REPORT BY THE U.S.

General Accounting Office

Donor Coordination And Project Monitoring Practices-- A Foreign Economic Assistance Project Study

Economic assistance to developing countries, today, comes from many international sources, public and private. It has been recognized that the contributions of these donors need to be coordinated in order to achieve maximum benefits for the recipient population. To date, coordination at the planning and policy levels has been done well, but the leadership needed at the project level to continue effective coordination during implementation is lacking.

Project achievements need to be monitored continually during implementation so that necessary changes can be made to meet program goals. In addition, lessons learned from better project monitoring can benefit managers of other projects and planners of future projects. Currently, project monitoring policies emphasize surveillance of the input schedules and quantities instead of the results.

ID-80-34
APRIL 24, 1980

UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

INTERNATIONAL DIVISION

B-196507

The Honorable Douglas J. Bennet, Jr.
Administrator, Agency for
International Development AGC00097

The Honorable Thomas Ehrlich
Director, International Development DLG02554
Cooperation Agency

This report is the result of our review of the Agency for International Development (AID) Maternal Child Health/Family Planning project in Kenya. Our report discusses the project results due to AID planning, monitoring, evaluation, and general management and also outlines the extent of effective coordination by the various donors. Our review identifies management problems in this project that may exist in other projects for which the Agency is solely or partly responsible.

We are sending copies of the report to the Director, Office of Management and Budget, the Chairmen of the House and Senate Committees on Appropriations, and other committees having authorization and oversight responsibilities.

J. K. Fasick

J. K. Fasick
Director

GENERAL ACCOUNTING OFFICE REPORT TO THE DIRECTOR, INTERNATIONAL DEVELOPMENT COOPERATION AGENCY AND THE ADMINISTRATOR, AGENCY FOR INTERNATIONAL DEVELOPMENT

DONOR COORDINATION AND PROJECT MONITORING PRACTICES--A FOREIGN ECONOMIC ASSISTANCE STUDY

D I G E S T

GAO performed an indepth case study of the multidonor Maternal Child Health/Family Planning project in Kenya to learn more about trends in the Agency for International Development (AID) project management and donor coordination process. GAO found that

DLG044469

--there was no formal arrangement among the donors to coordinate throughout the term of the project;

--planned objectives were not met, partly due to the absence of a monitoring plan and the lack of required evaluations; and,

--AID had paid reimbursement claims without assurances from the Government of Kenya that the pre-conditions had been met, and that AID's liability for additional claims had not been determined.

GAO chose the AID Maternal Child Health/Family Planning project in Kenya because it was part of a long-range, multidonor effort, it contained several of the types of assistance usually offered by AID, and it was nearing completion.

AID assistance was to be in four major areas: technical assistance, participant training, commodities procurement, and recurring cost financing. The total estimated expenditures were $3.5 million, and obligations, as of March 31, 1979, were $2.9 million. (See app. I.)

COORDINATION AMONG DONORS

There was no formal arrangement among the donors to coordinate during the project. The leadership for coordinating

the multidonor efforts was sporadic, and formal exchange of information among the donors did not take place during the latter part of the program. (See pp. 4 and 5.)

The absence of donor coordination resulted in AID specific and overall program goals not being achieved in some assistance areas. For example, the Health Education Unit was not able to meet its increased production goals at any time during the project because the AID equipment did not begin to arrive until 1 year after the completion of the World Bank-funded building. (See pp. 5 through 8.)

Division of assistance responsibilities exacerbated the coordination problem. The financing arrangement divided the responsibility for funding the recurring program costs among AID and two other donors. The donors never met to compare for whom each was paying. Further, these donors were not able to determine if the Government was paying its share of the recurring costs. These problems could have been avoided if a formal mechanism for exchange of information on project progress had been used, and if each type of assistance had been apportioned wholly to a single donor. (See pp. 8 and 9.)

Much has been done to improve coordination at the agency level, but little has been done to solve the problems of implementing coordination at the country/project level. Coordination at the country level is most essential when the recipient government is unable or unwilling to coordinate the assistance it receives. GAO believes that recipient government should lead all master planning and policy formulation. After that, competent and willing leaders, whether from the host governments or donor agencies, should be designated to manage donor input at the country/project level from project implementation to completion. (See pp. 9 through 11.)

MORE ATTENTION TO MONITORING
PROJECT OUTPUT IS NEEDED

The absence of a monitoring plan and inattention to the required annual evaluations contributed to the shortfalls in reaching the AID project objectives. Continued project funding was to depend on project progress. The yearly project agreements required that the Ministry of Health and AID conduct annual project reviews to compare planned objectives with actual accomplishments and to agree on a set of objectives for the following year. These annual evaluations were not always conducted. Annual targets were never made a part of the project agreements. Further, none of the documents included a monitoring plan identifying the sources, types, and quantities of data needed to measure progress. GAO believes such output targets should be made a part of project agreements so that recipient governments are held accountable for reaching them. (See p. 12.)

The assistance promised in the project agreements generally bore little resemblance to the planned output for the specific years. GAO recognizes that targets can change, and projects should not be inflexible. There were major changes in the technical assistance and participant training areas that were not directed toward project goals; but AID's agreements contained no discussion of the reasons for the deviations. GAO believes that such discussions should be made a part of new agreements to allow tracking of project changes. (See pp. 13 and 14.)

In a recent report to the Congress, GAO recommended that the International Development Cooperation Agency and AID seek ways to commit U.S. and other funds to improving the financial management capabilities of developing countries. Consideration of the information needed to monitor project progress should point up inadequacies in the recipient financial and program management systems, thus identifying the areas most in need of improvement. AID would then be in a

position to offer assistance to strengthen these areas and, in the multidonor projects, convince others to offer assistance. As a choice, AID could opt to shift funding to another, more easily controlled assistance area. (See pp. 12 and 13.)

