believe that the activities we reviewed (e.g., income-generation, sustainable agriculture production, bio-diversity, developing markets, management of land, management of water fisheries) did not specifically target children and could only ***indirectly*** impact on children/mother health and reducing child mortality. Agency officials maintain that it is difficult to know what the distinction between direct and indirect is, and feel that many of these activities could have an impact on children. We acknowledge that in addition to activities which are clearly designed to affect children and mothers' health (such as those seven activities specifically described in the appropriating language) and those which can only be said to have an indirect or incidental impact, there exists a "gray area" of activities where it is difficult to draw the line (see page 5). However, the Mission did not avail itself of procedures that were in place at the time to obtain advance approval for activities where there might be a question of qualifying for CSD funding. Recent policy has strengthened the requirements and procedures for demonstrating an impact on child and maternal health. (page 4)

We also believe that the Mission's method of allocating and accounting for the use of CSD funds under its integrated family planning and health SO 1 is imprecise. Under this integrated program, CSD funds are co-mingled with development assistance-population funds. The Mission's current method does not require recipients to account for CSD funds separately. As a result, USAID/Bangladesh does not have reasonable assurance that CSD funds are used for allowable CSD activities. The audit disclosed that the current method of allocating and accounting leads to CSD funds being used for other than allowable CSD expenditures. Because the Mission uses the USAID-wide system to allocate and account for CSD funds and because the CSD funds are no longer simply an earmark but are now also subject to appropriations law, we have referred this issue to our Office of the Inspector General (OIG) Headquarters in Washington, D.C. for possible follow up. (page 7)

USAID/Bangladesh has achieved some of the intended results of its child survival activities encompassed under its SO 1 *"Fertility Reduced and Family Health Improved."* For example, more people are visiting the program's clinics to use both family planning and health services. For other intended results under SO 1, the Mission has not yet achieved them. For example, the program has not significantly affected children's immunization coverage rates in the country. (page 12)

The audit found several areas needing attention:

- Although the Government of Bangladesh (GOB) is supposed to provide vaccines to the program's clinics to immunize children, only 51 of the 175 rural clinics in the program receive vaccines from the GOB. As a result, 124 of the 175 rural clinics were unable to provide an important maternal health and child health service directly, i.e., immunizations. This hinders the program's impact of increasing child immunization rates in the country and thereby leaves more children at risk. (page 13)

- The Mission's grantee for its Rural Service Delivery component has not yet resolved questioned costs totaling approximately $52,084 identified for one of its problem sub-grantees and has not accounted for fixed assets totaling $26,782 procured by this sub-grantee. (page 16)

- Two of the eight program clinics visited are located too close to GOB health facilities that provide similar services. As a result, the two clinics have difficulty attracting patients. Program resources could be better used in more neglected areas. (page 18)

- The program has been withholding approximately 2,135 boxes of unused Oral Rehydration Salt packets purchased during the major flooding in 1998. Thus, the packets were not used to treat and control diarrhea, potentially one of the most fatal childhood diseases. These commodities should be better utilized. (page 18)

Audit Recommendations

This report contains five recommendations addressed to USAID/Bangladesh that are intended to address the above-mentioned areas and strengthen the Mission's programs. Specifically, they call for USAID/Bangladesh to:

- Strengthen Mission procedures for programming and using Child Survival and Disease Funds that will ensure that the activities will directly benefit the health needs of children and mothers; establish procedures to obtain prior approval from USAID's Bureau for Policy and Program Coordination and the Global Bureau, with concurrence by regional bureau technical staff and clearance from the General Counsel if the Mission intends to use Child Survival and Diseases funds outside the parameters of USAID guidance; and obtain an opinion from the General Counsel on whether the obligations of $7.8 million

were allowable uses of the Child Survival and Disease Funds (page 4);

- Work with the Ministry of Health and Family Welfare to obtain a regular supply of vaccines for the rural clinics, and ensure that the non-governmental organizations take the necessary steps to provide regular child and mother immunization services at their rural clinics (page 14);

- Determine the final accounting of funds disbursed to the Rural Service Delivery grantee's sub-grantee, including the allowability of questioned costs totaling $52,084 and fixed assets totaling $26,782, and recover from the Rural Service Delivery grantee any amounts due (page 16);

- Determine whether the non-governmental organizations under the program should move the two clinics that we visited to a more suitable area, and review the locations of other low performing clinics and determine if any others should be moved to more suitable locations (page 18); and

- Require its Urban Service Delivery grantee to: (i) redistribute the remaining Oral Rehydration Salt (ORS) packets within the program's urban and rural clinics as needed, and (ii) instruct the clinics to distribute the ORS packets to their patients as needed (page 19).

Management Comments and Our Evaluation

In response to our draft audit report, USAID/Bangladesh provided written comments that are included in their entirety as Appendix II. Based on the Mission's comments, Recommendation Nos. 4.1 and 5 are closed upon issuance of this report. Recommendation Nos. 1, 3 and 4.2 have had a management decision and may be closed when the cognizant responding office provides evidence to USAID's Office of Management Planning and Innovation that it has implemented its planned actions. A management decision is pending on Recommendation No. 2 until there is a clear agreement on the planned course of action.

Office of the Inspector General
December 22, 2000

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INTRODUCTION

Background

The U.S. Congress has included specific authorizing language in the Foreign Assistance Act (FAA) of 1961, as amended, to address the special health needs of children and mothers. Section 104 (c) (2) (A) of the FAA states that *"In carrying out the purposes of this subsection, the President shall promote, encourage, and undertake activities designed to* ***deal directly with the special health needs of children and mothers****. Such activities should utilize simple, available technologies which can significantly reduce childhood mortality, such as improved and expanded immunization programs, oral rehydration to combat diarrhoeal diseases, and education programs aimed at improving nutrition and sanitation and at promoting child spacing[1]."* (Emphasis supplied)

In addition, since 1997, the U.S. Congress established a separate appropriation account called Child Survival and Disease (CSD) Programs Fund in the annual FAA appropriation legislation. This annual CSD appropriation provides the minimum amount of funds that are to be used for child survival and disease activities. For example, the fiscal year 2000 FAA appropriation legislation states that *"For necessary expenses to carry out the provisions of chapters 1 and 10 of part I of the Foreign Assistance Act of 1961, for child survival, basic education, assistance to combat tropical and other diseases, and related activities, in addition to funds otherwise available for such purposes, $715,000,000, to remain available until expended: Provided, That this amount shall be made available for such activities as: (1) immunization programs; (2) oral rehydration programs; (3) health and nutrition programs, and related education programs, which address the needs of the mothers and children; (4) water sanitation programs; (5) assistance for displaced and orphaned children; (6) programs for the prevention, treatment, and control of, and research on, tuberculosis, HIV/AIDS, polio, malaria and other diseases; and (7) up to $98,000,000 for basic education programs for children..."*

USAID has issued periodic guidance to its missions on allowable uses of CSD funds. For example, USAID's fiscal year 1998 guidance states that allowable activities are those that contribute directly to the strategic objective of improving infant/child health and nutrition and reducing infant/child mortality. At the time of the audit, USAID's Bureau for Policy

[1] Only birth spacing activities that are conducted primarily to reduce infant and child mortality are allowed.

and Program Coordination issued additional CSD guidance.[2] USAID officials believe that the new guidance will further help preserve the integrity of the CSD account. We think the new guidance is a step in the right direction and reinforces the previous USAID guidance. Compliance with the guidance needs to be more closely monitored, however.

USAID/Bangladesh has obligated and expended approximately $46.6 million and $16.4 million, respectively, in CSD funds during fiscal years 1997 through 1999.

Audit Objectives

The Office of the Regional Inspector General, Manila (RIG/Manila), as part of its approved fiscal year 2000 Annual Plan, audited USAID/Bangladesh to answer the following audit objectives:

1. **How were USAID/Bangladesh's child survival funds expended?**

2. **Has USAID/Bangladesh achieved the intended results of its child survival activities?**

Appendix I contains the scope and methodology for this audit.

Acknowledgements

RIG/Manila appreciates the excellent cooperation and assistance provided by USAID/Bangladesh during the audit. The Mission's assistance demonstrates their dedication to their jobs and their willingness to continue to improve their programs. Several of the findings under audit objective no. 2 were identified jointly by mission officials and RIG/Manila auditors during site visits. A special thanks to Mr. Jay Anderson, Ms. Polly Gilbert, Mr. Moslehuddin Ahmed, Mr. Belayet Hossain, and Mr. Shiril Sarcar of the Population and Health Team and to Ms. Herminia Pangan, Mr. Dean Pratt and Mr. Moksudar Rahman of the Financial Management Team.

[2] "Guidance on the Definition and Use of the Child Survival and Disease Programs Fund," dated April 10, 2000.

REPORT OF AUDIT FINDINGS

Objective 1: How were USAID/Bangladesh's child survival funds expended?

USAID/Bangladesh has obligated and expended child survival and disease (CSD) funds under two mission strategic objectives. First, the Mission uses CSD funding along with development assistance (DA) funding under the Mission's Strategic Objective (SO) No. 1 – *"Fertility Reduced and Family Health Improved."* Under SO 1, child survival activities are integrated with family planning (population) activities. The purpose of the CSD activities under this objective is to reduce infant, child and maternal mortality. CSD activities include social marketing of oral rehydration salt (ORS) packets, immunization (including polio eradication), disease surveillance, and quality assurance.

Second, the Mission used CSD funding along with DA funding and Public Law 480, Title II commodities under Strategic Objective (SO) No. 2 – *"Enhanced Household Income and Food-Based Nutrition."* According to the Mission's Activity Data Sheet attached to the Congressional Presentation for fiscal year 2000, this objective focused on both economic growth and nutrition levels through improved efficiency and diversification in agricultural production, and development of related rural industries and infrastructure.

The following table illustrates CSD obligations and expenditures under the two mission objectives for fiscal years 1997 through 1999 totaling $46.6 million and $16.4 million, respectively.

Table 1. CSD Obligations and Expenditures for Fiscal Years 1997 Through 1999

STRATEGIC OBJECTIVE (SO)	OBLIGATIONS	EXPENDITURES[3]
SO 1 – Fertility Reduced and Family Health Improved	$37.6 million	$15.4 million
SO 2 – Enhanced Household Income and Food-Based Nutrition	$9 million	$1 million

[3] USAID/Bangladesh did not have expenditure data available for field support activities and therefore the expenditure amounts shown are understated. Field support activities are services (i.e., technical assistance) provided to field missions through USAID's Global Bureau. Under this mechanism, missions acquire assistance through the provision of funds to the Global Bureau, which, in turn, procures the services under an existing contract or grant. Both obligation and expenditure data are unaudited.

The audit found that most of the CSD funds allocated and used for mission SO 2 were for activities which do not directly contribute to improving infant/child health and nutrition and reducing infant/child mortality. In addition, the method of allocating and accounting for the use of CSD funds under SO 1 being used by the Mission is imprecise and results in CSD funds used for non-CSD purposes. Discussions of the two issues follow.

Questionable Uses of Child
Survival and Disease Funds

The FAA and USAID's implementing guidance specify that allowable uses of CSD Funds are those activities that deal directly with the special health needs of children and mothers and contribute directly/significantly to reducing child mortality. However, the Mission's use of approximately $7.8 million of the $9 million of CSD funds obligated under mission SO 2 did not directly contribute to improving infant/child health and nutrition and reducing infant/child mortality. Rather, these activities as listed in Appendix III (e.g., income-generation, sustainable agriculture production, bio-diversity, developing markets, management of land, management of water fisheries) did not specifically target children and could only indirectly impact on children/mother health and reducing child mortality. Mission officials stated their belief that the activities could have an impact on rural households and on child and mother nutrition. We believe that the Mission could have used the $7.8 million for activities which may have more directly benefited children's and mother's health.

Recommendation No. 1: We recommend that USAID/Bangladesh:

1.1 Develop procedures for programming and using Child Survival and Disease Funds to ensure that the activities will directly benefit the health needs of children and mothers and directly contribute to improving infant/child health and nutrition and reducing infant/child mortality;

1.2 Establish procedures to obtain prior approval from USAID's Bureau for Policy and Program Coordination and the Global Bureau, with concurrence by regional bureau technical staff and clearance from the General Counsel if the Mission intends to use Child Survival and Diseases funds outside the parameters of USAID guidance; and

1.3 Obtain an opinion from the General Counsel on whether the obligations of $7.8 million were allowable uses of the Child Survival and Disease Funds.

Section 104 (c) (2) (A) of the FAA states that *"In carrying out the purposes of this subsection, the President shall promote, encourage, and undertake activities designed to deal directly with the special health needs of children and mothers. Such activities should utilize simple, available technologies which can significantly reduce childhood mortality, such as improved and expanded immunization programs, oral rehydration to*

combat diarrhoeal diseases, and education programs aimed at improving nutrition and sanitation and at promoting child spacing."

In addition, in the annual FAA appropriation legislation, the U.S. Congress appropriated minimum levels for USAID to use for CSD activities. For example, the annual appropriation language for fiscal years 1997 through 2000 states that the CSD funds are to be used for such activities as: (1) immunization programs; (2) oral rehydration programs; (3) health and nutrition programs, and related education programs, which address the needs of the mothers and children; (4) water sanitation programs; (5) assistance for displaced and orphaned children; (6) programs for the prevention, treatment, and control of, and research on, tuberculosis, HIV/AIDS, polio, malaria and other diseases; and (7) basic education programs for children. In addition to suggesting these activities, the House Appropriations Committee also directed USAID in July 1999 to separate the administration and coordination of activities in the CSD account from other global activities in order to "preserve the integrity of the Child Survival and Diseases Program Fund".

USAID has issued periodic guidance on acceptable uses of CSD funds. For example, the guidance issued for fiscal year 1998[4] states that allowable activities fall into four major categories: (1) child survival, (2) HIV/AIDS, (3) infectious diseases, and (4) other diseases/other health, including maternal health. Furthermore, this guidance states that allowable activities are those that contribute directly to the strategic objective of improving infant/child health and nutrition and reducing infant/child mortality. Finally, the guidance calls for missions to seek prior approval from the Bureau for Policy and Program Coordination, Global Bureau and regional bureau technical staff if they want to use CSD funds for activities outside the parameters of this guidance and to contact one of the above-mentioned bureaus if missions have questions about whether an activity falls within the guidance.

Moreover, as mentioned previously, USAID's Bureau for Policy and Program Coordination (PPC) issued additional CSD guidance at the time of our audit, dated April 2000. This new guidance is consistent with the previous USAID guidance and is more comprehensive. This guidance specifies, among other things, that CSD funds be used when there is a "direct impact." Direct impact is defined as the ability to relate the results of an activity in a measurable way to the desired objective. The guidance also instructs missions to direct questions about prohibitions, restrictions, and questionable uses to the PPC Senior Policy Advisor for Population, Health and Nutrition who will consult with the General Counsel as appropriate. Finally, if a mission proposes to use CSD funds for activities outside the parameters of the guidance, it must obtain prior approval from USAID's PPC and the Global Bureau, with concurrence by regional bureau technical staff and clearance from the General Counsel.

