
BY THE COMPTROLLER GENERAL

Report To The Congress

OF THE UNITED STATES

Management Problems With AID's Health-Care Projects Impede Success

The extent and gravity of poor health conditions throughout the *developing world* are such that malnutrition, common infections and diseases, and the effects of high birth rates pose constant threats to the populace. Although strides have been made to increase access to health care by the *international community*, much remains to be done. The United States has been a major partner in this international effort and continues to assist the poorest countries.

Design and implementation problems were noted in a number of health-care projects financed by the Agency for International Development. GAO recognizes that some corrective action has been taken, but makes recommendations to alleviate the management problems being encountered.



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COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON D.C. 20548

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To the President of the Senate and the
Speaker of the House of Representatives

This report concerns progress being made to extend access to badly needed health-care services to people in rural areas of several developing countries. It also describes problems being encountered with implementing various components of these programs. The report makes recommendations for more effective U.S. participation in primary health-care projects.

Recognizing that previous health assistance programs were not achieving desired results because they concentrated on sophisticated urban-based curative measures, U.S. interests shifted to an emphasis on preventive health care in rural areas. We made this review to provide a perspective on what this change has contributed to the development process and what remains to be done.

Copies of this report are being sent to the Director, Office of Management and Budget; Director, International Development Cooperation Agency; and to the Administrator, Agency for International Development.

A handwritten signature in cursive script that reads "Milton J. Jocola".

Acting Comptroller General
of the United States

D I G E S T

Poor health continues to be prevalent in many of the developing countries, posing a threat to the populace and critically hindering development progress. The severity of the conditions is illustrated by reports of

- an average life expectancy of 51 years (37 in parts of Africa),
- the death of 15 percent or more of all infants before their first birthday, and
- lack of access to safe water and inadequate sanitation facilities for 65 percent of the population.

In short, 85 percent of the population in developing countries does not have adequate access to basic health care.

The urgent need for basic health-care services has emerged as a primary topic in the international community. The U.S. Government continues to be a principal provider of assistance toward resolving health problems in developing countries.

The Agency for International Development (AID) has adopted a strategy that stresses (1) broad, community-oriented networks to provide low-cost primary health care; (2) improved water and sanitation; (3) selected disease control; and (4) health planning. Priority is given to those in most need of health-care services--children under five and women in their child-bearing years--especially in the rural areas. In addition to maternal and child health care, AID assistance often encompasses family planning, immunizations, basic medicine, first aid, health education, and data collection.

The GAO purpose was to determine (1) the extent greater access to health care services has been achieved, and (2) the implementation problems which must be overcome to realize the long-term goal--improved health.

GAO did fieldwork in the Dominican Republic, the Philippines, and Thailand. In addition to reviewing relevant documents and visiting rural project sites, GAO held discussions with officials representing AID, host governments and international organizations who are involved in health care. GAO also reviewed reports on three other AID projects in Niger, Senegal, and Nepal.

GAO believes the problems identified in the six projects discussed in this report are not isolated. Although these results cannot be generalized in any statistical sense, they seem typical of problems AID faces in delivering development assistance, including primary health care.

MANAGING PROJECT IMPLEMENTATION

Many of the AID projects GAO reviewed were successful in increasing access to health services and most were successful in achieving their intermediate objectives such as training health workers, building facilities, administering immunizations, and providing initial stocks of medicine. However, problems were being encountered during project implementation that involve logistic support, management oversight and impact evaluation. These problems raise questions about the prospects of achieving the long-term health goals of the projects.

AID needs to become more involved in managing project implementation and lending more assistance to recipient countries in resolving the obstacles they frequently encounter.

The Administrator, AID, should (1) remind the Agency's overseas health staff of their responsibility to help host governments identify and address health project implementation problems, emphasizing the importance of their monitoring and assistance roles; and (2) enforce the requirement to periodically report on the progress of project implementation and include actions being taken to resolve problems.

MANAGEMENT REVIEWS

Periodic management reviews are an important part of AID's involvement, and scheduled reviews are essential for successful primary health-care projects. Such assessments are an

annual requirement during AID participation, yet most projects GAO evaluated were not being reviewed as planned. Because of delays in signing agreements, host countries' difficulties in meeting conditions before disbursing project funds, their reluctance to cooperate in reviews in some instances, and other implementation problems, scheduled reviews are often postponed or even eliminated. As a result, opportunities were being lost to identify and correct problems which would improve prospects for the long-term effectiveness of AID's health projects. The Administrator, AID, should be more persistent in conducting periodic project management reviews. (See p. 13.)

HOST-COUNTRY RESOURCES

Although adequate medicine and other supplies, along with arrangements for their replenishment, are essential for effective health-care projects, shortages were evident in most of the projects GAO reviewed. Host-country health-care resources were not adequate to replenish initial stocks supplied through AID project assistance. Generally, AID health-care projects are intended to be within the capacity of a host country to manage, fund, and maintain without the need for long-term external financial assistance. In the projects GAO reviewed, however, there are doubts about the continuation of some projects and components of other projects when AID participation ends. GAO recommends that the Administrator, AID, require that added emphasis be given during project formulation to the ability and willingness of host countries to continue to provide the resources required to assure project continuity. (See p. 18.)

MEASUREMENT OF PROJECT IMPACT

AID is attempting to evaluate the impact projects have had on target populations. This type of evaluation goes beyond measuring the extent to which projects have realized their intermediate, and more easily measurable, objectives. Only one AID health project has been subjected to this internal evaluation process. That attempt was unsuccessful because of implementation delays and other problems the project had encountered. Another impediment is unavailable or unreliable information on the health status of the target population. In addition, the

relatively short period of time AID is actively involved in projects makes it difficult to objectively evaluate or measure the ultimate impact that projects may have on the health status of target populations. (See p. 23.)

AGENCY COMMENTS

AID commented on the draft of this report and generally agreed with GAO recommendations. (See app. II.) AID agreed that the projects have extended access to health care to many areas of developing countries previously without the benefit of these services. It also agreed that logistics support and management are problems.

The Agency agreed with the GAO recommendations that project management should be strengthened. It also agreed that progress reporting is a key element of implementation, and management reviews should not be postponed. Guidance is available and more is forthcoming to assist project managers in their oversight role. However, AID did not indicate what action would be taken to ensure that project officials meet these standards.

The Agency agreed that adequate supplies of medicine are essential to successful health projects. They have identified these shortages as an area of top priority. Although steps are being taken to alleviate this problem, such shortages continue to hamper the effectiveness of health-care projects.

AID recognizes the need to ensure the ability and willingness of host countries to support and continue the projects when outside assistance terminates. Several measures have been taken, or are underway, within the Agency to address the financial aspects of this issue.

AID has evaluated several health-care projects. However, the Agency acknowledged that only one health project had been evaluated as a part of its recently initiated series of special impact assessments. GAO's discussion of the one internal impact evaluation is intended to illustrate the types of implementation problems, many of which were evident in the other projects GAO reviewed, which must be overcome before meaningful assessments of impact can be accomplished.