The assistance area recurring cost financing contained a number of conditions precedent to payment. AID did not devise a plan to assure itself that these conditions were met and mission personnel did not request nor review supporting data from the Government of Kenya. (See pp. 15 and 16.)

AID obligated almost $580,000 to pay the recurring program costs of salaries and related expenses. As of June 1979, the Government of Kenya has submitted only two requests for reimbursement and had received about $353,300, leaving about $226,000 obligated but unclaimed. AID has not determined whether past payments were in accordance with project agreement conditions, nor determined its liability, if any, to pay additional claims. (See pp. 14 through 17.)

RECOMMENDATIONS

GAO recommends that the Director, International Development Cooperation Agency and the Administrator, Agency for International Development take the lead in working with other donors and recipient governments to establish a coordinating mechanism for implementing projects or programs at the country level.

GAO recommends that the Administrator, Agency for International Development

--emphasize the need to include output targets in project agreements for areas of Agency assistance,

--insure that required annual evaluations are carried out and reported to provide a record of progress in meeting Agency output targets,

--include requirements in the project assistance handbook for specific identification of financial and program data needs for output monitoring.

--consider refinements to the present system of grant accounting to provide missions with information on costs funded from sources outside the project, particularly those associated with contracts centrally funded and managed by AID in Washington; and

--reemphasize the need for project managers to obligate funds only in pursuit of project goals and require that reasons for any changes during the project are adequately documented.

GAO recommends that the AID Auditor General

--review the adequacy of the procedures supporting Government of Kenya salary cost reimbursement requests and take appropriate action to insure that the U.S. Mission adequately documents these reimbursement requests, and

--disseminate information on findings having wide-spread application for Area Auditors General in reviewing other projects containing similar types of assistance.

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ABBREVIATIONS

AID	Agency for International Development
GAO	General Accounting Office
MCH/FP	Maternal Child Health/Family Planning
UNFPA	United Nations Fund for Population Activities
IDCA	International Development Cooperation Agency

CHAPTER 1

DONOR COORDINATION: MORE FORMAL ARRANGEMENTS NEEDED FOR PROGRAM IMPLEMENTATION

For this particular study, we examined the design, implementation, and evaluation of one AID-funded project in one country. We chose the Maternal Child Health/Family Planning (MCH/FP) in Kenya because

--it was part of a long-range, multidonor effort;

--it contained most of the types of assistance usually offered by AID; and

--it was nearing completion at the time we began our work.

We were particularly interested in identifying the management techniques and methods used in project operations, with particular emphasis on donor coordination and project monitoring.

This chapter discusses the importance of donor coordination and why better coordination is needed before and during project implementation. It also outlines the effect of poor donor coordination in terms of project goals not being achieved and accountability over recurring costs. Lastly, this chapter presents donor views on the coordination issue and the AID/IDCA approach to this issue in the future.

DONOR COORDINATION IS NEEDED BEFORE AND DURING PROJECT

Kenya's 5-year MCH/FP program is based on a master plan developed by the Government of Kenya with assistance from the World Bank. However, the leadership for coordinating the multidonor efforts was sporadic, the program responsibility was not appropriately divided, and the formal exchange of information among the donors did not take place during the latter half of the program. AID project goals and overall program goals were not achieved in some assistance areas because of this absence of donor coordination.

In our view, there is a need to formalize the donor coordination dealing with implementation at the project

level. A new U.S. organization, the International Development Cooperation Agency (IDCA), will be charged with improving coordination of U.S. development assistance with other donors. Planning activities for this organization have been aimed at headquarters level coordination and have not considered how donor coordination will be carried out at the country level. We believe there is a need for ways in which mechanisms for formal coordination can be installed at this level.

IMPORTANCE OF DONOR COORDINATION

In our December 1978 report on coordination of population assistance, 1/ we emphasized that interaction among donors, program participants, and recipient governments is necessary to

- --provide assurance that there is no overlap or duplication;
- --ensure that resources are applied where needed most and where they will make optimal contributions toward attainment of goals and objectives;
- --ensure that opportunities for cost savings through consolidation of requirements for procurement of material, supplies, and services are identified; and
- --provide each donor, particularly the United States, with information on whether its contributions, whether direct or indirect are being used in manner consistent with contractual, grant, or loan requirements.

We also pointed out that to achieve these purposes, such interaction or coordination should be based on a long-range plan or strategy, have effective leadership, exhibit an appropriate division of program responsibility among participants, and have a framework for the continuing exchange of information.

1/ "Population Growth Problem in Developing Countries: Coordinated Assistance Essential", (ID-78-54, Dec. 29, 1978.)

COORDINATION ELEMENTS IN THE KENYA MCH/FP PROGRAM

The 5-year MCH/FP program was based on a master plan that included input from the major donors. In 1971, there were several such donors offering assistance to the Government of Kenya for population programs. These efforts were characterized as supportive of the existing Kenyan family planning program, but small, uncoordinated, and limited in scope. During the same time, the Government became increasingly concerned about population growth, and began drafting a 5-year family planning program for the years 1975 through 1979 to serve as a basis for expanded family planning activities.

The Government's chief assistant in preparing the plan was the World Bank. It initiated a review in 1972 of the Government plan for increasing and coordinating external assistance for its population program. After reviewing the plan and recommending changes, World Bank officials began liaison efforts with interested donors to mobilize available assistance. There were some problems in reaching agreement on the overall plan, but these were successfully resolved during a series of meetings ending late in 1973.