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[4] USAID General Notice entitled "*FY 1998 Child Survival and Diseases Program Fund Definition and Guidance*" issued on April 1, 1998.

The auditors believe that the Mission used approximately $7.8 million of the $9 million of CSD funds under mission strategic objective no. 2 "*Enhanced Household Income and Food-Based Nutrition*" for activities that did not directly contribute to improving infant/child health and nutrition and reducing infant/child mortality. Rather, as shown in the chart at Appendix III, these activities (e.g., income-generation, sustainable agricultural production, bio-diversity, developing markets, management of land, water fisheries) did not specifically target children and could only indirectly impact on children/mother health and reducing child mortality. Moreover, the Mission did not avail itself of procedures that were in place at the time, i.e., contact PPC, Global Bureau, or regional bureau, to obtain advance approval for these activities where there might be a question of qualifying for CSD funding.

The current Team Leader for mission SO 2 stated that these agricultural programs could have an impact on rural households and on child and mother nutrition. Moreover, the Mission Director said that the activities in question were intended to provide the very basic necessities such as household income, nutrition and food and were intended to have impacts on the most vulnerable sector of the society—the poor, especially women and children. He said that malnutrition in Bangladesh is a significant problem and that the Mission's food-based strategies aim to increase food production, household incomes and consumption of fish and vegetables, including increasing intake of micronutrients.

We acknowledge the mission officials' comments and are not questioning that the activities may be worthwhile endeavors. However, we are concerned that the use of CSD funds to carry out the activities which do not directly contribute to the strategic objective of improving infant/child health and nutrition and reducing infant/child mortality may raise an issue of compliance with the intent of the legislation, particularly now that the CSD Fund has achieved the status of a separate appropriation. The legislation, as noted above, tasks the President (and therefore USAID) with promoting activities which **"deal directly"** with the special health needs of children and mothers.

Moreover, several studies done of the projects in question did not find a link to improved nutritional status of women and children, a link that the Mission attempts to use to rationalize its use of CSD funds. One such study mentioned in Appendix III concluded that based on the evidence, there is little reason to believe that adoption of the technologies has improved the micronutrient status of members of adopting households through better dietary quality. Furthermore, the study also states that from a short-term perspective, the story that emerges is a discouraging one in the sense that food-based production strategies based on commercial incentives cannot immediately result in a substantial reduction in the number of malnourished people. Even a PPC official has acknowledged that the questionable activities were a "stretch" and that the Mission did not make the link/justification to benefiting children.

We noted that in the most recent results review and resource request (R4) submitted to USAID/Washington in April 2000, the Mission has broken out its SO 2 "*Enhanced Household Incomes and Food-Based Nutrition*" into four new strategic objectives. All

the activities which we have considered as being questionable in terms of their direct effect (shown in Appendix III) are now under two of these new strategic objectives:

- "*Growth of Agribusiness and Small Business*" in which the primary link to the Agency's Strategic Framework is "private markets", and

- "*Improved Management of Open Water and Tropical Forest Resources*" in which the primary link to the Agency's Strategic Framework is "biological diversity."

The current Team Leader for SO 2 stated that for fiscal years 2000-2005, the Mission does **not** plan to use CSD funds for the activities under these new SOs. We believe that the new strategic objectives better reflect the goals of the activities in question.

The Mission also has allocated new fiscal year 2000 CSD funding primarily for the integrated population and health SO 1 Activities. Nothing came to our attention to indicate that these funds were being allocated for questionable activities, although we do have other reservations regarding these integrated activities (see next section).

We discussed the Child Survival and Disease legislation with an official of the Agency's General Counsel. He stated that there was an understandable difficulty whenever a piece of legislation used words such as "direct" because it is difficult to draw the line precisely between what is considered direct and indirect. He also stated that some of the language regarding earmarks was misleading because they referred to directions that were put into the language of various House Committee Reports on the legislation, and were not statutory. While we recognize that differences in interpretation can occur, and that there might well be a "gray" area between what some clearly consider as clearly eligible for CSD funding, and what some might consider ineligible, we are recommending that the Mission obtain an opinion from the General Counsel on the $7.8 million that we believe did not directly relate to CSD objectives. We believe that this will help to establish some clearer boundaries between what is acceptable and what is not. We believe that the Mission could have used the $7.8 million for activities which may have more directly benefited children's and mother's health.

Imprecise Allocation/Accounting of CSD
Funds for Integrated Population and Health Program

As stated above, the FAA and USAID guidance require that missions use CSD funds for specified purposes. USAID/Bangladesh's SO 1 "*Fertility Reduced and Family Health Improved*" integrates both family planning (population) activities and health activities. As such, the Mission allocates and uses both CSD funds and development assistance-population funds.[5] However, the method of allocating and accounting for CSD funds to SO 1 is

[5] According to mission officials, in some years the Agency has a separate budget plan code for population funds. The population funds are part of the development assistance funds.

imprecise because (1) the Mission's qualitative analyses done to determine the mix is not always accurate or precise, (2) the actual mix of funding allocated to the Mission for SO 1 and actually obligated to the Mission's recipients[6] varies from year to year, and (3) the Mission's recipients are not required to account for CSD funds separately, including breaking out CSD expenditures in their vouchers. As a result, the Mission does not have reasonable assurance that CSD funds are used for allowable CSD activities. The audit disclosed that under the current method, CSD funds are being used for other than allowable CSD expenditures. Mission officials stated that the Mission is using the USAID-wide system to allocate and account for CSD funds. For example, they noted that USAID's Financial Management Office in Washington, D.C. is the designated paying office for many of the recipients under the program. They also noted that USAID has not mandated its missions to require recipients to account for CSD funds separately. Because this issue may have USAID-wide implications and because CSD funds are now channeled through a separate appropriations account that is subject to appropriations law, we are not making a recommendation in this report. Instead, we have referred this finding to our OIG Headquarters in Washington, D.C. for possible follow up. A detailed discussion of this issue follows.

Detailed Discussion

Under SO 1 "*Fertility Reduced and Family Health Improved,*" USAID/Bangladesh funds an integrated family planning (population) and health program. This integrated program, implemented by various U.S. and local private firms and non-governmental organizations, provides an "*Essential Service Package*" consisting of integrated family planning and maternal and child health services. Family Planning (population) services include financing and distributing contraceptives, and providing family planning information and counseling. Child and maternal health services include immunizations, diarrhoeal disease control, acute respiratory infection control, vitamin A supplements, and other maternal health services.

The Mission funds these activities with both CSD funds and DA-population funds. However, the Mission's method of allocating and accounting for CSD funds for the integrated program is imprecise and does not provide reasonable assurance that CSD funds are used for purposes specified in the Foreign Assistance Act. A look at how the CSD funds are allocated and accounted for follows.

Allocating CSD Funds

When the National Integrated Population and Health program (NIPHP) started in mid-1997, the Mission estimated that the overall proportion of population to CSD activities was about 65 percent to 35 percent, respectively. The Mission also estimated the mix of population to

[6] For this report, recipients refer to contractors, grantees and host country institutions that receive USAID assistance to help implement USAID activities.

CSD activities for each of its main bilateral components/recipients[7] under SO 1. According to mission officials, the overall estimate and the estimate for its main bilateral program components were not based on any detailed analyses and the Mission did not have any documentation to show how it arrived at these estimates.

In early 1999 (about 18 months after the start of the program), the Mission's Population and Health Team did qualitative analyses on its main bilateral components of the program to determine what adjustments to the proportions were necessary.[8] The qualitative analyses involved taking the recipients' progress reports (normally for one month) and comparing total outputs, i.e., number of patients served relating to population activities versus CSD activities. A break down of the original proportions and the revised proportions based on the qualitative analyses by bilateral program component is shown in the following table.

Table 2. Original and revised proportions of population to CSD activities.

NIPHP COMPONENT	ORIGINAL POPULATION/CSD MIX	REVISED POPULATION/CSD MIX
Rural Service Delivery	65/35	62/38
Urban Service Delivery	65/35	59/41
Quality Improvement	98/2	70/30
Social Marketing	68/32	72/28
Operations Research	67/33	47/53
Basic Support for Institutionalizing Child Survival	7/93	7/93

The audit disclosed that the Mission's qualitative analyses were not always accurate or precise. For example, the analyses were based on a less-precise method of reviewing outputs rather than reviewing the actual cost of inputs (e.g., salaries, travel, commodities, etc.). In addition, the analysis for the Rural Service Delivery component counted immunizations performed by the GOB personnel, not by the program's health clinics. Excluding the GOB immunizations would drastically change the Rural Service Delivery component mix from 62/38 to about 80/20 DA-population funds to CSD funds. Mission officials believe that since the expanded program on immunization was jointly organized by the GOB and USAID, whereby the rural non-governmental organization (NGO) clinics staff provided other assistance (e.g., family planning) during immunization days, these immunizations should be counted.

Furthermore, even if the Mission's qualitative analyses were accurate and precise, the actual funding mix allocated to the Mission's SO 1 by USAID/Washington varies from year to

[7] Each main bilateral program component is implemented by one main recipient. For example, Pathfinder implements the Rural Service Delivery component.

[8] The Mission also performed another qualitative analysis of its main components during the audit fieldwork in April 2000. No qualitative analyses were done of SO 1's field support components.

year and does not necessarily match the Mission's requested mix. For example, for fiscal year 2000, the Mission requested a mix of about 62/38 DA-population funds to CSD funds for its bilateral components. However, USAID/Washington actually allocated an overall mix of 35/65. This mix allocated to the Mission for fiscal year 2000 is a complete reversal of the original estimated mix for the program of 65/35.

Mission officials said that they are stuck with the proportion of DA-population and CSD funds actually allocated to the Mission by USAID/Washington each year. They said that they do the best they can to allocate and obligate funds among the recipients to match the mix per the qualitative analyses and that the mixes allocated to most of the recipients are relatively close. However, the audit found that some recipients were allocated too much of a certain funding source. For example, for fiscal year 1999, the total $700,000 allocated to the Quality Improvement recipient was CSD funds even though the results of the qualitative analysis suggested a mix of 70/30 population to CSD funds. In fiscal year 2000, the mix of population to CSD funds allocated to the Urban Service Delivery recipient totaling $2.5 million was 25/75 even though the qualitative analysis suggested a mix of 59/41.

Accounting for CSD Expenditures

Various recipients under the program receive both DA-population and CSD funds to implement the program components. However, the Mission does not require its recipients to separately account for the CSD funds. Therefore, vouchers submitted to USAID do not separately classify CSD expenditures from other expenditures.[9] Because recipients' vouchers do not separately classify CSD expenditures, USAID's paying office arbitrarily applies the voucher expenditures to DA-population funds and/or CSD funds using the first in, first out (FIFO) or other methods.[10] This leads to CSD funds being used for other than allowable CSD expenditures and this problem is magnified by the imprecise allocation/obligation of funds to the recipients as described above.

We believe the following examples will illustrate this point.

- All of a U.S. recipient's expenditures for the Urban Service Delivery component for the period October 1, 1998 to December 31, 1998, totaling $1,331,154, were liquidated using CSD funds when some of the expenditures for that period related to family planning activities.[11] This grantee clearly performed family planning activities during

[9] The Social Marketing Company (SMC) is the only recipient of the more than 15 recipients under the program that separately classifies CSD expenditures in its vouchers. SMC receives about five percent of the total program funds.

[10] For U.S. recipients, the paying office is FM/Washington. For Bangladeshi recipients, the payment office is USAID/Bangladesh Controller's Office. Under the FIFO method, the oldest obligated funds are applied to vouchers regardless of the nature of the expenditures (CSD versus population).

[11] U.S. recipients are paid using the letter of credit method. The paying office is USAID/Washington (M/FM/CMP).

this period. In fact, if it followed the mission's estimated mix of 65/35 population to CSD, the amount of $865,250 should have been charged against population funds.

- Also, all of a recipient's expenditures for the Rural Service Delivery component for the period July 1, 1998 to September 30, 1998, totaling $1,501,256, were paid with CSD funds when some of the expenditures for that period related to family planning activities. Again, if it followed the mission's estimated mix at that time of 65/35, the amount of $975,816 should have been charged against population funds.

In conclusion, the audit found that the Mission's current accounting system does not provide an audit trail that relates expenditures of CSD funds to CSD activities. Mission officials stated that the Mission is using the USAID-wide system to allocate and account for CSD funds. For example, they noted that USAID's Financial Management Office in Washington, D.C. is the designated paying office for many of the recipients under the program. They also noted that USAID has not mandated its missions to require recipients to account for CSD funds separately.

A U.S. General Accounting Office (GAO) report issued in November 1996[12] also noted problems with how USAID accounts for CSD funds. The report mentions that USAID is unable to determine with any degree of precision how much funding is actually being used for child survival activities. The report states that the amounts reported by USAID are not based on project expenditures, but rather on estimated percentages of project budgets. However, GAO deleted a recommendation made in its draft report to address this problem in its final report because USAID officials commented that the New Management System was underway that would link budgets, obligations, and expenditures and enable the Agency to track funds more accurately.[13]

During some additional discussions with USAID Financial Management officials in Washington, we were told that Office of Management and Budget (OMB) regulations and provisions of the Paperwork Reduction Act severely limited the amount of financial information that the Agency can require from awardees. However, we did note that the Agency has already requested and obtained a waiver from OMB to gather mission-specific information from awardees in connection with activities in non-presence countries. Monitoring compliance with Agency Congressional earmarks and appropriations in the CSD area appears to us to be equally deserving of such a waiver. We also note that the OMB-approved Form (Standard Form – 269A) used by USAID to report financial status information contains provision for "information required by Federal sponsoring Agency in compliance with governing legislation," which is an acknowledgement of a requirement to report such information.

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[12] Report entitled *"Contributions to Child Survival are Significant, but Challenges Remain."*

[13] USAID is intending to replace the accounting portion of the New Management System due to major system problems.

Congress has required reporting on CSD activities. The Conference Report on the fiscal year (FY) 2000 Appropriations Act directed USAID to provide a "detailed report not later than February 15, 2000 on the programs, projects and activities undertaken by the CSD Programs Fund during FY 1999." The Report however, does not supply actual expenditure information, but refers to estimated amounts allocated to the various Bureaus and mission activities. The House Committee on Appropriations in its Report (106-254) on the FY 2000 Appropriations Bill directs USAID to separate the administration and coordination of activities in the CSD Account from those of other global activities "in order to preserve the integrity of the Child Survival and Disease Programs Fund." Yet, the same Report also indicates that the Committee "is open to discussion about use of the Fund for specific environmental health interventions, especially in urban areas, where air and water pollutants directly affect child morbidity and mortality." This indicates some latitude in terms of integrated programs.

