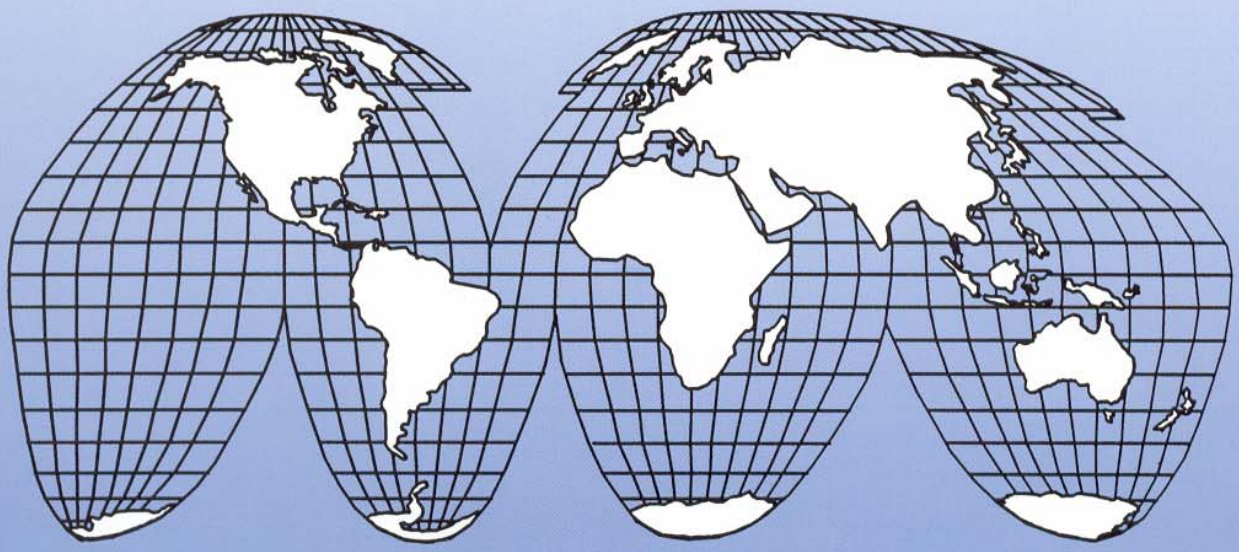
USAID

OFFICE OF INSPECTOR GENERAL

Audit of USAID/Democratic Republic of Congo's Monitoring and Reporting of Its Health Program

7-660-05-001-P

October 28, 2004



Dakar, Senegal

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October 28, 2004

MEMORANDUM

FOR: USAID/Democratic Republic of the Congo Director, Robert Hellyer

FROM: RIG/Dakar, Lee Jewell III /s/

SUBJECT: Audit of USAID/Democratic Republic of the Congo's Monitoring and Reporting of Its Health Program (Report No. 7-660-05-001-P)

This memorandum is our final report on the subject audit. In finalizing this report, we considered management's comments on our draft report and included them in Appendix II.

This report contains three recommendations to which you concurred in your response to the draft report. Based on your plans in response to the audit findings, management decisions have been reached on all three recommendations. Recommendation number one is considered closed upon the issuance of this report. However, the other two recommendations will remain open until the planned actions are completed by the Mission. Please coordinate final actions on recommendations number two and number three with USAID's Office of Management Planning and Innovation (M/MPI).

I appreciate the cooperation and courtesies extended to the members of our audit team during this audit.

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Summary of Results

The objective of this audit was to determine whether USAID/Democratic Republic of the Congo (DRC) monitors the performance of its health program to ensure that intended results are achieved. (See page 7.)

USAID/DRC made some good efforts to monitor its health program activities through September 30, 2003 and has continued to improve its efforts during the current fiscal period. Our review of the actual health results for 13 performance measures reported in the Mission's fiscal year (FY) 2004 Annual Report showed that more than half achieved 100 percent or greater of the planned results. Notwithstanding certain logistical difficulties associated with operating within the DRC, the Mission has engaged in developing structures to enhance the management, monitoring and reporting of its health program. These include recruiting a monitoring and evaluation specialist, and, for the first time, starting to implement a Performance Management Plan for FY 2004 through 2008. (See pages 7 through 9).