The plan also considered population growth as it affected overall development within the country. The Kenya development plan for 1974 to 1978 stated that the Government was committed to provide opportunities and facilities that would encourage efforts to control population growth while effectively using available resources to improve the welfare of all Kenyans. The World Bank appraisal of the 5-year population plan concluded that the population control effort in Kenya should be viewed in the context of the comprehensive programs to raise the socioeconomic status of the Kenyan family. The appraisal also stated that such efforts combined with decreased morbidity and mortality resulting from more comprehensive family health services would facilitate the acceptance and practice of family planning.

To facilitate donor coordination, the plan anticipated that the Government of Kenya would organize annual briefing meetings to exchange information and consult about the progress of the program. We located only one set of documents relating to such a briefing. That briefing was held in March 1975. The AID external evaluation of its part of the 5-year program criticized the donor coordination. The evaluation stated that:

"For a multilateral project of this size and complexity, donor coordination has been poor. Only one donor meeting was held during 1975. A luncheon meeting, with the Permanent Secretary, MOH, as guest speaker in November, brought the donors together but not for the purpose of discussing the project."

"An example of the state of donor non-communication is illustrated by the way in which the donors learned about the withdrawal of NORAD's [Norway's] support from the project in March, 1975. Two of the donors were told by NORAD four months later. USAID/Kenya was apprised of NORAD's decision by the MOH in December, and one of the donors learned of the action from a member of the Evaluation Team."

"There appear to be several explanations for such inadequate coordination between donors. These include

--the delay in filling the Project Advisor position which was to be sponsored by the World Bank.

--varying need for coordination as viewed by the individual donors.

--lack of initiative by any one of the donors."

The evaluators recognized the importance of good donor coordination. Their report stated:

"It is clear that improved donor coordination would be helpful to the GOK Program, to USAID/Kenya, and to the other donors in several ways, for example:

--duplication of support could be avoided.

--requests for assistance that could not be filled by one donor could be referred expeditiously to another donor.

--GOK/MOH fiscal and performance reporting could be expedited."

After this evaluation, there were attempts at formal donor coordination. According to the UNFPA country representative, the United Nations Development Program resident representative was instrumental in persuading the Ministry of Health to hold quarterly donor meetings. Such meetings were held during 1976 and ended in November 1976. There were no more formal donor meetings held after the mid-point donor review of the program in March 1977.

Though each of the donors had its own bilateral agreement with the Government of Kenya covering the agreed-upon areas of assistance, it did not appear to us that the responsibility for various assistance areas was appropriately divided. Many donors were involved in virtually all areas of assistance--construction, technical assistance, commodities procurement, participant training, and recurrent cost financing.

EFFECTS OF POOR DONOR COORDINATION

We noted two examples of the adverse effects on achieving AID MCH/FP project and overall program goals that stemmed from the lack of good donor coordination. Specifically, these problems could have been avoided if (1) the donors had had a formal mechanism for exchange of information on project progress and (2) the project assistance had been more appropriately apportioned among the donors. One example deals with the goal to improve information, education, and communication activities. The other example deals with the goal to have the Government of Kenya eventually assume total responsibility for paying recurring program costs.

Information, education, and communication: goals of an important component not met

The principle objective of the information, education, and communication effort of the Kenyan MCH/FP program was to increase understanding about MCH/FP concepts and to influence appropriate behavior modification among the people of Kenya, especially in the lower socioeconomic groups, so that they would seek and take advantage of the services offered by the Ministry of Health and other agencies.

The 5-year MCH/FP plan stated that full acceptance of family planning concepts required that the Kenyan program be based on a sophisticated understanding of the effect of cultural, social, and technological changes in individuals' lives and in family units. To accomplish this, the plan

envisioned that the Information and Education Division of the National Family Welfare Center would be responsible for

--planning, coordinating, and carrying out various family planning information, as well as education and communication activities;

--designing materials for the mass media to be produced or executed by the Health Education Unit of the Ministry of Health, the Ministry of Information and Broadcasting or by a commercial agency; and

--carrying out public relations activities.

To assist the Information and Education Division, the plan called for expanding the capacity of the Health Education Unit of the Ministry of Health. The plan recognized that among the problems facing the unit were (1) the need for technical personnel to produce materials and (2) the inadequate state of the unit's structure. Accordingly, the plan proposed constructing and equipping a facility for the production of family planning and health education information and materials.

The construction of the Health Education Unit was financed by the World Bank loan. The equipment for the buidling, consisting of production and audio visual equipment, was purchased by AID. The plan called for the building to be completed in 1976, and the AID project paper called for ordering most of the equipment in fiscal years 1975 and 1976. The plan provided that the goals of increased production during the time that the building was under construction and the equipment was being purchased, be met through commercial advertising agencies.

Construction of the Health Education Unit building began in April 1976 and was completed in April 1978. However, AID did not order equipment for the building until September 1977, and the equipment did not arrive until the spring of 1979--about 1 year after construction was completed. The delay in ordering the equipment resulted primarily from AID's reluctance to fund the equipment without a detailed work plan for the Health Education Unit.

It appears that AID may have lost sight of the goal of its commodities assistance: to increase the production capacity of the Health Education Unit. The March 1977 mid-point review pointed out that the unit was unable to produce the needed quantities of education materials because of its

inadequate equipment and because of the complex procedures which made procurement through commercial channels difficult. The report in the mid-point review stated that although the building was scheduled for completion by June 1977, the special production equipment needed to make the unit functional, had not yet been ordered. Further, the report stated that although AID had promised to provide this equipment, they were concerned over the lack of an information and education plan and the need for such sophisticated production equipment. Though this problem remained unresolved, AID indicated that it would procure the most essential printing and photographic equipment without delay.