Because this issue may have USAID-wide implications, we are not making a recommendation in this report. Also, since the two recipients cited as examples on pages 10 and 11 of the report are paid out of USAID/Washington, we are not making a recommendation regarding their expenditures for the same reason. Instead, we have referred this finding to OIG headquarters in Washington, D.C. for possible follow up.

Objective 2: Has USAID/Bangladesh achieved the intended results of its child survival activities?

USAID/Bangladesh has achieved some of the intended results of its child survival activities encompassed under its SO 1 *"Fertility Reduced and Family Health Improved."* For other intended results under SO 1, the Mission has not yet achieved its intended results.

The Mission initiated its integrated population/health program under SO 1, called the National Integrated Population and Health Program (NIPHP), in mid-1997. Under the NIPHP, the Mission funds a service-delivery program operated entirely by 45 local NGOs assisted by two main U.S. grantees. These NGOs provide services daily in 298 clinics and periodically at 9,140 satellite sites within the country.

In fiscal year 1999, substantially more people visited the clinics to use both family planning and health services, compared to the initially low levels during the first year of operation. Also, the NIPHP has exceeded its fiscal year 1999 target of *"number of ORS packets sold"* under the social marketing component and has met its 1999 target of *"percent of operating costs funded by NGOs."* However, thus far, the program has not had a significant effect on children immunization rates in the country. Child immunization rates have stagnated and have actually declined in some areas over the last several years. Please refer to Appendix IV for a summary of the progress towards some of the main intended results of the NIPHP.

A Demographic and Health Survey (DHS) in Bangladesh is conducted every three years. As of May 2000, the DHS for 1999/2000 was near completion. The preliminary results of the DHS showed that the Mission had exceeded its targets of reducing infant and child mortality. Mission officials, however, acknowledge that many factors outside the Mission's activities and control affect infant and child mortality rates. Some of these factors include GOB programs and policies, the multitude of other bilateral and multilateral donor programs, natural disasters or the nonoccurrence of natural disasters, etc. Nevertheless, the Mission believes that their activities have some influence on these national rates. Furthermore, the Mission conducted baseline surveys in 1999 and has budgeted funds for future impact surveys in the areas the program is operating to obtain information on the direct results of its program.

The audit found areas needing management attention.

- First, although the GOB is supposed to provide vaccines to the program's clinics to immunize children, only 51 of the 175 rural clinics within the program receive vaccines from the GOB. Therefore, 124 of the rural clinics could not provide one of the crucial child health services.

- Second, the Mission's Rural Service Delivery grantee has not yet resolved questioned costs totaling approximately $52,084 identified for one of its problem NGOs and has not accounted for fixed assets totaling $26,782 procured by this NGO.

- Third, two of the eight NGO clinics visited were located too close to GOB health facilities that provide essentially the same services.

- Finally, the program has been holding on to approximately 2,135 boxes of unused ORS packets purchased during the major flooding in 1998. These issues are discussed below.

USAID/Bangladesh Needs the Government of Bangladesh
To Fulfill its Agreement to Provide Vaccines to Rural Clinics

USAID/Bangladesh's program agreement with the GOB requires the GOB's Ministry of Health and Family Welfare (MOHFW) to provide an adequate supply of maternal and child health (MCH) supplies, including vaccines, to USAID-funded NGOs to carry out the program objectives. The program agreement also states a goal to increase child immunization coverage rates to 80 percent by the end of the program in 2004. However, the MOHFW has not provided vaccines to 124 of the 175 rural clinics in the program, which also operate in approximately 5,000 satellite locations. This occurred primarily because the Mission's Rural Service Delivery grantee did not pursue this requirement with the MOHFW. As a result, 124 of the 175 rural clinics were unable to provide an important maternal health and child health service directly, i.e., immunizations. Also, this will hinder the program impact of increasing child immunization rates in the country and thereby leave more children at risk.

Recommendation No. 2: We recommend that USAID/Bangladesh:

2.1 Work with the Ministry of Health and Family Welfare to obtain a regular supply of vaccines for the rural clinics; and

2.2 Develop a plan to ensure that the non-governmental organizations take the necessary steps (i.e., training, coordination with the Ministry of Health and Family Welfare, procurement of refrigerators, etc.) to provide regular child and mother immunization services at its rural clinics.

USAID/Bangladesh's program agreement[14] with the GOB requires the GOB's Ministry of Health and Family Welfare to provide an adequate supply of maternal and child health supplies, including vaccines, to USAID-funded NGOs to carry out the program objectives. The program agreement also states a goal to increase child immunization coverage rates to 80 percent by the end of the program in 2004. Child immunization rates in the country have stagnated over the last several years at about 52 percent. Vaccine-preventable diseases are one of the leading causes of death among children under age five in developing countries.

On one hand, the MOHFW generally provides vaccines[15] to the program's urban clinics. Therefore, as depicted in the following photograph, the urban clinics are able to provide immunization services regularly to children.

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[14] Strategic Objective Agreement between the United States of America and The People's Republic of Bangladesh for the Strategic Objective: Fertility Reduced and Family Health Improved.

[15] Routine childhood immunizations during the first 12 months include BCG, Diphtheria, Pertussis, Tetanus (DPT), polio, and measles.

An infant receiving a vaccination at an urban clinic (May 2000, Sylhet, Bangladesh)

On the other hand, the MOHFW has not provided vaccines to 124 of the 175 rural clinics, which also operate in approximately 5,000 satellite spots. This occurred primarily because the Mission's Rural Service Delivery grantee did not pursue this requirement with the MOHFW. Instead, this grantee accepted a less desirable arrangement where it arranged with the MOHFW to provide some vaccination coverage in some of the areas (approximately one-third of the satellite spots) covered by USAID's NGOs.[16]

Clinic personnel at several rural clinics said that it would be more beneficial and useful for the clinics to receive vaccines from the MOHFW so that they could provide immunization services directly. The clinics would be able to provide immunizations more regularly and reliably than the MOHFW. Clinic personnel said that MOHFW workers are not always reliable and do not always go to the satellite spots as scheduled. Furthermore, clinic personnel said that providing immunization services themselves would attract more people to utilize the clinics' other services for which they would also be able to charge minimal fees.

As a result of not obtaining vaccines from the MOHFW, 124 of the 175 rural clinics were unable to provide an important maternal health and child health service directly, i.e., immunizations. This also goes against the program's objective of *"one-stop shopping,"*

[16] The rural clinics do participate in the two National Immunization Days against polio each year.

or providing all the main health and family planning services to customers in its clinics. Finally, this will hinder the program impact of increasing child immunization rates in the country and thereby leave more children at risk.

The Mission Should Determine the Allowability
Of Questioned Costs Identified for a Rural NGO

USAID mandatory standard provisions for U.S. and non-U.S., non-governmental recipients require recipients to properly account for the use of U.S. Government funds. The Rural Service Delivery grantee, Pathfinder, had problems with a sub-grantee, e.g., irregularities in issuing checks, purchase of equipment and furniture, and poor bookkeeping, and had to terminate this NGO from the program. Pathfinder has not yet resolved questioned costs totaling approximately $52,084 that were either not supported with proper documentation or were of questioned eligibility under the grant and has not accounted for fixed assets totaling $26,782 procured by this NGO. As a result, U.S. Government funds have not been properly accounted for and may have been diverted. Furthermore, service delivery in the area covered by the NGO was disrupted for approximately six months.

Recommendation No. 3: We recommend that USAID/Bangladesh determine the final accounting of funds disbursed to Pathfinder's sub-grantee (Bangladesh Birth Control and Family Welfare Association), and recover from Pathfinder any amounts due. Specifically, USAID/Bangladesh should:

3.1 Determine the allowability of the $24,617 (1,145,934 Bangladeshi Taka) and $27,467 (1,332,434 Taka) mentioned on page 6 of the final audit report of a local auditing firm for the period September 1997 to February 1998 and on page 22 of the draft audit report for the period March to September 1998, respectively;

3.2 Determine the allowability of the remaining fund balance of $18,979 (920,683 Taka) frozen in the Non-Governmental Organization's local bank accounts;

3.3 Determine the allowability of the $26,782 (1,299,181 Taka) in fixed assets procured by the Non-Governmental Organization's (Bangladesh Birth Control and Family Welfare Association) as listed on pages 15-18 in the final audit report of a local auditing firm for the period March to September 1998 which have not been accounted for/recovered; and

3.4 Determine the allowability of the $74,440 (3,611,103 Taka) in unpaid obligations listed on page 26 of the final audit report for the period March to September 1998.

USAID mandatory standard provisions for non-U.S., non-governmental recipients require recipients to properly account for the use of U.S. Government funds. The recipient is required to maintain financial records and supporting documents to sufficiently substantiate charges to the award. The accounting records that are supported by documentation will as a minimum be adequate to show all costs incurred under the award, receipt, and use of goods and services acquired under the award. These provisions also state that costs incurred under grants must be reasonable, allocable and allowable.

The Rural Service Delivery grantee, Pathfinder, had problems with a local NGO. This local NGO was responsible for operating family planning/health clinics in 15 Bangladesh Thanas (counties). The total amount of U.S. Government funds disbursed to this NGO totaled approximately $230,000.

During a February 1998 visit to the local NGO sites, Pathfinder found several irregularities including issuance of checks without noting payee or description, purchase of equipment and furniture that were not at the sites, poor accounts bookkeeping and suspected false reporting on customer's attendance in satellite clinics. Based on the site visit findings, Pathfinder had a local auditing firm conduct audits of the local NGO. In addition to confirming the above-mentioned irregularities, the auditors questioned costs totaling $52,084[17] because the costs were either not supported with proper documentation or were of questioned eligibility under the grant. With USAID's approval, Pathfinder froze funding to the local NGO in July 1998 and stopped using the NGO in September 1998. In November 1998, Pathfinder assigned four other local NGOs to provide service delivery in the areas so that the people in these areas would no longer suffer from disruption of services.

Pathfinder officials stated that they have not recovered any of $52,084 in questioned costs or the fund balance of $18,979 (920,683 Taka) frozen in the local NGO's bank accounts. According to Pathfinder officials, there is a legal dispute over which executive committee has control of the NGO and said it could take years before the courts decide on this issue. Furthermore, Pathfinder has not accounted for the approximately $26,782 in fixed assets provided under the grant and has acknowledged that at this point, these assets could be long gone. Finally, Pathfinder has not determined the propriety of about $74,440 in unpaid obligations supposedly incurred by the NGO before it was terminated from the program. The independent auditor cautioned Pathfinder to review these purported obligations carefully.

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[17] This amount consists of 1,145,934 Bangladeshi Taka from the audit report for the period September 1997 to February 1998 and 1,332,434 Taka from the draft audit report for the period March to September 1998. For the second audit report, the auditors reduced the questioned costs of 1,332,434 Taka from the draft audit report down to 256,222 Taka in the final audit report. We believe that the Mission needs to review the questioned costs identified in the draft report for propriety because we did not receive satisfactory justification from the local auditing firm on why the questioned costs were reduced.

As a result of the above, U.S. Government funds have not been properly accounted for and may have been diverted. Furthermore, service delivery in the area covered by the NGO was disrupted for approximately six months.

NGO Clinics are Located
Too Close to GOB Health Facilities

One important objective of the program is to provide access to family planning and health services to residents in under-served areas. However, the audit found that two of the eight NGO clinics visited are located too close to GOB health facilities that provide similar services. For example, one urban clinic is located within 500 meters from a GOB hospital. Another clinic is located about a half kilometer from a GOB clinic. Personnel at these two clinics said that they have difficulty in attracting patients because the residents are already served by the nearby GOB health facilities. In addition, some residents prefer going to the GOB health facilities because they provide free services. The NGOs chose the locations based on other considerations (e.g., rent cost). As a result, program resources may not be optimally utilized. These program resources could be better used in more neglected areas.

Recommendation No. 4: We recommend that USAID/Bangladesh:

4.1 Determine whether the Non-Governmental Organizations should move the two clinics to a more suitable area; and

4.2 Require the two main grantees (for the urban and rural service delivery components) to review the locations of other low performing clinics and determine which clinics should be moved to more suitable locations.

Remaining Unused Oral Rehydration Salt (ORS) Packets
Held Since the Major Flooding in 1998 Should be Used

USAID financed the procurement of ORS packets[18] to help with the disaster relief efforts during the major flooding in Bangladesh in 1998. These ORS packets were procured at a unit cost of $7.15 per box (one box contains 200 packets) and were provided to several grantees under mission SO 1 and SO 2 for distribution. A total of 18,125 boxes of ORS packets, costing $130,000, were allocated to the grantees.

Although the other grantees have already used/distributed the ORS packets, many of the ORS packets allocated to the urban family planning/health clinics under SO 1 remain. As of May 2000, a total of 2,135 boxes (427,000 packets) costing $15,265 remained at the urban family planning/health clinics. These urban clinics have been holding on to the remaining ORS packets because Urban Service Delivery grantee, John Snow, Inc., had instructed them to not issue these packets to patients. John Snow had incorrectly thought that the packets

[18] ORS packets are used to help treat and control diarrhea cases.

could not be used in non-disaster situations. John Snow also was concerned that if these packets were distributed free that it would hurt the social marketing of ORS packets under the program. Mission officials said that this should not be a material barrier to distribute the packets.

One NGO that we visited said that it had between 80,000 to 100,000 packets stored in three of its clinics since about October 1998. This NGO stated that it did not have adequate storage space for these packets and was concerned about spoilage. The NGO also stated that John Snow had instructed it to hold on to the packets. The NGO was concerned that the expiration date may pass before it could distribute the packets. According to a John Snow report, the expiration date of the ORS packets is November 2002. Personnel at the NGO clinic that we visited said that they did not have other ORS packets in stock that could be distributed to patients.

In conclusion, the urban clinics were holding on to 2,135 boxes of ORS packets, costing $15,265, since October 1998. Thus, the ORS packets were not used to treat and control diarrhea, potentially one of the most fatal childhood diseases. Furthermore, these packets are at risk of spoilage/theft. These commodities should be better utilized by (1) redistributing the remaining packets within the program's urban and rural clinics as needed, and (2) instructing the clinics to distribute the packets to their patients as needed.

Recommendation No. 5: We recommend that USAID/Bangladesh require John Snow, Inc. to (1) redistribute the remaining Oral Rehydration Salts packets within the program's urban and rural clinics as needed, and (2) instruct the clinics to distribute the Oral Rehydration Salt packets to their patients as needed.