Nevertheless, despite these efforts, USAID/DRC did not have a system in place that provided for full management oversight and adequate reporting of its health program. Although the Mission had made some monitoring efforts, it did not systematically conduct visits to implementing partner sites, nor did it consistently document those visits it did make. Monitoring of project results and verifying data reported by implementing partners was only incidental to visits that were made. Without procedures in place to systematically and consistently monitor the health program activities, USAID/DRC cannot be fully assured that the program activities conducted by the implementing partners will lead to the achievement of the health strategic objective. We recommend that the Mission establish a schedule and procedures, including a checklist, for conducting site visits, as part of its Performance Management Plan. (See pages 9 through 11).

Additionally, audit site visits conducted in June and July in the Bas-Congo and the Equateur regions of the DRC revealed supervision and monitoring at the partner level, and specifically for the Basic Rural Health III (SANRU III) project, to be deficient. Problems noted included incomplete records at the clinics, data submitted by the clinics not matching those maintained at SANRU headquarters, and lack of controls over USAID-funded equipment and medical supplies. This situation might lead to inaccurate data being reported to USAID and ensuing inappropriate programmatic decisions. Furthermore, program equipment and other resources may be unduly at risk. We recommend that the Mission implement procedures requiring supervision to be more comprehensively performed by the project's implementing partner, and to report to the Mission regarding the supervisory efforts made in each quarter in its quarterly reports. (See pages 11 through 14).

Background

In fiscal year (FY) 2003 and prior years, USAID/Democratic Republic of the Congo (DRC) designed its health program to provide a package of key interventions to assist Government of Congo-designated health zones, focusing on prevention of morbidity and mortality among women and children. The Mission also supported national health initiatives, such as the campaign to eradicate polio. These activities were carried out as part of the Mission's broader strategic objective of assisting the Congolese population in solving a wide variety of developmental problems following years of civil war.

In December 2003, the Mission's new strategic plan was approved and included provisions for the continuation of health activities through Strategic Objective 2 titled "Use of Key Health Services and Practices both in USAID-supported Health Zones and at the National Level Increased." Subsequent to the approval of the strategic plan, a Performance Management Plan (PMP) was developed to describe the goals and expected program results for the 2004 to 2008 period. According to the latest version of the PMP dated May 10, 2004, Strategic Objective 2 aims to increase the use of key health services and practices through five intermediate results, namely (1) increased availability of key health services and practices; (2) improved financial access to key health services; (3) enhanced quality of key health services; (4) increased awareness and practice of healthy behaviors; and (5) increased access to key HIV/AIDS prevention and mitigation services.

In FY 2003, USAID/DRC funded the following five major health program activities:

- Basic Rural Health III (SANRU III), through Interchurch Medical Assistance, Inc. (IMA) and its local partner, the Church of Christ of Congo (ECC), for $25 million, for a period of 5 years (2001-2006), to strengthen the capacity of 60 non-governmental organization-managed health zones for priority primary health care intervention and support systems.

- Basic Health in the Kasais, through Catholic Relief Services (CRS), for $8.6 million over 5 years (2002-2007), to strengthen capacity of 20 health zones in the western and eastern Kasai regions.

- Integrated Heath and Nutrition in Bas-Congo, through CRS, for $1.3 million over 3 years (2000-2003), to revitalize vaccination activities in three health zones in Bas-Congo.

- Training, Research, Information Management, And Community Based Programs, through Tulane University/Kinshasa School of Public Health, for $3.3 million over 4 years (2000-2004), to train key health professionals in the principles and practices of public health, execute operations research in support of partners conducting public health interventions, and support

the development of a national integrated infectious diseases surveillance system.