The equipment which AID finally ordered was substantially the same as that initially requested by Ministry of Health. We agree with the conservative AID approach regarding the sophisticated audiovisual equipment, but there was no compelling reason to delay ordering the production equipment. It is interesting that the problem was not mentioned in any donor forum other than the mid-point review.

World Bank officials were concerned that the building was nearing completion and no equipment had been ordered. In mid-1976, a World Bank review encouraged the Government and AID to resolve the matter. In September 1976, the World Bank project officer met with the head of the African Branch of the AID Office of Population to register his concern. No progress was made, however, until the donor's mid-term review had again confronted AID with the problem. It appears to have been a joint Government of Kenya/World Bank/AID effort that finally initiated the equipment procurement. The World Bank project officer stated that the delays and problems were, in part, attributable to the absence of strong Kenya management of the Health Education Unit and to frequent shifts in the AID resident staff.

We visited the Health Education Unit building in June 1979. It was, in effect, a warehouse for another Ministry of Health program and for the uninstalled equipment ordered by AID. The head of the Unit told us that he wanted to move his existing equipment to the building late in 1978, but could not do so, because the new equipment had not yet arrived.

The head of the Health Education Unit told us that the production capacity has not increased since the program began. There had been problems in contracting with private firms for additional materials and with having printed materials bundled by the Government Printing Office. The resultant lack of information and education materials at the

service delivery points was cited as a serious problem in the 1977 mid-point report. Conditions at the service delivery points we visited in June 1979 had not changed from those conditions found in 1977.

Recurring costs should be reviewed by AID and other donors

AID joined three other donors -- UNFPA, the Norwegian Agency for International Development, and the Swedish International Development Agency--in providing local cost financing to cover part of recurring salary and operational expenses for certain staff categories assigned to the MCH/FP program. The financing plan, as stated in the 1974 plan, was designed to provide support that would decrease over time. This would gradually shift the responsibility for supporting the program operating costs to the Government of Kenya, so that by the end of the 5-year plan, the Government would be financing such costs in full. The Norwegian Agency for International Development withdrew from this part of the financing plan early in 1975.

AID, UNFPA, and the Swedish agency jointly financed the recurring costs for service delivery points. Sometime prior to the 1977 mid-point review, both UNFPA and the Swedish agency dropped the percentage financing method in favor of a predetermined, fixed-dollar amount, but AID declined to do so.

There were indications in AID mission files that the donors met with Ministry of Health officials early in the program to discuss a mutually acceptable format for supporting recurring cost claims. Such a format was never used, however, probably because of the change in financing methods, used by the other donors. The AID method of providing funds differed from that of other donors. AID required that the Ministry of Health file a reimbursement claim for salaries paid, but the other two donors advanced funds to the Ministry of Health and expected reports of funds application. AID had not received reimbursement requests from the Ministry of Health to cover the 1976 transition quarter, or any period after September 1977. The other two donors had not received reports since the summer of 1977.

The three donors have never met to compare their individual statements from the Ministry of Health to insure that different donors have not paid the salaries of the same individuals or paid for more than 100 percent of a given staff category. The donors could not be sure that the Government

of Kenya had met its obligation for funding recurring costs, nor could they be sure that all payments were used properly.

Both UNFPA and Swedish International Development Agency officials informed us that they would support efforts by the three donors to review salary payments. The Swedish officials believed that the problem stems from an inappropriate division of program responsibility. They believed that several donors funding small parts of an assistance area, such as recurring costs, can be confusing to donors and to recipient governments alike and can lead to duplication. We agree.

We suggested to AID mission officials that they take the lead in arranging meetings with the other two donors to resolve any problems with the recurring cost payments. By the time we departed Kenya, however, mission officials had taken no action to arrange these meetings.

DONOR VIEWS ON COORDINATION AND FUTURE AID DIRECTIONS

We met with representatives of most of the major donors in Kenya to discuss donor coordination. These representatives--including AID's--generally agreed that donor coordination in the MCH/FP program should be improved. All representatives, however, thought that the impetus for such improvement should come from the Government of Kenya. These officials did not want it to appear that their particular donor organization was attempting to influence Government policy or program philosophy.

It appeared to us that the donors extended this principle to day-to-day program implementation. Problems arise, though, if recipient governments are unwilling or unable to handle the coordination responsibilities. The Kenyan Ministry of Health, for example, had problems in financial and program management. Specifically, the 1976 external evaluation report, funded by AID, stated:

> "Part of the difficulty in implementing the Family Planning Program is due to the need for improved management systems in the Ministry of Health. In the past, USAID/Kenya has tried to interest the Government of Kenya regarding possible support for such an effort. Unfortunately, because of the inappropriate methods used by USAID/Kenya, no action has been taken in this area. Nevertheless, it is recognized, not least of all by the Ministry of Health, steps must be taken

to strengthen the planning, operations, evaluation, training and financial management of the Family Planning and Rural Health Programs."

Representatives of other major donors also told us that the management capability of the Ministry of Health was very inadequate.

On October 1, 1979, IDCA officially became the chief voice for the United States in development matters. Much planning has taken place to improve coordination of development assistance at the agency headquarters level, but relatively little thought has been given to the problems of implementing coordination at the field level. Other members of the international donor community are beginning to think about coordination in these terms. At the March 1979 consultation on population assistance coordination, sponsored by UNFPA, the members stated that:

"Responsibility for co-ordinating all external assistance rests unquestionably with governments of recipient countries. Given the diverse range of activities that together make up the population sector, the heavy work load that government administrations have to carry, and the variety of of legal instruments, programmes, it has become increasingly evident that some rationalization of arrangements for managing population assistance should be sought."