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ABBREVIATIONS

AID	Agency for International Development
GAO	U.S. General Accounting Office
WHO	World Health Organization
UNDP	United Nations Development Program
UNICEF	United Nations Children's Fund

CHAPTER 1

INTRODUCTION

Despite great scientific and technological achievements in the field of health, poor health prevails in many developing countries. A 1980 World Bank policy paper describes the extent and gravity of the health conditions which exist throughout the developing world. In many of these countries, short life expectancies and very high death rates among children under 5 years of age continue. In the poorest regions, half the children die during the first year of life. Those who survive often encounter serious problems during their lifetimes.

AID reports an average life expectancy of 51 years (37 in parts of Africa); the death of 15 percent or more of all infants before their first birthday; and lack of access to safe water and inadequate sanitation facilities for 65 percent of the population. In seeking solutions to these conditions, the urgent need for basic health-care services has emerged as a primary topic of international health forums. The major outcome of the Thirtieth World Health Assembly of the World Health Organization (WHO), held in 1978, was the recognition that a principal goal would be the attainment of a level of health that would enable all people of the world to lead socially and economically productive lives by the year 2000. The declaration, adopted at the September 1978, International Conference on Primary Health Care, jointly sponsored by WHO and the United Nations Children's Fund (UNICEF), clearly endorsed primary health care as the key to attaining this goal. The declaration broadly defined primary health care to include:

"* * *Education concerning prevailing health problems and methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs."

The international financial institutions, to which the United States is a substantial contributor, have become increasingly involved in lending for health-care projects in developing countries. For example, the World Bank announced a policy in February 1980, to

- begin direct lending for health projects;
- continue to finance health components of projects in other sectors, such as agriculture, education, family planning, urbanization, and nutrition;

--aim its projects to strengthen sectoral planning and budgeting capacity, and primary health-care systems; and

--include project elements such as

- development of the basic health system;
- training for community health workers and paraprofessional staff;
- strengthening transportation logistics and supply of essential drugs;
- promotion of proper nutrition;
- provision of maternal and child health care, including family planning;
- prevention and control of endemic and epidemic diseases; and
- development of management, supervision, and evaluation systems.

The United States has provided substantial resources over the years to help developing countries meet their basic human needs. A large part of these resources have been for assistance to improve health.

The Agency for International Development (AID) is the principal U.S. Government agency that provides health assistance. In recent years, the Congress has declared that development assistance should concentrate on those countries which are prepared to effectively use such help, especially those in greatest need. Assistance for health is to be used primarily for basic health services, safe water and sanitation, disease prevention and control, and related health planning and research.

AID's financial resources for health programs have increased substantially in recent years--from \$150.6 million in fiscal year 1977 to an estimated \$216.1 million in fiscal year 1980. In addition, AID programmed over an estimated \$200 million during fiscal year 1980 for family planning and nutrition programs. Health programs are funded through AID development assistance, economic support assistance, and regional development programs. Funding from all AID sources for health over the last 4 years is shown below.

AID Funding for Health
Fiscal Years 1977-80

	<u>1977</u>	<u>1978</u>	<u>1979</u>	<u>1980</u> <u>(estimated)</u>
	--(millions)--			
Primary health-care delivery	\$ 61.7	\$ 49.7	\$ 82.2	\$ 84.7
Health planning	5.3	6.6	7.9	7.1
Environmental sanitation	70.6	137.5	190.0	103.6
Disease control	<u>13.0</u>	<u>47.9</u>	<u>35.4</u>	<u>20.7</u>
 Total	 <u>\$150.6</u>	 <u>\$241.7</u>	 <u>\$315.5</u>	 <u>\$216.1</u>

In April 1980, AID had a total of 234 personnel positions devoted to health, population, and nutrition programs in Washington and at overseas missions. Of these positions, approximately 70 supported primary health-care delivery assistance. In addition, at many AID missions, contract personnel hold positions which support health activities.

Peace Corps volunteers also participate in many programs aimed at improving health care in developing countries. The involvement of these volunteers is largely concerned with nutrition, sanitation, communicable disease control, and the delivery of health services. In recent years, these activities have consumed about 20 percent of the annual Peace Corps volunteer personnel budget.

Indirectly, the Department of State also supports international health programs by channeling funds to international organizations such as WHO, UNICEF, and the United Nations Development Program (UNDP). The Department of the Treasury channels funds to the international financial institutions which support health development projects. The Department of Health and Human Services also supports health research and other disease control efforts abroad. Finally, many other U.S. Government agencies have an interest in the health conditions of developing countries.

THE AID HEALTH STRATEGY

Recognizing that previous health assistance programs were not achieving desired results because they concentrated on sophisticated urban-based curative measures, U.S. interests shifted to preventive health care. Because it encompasses a variety of basic services, primary health care has been given priority in the AID strategy for those developing countries where services are most needed--largely in the rural areas. AID programs usually depend on village health workers to reach the rural poor and link up with existing health-care systems where more complete services are available.

Primary health-care projects vary in each country. Such projects are usually designed to provide recipient countries

with the resources--medicine, trained village health workers, treatment facilities, etc.--to allow the target populations greater access to basic health-care services. Some projects are tailored to specific health problems of a target population, such as (1) diarrhea, respiratory infection and other recurring diseases; (2) malnutrition; and (3) high birth rates. Beyond these intermediate objectives, the ultimate goal of these projects is to improve health.

Most developing countries are committed to providing greater access to basic health services; however, many national programs are as yet rudimentary. In the expectation that the projects will continue when AID involvement ends, the agency emphasizes the use of local resources and community participation in project design and implementation.



**MIDWIFE IN RURAL AREA OF NIGER WITH MEDICAL KIT
SUPPLIED THROUGH AID-FUNDED PROJECT.**

(photo courtesy of AID)

OBJECTIVES, SCOPE, AND METHODOLOGY

This report concerns AID participation with developing countries in efforts to extend badly needed services to people in rural areas. Our purpose was to determine (1) the extent greater access to health-care services has been achieved, and (2) the implementation problems which must be overcome to realize the long-term goal--improved health. We also examined the design, implementation and management of selected projects, and the prospects of the efforts continuing after AID involvement terminates to ensure effective use of limited resources.

During fiscal year 1980, AID provided financial and technical assistance to health-care projects in more than 50 developing countries. We made a preliminary review of information available at AID Headquarters and discussed project status with Agency officials. Ongoing programs varied in stage of implementation, methods of financing, types of services, and AID mission involvement. Based on a desire to obtain a broad perspective, we selected a limited number of projects to represent a variety of these considerations. For example, one AID grant project was selected as representative of a substantially completed effort managed by a private voluntary organization. Another project was selected to represent a combined grant-loan funded effort implemented by the host country's health ministry. A third selection was made to illustrate the results of a project in the early stages of implementation and being managed by the country's economic development authority. Another selection examined the attempt to capitalize on a successful pilot primary health-care program already underway. Geographical considerations were built into our selection process by examining projects in three areas of the world--Africa, Asia and the Caribbean.

We did fieldwork in the Dominican Republic, the Philippines, and Thailand. In addition to reviewing relevant documents and visiting rural project sites, we held extensive discussions with many officials representing AID, host governments, and international organizations which are involved in health care. We canceled our visit to Niger because of conflicting project evaluation plans with AID, but we did review AID documents and discussed the project with officials in Washington, D.C. In addition, we undertook similar review activities for projects in Nepal and Senegal. Basic information on these projects is provided in Appendix I.