- Support and Care for People Living with HIV/AIDS, through Christian Aid, for $2.3 million for FY 2002, with extension to 2005, to reinforce the capacity of implementing local organizations and communities in the fight against HIV/AIDS.

In FY 2003, USAID/DRC obligated approximately $14.5 million for these health program activities.

Audit Objective

In accordance with its fiscal year 2004 audit plan, the Regional Inspector General/Dakar performed this audit to answer the following audit objective:

Does USAID/Democratic Republic of the Congo monitor the performance of its health program to ensure that intended results are achieved?

Appendix I contains a complete discussion of the scope and methodology of the audit.

Audit Findings

USAID/Democratic Republic of the Congo (DRC) does not have a system in place that provides for full management oversight of its health program. Mission staff made some efforts to monitor program activities, including performing some site visits and communicating with the program's implementing partners. Our review of the actual health results for 13 performance measures reported in the Mission's fiscal year (FY) 2004 Annual Report also showed that more than half (7 out of 13) or 54 percent achieved 100 percent or more of the planned results, while 23 percent (3 out of 13) achieved between 75 and 99 percent of the planned results. However, there were problems in monitoring the program which included the lack of a systematic and consistent approach to site visits and other partner encounters as well as a lack of a monitoring plan due to, until FY 2004, the lack of a Performance Management Plan (PMP).

USAID/DRC made some good efforts to monitor its health program activities through September 30, 2003 and has continued to improve these efforts during the current fiscal period. Some of the more important endeavors of the health team, in particular, and USAID/DRC, in general, are described in the following paragraphs.

The health activity managers had regular health team meetings to discuss program implementation issues and data reported by the implementing partners. Additionally, they maintained ongoing communication with partners.

To monitor the programs in the field, some site visits were made and documented. With regard to health activity data, indicator tables agreed-upon with the partners and found in the partner quarterly reports were detailed, showing unit of measure, description and relation to work-plan, targets, actual results, and other comments.

In order to restructure and formalize program management, the Mission recruited a performance monitoring specialist in 2003 to serve all strategic objective teams. The specialist has been instrumental in developing a database that will help integrate and facilitate reporting both by implementing partners and the Mission. Additionally, a new health team leader has been brought in to shore-up the team. Finally, the Mission attained a major milestone: the Mission received approval for their PMP for health activities, which was under development for several years and was being implemented at the time of the audit.

In other worthwhile efforts to improve its health program, at the request of the Mission, a field assessment of the SANRU project was performed by USAID/Washington in 2003, after two years of implementation, with its goal to inform the Mission whether SANRU's program of support to health zones is appropriate and manageable. The assessment team came up with several valuable recommendations, most of which the Mission has applied to this project's strategy. Similarly, an assessment was performed between our two audit fieldwork periods on the management and delivery of health services conducted in Catholic Relief Services-assisted zones in the Kasais. The purpose of this assessment was to determine the level of resources required to effectively implement the activities outlined in the Mission's new strategy, and to help enhance the grantee's performance. Several recommendations ensued, which the Mission likely will apply to the health program.

With regard to assessing how well the Mission achieved its planned health goals, we found that of the actual health results for 13 performance measures in the Mission's FY 2004 Annual Report more than half (7 out of 13) or 54 percent achieved 100 percent or more of the planned results, while 23 percent (3 out of 13) achieved between 75 and 99 percent of the planned results.

Following are four examples of performance measures that achieved or exceeded 100 percent of target. In "Other Immunization" DPT3 (a series of immunizations that can prevent diphtheria, pertussis and tetanus) attained 56 percent coverage in USAID-assisted zones, compared to the national average target for DPT3 of 40 percent. Socially Marketed Condoms units sold of 20,773,032 surpassed the planned 20 million units. Family Planning, with 87 clinics equipped and their staff trained to provide family planning services, exceeded the target of 75 clinics. Polio Campaign coverage (the effort to eradicate polio through immunization), which was the only health indicator reported in the Mission's strategic objective table, attained 100 percent of the 100 percent target. Mission reported in its FY 2004 Annual Report that the last

cases of wild poliovirus in the DRC (28 cases) were reported in 2000 and that since then no more have been reported. This was confirmed in a World Health Organization report. These efforts show that the Mission steadily made progress in managing its health program, notwithstanding certain logistical difficulties associated with operating within the DRC.