Management Comments and Our Evaluation

In response to our draft audit report, USAID/Bangladesh provided written comments that are included in their entirety as Appendix II. Based on the Mission's comments, Recommendation Nos. 4.1 and 5 are closed upon issuance of this report. Recommendation Nos. 1, 3 and 4.2 have had a management decision and may be closed when the cognizant responding office provides evidence to USAID's Office of Management Planning and Innovation that it has implemented its planned actions. A management decision is pending on Recommendations No. 2 until there is a clear agreement on the planned course of action.

The Mission made a specific request for the deletion of a discussion on the "Imprecise Allocation/Accounting of CSD Funds for Integrated Population and Health Program". This turned out to be a larger problem than the condition we noted in Bangladesh, and therefore, we did not include a recommendation directed only to USAID/Bangladesh. For that reason, USAID/Bangladesh requested that this topic be completely excluded from this Mission-specific report. While we recognize that USAID/Bangladesh would not be the action office for resolution of such an agency-wide problem, we do feel that it is important for the reader to have background into the amount of control and oversight that is accorded to CSD

funding. Not only are some types of activities being charged to CSD funds because of justifications which link the impact to children and maternal health, even if not directly, but it is also quite possible, given the accounting procedures used, that population activities under integrated programs are being charged to CSD appropriations due to a lack of information on contractor and grantee vouchers claiming reimbursement. Because many USAID missions throughout the world have integrated population and health programs, we believe that this topic is a very important finding despite the absence of a recommendation in this report.

In addition, the Mission requested us to revise the table illustrating "CSD Obligations and Expenditures for Fiscal Years 1997 Through 1999" to match with the amounts reflected in Mission records and to present separately Mission funded obligations from field support obligations. However, the present table illustrates both the obligations and expenditures figures provided by the Mission during the course of the audit. We believe that a footnote to the table already provides sufficient information to allow the reader to fully understand the distinction between USAID/Bangladesh-controlled and field support activities funded by the Global Bureau. Therefore, we have not revised the table, but refer the reader to the revised table provided by the Mission in its comments (Appendix II) if the more detailed breakdown is needed.

We address the remaining management comments under the appropriate recommendation below.

Recommendation No. 1

The Mission, in its response to Recommendation Nos. 1.1 and 1.2 of our draft report, has stated that in order to ensure appropriate review by the Mission's Program Office of any proposed CSD funds, the Mission plans to incorporate the Guidance directives regarding the clearance/approval process to its USAID Order No. 200-3, Checklist of Authorities and Responsibilities. We consider that a management decision has been made.

With respect to Recommendation No. 1.3, which recommended the Mission obtain an opinion from the General Counsel on whether the obligations of $7.8 million were allowable uses of CSD Funds, the Mission provided us a memo containing an opinion of the Regional Legal Advisor (RLA) that the questioned activities fall within the parameters of the USAID fiscal year 1998 Guidance and thus the CSD Funds provision set out in the annual Appropriations Act. The Mission also indicated that the Office of the General Counsel concurs with the RLA's opinion.

The RLA's interpretation that all of the activities listed in Appendix III are acceptable uses of CSD funds is a significant management decision. We believe this decision may make it increasingly difficult to draw the line between the activities listed in Appendix III and many of USAID's general economic growth, environmental and health-related activities funded by the Bilateral Assistance appropriation (since an equally strong case

can also be made that most of these activities will also eventually and indirectly benefit women and children).

Recommendation No. 2

In its response, the Mission took exception to the recommendation stating that because the Rural Service Delivery grantee (Pathfinder International) is not a party to the Strategic Objective Agreement [an agreement between USAID and the Government of Bangladesh (GOB)], it is inappropriate for Pathfinder International to intercede or act on behalf of USAID to ensure GOB compliance with the terms of the Strategic Objective Agreement. Although the audit team and the Mission's Population and Health Strategic Objective team agreed to the wording of the recommendation during the fieldwork, we agree that technically Pathfinder International cannot intercede in USAID's behalf. Therefore, we modified the recommendation slightly to state that "We recommend that USAID/Bangladesh work with the Ministry of Health and Family Welfare to obtain a regular supply of vaccines for the rural clinics."

The Mission also stated that the current method whereby the GOB staff provided some immunization coverage to some of the areas covered by the rural clinics was neither improper nor ineffective. For this reason, the Mission believes this recommendation should be deleted from the audit report.

We disagree. As stated in the finding, the rural clinic personnel themselves stated during our audit that under the current method, the GOB does not provide reliable and regular vaccination coverage. Furthermore, these rural clinic personnel believed that it would be more beneficial and useful for the clinics to receive vaccines from the GOB so that they could provide immunizations more regularly and reliably to children and mothers.

The Mission further mentioned in its response that subsequent to our finding in May 2000 (that only 51 of the 175 rural clinics, or 29 percent, received vaccines from the GOB), 116 rural clinics, or 66 percent, of all static rural clinics receive vaccines from the GOB as of the end of September 2000. Therefore, this statement suggests that the Mission is implementing our recommendation to obtain a regular supply of vaccines for the rural clinics in order to provide regular child and mother immunization services at its rural clinics.

Because we are unclear with the Mission's intended course of action on this finding and because we have modified Recommendation No. 2.1 slightly, a management decision is pending on Recommendation No. 2 until there is clear agreement on the planned course of action.

Recommendation No. 3

Under Recommendation No.3.1, the Mission determined that of the total questioned costs of $52,084 (Taka 2,478,368), $5,983 (Taka 288,877) is unallowable and $46,101 (Taka 2,189,491) is allowable. The Mission, however, indicated that part of the allowable expenses is $22,400 (Taka 1,042,699) which represents commodity expenses but as subsequently questioned in Recommendation No. 3.3.

Under Recommendation No. 3.2, the Mission indicated that Pathfinder International has requested Janata Bank to return the balance of funds amounting to $18,979 (Taka 920,683) to Pathfinder International. In the event the funds are not returned, Pathfinder International plans to recover this amount from the unpaid obligations (discussed under recommendation no. 3.4) due to Bangladesh Birth Control and Family Welfare Association (otherwise known as RFWP).

Under Recommendation No. 3.3, the Mission indicated that of the $26,782 worth of fixed assets procured by RFWP, Pathfinder has recovered $1,369 (Taka 66,420). Pathfinder International plans to recover the remaining balance of $25,413 (Taka 1,232,761) from the unpaid obligations (discussed under recommendation no. 3.4) due to RFWP.

Under Recommendation No. 3.4, the Mission indicated that Pathfinder International has made a payment of $2,721 (Taka 132,000) directly to a local vendor for services rendered on behalf of RFWP. In addition, Pathfinder International has already engaged a local auditor to verify the allowability of the remaining unpaid obligations of $71,719 (Taka 3,479,103) to RFWP.

Finally, the Mission indicated that in the event the disallowed costs exceeded the allowable unpaid obligations, USAID will issue a bill for collection to Pathfinder for the difference.

We consider that a management decision has been made on Recommendation No. 3.

Recommendation No. 4

In response to Recommendation No. 4.1, the Mission stated that the two clinics in question were not specified in either the subject draft audit report or the "Discussion draft for exit meeting". The Mission, however, assumed that the subject clinics are the RSDP Shimantic clinic at Bianibazar in Sylhet and the Urban Family Planning (UFHP) Sylhet Samaj Kallayan Sangstha (SSKS) facility in Moulvibazar based on the recollections of the Population and Health (PH) team members who traveled with the auditors and on "Site visit summary of issues/observations" paper distributed by the auditors to several PH staff.

As stated in the management response, a member of the PH team accompanied the auditor on our site visits, and therefore, he knew which two clinics the finding refers to.

In addition, the auditors identified the two clinics in question during a pre-exit meeting with the PH team and again, during the exit conference. Specifically, the auditors referred to the RSDP Shimantic Clinic at Bianibazar in Sylhet and the Urban Family Planning (UFHP) Sylhet Samaj Kallayan Sangstha (SSKS) facility in Moulvibazar.

The Mission indicated that the RSDP Clinic at Bianibazar was established fifteen months ago on its original facility because no other rental structure was available at that time. The Mission added that the NGO had already identified the problem and that in fact, planned to move to a more suitable site. On May 24, 2000, this clinic was relocated. The clinic is now located two and one-half kilometers from a GOB facility and four kilometers from the original site.

In reference to the SSKS Moulvibazar facility, the Mission indicated that there appears to have been some miscommunication between the auditor and the clinic staff during the visit. The Mission further said that the audit team did not verify the existence of "a GOB hospital" said to be located within 500 meters of the SSKS Moulvibazar Clinic and believes that the auditor misunderstood the information provided by the clinic staff. The Mission said that this clinic was previously located within 500 meters from a GOB Maternal and Child Welfare Center. However, with problems on low customer flow, the clinic was moved to its present location (visited by the auditor) in November 1999.

We disagree that there was a miscommunication between the auditor and the physician who works in the clinic and provided the information on the location of SSKS Moulvibazar and the problem in attracting patients in the catchment area during the visit. Again, the auditor was accompanied by a PH staff who was present during the interview and heard the physician's responses to our questions. In fact, the FSN Cognizant Technical Officer for UFHP said during our meeting with PH staff on "Site Visit Issues and Observations" that he will follow up on the move of this clinic in Moulvibazar.

At any rate, if the Mission has determined that this clinic, in its existing location, is suitable to provide primary health care to residents in the catchment area with an increasing number of customer contacts, we consider that a management decision has been made.

For Recommendation No. 4.2, the Mission indicated that it will request RSDP and UFHP to review and analyze clinic locations in relation to other health facilities to determine if there is, in fact, duplication of services and if proximity to other service centers is affecting client load.

Based on their comments, we consider that Recommendation No. 4.1 is closed and that a management decision has been made on Recommendation No. 4.2.

Recommendation No. 5

We recommended that USAID/Bangladesh require John Snow, Inc. to (1) redistribute the remaining Oral Rehydration Salts (ORS) packets within the program's urban and rural clinics as needed, and (2) instruct the clinics to distribute the Oral Rehydration Salt packets to their patients as needed.

In its response, the Mission stated that John Snow, Inc. (JSI) was fully aware of the remaining ORS packets in stock, and the decision to store the ORS packets until needed was based on the following: (a) the packaging labels clearly indicated the supplies were to be used in response to *disaster* and *were not to be sold*; (b) an integral feature of NIPHP service delivery is fee-for-service; and (c) the late expiration dates of the supplies and the availability of storage space made it possible to store the supplies without threat or loss or misuse. The Mission added that JSI began distributing the ORS packets over the summer and by the end of September 2000, JSI had delivered 90 percent of the balance. JSI is expected to distribute the remaining 10 percent by first of November 2000.

We consider that Recommendation No. 5 is closed upon report issuance.

SCOPE AND METHODOLOGY

Scope

We audited USAID/Bangladesh's child survival activities in accordance with generally accepted government auditing standards. We conducted the fieldwork in Bangladesh from March 28 to May 18, 2000 and met with USAID/Washington officials the week of August 14-18, 2000. The audit focused on $46.4 million CSD funds obligated, of which $16.4 million were expended during fiscal years 1997 through 1999.

Methodology

We reviewed USAID/Bangladesh documents and interviewed USAID/Bangladesh officials and recipients to determine (1) how child survival and disease funds were expended, (2) the intended results of the Mission's child survival activities, and (3) the progress of the child survival activities. Specifically, we:

- Reviewed USAID/Bangladesh planning and reporting documents, including the Mission's R4, qualitative analyses, and its contracts, grants and progress reports of its partners.
- Examined USAID/Bangladesh and recipient financial reports, including obligating documents, budget reports, and vouchers.
- Examined related evaluation reports and audit reports.
- Interviewed key persons, such as USAID/Bangladesh officials, recipients and sub-recipients.
- Performed field visits, as necessary, to USAID, recipient and sub-recipient sites (e.g., health clinics) to observe operations and confirm results/progress.

In addition, we met with USAID PPC, Global, and Bureau for Asia and Near East officials responsible for the program in Washington, D.C. to: (a) learn more about the new CSD

Guidance as well as controls in place to ensure the integrity of the CSD account and (b) obtain their views on the preliminary findings. We also met with USAID General Counsel officials to obtain their interpretations of the CSD legislation. Finally, we met with USAID Budget and Financial Management officials to better understand how USAID allocates and accounts for CSD funds.

MEMORANDUM

TO: Paul E. Armstrong, RIG/Manila

FROM: Mary C. Ott, Acting Mission Director, USAID/Bangladesh

SUBJECT: Audit of USAID/Bangladesh's Child Survival Activities, Report No. 5-388-00-00x-P

DATE: November 22, 2000

General Comments

Thank you for the opportunity to comment on the subject draft audit report. We share your interest in ensuring that Child Survival and Disease (CSD) Funds are directed to activities that deal directly with the special health needs of children and mothers. The Mission continues to look for ways to improve and strengthen our child survival program in Bangladesh, which is aimed at reducing childhood mortality and improving nutrition. We have taken note of your findings and have begun to address your recommendations.

We very much appreciate the professionalism demonstrated by the auditors during the site visits.

Specific Comments

We note that the subject report discusses at length what are termed the "imprecise" allocation and accounting of CSD Funds. The report recognizes that these issues have USAID-wide implications and, for that reason, the subject has been referred to the OIG headquarters in USAID/W for possible follow-up. Accordingly, no recommendations for the Mission are included in the audit report. Since the issues have Agency-wide implications and action(s) toward resolution, if any, would have to come from USAID/W, we request that the section entitled "Imprecise Allocation/Accounting of CSD Funds for Integrated Population and Health Program" (pages 7-12) and any other references thereto (page ii, last par.; and page 4, top par., 2nd sentence) be excluded in their entirety from this Mission-specific report.

See page 3, Table 1. It appears that the amounts shown for SO 1 and SO 2 in the OBLIGATIONS column of Table 1 reflect combined data for both Mission-funded and field support activities. This presentation projects a slanted picture of CSD obligations and expenditures at the Mission and implies a very large pipeline. In addition, the EXPENDITURES reported differ slightly from the amounts reflected in Mission records. We suggest that Mission-funded obligations be presented separately from field support obligations as shown in the revised Table 1, shown below, along with the revised introductory paragraph.

In reference to page 3, Footnote[3], planning, tracking and accounting for field support activities are the responsibility of the Global Bureau, not of the Mission. The Mission Accounting and Control System (MACS), which is currently the official accounting system for missions overseas, has the capability to record only transactions relative to funds directly appropriated to, via the budget allowance, and obligated by the mission. Accordingly, USAID/Bangladesh, like any other overseas mission, does not and cannot account for field support data in MACS. Stating that "USAID/Bangladesh did not have expenditure data available for field support activities and therefore the expenditure amounts shown are understated" implies an accounting weakness unique to the Mission, which is not the case. For that reason, we request that Footnote[3] be re-stated as shown below, following the suggested revised Table 1.