We believe the problems identified in the six projects which we reviewed in depth are not isolated. Although these results cannot be generalized in any statistical sense, they seem typical of problems AID faces in delivering development assistance, including primary health care. These results are consistent with those obtained by us in other reviews, some recently completed, 1/some still in process, covering a total of 38 projects in 7 other countries. The consistency of the finding of shortcomings in project implementation, evaluation and management in both health and other development projects tends to confirm our judgment that these problems are relatively frequent and represent a significant hindrance to the development process.

1/For example, see "AID Slow in Dealing With Project Planning and Implementation Problems," (ID-80-33, July 15, 1980). "U.S. Assistance to Egyptian Agriculture: Slow Progress After Five Years," (ID-81-19, Mar. 16, 1981). "Efforts to Improve Management of U.S. Foreign Aid--Changes Made and Changes Needed," (ID-79-14, Mar. 29, 1979).

Originally, we had also planned to evaluate the extent to which the AID projects were improving the health status of the target populations. It soon became evident, however, that the projects had not reached a stage where such results could be adequately measured.



HEALTH WORKERS BEING TRAINED IN THE DOMINICAN REPUBLIC.

(photo courtesy of AID)

CHAPTER 2

MANAGING PROJECT IMPLEMENTATION

Measured in terms of intermediate project objectives--training health workers, building treatment facilities, administering inoculations, etc.,--AID primary health-care projects have improved access to health services for low income people in many developing countries. To successfully and fully implement many of these projects--including logistics support, management and oversight--improvements are needed within AID and the recipient countries.

Although we noted that some corrective measures on specific projects are underway; we believe further action can be taken to strengthen AID involvement in health-care delivery and in assisting host-countries in solving implementation problems they often encounter. This chapter relates (1) some of the intermediate achievements we noted in our review and (2) problems we observed, including those disclosed in AID internal review and evaluation efforts.

INCREASED ACCESS TO HEALTH SERVICES

AID projects have increased the availability of needed health services. For example, a 3-year project in Thailand, funded through a \$5.5-million loan and a \$5.2-million host-government contribution, was undertaken as part of a larger population project to expand health-care staffs at local hospitals, health and birth attendant centers, and remote villages in 20 selected provinces. These locales had relatively high population growth rates and poor health service coverage. Approximately 97,000 people were to be trained in this project and about 87,500, or 90 percent, were to work in the villages. By June 1980, about 65 percent of the workers had been trained. Although delays were experienced in training the management and supervisory personnel, the overall achievement was characterized as quite impressive by AID consultants.

Two primary health-care projects in the Dominican Republic are supported by AID loans aggregating \$12.7 million. In the first project, access to health-care services increased dramatically according to AID--from 347,000 to 1.9 million people. Over 4,600 health workers were trained and were providing maternal and child health services, including immunizations. From March 1977 to August 1978,

- vaccinations of children under 5 years of age against diphtheria, pertussis, and tetanus increased from 51 to 69 percent;
- vaccinations of children under 10 years of age against measles increased from 15 to 47 percent;

- vaccinations of women of childbearing age against tetanus increased from 21 to 56 percent; and
- the number of women actively participating in family planning methods increased from 8 to 14 percent.

During the remaining years of the projects, similar health-care coverage is to be extended to an additional 100 communities.

A \$5.4-million AID loan partially supports a project in the Philippines, intended to use village-based health workers in about 600 rural communities. In our visits to the sites, we noted the enthusiasm of the local leaders. The program appeared well organized; 50 health workers had been placed in communities and others were scheduled for training.

PROJECT IMPLEMENTATION PROBLEMS

All the primary health projects we reviewed, and those which AID recently examined, had either encountered or were encountering a variety of problems. In one project, the problems were so severe that termination was considered as an option. In others, logistics support, periodic management reviews, and AID project monitoring were inadequate. The Sine Saloum Rural Health Project in Senegal and the Basic Health Care Delivery Services Project in Niger best illustrate the magnitude of the implementation, managerial, and financial problems which occur.

Senegal: Sine Saloum Rural Health Project

A \$3.3-million AID grant was to finance a technical assistance team; provide necessary vehicles, equipment, support training and supervision; and to purchase the initial inventory of medicine. Stated project objectives were to (1) establish a network of village-supported health posts to serve approximately 880,000 rural people throughout the region and (2) improve and strengthen the Government support system. Each hut was to be staffed by a trained health worker, a birth assistant, and a sanitarian. The huts were also to be stocked with medicine for common health problems.

AID intended this project to undergo an impact evaluation. However, the team quickly learned that the project had not progressed as anticipated. Accordingly, the emphasis shifted from a review of impact to an assessment of project implementation. In commenting on this change, the October 1980 report stated that "* * *when looking for indicators of potential impact the team found a project with serious problems and in danger of collapse."

The report characterized the project as being in serious trouble for the following reasons.

- One third of the project-constructed village health huts in one Department ^{1/} had already closed. In another Department huts were forced to close and more were expected to close due to shortages of money to replenish initial stocks of medicine.
- Adequate supervision and support were not being provided, even though AID was paying most of the costs.
- There were no grounds for optimism that the Senegal Government would pick up the supervision and support costs at the end of the project.
- Adequate mechanisms to effectively exercise joint Senegal and AID project responsibilities were not established.

Several other specific management difficulties were noted as contributing to the basic implementation problems. Matters, such as the selection of health workers, location of huts, procurement of medicine in the United States, remuneration of health workers, handling of transportation, and the use of records, were cited as not being resolved in ways to assure the integrity of the planned system. The team's report stated that

"Cutting across all the difficulties which beset the project is the clear failure of A.I.D. to manage the project prudently and effectively."

The report set out a series of recommendations which prompted corrective actions by the Senegal Government and AID. These included (1) a project review by the Senegal National Assembly; (2) the appointment of several new project personnel; (3) delays in opening new health huts, pending the resolution of existing problems; and (4) a redesign of the project by appropriate Government ministries and the AID mission.

Niger: Basic Health Care
Delivery Services Project

The 3-year Niger project was being financed by a \$2.8-million AID operating program grant to AFRICARE--a U.S. private and voluntary organization. The purpose was to strengthen the existing health-care delivery services. This was to be achieved through training Nigeriens and developing a functioning support system. The project was to operate at both national and Department levels.

^{1/}A Department is defined as one of several geographic regions within a country.

At the national level, an epidemiological surveillance unit was to be developed and Nigeriens trained through the project were to staff and eventually direct it. Other assistance was to enable the national laboratory to develop standardized testing procedures. At the Department level, AFRICARE was to assist in developing the health delivery system by training nurses, midwives and village health workers. The project was also to strengthen the support system by constructing a Department office building, vehicle repair and maintenance garage, and a medical equipment maintenance shop.

AFRICARE recruited and provided a public health doctor and an epidemiologist to work primarily on national aspects of the project. AFRICARE placed four advisors--a garage mechanic, a medical equipment technician, a gynecologist, and a surgeon at the Department level. The mechanic and medical equipment technician were to train Nigerien counterparts to a level of competence that would enable them to assume their responsibilities within 3 years. The gynecologist and surgeon were to train Nigerien doctors and nurses in health delivery services.