Photograph taken July 23, 2004 of the poor road conditions between Bolenge and Bikoro, illustrating the difficulties faced in delivering and monitoring health services in the DRC.

However, despite these efforts, we found that USAID/DRC did not have a system in place that provided for full management oversight and adequate reporting of its health program. The problems noted both at the Mission and implementing partner levels are described below, with recommendations for corrective action.

More Consistent and Systematic Approach Needed for Site Visits

Summary: USAID/DRC health staff performed some site visits, especially in regard to the launching of health campaign programs, accompanying visiting USAID specialists, and attending special health program events in the country. However, we found these site visits to be very few and not performed by the Mission in a systematic or consistent manner that would ensure adequate monitoring of the partners' activities—contrary to USAID guidance. The inconsistency in site visits was a result of the lack of procedures providing guidance for such visits. As a result, the Mission cannot be fully assured that the partners are carrying out activities that contribute to the achievement of the Mission's health strategic objective.

Although the health team staff conducted some site visits, we found the numbers to be very few. Only ten trip reports evidencing site and other types of visits were available over the past 3 years. Of these, four were in FY 2001, two in FY 2002, three in FY 2003 (our principal year of focus) and one, so far, in FY 2004. Our review of the site visit documentation that did exist showed

that visits were made for a variety of reasons that did not necessarily include any efforts to verify the validity of the data developed and reported by the partners. For example, one trip on March 15 to April 5, 2003 was made to accompany an acquisition specialist from another USAID mission, whose scope of work for the visit was for the Central African Regional Program for the Environment, although the trip included a visit to the SANRU III project. In several instances, USAID/DRC staff participated in meetings or workshops along with partner and government staff and officials. While these activities are worthwhile and important, they only provide partial assurance of management oversight.

USAID's Automated Directives System (ADS) section E303.5.13 states that site visits are an important part of effective award management and recommends that reports of the visits be maintained in official files. Similarly, ADS section 303.3.4.c indicates that the responsibilities of the CTO include monitoring and evaluating the recipient and the recipient's performance by maintaining contact through site visits. Additionally, ADS section 203.3.5.3 states that reviewing partner data and comparing field records with central records is an important part of assuring the quality of data used for reporting purposes. It also recommends that such efforts be documented. Moreover, U.S. Government Internal Control Standards require that important events be properly documented.

We believe that site visits that include reviewing and verifying implementing partners' data are an important event in the overall monitoring process and should be documented. The lack of consistent and documented site visits occurred because the Mission had not developed specific procedures for monitoring program activities. Such procedures would provide a framework for conducting site visits to better ensure proper management oversight. USAID/DRC health team staff and Program Office officials attributed the lack of structured procedures to the lack of a PMP. Health team members also indicated that, with the interim team leader being absent due to illness during most of FY 2003, there were additional time constraints on their staff.

Without conducting timely and appropriate site visits that include verification of data, the Mission cannot be fully assured that the partners are carrying out activities that contribute to and ensure achievement of the health strategic objective or that the data ultimately reported by the partners is accurate. The Mission's recently approved PMP does specify the need for quarterly meetings with partners to discuss general program management and technical issues. Also the PMP states that random checks of partner data can be integrated with site visits. However, the PMP does not provide specific procedures or requirements for conducting and documenting site visits that include assuring the accuracy and validity of the data. Furthermore, without formal key encounters with implementing partners, important program information may not be available to Mission management, and would ultimately be lost if health team staff were to leave USAID.

To address the lack of consistent procedures during site visits that would ensure systematic monitoring of program activities, we make the following two recommendations.