QUOTE The following chart illustrates CSD obligations and expenditures under the two Mission objectives for FY97 through FY99 totaling $46.6 million and $15.3 million, respectively.

Table 1. CSD Obligations and Expenditures for Fiscal Year 97 through Fiscal Year 99

STRATEGIC OBJECTIVE (SO)	OBLIGATIONS	EXPENDITURES
SO 1 – Fertility Reduced and Family Health Improved ■ Mission-funded per MACS ■ Field Support[3]	$28.7 million 8.9 million	$14 million Not Available Through Mission's MACS
SO 2 – Enhanced Household Income and Food-Based Nutrition ■ Mission-funded per MACS ■ Field Support[3]	$ 4 million 5 million	$ 1.3 million Not Available Through Mission's MACS

[3] Field support activities are services (e.g., technical assistance) provided to field missions through USAID's Global (G) Bureau. Under this mechanism, funds originally allowanced to field missions are transferred to the G Bureau, which, in turn, obligates the funds into existing instruments for activities to be implemented in the field. Planning and tracking, including accounting, for field support activities are managed by the G Bureau. Accordingly, the EXPENDITURES reported above reflect only the data for activities which are funded and obligated by the Mission and recorded in the official Mission Accounting and Control System (MACS). The Field Support OBLIGATIONS reported above are based on information obtained by the Mission from the G Bureau.END QUOTE

Comments Regarding the Audit Recommendations

Recommendation No. 1:

1.1 Develop procedures for programming and using CSD Funds to ensure activities will directly benefit health needs of children and mothers and directly contribute to improving infant/child health and nutrition and reducing infant/child mortality;

1.2 Establish procedures to obtain prior approval from USAID's Bureau for Policy and Program Coordination and the Global Bureau, with concurrence by regional bureau technical staff and clearance from the General Counsel if the Mission intends to use Child Survival and Disease funds outside the parameters of USAID guidance; and

1.3 Obtain an opinion from the General Counsel on whether the obligations of $7.8 million were allowable uses of the Child Survival and Disease Funds.

We believe the April 2000 Guidance (hereinafter referred to as "Guidance") on the Definition and Use of the Child Survival and Disease Program Funds is by far the most comprehensive reference document issued by USAID/Washington for programming and using CSD Funds. Among other things, the Guidance clearly delineates the parameters for the use of the CSD account, including illustrative examples of allowable uses. It also provides directives regarding the approval process in cases where proposed use of CSD Funds is for activities outside the parameters of the Guidance. We plan to update our internal USAID Order No. 200-3, Checklist of Authorities and Responsibilities, to incorporate the Guidance directives regarding the clearance/approval process (Recommendation No. 1.2) and to ensure appropriate review by the Mission's Program Office of any proposed use of CSD funds (Recommendation No. 1.1). The Mission Checklist, which was developed to ensure fiscal integrity of our internal operations and was last revised in February 2000, identifies important Mission actions and the respective offices responsible for initiating, clearing and approving use of funds.

See page 6, par. 1. The audit report indicates that the Mission did not avail itself of the procedures in place at the time for advance approval of activities where there might be a question of qualifying for CSD funding. However, it fails to note that several of the obligations in question were made not by the Mission, but by the Global Bureau through field support transfers. In one case, the Helen Keller International (HKI) Home Gardening program, the Mission transferred child survival funds back to the Global Bureau/Health, Population and Nutrition (G/PHN) Center for obligation into their cooperative agreement with HKI. G/PHN is one of the Washington offices mentioned in the 1998 Agency Guidance which were to be contacted concerning the use of CSD funds. In two other cases, one involving the Asian Vegetable Research Development Center (AVRDC) program ('Introducing and Developing Adaptive Technologies...') and the other involving CIMMYT ('Whole Family Training'), the Mission transferred funds to the Global Bureau/Center for Economic Growth and Agriculture Development for obligation into agreements managed by that center.

See page 6, last par. The audit report refers to a Mission Team Leader statement that the Mission does **not** plan to use CSD funds for the activities under the new SOs. It would be more accurate to state that the Mission does not plan to use CSD funds for the activities under SO 5 and SO 6 with the possible exception of further funding for the HKI Home Gardening Program. A decision regarding the full funding of this program awaits the completion of an independent evaluation by the International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B) and an evaluation to be conducted by the recipient, HKI.

With respect to Recommendation No. 1.3, Attachment A contains the opinion of our Regional Legal Advisor (RLA), General Counsel representative at the Mission, regarding the allowability of the use of the $7.8 million in CSD Funds ($5 million of which were obligated by the Global Bureau as field support). The Office of the General Counsel concurs with the RLA's opinion that the cited $7.8 million CSD funds were used in compliance with the requirements of the CSD appropriation.

Based on the above, we request your concurrence that a management decision has been reached with regard to Recommendation Nos. 1.1 and 1.2. We also request that Recommendation No. 1.3 be closed upon issuance of the final audit report.

Recommendation No. 2:

2.3 Require Rural Service Delivery grantee to work with Ministry of Health and Family Welfare to obtain a regular supply of vaccines for the rural clinics; and

2.4 Develop a plan to ensure NGOs take the necessary steps (i.e., training, coordination with the Ministry of Health and Family Welfare, procurement of refrigerators, etc.) to provide regular child and mother immunization services at its rural clinics.

USAID/Bangladesh takes exception to the recommendation that we require our recipient to work with the Ministry of Health and Family Welfare (MOHFW) to obtain a regular supply of vaccines for the rural clinics. The parameters of our assistance instruments are prescribed by USAID's Automated Directives System, the Code of Federal Regulations, the Foreign Assistance Act of 1961, as amended, and the Federal and the Grants and Cooperative Agreements Act of 1977.

While the Rural Service Delivery Partnership (RSDP), through Pathfinder International, is responsible for providing immunization services in all RSDP static and satellite clinics, Pathfinder International is not the supplier of the immunization vaccines. Under the terms of the Strategic Objective Agreement between USAID and the Government of Bangladesh (GOB), the GOB has agreed to provide a regular supply of vaccines for the expanded program of immunization (EPI). Given that Pathfinder International is not a party to the Strategic Objective Agreement, it is inappropriate for Pathfinder International to intercede or act on behalf of USAID to ensure GOB compliance with the terms of the Strategic Objective Agreement. It is also contrary to USAID's assistance policies and regulations to require a recipient to perform services outside the scope of their award.

The NIPHP partnership is a collaborative one in which all organizations accept joint responsibility for achieving the strategic objective and the intermediate results. The GOB's role in the NIPHP, in fact, is one of providing commodities, e.g., contraceptives, vaccines, drugs to fight acute respiratory infections and diarrheal diseases, vitamin A capsules, and logistical support, to the NIPHP service delivery partnerships, both urban and rural. Although the process and mechanisms by which this support is provided have evolved over the course of the NIPHP's development, the GOB has played its role willingly and responsibly through the MOHFW.

On background, it is useful to note that at the initiation of the rural service delivery component, it was agreed that the RSDP contribution to the GOB's Expanded Program of Immunization (EPI) would develop as a collaborative effort. There was an understanding that the GOB would provide 24 EPI sessions per union (local administrative area) per month. Most of the RSDP NGOs successfully integrated the regular GOB sessions at their respective clinic sites. Such activities required considerable planning between RSDP and the MOHFW, along with community-level promotion and mobilization by RSDP clinic staff. This cooperative means of providing EPI services has resulted in significant increases in vaccination coverage across the RSDP areas. Measles vaccinations increased by 37 percent per quarter during FY 1999 and FY 2000. Immunization against diphtheria, pertussis and tetanus (DPT) grew by an average of 16 percent per quarter during FY 1999 and FY 2000. The quarterly totals for these vaccinations range from approximately 91,000 at the start of FY 1999 to 300,000 by the end of FY 2000. For the two-year period, RSDP and GOB EPI cooperation resulted in approximately 1.335 million child vaccinations.

As the RSDP program matured, more clinicians were fully trained and clinic infrastructure was upgraded. The GOB then began to fully stock the clinics with vaccine and other necessary commodities. As cited in the audit report, and based on the RSDP Annual Report for FY 1999, 51 of the 175 RSDP clinics (29 percent) routinely received GOB-supplied EPI vaccines. By the end of FY 2000, the number of clinics had risen to 116, or 66 percent of all static facilities. The RSDP 2001 workplan (Section 1.1.2.1, Appendix A, page 3), approved by the MOHFW, includes provisions to "Ensure EPI services in every RSDP static clinic through appropriate frequency" by the end of the third quarter of FY 2001.

We believe that in light of the stated audit objective questions—How were USAID/Bangladesh's child survival funds expended? Has USAID/Bangladesh achieved the intended results of its child survival activities—the above findings do not indicate significant problems that warrant an audit recommendation. Immunizations are legitimate child survival expenditures, whether they are provided at all RSDP clinics by RSDP staff themselves or by GOB staff with RSDP assistance in organizing and promoting immunization sessions. We believe that the method of providing immunizations employed by RSDP was neither improper nor ineffective. For this reason, we think that this recommendation should be deleted from the audit report.

Recommendation No. 3:

Determine the final accounting of funds disbursed to Pathfinder's sub-grantee [Bangladesh Birth Control and Family Welfare Association, ***(otherwise known as***

***RFWP)*]** **and recover from Pathfinder any amounts due. Specifically, determine the allowability of:**

3.1 $24,617 (Taka 1,145,934) and $27,467 (Taka 1,332,434) mentioned on page 6 of the final audit report of a local auditing firm for the period September 1997 to February 1998 and on page 22 of the draft audit report for the period March to September 1998, respectively;

$24,617 (Taka 1,145,934) – Although Pathfinder International subsequently determined that all the questioned costs for the audit period September 1997 to February 1998 were allowable costs, the Mission has determined Taka 19,800 ($425) of unverified trips, Taka 8,293 ($178) of pre-award expenses, and Taka 4,562 ($98) due to unreasonable car rental expenses, to be unallowable.

From the balance of Taka 1,113,279 that was determined to be allowable, Taka 1,042,699 was for commodity expenses which were subsequently questioned in Section 3.3 below.

$27,467 (Taka 1,332,434) – Subsequent to the issuance of the draft report for the audit period March to September 1998, RFWP provided additional documentation, based on which the local auditors reduced the questioned costs from Taka 1,332,432 to Taka 256,222 in their final audit report. Pathfinder International then determined Taka 256,222 in questioned costs to be unallowable. We have independently reviewed RFWP's documentation and fully concur with Pathfinder International's decision to disallow Taka 256,222.

In summary, the total disallowed amount under Recommendation No. 3.1 is Taka 288,877 (Taka 19,800 + Taka 8,293 + Taka 4,562 + Taka 256,222). Pathfinder International plans to recover this disallowed amount from the unpaid obligations due to RFWP. See Item 3.4 below.

3.2 $18,979 (Taka 920,683) frozen in [RFWP's] local bank accounts;

Pathfinder International previously requested that Janata Bank freeze RFWP's bank accounts pending resolution of a legal dispute between Pathfinder International and RFWP. The frozen bank accounts have a combined balance totaling Taka 920,683 as of October 2000. Pathfinder International requested the bank to return the balance of funds to Pathfinder International. In the event the funds are not returned, Pathfinder International plans to recover this amount from the unpaid obligations due to RFWP. See Item 3.4 below.

3.3 **$26,782 (Taka 1,299,181) in fixed assets procured by Non-Governmental Organization's (Bangladesh Birth Control and Family Welfare Association) as listed on pages 15-18 in the final audit report of a local auditing firm for the period March to September 1998 which have not been accounted for/recovered; and**

To date, Pathfinder International has recovered fixed assets worth Taka 66,420. Therefore, the net value of assets for which RFWP remains accountable is Taka

1,232,761. Pathfinder International plans to recover this amount from the unpaid obligations due to RFWP. See Item 3.4 below.

3.4 $74,440 (Taka 3,611,103) in unpaid obligations listed on page 26 of the final audit report for the period March to September 1998.

This amount represents unpaid obligations due to RFWP. Subsequent to the local audit, and after having assured itself of the allowability of the cost, Pathfinder International made a payment of Taka 132,000 directly to a local vendor for services rendered on behalf of RFWP, leaving a balance of Taka 3,479,103 in unpaid obligations. Pathfinder International has already engaged a local auditor to verify the allowability of the remaining unpaid obligations. Based on the results of this ongoing audit, Pathfinder International plans to recover the total amount of Taka 2,442,321 (questioned costs of Taka 288,877+ frozen funds of Taka 920,683 + unrecovered fixed assets of Taka 1,232,761) from the allowable unpaid obligations balance. In the event the disallowed costs exceed the allowable unpaid obligations, USAID will issue a Bill for Collection to Pathfinder International for the difference.

Based on the above discussion, we request your concurrence that a management decision has been reached with respect to all sections of Recommendation No. 3.

Recommendation No. 4:

4.1 Determine whether the Non-Governmental Organizations should move the two clinics to a more suitable area; and

4.3 Require the two main grantees (for the urban and rural service delivery components) to review the locations of other low performing clinics and determine which clinics should be moved to more suitable locations.

These two clinics are not specified in either the subject draft audit report or the "Discussion draft for exit meeting" prepared by the auditors and dated May 18, 2000. However, based on discussions during the auditors' exit meeting with the PHN Team, on the auditors' undated "Site visit summary of issues/observations" passed by the auditors to several PHN staff, and on the recollections of the PHN members who traveled with the auditors, we assume that the subject clinics are the RSDP Shimantic clinic at Bianibazar in Sylhet and the Urban Family Planning Partnership (UFHP) Sylhet Samaj Kallayan Sangstha (SSKS) facility at Moulvibazar.

The RSDP clinic at Bianibazar was established fifteen months ago in its original facility because no other rental structure was available at the time. During the auditors' exit meeting, the FSN Cognizant Technical Officer who had traveled with the auditor to the clinic site stated that the clinic staff had said that the NGO had already identified the problem resulting from proximity to the GOB facility and that, in fact, plans were underway to move the clinic to a more suitable site. Relocation of this clinic was completed on May 24, 2000, approximately two weeks after the auditor's visit to

Bianibazar. The clinic is now located two and one-half kilometers from a GOB facility and four kilometers from the original site.

In reference to the SSKS Moulvibazar facility, there appears to have been some miscommunication between the audit team and the clinic staff during that visit. The audit report states, "For example, one urban clinic is located within 500 meters from a GOB hospital. Another clinic [presumably the RSDP Shimantic clinic at Bianibazar, Sylhet] is located about a half kilometer from a GOB clinic." We understand that the audit team did not verify the existence of "a GOB hospital" said to be located within 500 meters of the SSKS Moulvibazar clinic. We believe that the auditor misunderstood the information provided by the clinic staff.