Despite the rather straight-forward objectives of the project, implementation problems were encountered from the outset. Although the project agreement was signed in September 1976, no significant project activities were actually initiated in the Department until 1978. The delay was partially due to the elapse of 20 months in recruiting AFRICARE project personnel, an 18-month delay for AID to grant a local procurement waiver, and the completion of construction of facilities.

Beyond this initial delay, other shortcomings in implementing the project were identified in two separate AID internal studies--one by a joint team of AID/AFRICARE/Niger officials and one by the AID Auditor General. Both studies were completed near the latter part of 1980, and each identified significant implementation problems.

The joint team reported the following.

- In contrast to the original purposes of the project expected by AID--to strengthen and expand the existing health-care system through on-the-job training--AFRICARE found itself providing direct services.
- The host country did not provide counterparts for training by AFRICARE. As a result, the training, a critical component of the project, was not achieved.
- No records existed of supervisory visits to the health workers.

The Auditor General's review was only one aspect of a larger assessment of AFRICARE's overall effectiveness in implementing AID-financed development projects. The report characterized

AID-funded projects with AFRICARE as being too large and ambitious to effectively administer. The report states that the Basic Health Services Delivery project

"* * *has encountered long delays in implementation; planning and coordination between AFRICARE and Niger officials needs to be improved; and Niger's ability to continue health services after the project ends is highly questionable."

Both AFRICARE and the AID Bureau for Africa responded to the Auditor General report. AFRICARE pointed to the constraints of effectively implementing assistance projects, but did not take exception to the problems included in the above discussion. The AID Bureau for Africa expressed doubt that AFRICARE could influence the Niger Government to continue the project without continued external assistance.

In commenting on monitoring AFRICARE grants, the Auditor General report concluded that "* * *AID officials have not met their oversight and evaluation responsibilities." Shortcomings specifically mentioned included the following.

- Missions were not submitting periodic reports to AID headquarters on AFRICARE projects.
- Washington officials were not making fieldtrips to project sites.
- AID mission officials had little contact with AFRICARE to monitor the projects. The Auditor General viewed the quarterly reports by AFRICARE as lacking sufficient information to measure whether project objectives were being accomplished.

The report contained several recommendations. Actions were either underway or planned to deal with some of the problems.

In addition to the implementation problems which these two reviews uncovered, the completion date was extended 1 and 1/2 years (from September 30, 1979, to March 31, 1981.) Upon completion, \$2.8 million will have been expended, and some doubt will nevertheless remain as to actual achievements in terms of continued health service delivery.

The termination of the project does not end AID funding of health services in Niger. Even with the implementation problems experienced on the first project, AID in April 1978, authorized a \$14-million grant to the Niger Government for a second project to expand and improve the existing rural health system nationwide. Subsequently, in August 1979, the AID mission approved a \$1.1-million host-country contract with AFRICARE to provide the technical assistance required for the second project.

We were able to locate only one progress report in AID, Washington on the second project. We also had difficulty in locating a copy of the contract between Niger and AFRICARE.

Although initiated in April 1978, implementation of the second project was just getting underway at the conclusion of our review. Because we were aware of the delays and problems on the first project and because the same organizational entities were involved in the expanded and more costly second effort, we sought assurances from AID officials that safeguards had been taken to ensure more timely and efficient implementation. It remains to be determined whether these actions will adequately result in improved monitoring and timely resolution of problems.

MANAGEMENT OF PROJECTS NOT BEING REVIEWED AS PLANNED

AID recognizes the value of assessing the extent to which projects progress toward planned targets; overcome implementation problems; and remain relevant to host-country needs. Periodic management reviews are an integral part of the design of primary health-care projects, and are usually included as an annual requirement during the life of the project. Other reviews can be conducted when the projects require major redesign. In addition, the AID Auditor General and other internal AID offices examine the financial, administrative, and management aspects of projects. The following examples illustrate the problems AID is experiencing in assessing project implementation.

The implementation schedule for the project in the Philippines planned five management reviews during AID participation. At the time we visited the project in February 1980, no reviews had taken place. There was a 6-month delay in signing the grant agreement, and another 8-month delay because the host government was having difficulty meeting the conditions precedent to disbursing the loan. The first review was to have taken place in February 1979, but was subsequently rescheduled for July 1980. It was eventually conducted in November and December of 1980.

In Niger, AFRICARE proposed mid-term and end-of-project management reviews. The AID grant included funds for this purpose. The reviews were not conducted and we found no evidence that AID brought this to the attention of AFRICARE. Except in the context of "lessons learned", many AID Auditor General and joint team recommendations were of little value because the project had essentially been terminated. Had the scheduled reviews taken place and these problems been identified and corrected earlier, the proposed long-term benefits of this effort might have been improved.

During 1980, AID attempted to review the second AFRICARE health-care project in Niger. The purpose was to redesign the project and to allow the mission to obligate fiscal year 1980 funds. Despite signed agreements, the host country objected and the review was cancelled.

PROVISION OF PROJECT DRUGS AND MEDICINE

One essential ingredient of effective primary health-care projects is adequate supplies and medicine, and a working replenishment system. Shortages of medicine and problems in replenishing supplies were prevalent in four of the six projects we examined. Continued shortages can demoralize health workers and disappoint people needing medication. In the Sine Saloum project, medicine was described as the "life blood" of the project. Although the initial supply was appropriate for the treatment of many health problems, a widespread need existed for alcohol and mercurochrome to use as disinfectants for cuts and wounds and for use during childbirth. Health workers were also concerned about the absence of medicine to treat diarrhea.

The initial stocks of medicine for this project were to include aureomycin to treat common eye infections. The medicine was not issued because, by the time it was acquired through the AID procurement process and Senegal Customs, the expiration date had passed. The AID practice of purchasing medicine from U.S. sources with English labels, names, and dosages, has been questioned because local Senegal brands and sources will be used if the project continues when AID participation terminates.



SENEGAL--MEDICAL SUPPLIES IN A HEALTH HUT WHICH WAS OPEN FOR THREE MONTHS (LEFT) AND DEPLETED MEDICAL SUPPLIES IN ANOTHER HEALTH HUT WHICH WAS OPEN FOR NINE MONTHS (RIGHT).
(photo courtesy of AID)

At village health facilities in the Philippines, we also observed a lack of medicine. Initial stocks which the project provided were to be replenished by the Philippine rural health network. Government clinics were experiencing shortages of their own stocks at the time of our visits and were unable to meet the additional needs of the village health workers. Project health workers frequently mentioned that the inadequate quantity of medicine was a major problem.

The Auditor General report on the basic health-care delivery project in Niger noted shortages of drugs and supplies at all project locations visited. An AID consultant reported that the health posts in Nepal had adequate supplies for only 3 months of the year and that a continuing and chronic shortage of medicine existed. Although acknowledging some improvement in supply management, the report contended that transportation had not been adequate; and commodity storage, training, and administrative facilities were not meeting program needs.

CONCLUSIONS AND RECOMMENDATIONS

On the basis of information developed on the primary health-care projects we reviewed, a better job needs to be done in (1) monitoring project implementation and more actively resolving problems, (2) insuring that periodic project management reviews are performed, and (3) assisting host countries in alleviating shortages of project-essential medicine.

Almost without exception, the problems can be traced to either the project design or the in-country implementation phases. In either case, AID overseas mission officials seem to be in the best position to guide the project design and to provide experienced management during implementation.