> **Recommendation No. 1: We recommend that USAID/DRC create a schedule of site visits to be conducted for each partner implementing health program activities and incorporate the schedule in the Performance Management Plan.**
>
> **Recommendation No. 2: We recommend that USAID/DRC develop procedures to monitor health program activities that would include a checklist specifying the purpose and activities to be conducted during each scheduled site visit.**

Improvement Needed in Partner Oversight of SANRU III Project

Summary: SANRU headquarters staff performed and documented some supervisory visits to health zone offices and local clinics as required by the terms of the cooperative agreement. However, problems found during audit visits to four health zone offices and six local clinics indicated that in some cases, visits were infrequent and when made, the extent of oversight was inadequate and insufficient. Problems included incomplete and inaccurate documentation of health zone office or clinic activities, lack of follow-up on problems noted during previous visits and poor controls over USAID-funded equipment and supplies, yielding an overall error rate of 58.7 for the controls tested. As a result, data reported to USAID/DRC contained errors and USAID-funded equipment and supplies were at risk.

In its quarterly reports submitted to USAID/DRC, SANRU headquarters reported on the number of supervisory visits made to health zone offices. At the four health zone offices we visited—Nselo, Sona-Bata, Bikoro, and Bolenge—records documented supervisory visits made by SANRU headquarters staff. Additionally, records maintained at the health clinic level documented supervisory visits made by either health zone office or SANRU headquarters staff. However, even though the project implementation plan specified that each health clinic would receive at least one supervisory visit per month, records at six health clinics showed visits occurred less frequently. For example, during FY 2003, there were only four visits each for Nselo and Sona-Bata health zone offices, and three visits each for Bolenge and Bikoro health zone offices, instead of the planned 12 each.

Supervisory visits were documented in a notebook at the clinic, in which basic visit information, such as the date and staff involved, was recorded. This notebook formed the basis for a form that summarized these visits in the quarterly reports submitted to USAID/DRC. The notebook also provided the staff conducting the visit opportunities to describe any weaknesses or problems found during the visit.

However, we noted that the notebooks did not show that any follow-up had been performed to determine if actions had been taken to address the previously identified problems. For example, at Sona-Bata, documentation of a visit made on April 17, 2003 noted that the data relating to birth control activities was not accurately reported, yet the notebook did not subsequently indicate how this issue was resolved. On the other hand, we observed that certain issues also noted in the notebook, such as the lack of a list of essential drugs and the non-posting of the monthly activity plan, had been resolved but not mentioned subsequently in the notebook.

The health zone offices were also responsible for collecting monthly data on health clinic and other program activities conducted throughout the zone, as well as aggregating this data on a quarterly basis. The quarterly reports were provided to SANRU headquarters, which then used the data to report to USAID/DRC. Yet we noted that the health zone offices had not maintained adequate documentation to support their monthly reports. For example, at the Bikoro health zone office, reports from 3 of 40 health clinics were missing for September 2003, and reports from 2 of 40 health clinics were missing for August 2003.

During our site visits of four health zone offices and six clinics within these zones we noted many errors regarding record maintenance and deficiencies in control over supplies and equipment in the SANRU III project. An error rate of over 58 percent was obtained from our review of 92 judgmentally selected health statistics, equipment and supplies data at these locations. Data from clinic records were compared to those reported to the heath zone offices, and similarly those from the health zone offices were compared to data submitted to the national office of the implementing partner and used for reporting to USAID. For health equipment and supplies, the physical inventory was compared to recorded documentation and other procedures were performed to check compliance with the cooperative agreement. The review results are summarized in the following table.

	Bas-Congo Region			Equarteur Region			
	Nselo Health Zone	Sona-Bata Health Zone	Total Bas-Congo Region	Bikoro Health Zone	Bolenge Health Zone	Total Equarteur Region	Total Tested
Items Tested	14	12	26	36	30	66	92
Errors Noted	6	5	11	24	19	43	54
Error Rate (%)	42.9	41.7	42.3	66.7	63.3	65.2	58.7

First, we found discrepancies between the monthly data sheets maintained by the health zone offices and their quarterly aggregated figures reported to SANRU headquarters. For example, at the Bolenge health zone office, the report for the quarter ending September 30, 2003 showed an average monthly consumption of 1,650 units of one particular drug for the quarter. However, this figure was not the average for the quarter but rather the average only for the month of September.