In talks with the Chief of Party of the principal recipient of the Urban Family Planning Partnership, we learned that the urban clinic in question had originally (i.e., prior to the auditor's visit) been located at another site some 500 meters from a GOB Maternal and Child Welfare Center. Problems with low customer flow, however, had been recognized early on, and the clinic was moved to its present location (visited by the auditor) in November 1999. The Chief of Party knows the area well, and he confirms without reservation that the SSKS Moulvibazar clinic that the auditor visited is located on Idaha Road in the neighborhood of Darga Mohalla and that it is situated more than one kilometer from a GOB hospital. (N.B. Monthly averages of customer contacts for this clinic rose from 455 in FY 99 to 1,771 as of the eleventh month of FY 2000.)

Although the issue regarding the Bianibazar clinic has been resolved and that of Moulvibazar was a matter of miscommunication, we will, for our own monitoring purposes, request that RSDP and UFHP review and analyze clinic locations in relation to other health facilities to determine if there is, in fact, duplication of services and if proximity to other service centers is affecting client load. Based on the results of this review, we will take appropriate action. (We note that decisions regarding clinic location are not solely based on distance from other facilities. A clinic was purposefully established next door to the ICDDR,B Hospital in Dhaka in order to provide primary health care near the overburdened hospital, and it has excellent client flow.)

Based on the above discussion, we request that Recommendation No. 4.1 be closed upon issuance of the final report. Also, please concur that a management decision has been reached regarding Recommendation No. 4.2.

<u>Recommendation No. 5</u>: Require John Snow, Inc. to (1) redistribute the remaining Oral Rehydration Salts (ORS) packets within the program's urban and rural clinics as needed, and (2) instruct the clinics to distribute the ORS packets to their patients as needed.

John Snow, Inc. (JSI) was fully aware of the remaining ORS packets in stock. The decision to store the ORS packets until needed was based on the following: (a) the packaging labels clearly indicated the supplies were to be used in response to *disaster* and were *not to be sold;* (b) an integral feature of NIPHP service delivery is fee-for-service; and (c) the late expiration dates of the supplies and the availability of storage space made it possible to store the supplies without threat of loss or misuse. Over the summer, JSI

began to distribute the supplies to clinics in flood-prone areas in anticipation of seasonal flooding. By the end of September 2000, JSI had delivered 90 percent of the balance of the supplies to Khulna and Rajshahi Divisions. By the first of November, the remaining 10 percent had been sent to Satkira and Jessore (Khulna Division), areas seriously hit by recent flooding.

Since all the ORS packets in stock have now been distributed, we request that Recommendation No. 5 be closed upon issuance of the final report.

MEMORANDUM

TO: Gordon H. West, Mission Director

FROM: R. David Harden, Regional Legal Advisor

DATE: November 22, 2000

SUBJECT: Allowable Uses of Child Survival and Disease Funds

ISSUE

Whether certain obligations of the Child Survival and Disease Program Funds ("CSD Funds") for the activities listed below exceeded the legal purpose of the congressional appropriation. Specifically, this opinion addresses whether the obligation of: (i) $525,000 to the International Center for Living Aquatic Resources Management ("ICLARM") under the "Development of Sustainable Aquaculture" Grant; (ii) $1,340,000 to the Asian Vegetable Research Development Center ("AVRDC") under the "Introducing and Developing Adaptive Technologies for Year-Round Vegetable Production in Bangladesh" Grant; (iii) $175,000 to the International Maize and Wheat Improvement Center ("CIMMYT") under the "Whole Family Training" Grant; (iv) $3,500,000 to Helen Keller International ("HKI") under the "Sustainable Interventions to Reduce Micronutrient Malnutrition Across the Generations" Grant; and (v) $2,275,000 to Winrock International under the "Management of Aquatic Ecosystems through Community Husbandry" ("Winrock") Cooperative Agreement[19] of CSD Funds exceeded the purpose[20] of the appropriation in the annual Foreign Operations, Export Financing, and Related Programs Appropriations Act ("Appropriations Act"). [21]

LAW

This section outlines: (i) the "Purpose Clause"; (ii) the provision of the Appropriation Act as authorized under the Foreign Assistance Act of 1961, as amended ("FAA") that appropriated the CSD Funds; and (iii) written guidance on the definition and use of CSD Funds.

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[19] The ICLARM, AVRDC, CIMMYT, HKI and Winrock Agreements are collectively referred to as the "Implementing Agreements". The Implementing Agreements are listed chronologically, by effective date.

[20] See 31 U.S.C § 1301(a).

[21] As discussed below, United States Agency for International Development's ("USAID" or "Agency") policy guidance on the use of CSD funds represents the executive branch's interpretation and implementation of this provision. As a presumptive matter, compliance with Agency guidance constitutes compliance with the purpose of the appropriation.

I. The Purpose Clause

A cornerstone of federal appropriations law is that "[a]ppropriations shall be applied only to the object for which the appropriations were made except as otherwise provided by law".[22] This provision – the Purpose Clause – simply means that public funds may be used only for the purpose for which they were appropriated. The starting point in applying the Purpose Clause is that, absent a clear indication to the contrary, the common meaning of the appropriating statute governs the purposes to which the appropriation may be applied. Thus, if a proposed use of funds is inconsistent with the statutory language, the expenditure is improper.[23]

II. The FAA and the Appropriation Act

The U.S. Congress has included specific authorizing language in the FAA to address the special health needs of children and mothers. Section 104(c)(2)(A) of the FAA states that

> . . . the President shall promote, encourage, and undertake activities designed to deal directly with the special health needs of children and mothers. Such activities should utilize simple, available technologies which can significantly reduce childhood mortality, such as improved and expanded immunization programs, oral rehydration to combat diarrhoeal diseases, and education programs aimed at improving nutrition and sanitation and at promoting child spacing.

In addition, in 1997, the U.S. Congress established a separate CSD Fund in the annual Appropriation Act. For example, the fiscal year 1998 Appropriation Act states that

> [f]or necessary expenses to carry out the provisions of chapters 1 and 10 of part I of the Foreign Assistance Act of 1961, for child survival, basic education, assistance to combat tropical and other diseases, and related activities, in addition to funds otherwise available for such purposes, $650,000,000, to remain available until expended: *Provided,* That this amount shall be made available for such activities as: (1) immunization programs; (2) oral rehydration programs; (3) health and nutrition programs, and related education programs, which address the needs of mothers and children; (4) water and sanitation programs; (5) assistance for displaced and orphaned children; (6) programs for the prevention,

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[22] See n. 2, supra.

[23] See GAO, Principles of Federal Appropriations Law, p. 4-16 (2d ed. 1991).

treatment, and control of, and research on, tuberculosis, HIV/AIDS, polio, malaria and other diseases; (7) up to $98,000,000 for basic education programs for children; and (8) a contribution on a grant basis to the United Nations Children's Fund (UNICEF) pursuant to section 301 of the Foreign Assistance Act of 1961.[24]

III. Agency Guidance

On April 1, 1998, the Agency issued the "FY 1998 Child Survival and Disease Program Fund Definition and Guidance" ("FY 98 Guidance") which serves as the guidance on the use of CSD Funds for all obligations made after that issuance date but before the FY 2000 Guidance (as defined below). The FY 98 Guidance noted that "allowable activities fall into four major categories: (1) child survival; (2) HIV/AIDS; (3) infectious disease; and (4) other diseases/other health, including maternal health." The FY 98 Guidance further identified several specific allowable activities that relate to this opinion. First, under the "child survival" category, allowable activities are those that "contribute directly to the strategic objective of improving infant/child health and nutrition and reducing infant/child mortality", including nutrition based programs.[25] Second, under the category of "other diseases/other health, including maternal health", the FY 98 Guidance states that allowable activities include "the prevention and treatment of anemia, nutrition-enhancing activities including improved nutritional practices and micronutrient supplementation in order to reduce deaths, nutrition insecurity and adverse outcomes to women as a result of pregnancy and child birth". The FY 98 Guidance is central to this opinion for it represents the executive branch's definitive interpretation and policy guidance for the implementation of activities that obligate CSD Funds.

The Agency issued substantively more detailed guidance on April 10, 2000 ("FY 2000 Guidance" together with the FY 98 Guidance, the "Agency Guidance").[26] The FY 2000 Guidance is not controlling for this opinion because it was issued after all the questioned obligations had been incurred. Nevertheless, the FY 2000 Guidance is instructive in that the Agency recognized that the "attainment of micronutrient sufficiency is a prime focus of USAID's overall child survival strategy. Interventions include supplementation, fortification and dietary modification activities, ***including home gardening.***"[27] As this opinion discusses, the primary focus of the Implementing Agreements was – and remains

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[24] The CSD Fund provisions of the Appropriation Act for fiscal years 1997, 1998 and 1999 - the years in question - are very similar except for funding levels.

[25] The FY 98 Guidance specifically mentions vitamin A interventions as well as "other micronutrients demonstrated to have a direct and substantial impact on child survival, and other nutrition", p. 4.

[26] The Assistant Administrators of all Agency Bureaus cleared the FY 2000 Guidance. Moreover, the Agency worked with relevant staff on Capitol Hill to assure congressional review and consultation of this guidance. FY 2000 Guidance, p. 5

[27] Ibid., p. 10 (emphasis added).

– a systematic approach to combating childhood malnutrition by enhancing the diets of poor households through nutritional interventions such as home gardening and fishing.

ANALYSIS

This analysis examines: (i) the findings of the recent final draft audit on USAID/Bangladesh's ("Mission") use of CSD Funds; (ii) the scope of malnutrition in Bangladesh; (iii) the Mission's strategic framework; (iv) the management agreement between Mission and the Agency ("Management Agreement"); and (v) each of the Implementing Agreements in order to determine whether the use of CSD Funds exceeded the purpose of the appropriation.

I. Findings of the Final Draft Audit

Beginning in March 2000, the Regional Inspector General for Audit based in Manila ("RIG") conducted an audit of the Mission's child survival activities. The audit focused on $46.4 million of obligated CSD Funds, of which $16.4 million were expended during fiscal years 1997 through 1999. The RIG issued a final draft report of the audit on September 29, 2000, ("Final Draft") stating, inter alia, that

> [t]he FAA and USAID's implementing guidance specify that allowable uses of CSD Funds are those activities that deal directly with the special health needs of children and mothers and contribute directly/significantly to reducing child mortality. However, the Mission's use of approximately $7.8 million of the $9 million of CSD funds obligated under mission [sic] SO 2 did not directly contribute to improving infant/child health and nutrition and reducing infant/child mortality. Rather, these activities as listed in Appendix III (e.g., income-generation, sustainable agriculture production, bio-diversity, developing markets, management of land, management of water fisheries) did not specifically target children and could only indirectly impact on children/mother health and reducing child mortality. Mission officials stated their belief that the activities could have an impact on rural households and on child and mother nutrition. We believe that the Mission could have used the $7.8 million for activities which may have more directly benefited children's and mother's [sic] health.[28]

In Recommendation 1.3 of the Final Draft, the RIG suggested that the Mission "[o]btain an opinion from the General Counsel on whether the obligations of $7.8 million were

[28] See RIG Final Draft Audit No. 5-388-00-00X-P, p. 4 (issued September 29 2000, but undated).

allowable uses of the Child Survival and Disease Funds."[29] This opinion is in response to Recommendation 1.3.

II. The Scope of Malnutrition in Bangladesh

The Mission's activities must be analyzed in the context of Bangladesh. This country has one of the highest rates of malnutrition in the world. At the time when the Mission was making decisions regarding the use of CSD Funds, the World Bank reported that a staggering 60 million people – or 53% of the population[30] – lived below the poverty line, with 40 million of them, approximately 36%, classified as "hard core" poor.[31] The World Bank also noted that 56% of the rural households was functionally landless and therefore almost certainly "food insecure".[32]

Although the numbers are overwhelming, it is the realities of malnutrition at the individual level that are most alarming. Micronutrient deficiency can retard child growth, increase the duration and severity of illness, reduce output and slow social and cognitive development.[33] At the time of the World Bank report, about 67% of Bangladesh's children suffered from chronic malnutrition,[34] 65% were stunted and 16% suffered from acute wasting.[35] A further 70% of infants and mothers were anemic.[36] These statistics

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[29] Ibid.

[30] See "Bangladesh: A Proposed Rural Development Strategy", a World Bank Study, The World Bank, p. 3, (2000); see also, "From Counting the Poor to Making the Poor Count", The World Bank, p. 6. (1998).

[31] Ibid. See also, 1997 Statistical Yearbook of Bangladesh, Bangladesh Bureau of Statistics, p. 638 (18th ed. 1998).

[32] Ibid. Landless are those rural households that own less than 0.5 acres of land.

[33] See "Increasing the production and consumption of vitamin A rich fruits and vegetables: Lessons learned in taking the Bangladesh homestead gardening programme to a national scale", Food and Nutrition Bulletin, vol. 21, no. 2, the United Nations University, Talukder, Kiess, Huq, de Pee, Darton-Hill and Bloem, p. 165 (2000).

[34] See n. 12, supra. See also "Bangladesh Demographic and Health Survey, 1996-1997", Mitra, Al-Sabir, Cross, and Jamil, Dhaka and Caverton, Maryland: National Institute of Population Research and Training (NIPORT), Mitra and Associates, and Macro International, p. 137, (1997), which reports that in 1996, 55% of the children in Bangladesh suffered from malnutrition and stunting and 18% from wasting; but see, "Preliminary Report Bangladesh Demographic and Health Survey, 1999-2000" National Institute of Population Research and Training (NIPORT), Mitra and Associates, and Macro International, p. 28 (2000), a more recent report which suggests that there have been significant decreases in childhood stunting, wasting and mortality during the past three to four years; see also, n. 57, infra.

[35] Ibid.

[36] Ibid.

translate into 600 to 700 children who died each day during those years.[37] Additionally, micronutrient malnutrition among women of reproductive age increases the risk of mortality during labor and delivery and increases the risk of dietary deficiency in their newborn children during critical growth and development periods.[38] In fact, in Bangladesh more than half of the women of reproductive age are malnourished making them more likely to bear low birth-weight babies. A distressing 45% of all Bangladeshi children are born with low birth weight – perhaps the highest rate in the world.[39] Clearly, malnutrition has been and continues to be a fundamental constraint to economic and human development in Bangladesh.

Combating malnutrition at the household level has been an essential element of the Mission's development objective since at least 1994. The Mission recognized that poor dietary quality is the primary cause of malnutrition in Bangladesh[40] and, as a result, opted to develop a sustainable food-based approach to addressing the problems of malnutrition.[41] The Mission sought to improve the diets of poor households by systematically providing these families with the skills, interventions, and resources to feed themselves adequately. The Mission sought to promote the consumption of vegetables (rich in vitamin A, iron and other micronutrients) and fish (rich in protein and iron, vitamin A and other micronutrients). This conceptual approach provided the underpinnings of the Mission's strategic framework, as outlined in its Strategic Plan (defined below).