CONCLUSIONS

Some of the AID project goals and goals of the entire program were not met because of the absence of donor coordination. The overall program was based on a master plan with each donor having its own bilateral agreement with the Government of Kenya. However, there was no lasting formal arrangement among the donors to coordinate during project implementation. There was formal exchange of information during the early years of the program, but this ceased after the multidonor, mid-point review. Several donors contributed to the same assistance areas, such as participant training and recurring operating expenses. Without good coordination, such a division of responsibility resulted in problems in achieving program goals.

It did not appear to us that the planners for IDCA had given enough attention to the problems of coordinating multidonor assistance at the country level. Coordination at this

level is especially important when the recipient governments are unwilling or unable to handle the responsibility of coordination the assistance it receives.

We would agree that coordination, in the sense of defining policy and establishing master plans for the use of external assistance, should be vested in the recipient governments. In light of the techniques of program management currently used in developing countries, however, it might be prudent to consider assigning the responsibility for coordinating implementation to one of the major donors in a multidonor arrangement, such as the one for the MCH/FP program.

RECOMMENDATION

Accordingly, we recommend that the Director, International Development Cooperation Agency and the Administrator, AID, take the lead in working with other donor and recipient governments to establish coordinating mechanisms for implementing projects or programs at the country level.

CHAPTER 2

MORE ATTENTION SHOULD BE GIVEN TO MONITORING PROJECT OUTPUT

The AID project paper and the yearly project agreements for the MCH/FP project both contained the condition that continued funding would depend, among other things, on the progress of the program in meeting its objectives. These documents also contained the provision that the Ministry of Health and AID would conduct annual project reviews to discuss project objectives and accomplishments funded by AID and to agree on goals for the following year.

The AID project paper contained yearly targets for areas of planned assistance, however, these targets were never made a part of the project agreements signed with the Government of Kenya. Further, neither document included a monitoring plan, which would have given consideration to the types and quantities of data needed from the Government of Kenya or other sources to track progress in meeting AID objectives. In its project agreements, AID established several conditions for payment of recurring cost claims. AID mission officials, however, did not review supporting documentation to assure that these conditions were met prior to payment.

All the required evaluations were not carried out and those that were, were based on external reviews early in the program. In our view, the absence of a monitoring plan and the inattention to required annual evaluations contributed to the project's failure in reaching AID objectives.

AID has been planning for some time to revise its handbook on project assistance to include project implementation and monitoring. The drafts state the requirement for a monitoring plan, but the requirements are geared more toward input rather than the data needed to monitor output.

More attention to planning for project monitoring at the design stage can result in another benefit. In our recent report to the Congress, 1/ we recommended that IDCA and AID seek ways to commit U.S. and other donor funds to improving the financial management capabilities of developing countries. Consideration of the information needed to monitor project

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1/"Training and Related Efforts Needed to Improve Financial Management in the Third World," ID-79-46, September 20, 1979.

progress should point up inadequacies in recipient government's financial and program management systems, thus identifying the areas requiring improvement.

TARGETS FOR AID ASSISTANCE

In the 1974 project paper, AID included yearly targets to be met for participant training and for educational materials to be produced with the equipment purchased for the Health Education Unit. AID listed each category of participants trained--such as Provincial Medical Officer, Provincial Matron, Family Planning Field Officer--and showed the total to be trained for each category in each of the 5 years. In the case of education materials, AID listed such items as family-planning calendars, color slides, films, posters, booklets, and pamphlets, with a production estimate for each item to be met each year.

The initial project agreement between AID and the Government of Kenya was effective June 16, 1975. The agreement contained a section on AID input for the 5-year program and listed the totals that AID was going to provide for each assistance area. For participant training, only total numbers of each staff category were listed. Under commodities, AID listed the types to be purchased, such as audiovisual and production equipment, small-scale office equipment, and clinical equipment. No mention was made of the target outputs to be achieved with the equipment purchased for the Health Education Unit.

Each succeeding project agreement, through fiscal year 1978, included a section dealing with AID actions and contributions related to output achievement for that particular fiscal year. In addition, the project agreements contained a provision that continued funding would depend upon the progress of the MCH/FP program, the contributions of other donors, and on the input of the Government of Kenya. The agreements also contained a provision for an annual joint Ministry of Health/AID review of project accomplishments and future objectives.

An examination of the yearly agreements showed that neither progress toward reaching targets nor deviations from these targets were discussed. Rather, AID merely stated what was anticipated for the fiscal year involved. For example, the table below shows what was targeted for fiscal year 1978 in participant training and what was stated on the fiscal year 1978 program agreement for those to be trained.

Type of staff to be trained	To be trained	
	Project paper	1978 program agreement
Provincial medical officer	2	-
Provincial matron	2	-
District medical officer	7	10
Nurse supervisor/trainer	-	8
Family planning field officer	3	-
Health education staff	4	a/
National Family Welfare Center or Ministry of Health staff	3	2
Nurse tutor (training schools)	-	-
Nurse tutor (rural health center)	-	7
Research/evaluation officer	1	a/

a/ The agreement stated that about 24 months of short-term training would be provided in these areas plus special courses for physicians. No specific numbers were shown.

Neither the AID project paper nor program agreements contained specific plans for the data needed to monitor output. For example, the project paper contained a section known as the logical framework. It listed each area of AID assistance, objectively verifiable indicators for each area, and the means for verifying these indicators. In most cases, the means of verification were broad categories of data such as "Ministry of Health records and reports," or "personnel records," or "reimbursement requests."