We also found discrepancies between the figures included in the local clinics' reports to the health zone office and the clinics' original records. For instance, at the Kalamba health clinic, the register recording pre-school consultations in June 2004 showed 39 consultations, but the clinic reported 57 to the health zone office.

Finally, we found instances of poor controls over USAID-funded supplies and equipment. There were equipment—including bicycles, gas and solar refrigerators, and solar lights—at two health zone offices that were not included in the inventory maintained by SANRU headquarters. Additionally, the quantity of some medical supplies and drugs maintained in medical depots did not reconcile with the amounts shown on the depot stock cards. For example, the stock card for the drug Doxicycline showed 1,736 units whereas the inventory count was 1,708; for the drug Metazole, the stock cards showed 961 units whereas the count was 951. Also, project equipment provided by USAID was not properly identified and labeled with the USAID logo. At Wendji Secli Clinic, for instance, we found a freezer not labeled with USAID logo.

USAID's ADS 303.5.13 incorporates by reference regulations contained in Title 22, Volume 1 of Code of Federal Regulations (CFR), Part 226 governing the administration of assistance to non-governmental organizations such as those implementing the SANRU III project. Specifically, the CFR states that recipients are responsible for managing and monitoring each project, program, sub-award, function or activity supported by the award. Accordingly, we believe that the implementing partner is responsible for monitoring and providing oversight of all of its activities and interventions to ensure maximum impact on the health population in the DRC. As such, we expect that accomplishments of project activities would be systematically monitored via internal systems built into project management procedures. These procedures include continuous supervision and training of health center staff, Village Health Committee meetings, and review of health clinic monthly activity reports.

These discrepancies indicate a lack of appropriate attention paid to reporting accurate and correct data from the clinic level up to the health zone office, onto SANRU headquarters and ultimately to USAID/DRC.

These problems occurred because of inadequate monitoring and oversight of clinics by health zone offices and of the health zone offices by SANRU headquarters. Although some procedures for supervisory visits had been developed by SANRU, these procedures focused more on reviewing the day-to-day operations of the clinics and health zone offices. The procedures did not address a more comprehensive or complete approach to oversight. They did not, for instance, contain guidance or otherwise suggest that activities such as verifying data back to source documents or reports be conducted as part of a supervisory visit. Similarly, no guidance was provided for ensuring that inventories of equipment and supplies as recorded by SANRU were correct and corresponded to the centers' records, nor were any mechanisms in place to ensure that follow-up occurred after weaknesses were identified.

As a result of inadequate supervision, inaccurate data may be reported to USAID leading to inappropriate programmatic decisions by USAID management. Additionally, program resources and equipment may be at risk. To address this issue, we are making the following recommendation.

Recommendation No. 3: We recommend that USAID/DRC develop procedures requiring periodic and comprehensive supervisory visits be performed by its Basic Rural Health III project implementing partner and that discussions on the nature and findings of the supervisory visits be included in the partner's quarterly reports to USAID/DRC.

Our Evaluation of Management Comments

In response to the draft report, USAID/Democratic Republic of the Congo (USAID/DRC) concurred with all of the findings and recommendations in the draft audit report. Based on appropriate action taken by the Mission, management decisions have been made on all recommendations and Recommendation No. 1 is considered closed upon the issuance of this report. However, Recommendations No. 2 and No. 3 will remain open pending final corrective action by the Mission. The attachments to management comments are not included in this audit report.