III. The Strategic Framework

The Mission's rationale for using CSD Funds during fiscal years 1997 through 1999 begins with its
strategic framework for fiscal years 1995 through 1997, together with its subsequent modifications through 2000 (the strategic framework from 1995 to 2000, as modified and amended, the "Strategic Plan").

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[37] See "Project Appraisal Document on a Proposed IDA Credit to the People's Republic of Bangladesh for a National Nutrition Project", the World Bank, Report No. 20333-BD, p. 5 (2000).

[38] See n. 15, supra.

[39] See n. 19, supra.

[40] The typical Bangladeshi diet is high in carbohydrates (e.g., rice), low in protein (e.g., animal products) and almost void of fat, vitamins and minerals. Over 75% of all calories consumed in rural households come from rice or wheat - a high energy and low nutrient dense food. See "Government Policy, Markets and Food Security in Bangladesh", International Food Policy Research Institute, Dhaka, Bangladesh, del Ninno and Dorosh (1998).

[41] As opposed to vitamin A capsule interventions that fail to alter the household diet and is not sustainable.

Beginning on October 1, 1994, the Mission and the Agency agreed to Strategic Objective 4: "Diets of the Poor Nutritionally Enhanced" ("SO 4"). There were initially two SO 4 indicators:

(i) wasting (weight for height) for children aged 6 to 59 months reduced; and
(ii) night blindness among children 24 to 71 months reduced.

On September 22, 1995, the Office of Procurement/Washington ("OP") signed the ICLARM and AVRDC Agreements as activities under SO 4. In May 1996, the Mission modified SO 4 indicators to include:

(i) wasting for children (6 to 59 months) decreased;
(ii) yearly averages of stunting among children (6 to 59 months) reduced; and
(iii) night blindness among children (24 to 59 months) reduced.

In September 1997, OP obligated the first tranche of CSD Funds to the AVRDC Agreement and signed the CIMMYT Agreement. On February 10, 1998, the Mission consolidated several strategic objectives and reconfigured SO 4 to Strategic Objective 2: "Food Security for the Poor in Targeted Areas Improved" ("SO 2"). The SO 2 indicators were:

(i) average stunting in children 6 to 59 months;
(ii) children 6 to 24 months consuming fish at least four times per week; and
(iii) children 6 to 24 months consuming green leafy vegetables at least four times per week.

In April 1998, the Agency issued the FY 98 Guidance. During the remainder of the 1998 fiscal year, OP signed and obligated $3.2 million of CSD Funds to the HKI Agreement and $1 million of CSD Funds to the AVRDC Agreement, while the Mission signed the Winrock Agreement, all as activities reported under SO 2.

In March 1999, the Mission renamed SO 2 to "Enhanced Household Incomes and Nutrition" ("Revised SO 2") and decided not to report the SO indicators. Instead the Mission developed the following Intermediate Results ("IR") and indicators:

(i) IR 2.1: Availability of Nutritious Food for Poor Households in Target Areas Increased

  (a) Vegetable Production from Home Gardening Plots; and
  (b) Kilometers of Environmentally Sound Roads Rehabilitated.

(ii) IR 2.2: Household Incomes in Targeted Regions Increased

(a) Households Producing Vegetables; and
(b) SMEs Created or Expanded.

Under the Revised SO 2, from June to September 1999, the Mission obligated $2,275,000 of CSD Funds to the Winrock Agreement and $525,000 of CSD Funds to the ICLARM Agreement. OP obligated another $300,000 and $175,000 of CSD Funds to the HKI and CIMMYT Agreements, respectively.

On April 10, 2000, the Agency issued the FY 2000 Guidance.

IV. The Management Agreement

The Automated Directives System ("ADS") states that the "approval of all Operating Unit Strategic Plans must result in the establishment of a management agreement between the unit and Agency Management. The agreement will consist of the Strategic Plan, together with an official record of the guidance emerging from the review of the plan." Further, "[a]ll parties . . . agree to the text of the management agreement."[42] Thus, the Mission's Strategic Plan formed the Management Agreement by which it bound itself to the Agency. In this case, the Management Agreement is critical in determining whether the use of CSD Funds for activities under each of the Implementing Agreements reasonably relates to the FY 98 Guidance and the purpose of the appropriation. This analysis examines the Management Agreement from two perspectives.

A. The Management Agreement – Pre-March 1999

Prior to March 1999, the Management Agreement unequivocally targeted children as beneficiaries of nutritional interventions. SO 4 sought to enhance the diets of the poor. SO 2 emphasized food security for the poor. Under this framework, the Mission chose – and the Agency agreed to – SO indicators that related directly to children. In the case of SO 4, the indicators targeted reduced wasting, stunting and nightblindness for children under the age of five. In the case of SO 2, the indicators targeted stunting, vegetable consumption and fish consumption for children under the age of five. The Mission could have adopted – or the Agency could have required – other indicators that would have measured improved diets among poor people.[43] Instead, both the Mission and the Agency agreed to indicators that related directly to childhood disease and survival. This decision is reasonable given both the scope of the malnutrition in the country and the fact that children under the age of 15 represent 41% of the population,[44] and women of reproductive age represent 25%[45] of the

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[42] ADS § 201.3.4.16.

[43] For instance, indicators relating to: (i) increased caloric intake among adults; or (ii) nutritional changes in adult women as measured by body mass index or vitamin A and iron levels.

[44] See n. 16, supra.

population.[46] Under the terms of the Management Agreement then in effect, the Mission entered into the Winrock Agreement and OP entered into the ICLARM, AVRDC, HKI and CIMMYT Agreements. OP also obligated $4,540,000 of CSD Funds during this time – $1,340,000 to AVRDC and $3,200,000 to HKI. The Mission's intent – as evidenced by the Management
Agreement, the execution of all of the Implementing Agreements and OP's initial obligations of CSD Funds – falls within the scope of the FY 98 Guidance and purpose of the appropriation.

B. The Management Agreement – Post-March 1999

In March 1999, the Mission and the Agency modified the Management Agreement by agreeing to Revised SO 2 that included not only increased availability of nutritious food to poor households but also increased family income. The Mission continued tracking, but stopped reporting on, the child-related SO indicators. Instead, the Mission established IR indicators that measured "vegetable production from home gardening plots" and "households producing vegetables".[47] The Revised SO 2 also reflected an attempt to incorporate otherwise disparate activities under one SO.[48] From June 1999 to the end of the fiscal year, the Mission obligated $2,800,000 of CSD Funds – $2,275,000 to the Winrock Agreement and $525,000 to the ICLARM Agreement. OP obligated $300,000 and $175,000 of CSD Funds to the HKI and CIMMYT Agreements, respectively.

At one level, the Mission's shift in the Management Agreement could suggest that combating childhood malnutrition was no longer a central focus of its efforts. Such a view would be wrong, however. According to the Mission, the shift in the focus from children to households reflected a family-centered approach to raising nutritional levels for the poor.[49] This argument is reasonable given that children under the age of 15 and women of reproductive age represent 66% of the population. The Mission's intention of weaving together household nutritional levels with household vegetable production is illustrated by the two Revised SO 2 IR indicators that relate directly to home gardening. Finally, it seems apparent that the Mission did not abandon childhood nutrition as a primary focus of its activities under the Revised SO 2. The ICLARM, AVRDC, HKI, CIMMYT and Winrock Agreements were all

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[45] Ibid.

[46] In Bangladesh, nearly all of the women of childbearing age either have children or are pregnant.

[47] This opinion does not address the other two IR indicators and their relevancy to the use of CSD Funds.

[48] The Mission recognized the cumbersome nature of the Revised SO 2 and eight months later divided the SO into four distinct SOs by which the Mission now operates.

[49] The Mission also responded to a theoretical gap between the SO level indicators and what was actually within the Mission's manageable interest.

planned, executed and, for the most part, substantially implemented under the pre-March 1999 Management Agreement. The Mission did not modify any of these Implementing Agreements when it adopted the Revised SO 2 and related indicators. In fact, the Mission merely restructured the packaging of its activities for reporting purposes while retaining the substance of direct sustainable micronutritient intervention at the poor household level – a focus entirely within the parameters of the FY 98 Guidance and the CSD Funds appropriations.

V. The Implementation Agreements

The Management Agreement demonstrates the Mission's intention to address child and maternal malnutrition through micronutrient intervention at the household level. An analysis of the each of the Implementing Agreements is equally important to determine whether the activities directly promote childhood survival and conform to the FY 98 Guidance and therefore the purpose of the legislation.[50]

A. ICLARM

OP signed the ICLARM Agreement in September 1995 under SO 4 for a total of $2,503,652, of which $525,000 (or 20.97%) of CSD Funds was obligated in September 1999.[51] From the outset, ICLARM's program objective was – and is – to improve aquacultural practices of the rural poor. It aims to demonstrate the viability of small fishponds at the individual household level and is analogous to home gardening.[52] In the program description of the Agreement, ICLARM anticipated that "over 100,000 rural households w[ould] increase their consumption and production of fish relative to the 1991 baseline period, consistent with USAID/Dhaka's strategic objective of improving diets of the poor."[53]

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[50] As part of this analysis, I met with representatives of each of the implementing partners and a number of subgrantee partner organizations. I also conducted site visits on October 19 and 25, 2000. During these site visits, I spoke with roughly 200 beneficiaries, 95% of whom were women and children.

[51] OP transferred the ICLARM Agreement to the Mission in March 1999.

[52] Sections of virtually every village have been excavated so homes do not flood during the monsoon season. As a result, nearly every village home has a corresponding ditch that becomes flooded with rain and water runoff. This ditch becomes the household fishpond that supplies fish to the family throughout the year - functionally comparable to the home chicken yard.

[53] In this context, 100,000 rural households equate to 530,000 people, at least 66% of whom are children under the age of 15 or women of childbearing age.

Since 1995, the Mission has reported ICLARM's results predominately under SO 4 and SO 2. From October 1999 to the present, ICLARM reports that there have been an estimated 80,000 beneficiaries – 40,000 of them children below the age of five.[54] ICLARM also reports that since the inception of its activities 180,000 households or 954,000 people – 66% of whom are children or women of childbearing age – have been beneficiaries.[55] Further, ICLARM notes that 20% to 30% of all fish produced in the home pond is consumed within the household.[56] ICLARM is now conducting studies of the impact of small indigenous fish consumption on vitamin A and anemia in children and women.

The totality of factors makes clear that the use of CSD Funds under ICLARM is allowable. The Mission intended to use ICLARM as an activity that would impact child and maternal nutrition. The beneficiaries are overwhelmingly children and women of childbearing age – important given the fact that CSD Funds represents less than 21% of the funding. Finally, the Agency's Guidance itself illustrates that combating malnutrition through micronutrient interventions of vitamin A, iron and zinc is "a prime focus of USAID's overall child survival strategy". Household fish farming, like household gardening, is an appropriate intervention to combat malnutrition and constitutes an allowable use of CSD Funds. This activity is within the scope of the FY 98 Guidance and thus the CSD Funds appropriation.

B. AVRDC

OP signed the AVRDC Agreement on September 20, 1993, and the Mission reported results of this activity predominately under SO 4 and SO 2. OP obligated the first tranche of $340,000 of CSD Funds on September 25, 1997 – prior to the issuance of any Agency guidance on the use of such funds. OP obligated the second tranche of CSD Funds on September 30, 1998, under SO 2. The total of $1,340,000 of CSD Funds represents 36.48% of the total USAID obligation. This Agreement closed on October 31, 2000.

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[54] EGAD Portfolio, Economic Growth & Agricultural Development ("EGAD") Unit, p. 7, (2000).

[55] Ibid.

[56] Home consumption of fish is vital for two reasons. First, fish can be harvested during otherwise lean times of the year – seasonal lows of rice production – and can therefore provide a vital nutritional stopgap to the most vulnerable groups in this society, the children and women. Second, "[f]ish . . . add diversity to diets dominated by staple grains and contribute intake of essential nutrients. Small fish are particularly important for food and nutrition security in developing countries, especially in light of the high prevalence of micronutrient deficiency. Small fish are consumed whole, with bones and organs, and are a rich source of minerals and vitamins, such as calcium, iron, zinc and vitamin A." See "Policy Issues on Fisheries in Relation to Food and Nutrition Security", Thilsted, S.H. and N. Roos, Fisheries Policies research in Developing Countries: Issues, Priorities and Needs, eds. Ahmed, Delgado, Sverdrup and Santos, p. 61 (1999).

The aim of the AVRDC Agreement was to enhance the nutritional well-being and to raise the incomes of poor people through developing improved varieties and methods of vegetable production, marketing and distribution. To accomplish these goals, AVRDC concentrated on improving the homesteading practices of very small farming households. AVRDC also developed and introduced adaptive technologies for year-round vegetable production in order to provide vital micronutrient inputs at the household and village level during the cyclical "lean times" in May and October when rice stocks are at a low.

Under the research component, AVRDC introduced a number of year-round, high-yield vegetables at the village level providing much needed food and micronutrients to poor homesteaders throughout the year. In its technology transfer efforts through home gardening, AVRDC reports that 230,000 households were assisted – representing more than one million people, the overwhelming majority being women and children.[57] According to AVRDC, 90,000 households – or nearly 500,000 people – have been the beneficiaries of the home gardening activities within the last 18 months alone.[58] All of these beneficiaries are small, poor homesteading families who consume roughly 30% of their vegetable production, although surveys on consumption patterns range between 9% and 70%.[59] Additionally, through its subgrantees, AVRDC has provided nutritional awareness programs at the village level to some 10,000 mothers and children.[60] Finally, AVRDC provided technical assistance, nutritional training and resource input to a home for 88 abandoned children of commercial sex workers.[61]

Based on these facts, the use of CSD Funds for the AVRDC Agreement is allowable. The training of improved home gardening techniques, the nutritional awareness programs and the high-yield, year-round vegetables directly provided critically needed food security to very poor families. These activities thus fit squarely within the intent of the Management Agreement, the Agency Guidance and the appropriation itself.

C. CIMMYT

OP signed the CIMMYT Agreement in September 1997, although $175,000 of CSD Funds (representing 30.43% of the total obligation) was not obligated until September 1999. The objective of the CIMMYT Agreement is to improve the quality and quantity of wheat

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[57] See n. 36, supra, p. 10.

[58] Discussions with AVRDC representative Dr. Hamizuddin Ahmad on October 25, 2000, during site visit.

[59] See various AVRDC surveys; and based on discussions with AVRDC representatives and beneficiaries during my October 25, 2000 site visit.

[60] Discussions with AVRDC representative Dr. Hamizuddin Ahmad during site visit on October 25, 2000.