The shortcomings in AID monitoring and management, as discussed above, are more than should reasonably be tolerated. Health care is simply too important and costly for an AID mission to do its oversight job in "* * * a kind of 'arm's length' or 'hands off' style"--the way one mission operation was described in an AID report. Planned AID funding of approximately \$85 million for primary health-care projects in fiscal year 1980, suggests that corrective measures should be undertaken immediately.

We, therefore, recommend that the Administrator, AID, (1) instruct mission directors and health officers to take a more active role in monitoring and managing health projects; (2) insure compliance with procedures which require periodic progress reports on the implementation of health projects, identifying actual or anticipated difficulties and the proposed remedies; and (3) insist that periodic management reviews be completed regardless of the stage of project implementation.

AGENCY COMMENTS AND OUR EVALUATION

AID agreed that many of the health-care projects in which they have collaborated have succeeded in extending access to health services. However, they also acknowledged that management of these projects needs to be strengthened and logistics support needs to be improved.

Management reviews are an annual requirement during project implementation and the Agency agreed that these reviews should not be postponed because of implementation delays. Also, the Agency agreed that progress reporting is another key element to sound project management. The AID Project Assistance Handbook and the Project Officers Guidebook require periodic reporting on the status of project implementation, and when problems develop that require special attention. The Agency is preparing additional guidance for monitoring and reporting on projects involving host-country contracts.

AID stated that the problems discussed in this report are not unique to health projects. Previous GAO reports have identified the lack of adequate management, including monitoring of AID assistance projects. In the past, the Agency responded that guidance was either available or was being developed for project managers. We note that in responding to this report on health-care projects, AID did not indicate what action will be taken to ensure that project officials adhere to existing and forthcoming management guidelines.

AID emphasized that its direct hire personnel in most missions are managers of technical assistance resources. The actual assistance is usually provided by contractors, private and voluntary organizations, or other intermediaries. AID is trying to increase the involvement of private and voluntary organizations in development programs. Also, AID is increasingly relying on host-country involvement in project implementation as part of the overall Agency development strategy. As AID becomes less involved in directly providing technical assistance and implementing projects, we believe that the monitoring responsibilities of the Agency take on added importance to ensure efficient use of U.S. financial support.

According to AID, adequate supplies of medicine have been identified as an issue of top priority. Measures have been initiated to

- analyze requirements and eliminate supply bottlenecks;
- develop a manual for supply management;
- identify ways of resolving pharmaceutical supply problems in Africa;

--centrally procure commodities to combat
diarrhea; and

--field test country-specific, uniform drug lists
to assure adequate supplies of a limited number
of drugs.

We believe these actions are steps in the right direction. If the Agency is successful in resolving situations of inadequate supplies of appropriate drugs, and procurement and transportation delays, it will have overcome one of the principal obstacles to effective health-care projects.

CHAPTER 3

GREATER ASSURANCE OF PROJECT CONTINUITY IS NEEDED

General AID policy is that any project should leave in place a functioning capacity to manage, fund, maintain, and operate the activity developed, improved or established through U.S. assistance. AID emphasizes the design of primary health-care projects which are within the capacity of the host countries to maintain without long-term external support. AID usually finances only the initial investment costs--start-up training and salaries, basic medicine, facilities, and equipment. The project beneficiaries, local organizations, or the central government are then expected to contribute the remaining investment costs, and finance the recurring costs of ongoing projects--retraining, replenishing supplies, supervision, and equipment maintenance and repair. In some special cases, however, the Agency will also finance these recurring costs.

We have doubts about whether some projects and components of other projects will continue when AID participation is completed. For example, we found indications that some projects may exceed the financial means and technical capacity of recipient countries. Further, some projects included elements and objectives which were unacceptable to the recipient countries. In a few instances, projects may not be supported even after grant agreements have been formalized. The following cases illustrate the problem.

PROJECTS BEYOND THE FINANCIAL MEANS OF THE HOST COUNTRIES

The extent to which recipient countries can financially continue to support health-care projects will not be known until sometime after external assistance is ended. However, information developed on two projects we reviewed, raised questions about the ability of the countries to continue the efforts. In one case, the Harvard Institute for International Development sponsored the "Study on the Financing of Recurrent Costs," involving projects in several countries in the Sahel. The study examined the AID-financed health-care project in Senegal and (1) noted that expenditures for medicine were already inadequate to keep the medical establishments stocked for the entire year and (2) questioned the likelihood of Senegal shifting additional funds from other sources to the primary health-care project. The Harvard study also concluded that to continue the project, the existing budget would have to increase 310 percent.

In another example, formal agreements obligate local governments in the Philippines to eventually assume financial responsibility for the AID-supported health-care project. The source of funds to continue the project, however, had not been identified. Although in only one region of the country, this project is considered an opportunity to obtain valuable information for planning a national program. In commenting on pilot projects in

the Philippines, the AID Operations Appraisal Staff reported in December 1978, that neither the mission nor the host government had adequately studied the long-range budgetary implications of attempting wide replication of various pilot and outreach activities. The study concluded that the Philippine government might find it very difficult to finance pilot projects on a nationwide basis.

COMPONENTS OF PROJECTS NOT SUPPORTED BY HOST GOVERNMENTS

A 1974 assessment of the Dominican Republic health-care system indicated the need for substantial administrative and organizational government reform. At that time, the emphasis was toward urban-based, curative services. AID project loan funds provided almost \$1.5 million to solve these problems. A consulting firm reviewed the organizational structure of the government health-care system and offered eight recommendations. Although the rural health delivery system has been incorporated into the administrative framework of the current government, implementation of six remaining recommendations is doubtful. Our discussions with AID and host-government officials disclosed that problems in implementing administrative reform have always existed. Administrative reform was included as a non-negotiable element of the overall project.

In addition, efforts to develop an urban health services component and two elements of a nutrition program have been eliminated from the project. An earlier mission management review disclosed that the urban health services duplicated existing efforts to increase access to health care. In addition, the services the project delivered to the urban population were not considered effective because of the mobility of both the target group and the health workers which the project trained.

The project intended to support research into the causes of malnutrition and the cost effectiveness of current and future nutrition programs. The effort was discontinued because of inadequate host-government support at the time the project was implemented. Another project element was to develop a commercially marketable food supplement for young children and for nursing and pregnant women, but this component was also abandoned when it was determined that the government could not financially support this effort.

Mission oversight during project implementation identified the above problems. As a result, the undisbursed funds originally budgeted for administrative reform and improved nutrition are being reallocated to the rural health delivery component of the project.

A project in Thailand included evaluation and research to strengthen the government capability to (1) coordinate health activities, (2) improve project planning and monitoring in rural areas, and (3) to design and conduct selected evaluations. These

components have not kept pace with other project activities. Government reluctance to use AID loan funds for indirect health service delivery activities such as research and evaluation, combined with delays in recruiting personnel, have delayed overall progress. At the time of our review, the project was entering the final year of scheduled AID involvement. Of nine proposed studies, only three had been initiated; and of the original \$516,000 programed, \$400,000 had not been expended.