Recommendation No. 1 recommends that the Mission create a schedule of site visits to be conducted for each partner implementing health program activities and incorporate the schedule in the Performance Management Plan (PMP). The Mission, in coordination with the implementing partners, has developed a schedule of site visits for fiscal year 2005, based on the reviewed and approved PMP. In addition to providing specific dates for the monitoring visits, the schedule also indicates the health activity partners to be visited, and the locations and the purpose of the visits as well. We believe that, although it would also be useful for the Mission to specify when trip reports would be due after each site visit, the Mission has adequately acted on this recommendation, and it is considered closed upon the issuance of this report.

Recommendation No. 2 states that the Mission should develop procedures to monitor health program activities that would include a checklist specifying the purpose and activities to be conducted during each scheduled site visit. The Mission, in response, has developed a standard 'field visit checklist' specifying the purpose and activities to be conducted during each scheduled site visit by the USAID Health officials. However, we believe to fully act on this recommendation, the Mission needs to develop administrative procedures (usually in the form of a Mission Order) to monitor health program activities that incorporate the checklist and requires Mission employees to use it in performing the appropriate control activities during site visits. This recommendation will remain open pending final action by the Mission.

Recommendation No. 3 recommends that the Mission develop procedures requiring periodic and comprehensive supervisory visits be performed by its Basic Rural Health III project implementing partner and that discussions on the nature and findings of the supervisory visits be included in the partner's quarterly reports to USAID/DRC. The Mission, in response, has written a letter requiring this implementing partner to develop procedures for, and perform, periodic and comprehensive supervisory visits. The Mission also scheduled a meeting with the implementing partner to discuss this requirement. We believe that, while the Mission is on the right path, actual procedures have to be developed and ready for implementation in order to close the recommendation. This recommendation also will therefore remain open pending final action by the Mission.

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Scope and Methodology

Scope

The Regional Inspector General/Dakar conducted this audit in accordance with generally accepted government auditing standards. The purpose of the audit was to determine whether USAID/Democratic Republic of the Congo (USAID/DRC) monitors the performance of its health programs to ensure that the intended results are achieved.

The audit was conducted at USAID/DRC in Kinshasa from June 22 to July 2 and from July 19 to July 30, 2004. For discussions and review of program documentation and assets, we visited the offices of three implementing partners: Tulane University/Kinshasa School of Public Health (KSPH), Interchurch Medical Assistance, Inc/The Protestant Church of Congo (IMA/ECC) for the SANRU III activities (including its medical warehouse annex on its premises and its main supplies warehouse in Kinshasa), and Catholic Relief Services (CRS), also located in Kinshasa, and a satellite office of CRS located in Kisantu in the Bas-Congo region. We also made site visits to four health zone offices and six clinics within those zones. These health zone offices and clinics, in which SANRU III (IMA/ECC) and CRS intervene, are administered by the DRC's Ministry of Health (MOH).

During the site visits to the health zone offices we discussed project administration with the officials in charge and reviewed supporting documentation for the data reported to SANRU and CRS that were in turn used in health zone offices' quarterly reports to USAID/DRC. Similarly, we reviewed the data reported by Tulane University/KSPH, as well as tested their student admissions and graduation procedures against the established criteria. At SANRU (IMA/ECC) headquarters and health zone offices, we also observed the inventories, comparing the physical stocks to the records of medicines, medical supplies, and other program equipment supplied by SANRU and held at these offices for distribution to the clinics. We acted similarly at the clinics, with emphasis on the project supervision and monitoring by SANRU and MOH officials as well as review of the detail support for data reported to the health zone offices.

We assessed the management controls of the program using USAID guidance including the Automated Directives System, Mission reports and other internal policies and procedures. The audit scope focused on examining the procedures used by the Mission and the selected implementing partners to monitor health program activities. This included reviewing reports prepared by the Mission and partners, reviewing and tracking indicators back to a variety of source documents, and visiting partner offices and field sites to review documentation and observe activities. It also included reviewing the Mission's achievement

of its reported results as compared to expected results for fiscal year (FY) 2003.