REIMBURSEMENT CLAIMS NOT REVIEWED FOR COMPLIANCE WITH PROJECT AGREEMENTS

One of the major areas of AID assistance was local cost financing to cover part of the recurring program operating expenses. AID joined two other donors--UNFPA and the Swedish International Development Agency--in providing this financing. Planned financing amounted to about $1.45 million, but as of June 3, 1979, AID had obligated about $579,500. As of the same date, AID had received two requests for reimbursement from the Government of Kenya and had paid out about $353,300. AID has never asked for, nor reviewed, any documentation in support of these claims. We believe that based on observations during our fieldwork and other organization comments

about the financial management capability of the Ministry of Health, it is highly unlikely that the reimbursement claims are fully supported.

Recurring costs defined and conditions for payment

The 1974 project paper defined these recurring costs as additive salaries and operational costs for

--administrative personnel of the National Family Welfare Center,

--Health Education Unit personnel of the Ministry of Health,

--provincial and district-level supervisory personnel, and

--fixed-service delivery point personnel providing MCH/FP services.

Subsequent project agreements specified the categories and total numbers of personnel to be supported with AID funds and established conditions precedent to the payment of funds.

AID established that it would only pay for personnel costs that were additive in nature, that is, salaries and related costs over and above those included in the Ministry of Health budget estimates for fiscal years 1974-76 and for new positions in each succeeding year. Further, AID stipulated that, in the case of reassignments of existing Ministry of Health personnel to the MCH/FP program, AID would only pay the associated recurring costs if additional positions were established and if personnel were recruited to replace those reassigned. However, the conditions seem to have evolved from the original project paper.

The first project agreement in fiscal year 1975 added two more conditions:

--Reimbursement by AID would conform to Government of Kenya civil service standards.

--Amounts to be paid would be subject to AID fund availability and to the progress in achieving yearly program targets.

This first program agreement did not specify a format to be used by the Government of Kenya in applying for reimbursement of recurring costs.

The second program agreement for fiscal year 1976 again refined the definition of additive personnel and included a format for submitting reimbursement requests. The format requested the Government of Kenya to certify that

--payment of the sum claimed was proper under the terms of that project agreement,

--claims for reimbursement were only for personnel defined as additive by the project agreement,

--claims included for supervisory office drivers and service delivery point clerks included salaries and allowances for only those clerks and drivers that formed a part of an otherwise fully staffed office or delivery point, and

--such detailed supporting documentation as AID may require would be furnished promptly upon request.

This program agreement did not mention conformity to Government of Kenya civil service standards or progress in achieving program targets as conditions precedent to payment of reimbursement requests. Project agreements for fiscal year 1977 and 1978 contained similar formats for reimbursement claims, but dropped the certification requirement that salaries and allowances be for personnel that were additive to the Ministry of Health.

What AID has paid thus far

The Government of Kenya has submitted two claims for reimbursement--one submitted in November 1976 covering fiscal years 1974 through 1976; the other submitted in December 1977, covering October 1976 through September 1977. Payments made by AID covering these two requests amounted to about $353,300. At the time of our visit, the AID mission had accrued additional expenditures of about $226,000 for which the Government of Kenya has yet to submit a claim.

The first request for reimbursement contained fairly detailed supporting documentation, however, this information did not show

--which personnel were additive to the Ministry of Health,

--how many supervisory offices and service delivery points were fully staffed, or

--whether salaries and related costs claimed conformed to Goverment of Kenya civil service standards.

The second reimbursement request was not accompanied by any supporting documentation.

The AID Mission Controller and the AID population officer both told us that, to their knowledge, the mission had not requested the Government of Kenya to supply additional information nor had any supporting data at the Ministry of Health been reviewed. These officials had assumed that support for these payments had been covered in project audits conducted by the AID Area Auditor General in Nairobi. Our discussions with officials and our review of their reports showed, however, that reimbursement payments for the MCH/FP program had not been covered in audits of the mission programs.

Further, both mission officials told us that they did not have enough time to monitor projects or to validate such claims. The population officer stated that his project monitoring was generally limited to periodic telephone discussions with the Director of the National Family Welfare Center.

MINISTRY OF HEALTH
FINANCIAL MANAGEMENT PROBLEMS

Independent contractors and donor representatives stated that weaknesses existed in the Ministry of Health financial and program management. A 1976 evaluation of the AID MCH/FP project stated

"At present, the Director of the Family Planning Program does not have a fiscal advisor who is responsible for knowing the accountability requirements of all the donors plus the budgeting requirements of the Ministry of Finance and Planning. Thus, there is no one charged with the maintenance of fiscal plans, the records on

all expenditures to date (particularly those which are expected to be reimbursed by any of the donors), nor the preparation of the fiscal aspects of all reports to the donors."

This evaluation reported that steps must be taken to strengthen all management systems for the MCH/FP program, including financial management.

The multidonor, mid-point review in 1977 stated: " * * *the National MCH/FP Program in Kenya has developed in an unbalanced way because, while there has been a considerable expansion of human and physical resources at its disposal, there has been no corresponding increase in the capacity to manage and supervise these resources at the national, provincial, or district level* * *. Also there is insufficient coordination between MCH/FP management and the Chief Accountant's Office Ministry of Health, the latter of which has neither the time nor the staff to assist the NFWC in preparing accounts and routine reports on MCH/FP activities. The Misssion recommends that an Accountant Officer: Grade 1, either seconded by the Chief Accountant or engaged on contract, be employed in the Administration and Planning Unit."

To help correct the situation, this evaluation report recommended that the administration and planning unit of the National Family Welfare Center be upgraded to division status and that an accountant be added to the staff. The report recommended that this person be responsible for, among other duties,

--liaison with the Chief Accountant's Office in the Ministry of Health,

--preparation of monthly financial reports, and

--preparation of financial statements on reimbursement claims for donors.