In all cases we reviewed, developing countries recognize the need to expand access to health services in rural areas. A recipient-country concept of what these services should involve, however, often differs from AID objectives for primary health care. In Niger, for example, AFRICARE provided qualified personnel to train host-country counterparts. However, the Nigerien Government viewed the project as a source of badly needed direct medical services and no counterparts were assigned for training. As a result, the AFRICARE surgeon and gynecologist worked mostly in the district hospital. The mechanic and medical technician were limited to vehicle and equipment repair, and no one was trained to assume their responsibilities when AID involvement ended, as originally intended.

Another project component was to develop a stronger curriculum at the public health and nursing schools. The AFRICARE physician was to assist in these improvements. However, the government directed efforts away from these objectives, and progress has not been significant.

As noted earlier, AID authorized a \$14-million grant to the Government of Niger to expand health-care coverage nationwide. AFRICARE has again been engaged, on the basis of a non-competitive \$1-million host-country contract, to provide technical assistance for this larger effort. At the conclusion of our work, consideration was being given to include some of the objectives of the original project in this new, broader, and more costly effort.

CONCLUSIONS AND RECOMMENDATIONS

The AID policy is to finance initial investment costs of primary health-care projects. In some special cases, the Agency will also finance recurring costs. The scope of each project is supposed to be tailored to be within the resources of the host countries so that the remaining investment and recurring project costs can be financed when AID support terminates. The objective is to establish a health-care delivery system that fulfills the long-term needs of the recipient countries, but within their financial resources. In cases such as Senegal and Niger, the scope of the AID primary health-care projects could exceed the financial resources or technical capabilities of the countries. In Thailand, the Dominican Republic, and again Niger, the project designs included components which did not address the health-care priorities as seen by the recipient countries. In cases where AID loan funds are used for projects or components of projects

which have little hope of continuing without long-term external support, the host countries are burdened not only with the recurring costs of supporting ongoing health-care delivery, but also the cost of repaying investments which offer little hope of continuing returns. Inadequate monitoring and management review have led to situations where projects and components of other projects continue to be funded with questionable prospects of long-term success.

All of the projects included in this review could be described as overly ambitious in terms of what they proposed to accomplish during AID's active participation. In commenting on this observation, AID representatives responded that project designs must necessarily be optimistic if recipient countries are to be persuaded to commit the financial and technical resources needed to meet the objectives of primary health-care. As the examples in the Sahel particularly illustrate, however, such projects consume scarce and valuable host-country resources and result in only short-term benefits for the target groups.

To improve the long-term effectiveness of primary health-care projects and to assure project continuity, we recommend that the Administrator, AID, require a more critical, realistic, and continuing analysis of the ability and willingness of host countries to continue providing financial and technical support when external assistance ends. Significant improvements in the efficient use of U.S. financial and technical assistance can only be achieved if this type of analysis starts at the project design stage and continues throughout implementation to ensure that the initial assumptions concerning host-country support remain appropriate.

AGENCY COMMENTS AND OUR EVALUATION

AID stated that a number of steps have been taken, or are underway, to ensure that projects do not exceed the financial resources of developing countries. These include studies and reviews of recurring costs, financing mechanisms, and the adequacy of cost analyses in AID project proposals. Also, guidelines are being prepared for the analysis of project costs and estimating the cost of health projects in the Sahel.

We believe these actions are steps in the right direction. However, they address only one aspect of project continuity--financial viability. AID did not indicate what additional steps would be taken to ensure the scope of the projects are (1) within the technical and administrative capacity of the host country and (2) limited to those longer-term objectives the responsible implementing organization sees as needing to be pursued. In Niger, the project clearly exceeded the technical capacity of the country to continue. In the Dominican Republic, Thailand, and again Niger, the projects had objectives beyond the health-care priorities perceived by these host countries. GAO believes that until all aspects of project continuity--financial support, technical and administrative capacity, and mutually agreed upon

objectives and priorities--are realistically considered and resolved during project design, the prospects that health-care projects will continue when AID assistance ends, may still be in doubt.

CHAPTER 4

DIFFICULTIES IN MEASURING PROJECT IMPACT

AID recently instituted an internal process to evaluate project impact. This new effort attempts to identify and measure the longer-term results which projects are having on the intended beneficiaries. To date, only one AID primary health-care project has been evaluated through this in-house process. However, due to delays and other problems during implementation, impact could not be determined. Even if implementation problems are resolved, other difficulties in assessing project impact include the following.

- Data used for measurement purposes is unreliable or not available.
- Data recorded on services delivered by health workers is not being gathered or analyzed to establish population coverage, service utilization, and current health status.
- The relatively short period of active AID involvement in the projects makes it difficult to measure improvements in health.

LACK OF HEALTH DATA

Reliable and timely information on the health status and problems of rural populations is usually not available in most developing countries. Incomplete reporting is common for some diseases, the existence of multiple causes of morbidity and mortality leads to misreporting, and many deaths are reported without identifying causes. In addition, data which is available usually reflects the experience of hospitals and clinics. Because these are located in urban areas, and provide little outreach to the rural communities, the information may not accurately measure the incidence and prevalence of illnesses commonly experienced by the people AID projects are intended to reach.

Compiling and analyzing information

A requirement to collect health-related data was in the design of many of the projects we reviewed. Health workers are trained to maintain records--usually by family unit--on births, nature of illnesses, immunizations, and other information.

In most of the projects we reviewed, the data was not being compiled or analyzed. As a consequence, opportunities are being lost to identify health problems; select priority areas in community health for special attention; direct resources to where they can be most effectively applied; establish realistic and

achievable long-term program goals; and record project accomplishments. The following examples illustrate that AID needs to direct more attention to the data gathering and analysis elements of its health projects.

The AID project in Niger provided funds through AFRICARE to retain the services of a trained epidemiologist, experienced in establishing systems to identify disease patterns. However, efforts were concentrated at the national level, and no attempt was made to develop reliable data at the rural project sites. Therefore, no systematic analysis was accomplished to identify problems or contribute to health-care activities AFRICARE proposed to benefit the target groups.

As an initial step, the design of the project we evaluated in the Dominican Republic proposed collecting data on population, births, deaths, and incidences of specific diseases. Subsequent AID assessments repeatedly noted the lack of such data. The health workers are the only reliable and consistent source for such information. The program became active in 1976, but of the 300,000 available records, the government only recently began analyzing about 34,000.

AID consultants reviewed the primary health-care project in Thailand prior to our fieldwork. Their report commented on the lack of adequate data on health services being provided through the project. This prevented a determination of what progress was being made toward intermediate objectives, such as coverage, immunizations, and professionally attended childbirths. The goals to reduce both population growth and maternal and infant mortality rates were to be the ultimate measures of success. The consultants recommended that the program begin to focus on priority areas of community health. They commented that failure to identify such areas would likely lead to a waste of resources.

SHORT PROJECT LIFE AND IMPLEMENTATION DELAYS

AID participation in primary health-care projects averages only about 3 years. However, a large part of this time is consumed by (1) recruiting and fielding technical assistance; (2) training health workers; and (3) awaiting construction of facilities and delivery of needed commodities, before any health services can effectively be delivered to the target groups. In addition, delays in scheduled project implementation often result in postponed program activities. For example, four of the AID-sponsored projects we reviewed were significantly behind schedule.

--The project in Senegal started in August 1977. It was designed as a 3-year project. However, in April 1980, the AID Impact Evaluation team found the project to be far behind schedule and in danger of collapse. They were unable to evaluate project impact because of the more

immediate issue of poor management and lack of financial solvency.