[61] Observation during site visit, October 25, 2000.

production and consumption by marginal farmers through training and seed preservation. The Whole Family Training involves training a farming family (husband, wife and two children (ages 8-18)) in wheat production and nutrition.[62] CIMMYT reports that it will have directly trained 6,240 families (or roughly 33,000 people) by the end of 2000.[63] This figure does not include indirect training, i.e., families who have learned improved farming techniques as a result of watching their neighbors enjoy the benefits of improved yields. CIMMYT reports that these households consume between 60% and 80% of the produced wheat, notably much of it during lean times. It is also important to recognize that in terms of combating malnutrition, wheat far surpasses rice in nutritional value.[64]

Given the above, the use of CSD Funds for activities under the CIMMYT Agreement is allowable and fits within the FY 98 Guidance and, therefore, the purpose of the appropriation. The Mission intended to enhance maternal and child nutrition when OP entered into the CIMMYT Agreement. The facts show that there is a high level of home consumption of the wheat product, particularly during lean times, and that 75% of the trainees are children and mothers. Finally, CIMMYT activities are essentially home gardening activities since these homesteading families consume most of their produce.

D. HKI

OP signed the HKI Agreement on April 23, 1998, and obligated $3,200,000 of CSD Funds between June and August 1998[65] and another $300,000 in September 1999.[66] To date, the entire HKI Agreement has been funded from the CSD Funds account. The program objective is to reduce vitamin A deficiency through the introduction, production and consumption of vitamin A-rich vegetables and fruit. This home gardening project encourages improvements of existing gardening practices, including promotion of year-round gardening and increased varieties of fruits and vegetables. In the past year, HKI assisted 100,000 new households.[67] Additionally, as part of its selection criteria, HKI requires that a potential household beneficiary have at least one child under the age of five. These homesteading families

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[62] Statement by Craig Meisner, CIMMYT Chief of Party on October 17, 2000. These people are small and medium farmers, i.e., those with less than 2.5 or 5.0 acres of cultivable land, respectively. CIMMYT reports that 80% of the trainee families are small farmers. The percentage of mothers and children trained under the CIMMYT program is roughly 75% since the program targets the mother, father and two children from each household.

[63] CIMMYT Annual Progress Report, p. 75 (1999).

[64] Wheat has substantially more calories and is higher in protein, fat, fiber, minerals, calcium, phosphorus, vitamin A, thiamin, riboflavin and niacin than rice. Wheat Research Center Publication (1999).

[65] Under SO 2.

[66] Under Revised SO 2.

[67] See n. 36, supra, p. 9.

consume the vast bulk of produce from their gardens. HKI also produces extensive village nutrition education programs directed toward pregnant and lactating mothers.

Given the fact that home gardening is a numerated activity under the FY 2000 Guidance, the use of CSD Funds in this case is also allowable. As this FY 2000 Guidance recognized, micronutrient intervention at the poor household level is vital in addressing child and maternal nutritional deficiency in a systematic and sustained manner. The use of CSD Funds under the HKI Agreement, fits within the Agency Guidance and therefore meets the purpose of the appropriation.

E. Winrock

The Mission signed the Winrock Agreement in July 1998, and obligated $2,275,000 of CSD Funds (representing 35.05% of the total obligation) in June 1999.[68] Under the Management of Aquatic Ecosystems through Community Husbandry ("MACH") project, Winrock's primary goal has been to promote ecologically sound management of floodplain resources for the sustainable supply of food to the poor. Specifically, MACH seeks to reduce poverty and improve nutrition by increasing overall fish production in the open-water areas. In addition, one of MACH's other stated goals is that "children of fisheries households will have improved access to schooling through community organizations and improved diets as a result of enhanced catch and incomes of their households".[69] To achieve these goals, Winrock targets, among others, non-professional subsistence fishers, many of whom are women and children.[70]

The Mission reports that there have been 2,000[71] direct beneficiaries, with an additional 60,000[72] indirect beneficiaries – 66% of whom are children and women of childbearing age. Winrock has created fish sanctuaries that supply villages with fresh fish throughout the year and, importantly, during the seasonal lean times. Winrock reports that the great bulk of their beneficiaries, subsistence fisherfolk, consume 80% of their catch.[73] Additionally, through its partner CARITAS, Winrock provides nearly $1,000,000 to poor fishing households[74] for activities that directly relate to increased food security. Specifically, CARITAS

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[68] Under Revised SO 2.

[69] Winrock Cooperative Agreement, Program Description, p. 13 (1997).

[70] During my site visit, the great bulk of fisherfolk were boys, roughly ages 8 through 16.

[71] See MACH September 2000 Performance Monitoring Review, p. 2 (2000).

[72] Ibid.

[73] Statement by Winrock Chief of Party Darrell Deppart, during site visit on October 19, 2000.

[74] Virtually all of these are homestead households i.e., families with less that one acre of land.

provides animal husbandry and home gardening technical assistance, resulting in increased food supply that is overwhelmingly consumed by these poor households. CARITAS also provides technical assistance to help these families dig tube wells for clean water supply and to construct basic sanitation systems. Finally, CARITAS and another subgrantee partner, the Center for Natural Resource Studies, provide primary school education to the children of these households.

Given the above, the use of CSD Funds under the Winrock Agreement for MACH activities is allowable. The Mission intended to enhance the nutritional intake of children by providing a local and sustainable source of fish when it entered into the Winrock Agreement. Further, Winrock's MACH activities have provided a high level of home consumption of fish, an emphasis on home gardening and small animal husbandry, a clean water supply, and basic sanitation at the household and village levels. All of these activities reasonably fit with the notion of reducing childhood disease and malnutrition. Thus, the use of CSD Funds under the Winrock Agreement for the MACH project is within the scope of the FY 98 Guidance and the appropriation.

CONCLUSION

Based on this analysis, it is my opinion that the activities under each of the Implementing Agreements: (i) fall within the parameters of the FY 98 Guidance and thus the CSD Funds provision as set out in the annual Appropriations Act; and (ii) relate directly to the Agency's goal of combating childhood and maternal malnutrition. Specifically, the Mission entered into the Management Agreement with the stated intention of reducing malnutrition among poor households. Each of the ICLARM, AVRDC, CIMMYT, HKI and Winrock Agreements was executed and most of the obligations were made under this Management Agreement. The Mission sought to develop sustainable mechanisms for reducing the effects of malnutrition through interventions at the household level. As a result of these interventions, the Mission did indeed enhance the diets of the poor through home-based agriculture (AVRDC, HKI, CIMMYT and, to a lesser extent, Winrock) and home-based or localized aquaculture (ICLARM and Winrock). The Mission's efforts have reduced child and maternal malnutrition, resulting in reduced child and maternal mortality and disease.[75] After March 1999, the Mission merely repackaged the reporting

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[75] During the three-year period that the RIG questioned these food-based activities, the nutritional status of Bangladeshi children markedly improved. A 1999 preliminary health survey reports that there was an 18% decrease in childhood stunting from 55% in 1996 to 45% in 1999 and a 41% reduction in childhood wasting, from 18% in 1996 to 10% in 1999 (using statistics from the more conservative Bangladesh Demographic and Health Survey 1996-1997, obviously the improvements are greater when compared to the World Bank statistics from the same period). See, n. 16, supra.; see also, n. 11, supra. Similarly, the same survey indicates a 19% drop in childhood mortality, from 116 deaths per 1000 births to 94 in 1999. Ibid. This drop in childhood mortality substantially exceeded the Mission's target for 2000 at 112 deaths per 1,000 births. The Mission believes that its pioneering efforts in food-based nutrition were a factor in this successful trend.

of its activities into Revised SO 2. The substance of the activities, however, did not change. Thus, after applying the law to the facts, the obligation of CSD Funds for these activities is allowable and did not exceed the scope or intent of the congressional appropriation.

QUESTIONABLE USES OF CHILD SURVIVAL AND DISEASE (CSD) FUNDS

ACTIVITY NAME	CSD FUNDS OBLIGATED	FISCAL YEAR OBLIGATED	ACTIVITY DESCRIPTION
Management of Aquatic Ecosystems through Community Husbandry (MACH)	$2,275,000	1999	The program goal is to promote ecologically sound management of floodplain resources for the sustainable supply of food to the poor. The major purpose is to demonstrate to communities, local government and policy-makers the viability of a community approach to natural resource management and habitat conservation in Bangladesh over an entire floodplain. Activities include income-generation programs for the poor and landless fishers and farmers, community-based fisheries management, environmental awareness, and credit programs. Children are not specifically targeted.
Research and Development of Sustainable Aquaculture Practices	$525,000	1999	The program objective is to improve aquacultural practices to the rural poor. Activities include providing training to farmers and farmer groups on different production methodologies, research on technologies to reducing weeds needed to sustain the desired fish growth, etc. Children are not specifically targeted.
Home Gardening Project	$3,500,000	1998, 1999	The program objective is to reduce vitamin A deficiency (mostly in the vulnerable groups) through the introduction, production and consumption of vitamin A rich vegetables and fruit. The program encourages improvements of existing gardening practices, such as promotion of year-round gardening and increased varieties of fruits and vegetables. Several studies have made conflicting conclusions on the impact of these food-based approaches on nutritional status, and in particular, improving vitamin A status. One such study stated that the role of food-based programs, in particular, those that focus on increasing production and consumption of vegetables, for improving vitamin A status has been questioned. The study also mentioned that it is generally very difficult to identify whether and to what extent a change in nutritional status/health can be attributed to the food-based intervention itself.
Introducing and Developing Adaptive Technologies for Year-Round Vegetable Production in Bangladesh	$1,340,000	1997-1999	The objective of the program was to enhance the nutritional well being and raise the incomes of poor people in rural and urban areas of developing countries (children are not specifically targeted) through improved varieties and methods of vegetable production, marketing and distribution. Some of the expected outputs were to introduce new vegetable varieties, increase vegetable production and increase income for vegetable farmers. A recent study (report dated February 1999) of the project concluded that based on the evidence, there is little reason to believe that adoption of the technologies has improved the micronutrient status of members of adopting households through better dietary quality. Furthermore, the study also states that from a short-term perspective, the story that emerges is a discouraging one in the sense that food-based production strategies based on commercial incentives cannot immediately result in a substantial reduction in the number of malnourished people.
Whole Family Training	$175,000	1999	The concept is that both spouses (husband and wife) and adult children are given training in growing wheat, preserving seeds, and then marketing the seeds the next season. Children are not specifically targeted.
TOTAL	**$7,815,000**		

PROGRESS TOWARDS INTENDED RESULTS (SO 1)

DESCRIPTION OF INTENDED RESULTS	PLANNED RESULT	REPORTED RESULT	VERIFIED RESULT	COMMENTS
1. Number of ORS Packets Sold	58 million (FY 1999)	70.3 million (FY 1999)	70.3	The planned and reported results are from the April 2000 R4 Performance Data Table.
2. Number of Contacts Increased				The results on the number of contacts came from the R4 Narrative dated April 2000 which reports results for FY1999. The number of contacts represents patients/customs receiving a particular service (e.g., Diarrhea treatment). The percentages represent the increase in the number of contacts over the prior year. The Mission did not have specific planned targets for these results. These services are part of the Essential Service Package provided by Mission-financed health clinics.
(a) Childhood Diarrhea (rural)	Not Specified	131% (FY1999)	131%	
(b) Child Pneumonia (rural)	Not Specified	144% (FY1999)	144%	
(c) Measles Vaccination (rural)	Not Specified	174% (FY1999)	174%	
(d) Ante Natal Care (urban)	Not Specified	104% (FY1999)	104	
(e) Pre Natal Care (urban)	Not Specified	156% (FY1999)	156%	
(f) Tetanus Immunization (mothers)	Not Specified	Doubled (FY1999)	Doubled	
3. Percent of Operating Costs Funded by NGOs	10% (FY1999)	10% (FY1999)	10%	The planned and reported results are from the R4 Performance Data Table.
4. Fully Vaccinated Children by Age 12 Months	80% (by 2004)	51.60% (1999) 54 % (1998)	51.60%	The planned result is from the Strategic Objective One Agreement. The reported result for 1999 is from a World Health Organization survey. According to the R4 narrative, dated April 2000, this rate is stagnant and indicates a need to improve the quality and reach of the national immunization program. Also, an evaluation dated June 1999, of the Mission's previous program, indicated that immunization rates are stagnant or even falling in some urban areas.
5. Infant Mortality Rate	78 (1999/2000)	66 (1999/2000)	66	The reported result is a preliminary result of the Bangladesh Demographic Health Survey. The number represents the number of deaths to infants under age 1 per 1000 live births. Various factors influence/contribute to decreasing the infant mortality rate that are outside USAID's activities and control. Some of these factors include GOB programs and policies, the multitude of other bilateral and multinational donor programs, natural disasters or the nonoccurrence of natural disasters, etc.

PROGRESS TOWARDS INTENDED RESULTS (SO 1)

DESCRIPTION OF INTENDED RESULTS	PLANNED RESULT	REPORTED RESULT	VERIFIED RESULT	COMMENTS
6. Child Mortality Rate	34 (1999/2000)	30 (1999/2000)	30	The reported result is a preliminary result of the Bangladesh Demographic Health Survey. The number represents the number of deaths of children 1-4 years of age per 1000 children. Various factors influence/contribute to decreasing the infant mortality rate that are outside USAID's activities and control. Some of these factors include GOB programs and policies, the multitude of other bilateral and multinational donor programs, natural disasters or the nonoccurrence of natural disasters, etc.
7. Build ORS Factory and Begin Production	Start in Oct-97	See Comments Section	Not Yet Started Building	According to the grant agreement with the Social Marketing Company (SMC), SMC was to begin building an ORS factory in October 1997. However, due to various reasons (legal disputes), there have been long delays and SMC has yet to begin construction. According to SMC officials, the legal disputes have been resolved and they planned to begin construction shortly. We recommended to the Mission that it obtain a current timeline for constructing the ORS factory and beginning production. This ORS factory would help ensure that there is a ready supply or ORS packets in the country.

ACRONYMS USED IN THE REPORT

CSD – Child Survival and Disease

DA – Development Assistance

DHS – Demographic and Health Survey

FAA – Foreign Assistance Act

FIFO – First In, First Out

FY – Fiscal Year

GAO – General Accounting Office

GOB – Government of Bangladesh

MCH – Maternal and Child Health

MOHFW – Ministry of Health and Family Welfare

NGO – Non-Governmental Organization

NIPHP – National Integrated Population and Health Program

OIG – Office of the Inspector General

OMB – Office of Management and Budget

ORS – Oral Rehydration Salts

PPC – Bureau for Policy and Program Coordination

R4 – Results Review and Resource Request

RIG/Manila – Regional Inspector General, Manila

SMC – Social Marketing Company

SO – Strategic Objective