These recommendations to the Ministry of Health were never implemented. Ministry of Health officials informed us that it is extremely difficult to attract and retain accountants in government service because of the greater salaries they command in the private sector. These officials also mentioned that this was a universal problem in the Kenyan Government.

Other donors were also critical of the Ministry of Health's financial management capabilities. The UNFPA coordinator in Kenya told us that the Ministry of Health operations had been receiving adverse press. World Bank representatives told us that their own people had to prepare the financial paperwork for the MCH/FP loan to insure that it is done correctly. These officials also told us that the Ministry of Health recognizes the problem and will attempt to solve it during the second 5-year plan for fiscal years 1980-84.

With specific regard to recurring cost payments, mission and Area Auditor General officials doubt that the Ministry of Health has records to show which staff were newly hired or which already belonged to fully staffed supervisory offices or service delivery points. Our field visits tended to corroborate their belief. Detailed records of staff assignments were not maintained at the district or provincial levels. Officials at these levels told us that staff are very transient and difficult to track.

As a result of our review, the Mission Controller requested the auditors to visit the Ministry of Health to examine supporting documentaion. However, the Area Auditor General advised us that he could not make such a visit until early 1980 due to other commitments.

EVALUATIONS NOT PERFORMED AS REQUIRED

AID did not perform evaluations as called for by the project agreements and the AID Handbook. It appeared that the mission relied solely on external evaluations--one contracted for by AID, and the other performed by the multi-donor panel--to assess progress.

AID policy states that projects be evaluated during implementation in terms of efficiency, effectiveness, and significance in contributing to the accomplishment of project objectives. These evaluations are to be carried out at key decision points during the life of the project, but no less frequently than once each year. In addition, all the project agreements for the MCH/FP project contained clauses which called for an annual joint AID/Ministry of Health project review to discuss project objectives and accomplishments and to agree on objectives to be achieved the following year.

AID contracted for an external evaluation. It was carried out in January 1976 by two U.S. physicians. Based on the results of this study, the AID project officer prepared a staff paper in April 1976, outlining accomplishments and future directions. These areas were discussed with Ministry of Health officials. AID officials also participated in the March 1977 multidonor, mid-point review which included input from and discussions with the Ministry. These efforts, although essentially external, could be construed as meeting the condition in the project agreement for joint annual review.

Two evaluations of the type called for in the AID handbook were prepared, but these appeared to be restatements of the issues raised in the two external evaluation studies. Handbook requirements changed in February 1978 and required that a project evaluation summary be prepared that would include a section on output. Instructions for completing the summary stated:

> "Measure actual progress against projected output targets in current project design or implementation plan . . . Comment on significant management experiences. If outputs are not on target, discuss causes (e.g. problems with inputs, implementation assumption). Are any changes needed in the outputs to achieve purpose?"

No evaluation summaries of the type prescribed in the 1978 handbook revision were prepared by the mission.

The Nairobi Area Auditor General included the MCH/FP project in its February 1977 report on AID activities in Kenya. The report dealt largely with issues related to the demographic goals of the overall MCH/FP program. Mission management rejected the findings as either inappropriate to the project or citing problems AID had already solved. The Area Auditor General surveyed the MCH/FP project in the 1979 report on mission activities. They determined that no significant changes had occurred and that another detailed analysis was unwarranted.

AID draft handbook on project monitoring

The AID handbook for project assistance currently consists of only one part which deals with analysis and authorization of AID-assisted projects. For many years, AID has

planned to issue part two of the handbook dealing with project implementation and monitoring, but, as of September 1979, this part was still in the drafting stage.

The draft chapters on monitoring do contain some requirements that should help improve the monitoring process. For example, the draft handbook requires

--a written record of the monitoring steps to be used and staff assigned to monitor each project,

--a checklist showing the key events of the project implementation, and

--memoranda of acceptance for each condition that must be met before disbursement of grant or loan funds.

The new features, however address monitoring project input rather than expected output. For example, the key-events checklist requires only a listing of input and the dates they are required. There is no guidance in the draft handbook for dealing with the types of information needed for monitoring or evaluation.

CONCLUSIONS

AID project agreements with the Government of Kenya provided that continued assistance would depend upon progress in meeting project objectives. The AID project paper listed specific yearly output for AID assistance areas, yet these targets were never placed in the subsequent agreements. Further, timely evaluations were not always carried out. In our view, such output targets should be made a part of project agreements so that recipient governments are held accountable for reaching them. The assistance provided in the project agreements generally bore little resemblence to the planned output for specific years. We recognize that targets can change and projects should not be inflexible, but the AID agreements contained no reasons for the deviations. We believe that such discussion should be made a part of new agreements to allow tracking of project changes.

Although the project paper contained a "logical framework" listing output indicators, it did not consider the types and quantities of data needed from the Government of Kenya or other sources to monitor progress in meeting the output targets. The assistance area--recurring cost financing--contained several conditions for payment. AID did not

establish objectively verifiable indicators or devise a plan to assure itself that these conditions were met, and mission did not require supporting data from the Government of Kenya.

Accurate accumulation of project cost information is essential to proper management, cost/benefit analysis, and project evaluation. Yet, managers at the missions are not including some salaries and AID/Washington input in their cost summaries.

Some recurring salary costs paid to the Government of Kenya under this project may not have met payment conditions required by governing project agreements. It is also highly probable that similar problems exist with the amounts yet to be claimed by the Government of Kenya. We believe that validation of all past claims and any future claims is necessary.