--The project in Niger commenced in September 1976, as a 3-year effort. However, it was extended to September 1980, and again to March 1981, due to implementation problems.

--The project in the Dominican Republic that began in 1975 was scheduled to be completed in 1978. By June 1980, however, it was about 36 months behind schedule.

--The project in the Philippines commenced in 1978 and was planned as a 5-year AID program. However, there were significant delays. When we visited the project in early 1980, the first group of health workers had only recently been placed in the rural communities. According to AID, significant progress has been made since our fieldwork.

CONCLUSIONS

AID recognizes the value of identifying the impact projects have on poor health, as well as how effectively needed services have been delivered. In the one internal AID attempt to ascertain impact, described in Chapter 2, implementation problems precluded such an assessment. Many of the difficulties--poor project design, insufficient supplies, inadequate management and oversight, lack of host-country support--were also evident in other projects we reviewed. We believe these shortcomings, combined with the questionable health data, failure to compile and analyze available information, implementation delays and short project life, illustrate the issues needing increased attention before the objectives of impact evaluations can be achieved.

AGENCY COMMENTS AND OUR EVALUATION

AID stated that a recent Agency task force encouraged an emphasis on impact evaluations and proposed that such assessments be conducted at the completion of separate phases of project implementation. The Agency prefers this approach over fixed schedules that do not take into account project delays. GAO did not recommend that impact evaluations be conducted on the same basis as periodic management reviews intended to monitor project implementation. We agree with the AID comment that implementation delays now being experienced would make rigidly scheduled impact evaluations a waste of resources.

Several additional AID health projects have been evaluated to measure impact and cost-effectiveness. The purpose of our discussion of the AID attempt to evaluate the impact of the Senegal health-care project was to identify Agency interest in this area, and illustrate the range of problems which must be

overcome before the objective of impact evaluations can be realized. In addition, the lack of reliable data on the health status of the target groups prior to the projects, slow progress in compiling and analyzing data recorded by the health workers, and the relatively short period of time AID is actively involved in the projects add to the difficulty in successfully accomplishing this task.

AID stressed the distinction between periodic management reviews and impact evaluations. Impact evaluations can only be useful if a project has reached a given stage of implementation. Our draft report was revised to more clearly reflect this difference.

AID PRIMARY HEALTH-CARE PROJECTS
REFERRED TO IN THIS REPORT

PHILIPPINES: Panay Unified Services for Health

Purpose:

To strengthen the regional health system to deliver integrated services at the village level.

Goal:

To improve the health of the residents in 600 villages on Panay Island.

Estimated life of project: FY 1978-83

Estimated cost of project:

AID loan	\$5,400,000
AID grant	316,000
Host country	3,000,000
Other	<u>1,000,000</u>
Total	<u>\$9,716,000</u>

THAILAND: Rural Primary Health-Care Expansion

Purpose:

To make primary health-care services more readily available to the rural poor in Thailand with emphasis on 20 provinces.

Goal:

To improve the health in Thailand as a major contribution to the social, physical, and mental well-being of the population.

Estimated life of project: FY 1979-81

Estimated cost of project:

AID loan	\$ 5,519,000
Host country	<u>5,230,000</u>
Total	<u>\$10,749,000</u>

AID PRIMARY HEALTH-CARE PROJECTS
REFERRED TO IN THIS REPORT

DOMINICAN REPUBLIC: Health and Nutrition Sector Development

Purpose:

To reduce infant and preschool mortality rates and the crude birth rate; improve the performance and management of the public health system; and fulfill the health policy and planning role of the government. Also, to develop a nutrition program to provide a basis for a long-term improvement in overall nutrition.

Goal:

To bring about a reduction in the population growth rate as a result of improved, more widely available health services, and to improve the health and well being of the population, particularly infants and children without access to health services.

Estimated life of project: FY 1974-79

Estimated cost of project:

AID loan	\$ 4,725,000
Host country	<u>6,919,000</u>
Total	<u>\$11,644,000</u>

SENEGAL: Sine Saloum Rural Health Care

Purpose:

To create a network of village health posts supported by local communities within the region of Sine Saloum, and to strengthen the supporting system for secondary health posts.

Goal:

To improve the level of health among the rural population and to establish a model national health-care delivery system for preventive medical care and treatment that can be maintained through support of the rural population.

Estimated life of project: FY 1977-81

Estimated cost of project:

AID grant	\$3,374,000
Host country	<u>1,648,000</u>
Total	<u>\$5,022,000</u>

AID PRIMARY HEALTH-CARE PROJECTS
REFERRED TO IN THIS REPORT

NEPAL: Integrated Health Services

Purpose: To help the Government develop a capacity to organize and manage an effective national integrated basic health service.

Goal: To improve health by providing effective, low-cost integrated basic health services, equitably distributed in predominantly rural Nepal.

<u>Estimated life of project:</u>	FY 1976-79		
<u>Estimated cost of project:</u>	<u>Approved</u> <u>6-9-76</u>	<u>Additional</u> <u>requested</u>	<u>New total</u> <u>Approved 6-2-78</u>
AID grant	\$1,450,000	\$2,127,000	\$ 3,577,000
P.L. 480 local currency (in equivalent U.S. dollars)	<u>745,000</u>	<u>115,000</u>	<u>860,000</u>
Total U.S.	<u>\$2,195,000</u>	<u>\$2,242,000</u>	<u>\$ 4,437,000</u>
Host country (in equivalent U.S. dollars)			13,498,000
Other donors			<u>4,091,000</u>
Total			<u>\$22,026,000</u>

NIGER: Basic Health Services Delivery System

Purpose: To increase the level of adequate and accessible basic health services over a 3-year period; to establish formal public health training, in-service education, and field supervision; to create a systematic approach to data collection, reporting, and analysis within the government; and to increase the capability of the government to deliver health services to the rural population, especially in Diffa Department.

Goal: To establish within the host government a low cost comprehensive basic health services delivery system of preventive, educative as well as curative care which incorporates local community participation of the urban and rural population.

<u>Estimated life of project:</u>	<u>Estimated cost of project:</u>		
FY 1977-79 a/	AID grant	\$2,818,000	
	Host country	<u>992,600</u> b/	
	Total	<u>\$3,810,600</u>	

Note a: Two extensions granted by AID; completion now estimated to be March 1981.

Note b: Includes major in-kind costs.

UNITED STATES INTERNATIONAL DEVELOPMENT COOPERATION AGENCY
AGENCY FOR INTERNATIONAL DEVELOPMENT
WASHINGTON, D.C. 20523

THE INSPECTOR GENERAL

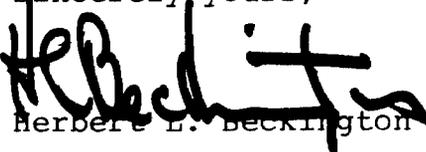
March 10, 1981

Mr. J. K. Fasick
Director, International Division
United States General Accounting
Office
Washington, D. C. 20548

Dear Mr. Fasick:

Thank you for the opportunity of providing comments on the draft report of the General Accounting Office titled, "Managing Health Care Projects In Developing Countries" (ID-81-24). We hope the attached Agency comments and the additional information presented will be helpful in preparing the final report. If you or members of your staff should have any questions or wish to discuss any of the matters covered in our response, please let me know.