Methodology

While conducting fieldwork, we performed limited tests of compliance with USAID procedures regarding results reporting and program monitoring at the Mission level. To verify the accuracy of performance indicator data reported to USAID/Washington in the FY 2004 Annual Report (for activities conducted in FY 2003), we judgmentally selected verifiable health program data from the Annual Report and traced the reported data back to reports submitted by the implementing partners. We then traced the partners' data back to their supporting documentation. Our verification included examining source documents and electronic and manual records.

To determine the extent to which program results had been achieved, we compared the actual FY 2003 results for the single performance measure reported at the strategic objective level to the planned results for the same year contained in the Mission's Performance Management Plan. We also compared data in the Annual Report for 11 other performance measures (12 data variables) against the partners' targets approved by the Mission and the Government of Congo's and International Health Organizations' expected achievement levels for certain health indicators.

We also interviewed responsible personnel at the USAID Mission in Kinshasa as well as at selected implementing partners' offices and field sites concerning program activities, monitoring efforts and data accuracy issues. During partners' site visits, we selected controls and project related data from their records for testing on a judgmental basis, depending on whether it was the partner's head office, a health zone office or a clinic.

In assessing the accuracy of the data, we used a threshold of one percent for transcription accuracy and five percent for computation accuracy.

Management Comments

EMBASSY OF THE
UNITED STATES OF AMERICA

Agency for International Development
Kinshasa

MEMORANDUM

Date : October 7, 2004

To : Lee Jewel III, RIG/Dakar

From: Mikaela Meredith, Acting Director, USAID/DRC /s/

Subject Audit of USAID/Democratic Republic of the Congo's Monitoring and Reporting of Its Health Program (Report No. 7-660-04-00X-P)

Reference: RIG/Dakar Memo dated 8/31/04

USAID/DRC would first like to express its gratitude for the time and effort the RIG/Dakar staff dedicated to this audit. It has been very useful in identifying certain weaknesses in the overall management of the Health Program in Congo. We fully concur with the draft audit findings and the three recommendations.

Over the course of the last few months, USAID/DRC has taken the following steps to address the recommendations before the issuance of the final audit report:

Recommendation No. 1: We recommend that USAID/DRC create a schedule of site visits to be conducted for each partner implementing health program activities and incorporate the schedule in the Performance Management Plan.

Action Taken: Mission's new Health Office Director Aleathea Musah arrived to post on June 22, 2004. She closely worked with RIG/Dakar auditors while they were performing the audit in Kinshasa. In coordination with the implementing partners, she has developed a schedule of site visits based on the reviewed and approved PMP. A copy of site visit schedule is attached for RIG/Dakar's records.

We believe that necessary action has been taken to resolve this recommendation and request RIG/Dakar close Recommendation No. 1 accordingly.

Recommendation No. 2: We recommend that USAID/DRC develop procedures to monitor health program activities that would include a checklist specifying the purpose and activities to be conducted during each scheduled site visit.

Action Taken: In accordance with the audit recommendation, Mission has developed a standard 'field visit checklist' specifying the purpose and activities to be conducted during each scheduled site visit by the USAID Health officials. A copy of 'Checklist' is attached for RIG/Dakar's records.

We believe that necessary action has been taken to resolve this recommendation and request RIG/Dakar close Recommendation No. 2 accordingly.

Recommendation No. 3: We recommend that USAID/DRC develop procedures requiring periodic and comprehensive supervisory visits be performed by the implementing partner, SANRU (IMA/ECC) and that discussions on the nature and findings of the supervisory visits be included in the partner's quarterly reports to USAID/DRC.

Action Taken: In compliance with this audit recommendation, Mission's Health Officer Aleathea Musah has written a letter dated 9/23/04 to SANRU Project Director Leon Ngoma Kintavdi requiring SANRU to develop procedures for and perform periodic and comprehensive supervisory visits. A meeting with SANRU officials has been scheduled on October 18, 2004. A copy of letter is attached for RIG/Dakar's records.

We believe that necessary action has been taken to resolve this recommendation and request RIG/Dakar close Recommendation No. 3.

Please advise the mission of your decision on the above recommendations at the earliest opportunity. If you require any additional information, please let us know.