Sincerely yours,


Herbert L. Beckington

UNITED STATES INTERNATIONAL DEVELOPMENT COOPERATION AGENCY
AGENCY FOR INTERNATIONAL DEVELOPMENT
WASHINGTON, D.C. 20523

ASSISTANT
ADMINISTRATOR

Mr. J. K. Fasick
Director
International Division
General Accounting Office
Washington, D. C. 20548

Dear Mr. Fasick:

I have been asked to reply to your letter of February 3, 1981, transmitting the GAO draft report, "Managing Health Care Projects in Developing Countries." We appreciate the opportunity to comment on the draft report.

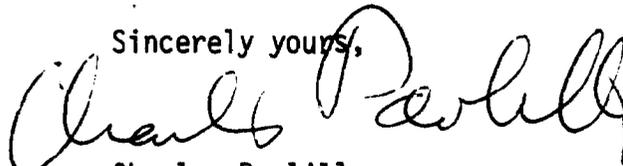
I am pleased to note that the GAO found most of A.I.D.'s health projects successful in achieving their objectives.

The report contains a number of observations and recommendations which I readily endorse. Indeed, the Agency had reached many of the same conclusions in the course of its reviews of A.I.D.-supported health activities. However, we feel the report should make a careful distinction between project monitoring and project evaluation in its analysis and recommendations.

Comments and observations on the recommendations of the GAO draft report are attached. Included are specific actions which the Agency is taking to alleviate, if not solve, the problems identified by the GAO.

I am most willing to discuss any of our comments with you or provide additional information.

Sincerely yours,



Charles Paolillo
Acting Assistant Administrator
for Program and Policy

Attachment: a/s

A.I.D.'s Comments on GAO Draft Report
"Managing Health Care Projects in Developing Countries"

Introduction

We appreciate GAO's recognition that many of the primary health care projects in which A.I.D. has collaborated have been successful in increasing access to health services. As the report points out, our own evaluations have uncovered problems in logistic support and management. These problems are among the "second generation" issues which had become evident during the implementation of the early health care delivery projects. As a result, A.I.D. began several years ago to address logistics and management problems in its health projects.

We agree with GAO's recommendation that project management should be strengthened in some Primary Health Care ("PHC") projects, but would like to stress that there is a difference between management reviews (called evaluations in the Draft Report), for spotting implementation problems, and impact evaluations.

The former are used routinely during the course of project implementation as a management tool, and, as the GAO points out, should not be delayed or postponed because of delays in project implementation. Impact evaluations, on the other hand, cannot be usefully conducted until the project has reached a given stage in its implementation. To attempt impact evaluations at a predetermined time, in spite of implementation delays, would, in our judgment, be a waste of evaluation resources.

The role of the A.I.D. direct hire health advisor in providing technical assistance should be more clearly stated in some sections of the report. Under A.I.D.'s current method of operation, the direct hire personnel in most missions are managers of technical assistance resources. The actual technical assistance to the host country is generally provided by contractors, private, voluntary organizations ("PVO"), or other intermediaries. With encouragement from the Congress, A.I.D. has been making special efforts to increase the technical assistance that U.S.-based PVOs provide in development programs.

We provide below specific comments and suggestions on these points.

1. Project Monitoring and Implementation:

The draft report suggests that A.I.D. improve its monitoring of project implementation and take a more active role in resolving implementation problems.

- We agree with GAO that progress reporting is a key element of sound project monitoring and implementation. A.I.D. currently requires periodic reporting on implementation status (Handbook 3, Project Assistance, and the A.I.D. Project Officer's Guidebook on Management of Direct A.I.D. Contracts, Grants and Cooperative Agreements, dated June 1980). In addition project managers are responsible for special reporting when substantive problems require urgent attention. Additions to Handbook 3, now being prepared, will provide further instructions and guidance for monitoring and reporting on projects which are planned and implemented under host country contracts.
- Under A.I.D.'s current policy, programs will be increasingly carried out by private organizations while A.I.D.'s own staff will concentrate on monitoring their implementation.
- It should also be noted that monitoring, implementation and management problems are not unique to health projects.

2. Project Evaluation:

The second recommendation is that A.I.D. adhere to a schedule of periodic evaluations during the course of each project.

We note that evaluation has two rather distinct meanings in the GAO Report: A.) management review, and B.) the measurement of a project's impact.

A. Management Reviews: As noted in the previous section, A.I.D. already uses management reviews routinely during the course of project implementation. In addition to this periodic reporting requirement, the following measures reinforce A.I.D.'s implementation and management of projects:

- Project evaluation summaries ("PES") for all projects, including health, are required on an annual basis.
- Evaluation officers in each bureau review and disseminate all PES's.

B. Project Impact Evaluation: An Agency Evaluation Task Force recently stressed the distinction between "evaluation" and "monitoring". The Task Force Report encouraged A.I.D. to emphasize project impact evaluation, and to link evaluations to turning points, major events, or the termination of separate phases of a project. This flexible timing is preferable to a fixed schedule that does not take project delays into account.

Last year A.I.D. initiated a series of special impact evaluations. Because this activity is so new, only one health project has been evaluated thus far. Several other special impact evaluations of health projects are scheduled for 1981.

In addition, the report overlooked a number of evaluations which measured the impact of health programs. For example, major evaluations that analyzed the impact of A.I.D.-supported projects on health status were conducted on the following projects:

- Danfa (Ghana) Rural Health Project
- Narangwal (India) Health and Nutrition Project
- Lampang (Thailand) Health Project
- Strengthening Rural Health Delivery Project (Egypt)
- Several operations research projects to assess the cost-effectiveness of various combinations of health and family planning services.

3. Supply Problems with Drugs and Medicines:

The report comments that developing countries require assistance to alleviate shortages of drugs essential to the success of A.I.D.-funded projects. A.I.D. health officers have already identified drug supply as a top priority. To solve the problem of drug supply, the Agency has initiated a number of activities which were not described in the report:

- Technical assistance to analyze drug requirements and eliminate procurement and transportation bottlenecks.
- A world-wide study of logistics systems for drugs, which will result in a manual for drug supply management.
- A study of the management of pharmaceuticals in Africa, to identify feasible ways of ameliorating supply problems.
- A mechanism for the central procurement of oral rehydration salts, a new, technologically appropriate means of combatting diarrhea, a major cause of death in LDCs.
- Country-specific, uniform drug lists, which restrict the types of drugs available, but help assure adequate supplies. This approach is being tested in the field in several projects, including one with the University of Hawaii.

4. Greater Assurance of Project Continuity:

The GAO report further recommends that A.I.D. take into consideration the ability and willingness of host countries to provide the resources required to assure that projects continue after A.I.D.'s assistance terminates.

Even before the GAO completed its study, A.I.D. had taken a number of steps to assure that projects do not exceed the means of developing countries:

- An intensive study of recurrent costs in all sectors, including health
- A workshop on the cost and financing of Primary Health Care
- A review of the adequacy of cost analyses in A.I.D.-funded Primary Health Care projects
- A review of current health financing mechanisms, conducted by the American Public Health Association
- Draft guidelines for the analysis of costs in Primary Health Care projects
- A draft manual for estimating the cost of Primary Health Care programs in Sahelian countries

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