Further, widespread use of reimbursement for recipient government recurring costs indicates that it is necessary to publicize this finding to all Area Auditors General and perhaps require that this area be made a part of all project reviews where applicable. This could also apply to other similar findings.

AID's new project assistance handbook, aimed at implementation and monitoring, contains some requirements that will help improve the present situation, but it focuses mainly on monitoring project input. The handbook could be more useful by specifically requiring that the information needed for monitoring project output be identified.

More attention to planning for project monitoring will help insure achievement of overall project objectives and could also form a basis for changes in project design. Adequate consideration of financial data needs could disclose weaknesses in recipient government financial management systems. AID would then be in a position to offer assistance to strengthen these areas, or in the case of multidonor projects, convince others to offer assistance. As a last choice, AID could also shift funding to another, more easily controlled, assistance area.

RECOMMENDATIONS

We recommend that the Administrator, AID

--emphasize the need to include output targets in project agreements for areas of AID assistance;

--insure that required evaluations are carried out and reported to provide a record of progress in meeting AID output targets;

--include requirements in the project assistance handbook for specific identification of financial and program data needs for output monitoring;

--consider refinements to the present system of grant accounting to provide mission staff with information on costs funded from sources outside the project, particularly those associated with contracts centrally funded and managed by AID in Washington; and

--reemphasize the need for project implementers to obligate funds only in pursuit of project goals and that reasons for changes during projects be adequately documented.

We recommended that the AID Auditor General

--review the adequacy of the procedures supporting Government of Kenya salary cost reimbursement requests and take appropriate action to insure that the U.S. Mission adequately documents these requests, and

--disseminate information on findings having widespread application for Area Auditors General in reviewing other projects containing similar types of assistance.

AID MCH/FP PROJECT

PROGRAM BACKGROUND

Family planning efforts were started in Kenya in 1955 in Nairobi and Mombasa by autonomous local groups that provided information on alternatives to unwanted children. In 1961, the Population Council advised the Government of Kenya to integrate population planning into the overall development plan and to link it to the national health scheme. They also advised the Government that any family planning program should be voluntary, should have the total support of the Government, should be multi-ministerial, and should be augmented with a comprehensive health information program.

In the 1966-67 time period, the Government vowed to pursue a vigorous policy toward the reduction of the population growth rate. The National Family Planning Program was begun and the Ministry of Health was given the policymaking role.

In early 1972, the Government sent a proposal to the World Bank for assistance. The World Bank made recommendations upon which the Government developed its 5-year MCH/FP program. In December 1972, the World Bank and the United Nation's Fund for Population Activities jointly appraised the Kenyan plan. After providing the interested donors with preliminary summaries of the plan and a draft appraisal report, the World Bank began informal liaison efforts to mobilize available assistance.

At the request of the Kenyan Government and using the donor input, the World Bank formulated the financial arrangements for the program. Under the arrangements, termed parallel co-financing, each donor made bilateral agreements with the Government of Kenya. Each agreement was intended to be supportive of the coordinated master plan, yet it allowed each donor to stipulate conditions and restrictions to maintain control over its segment of the plan.

Some donors had solitary responsibilities, and some shared funding for other portions of the program. According to the plan, the input from all the donors was to be as follows:

Donor	Major purpose	(millions of dollars)
Government of Kenya	Personnel and operating costs, capital, research, and technical assistance	$12-14.3
World Bank	Construction, technical assistance, vehicles, and program advisor	12.0
Swedish International Development Agency	Technical assistance, rent, salaries, construction, training for the health education unit, and contraceptives	5.4
U.S. Agency for International Development	Salaries, training (scholarships), commodities, technical assistance, and contraceptives	3.5
United Nations Fund for Population Activities	Equipment, salaries, and technical assistance	3.5
Federal Republic of Germany	Construction of a training school for nurses	0.9
Danish International Development Agency	Construction of a training school for nurses	0.6
Total		$37.9-40.2

The overall purpose of the 5-year program was to establish an organization in the Kenyan Ministry of Health through which the basic goals of the program could be achieved. The primary goal, as stated in the plan, was to reduce population growth by improving the overall health care delivery system. The rationale was that improved health and decreased child mortality would induce people to have smaller families. Statistically, the plan was geared to reduce the population growth rate in Kenya by .3 percent by the end of the plan period. This translated into a goal of 640,000 new acceptors of family planning over the 5-year plan period.

The projected new system at the end of the program included

--a National Family Welfare Center consisting of four Divisions: Clinical Services, Training, Information/ Education, and Research and Evaluation;

--associated facilities, including a training center, a demonstration family planning clinic, and a Health Education Unit;

--thirty rural health centers;

--eight community nurse training schools;

--forty-six provincial and district supervisory offices; and

--four hundred full-time service delivery points which would be offering MCH/FP care on a part-time basis.

The plan also established several goals for employment of administrative, medical, and paramedical personnel.

AID PROJECT INPUT

The AID project paper stated its relationship to the MCH/FP program as one of several donors in a coordinated effort to create a national framework capable of reaching the program goals. AID assistance comprised four areas: technical assistance, participant training, commodities procurement, and payments for a portion of recurring program costs. The projected funding for these areas was set at $3.5 million or about 15 percent of the total estimated donor financing.

STATUS OF AID PROJECT INPUT AND OUTPUT

AID obligations for assistance areas in the MCH/FP project were below those planned at the project's inception in 1974. Further, although funding approximated planned levels in some assistance areas, output goals for these areas were not reached. Some of the differences can be explained by project changes to meet changing Government of Kenya needs, others resulted from problems in donor coordination and inattention to monitoring during project implementation.

APPENDIX I

The table below shows the estimated budget for the project and funds obligated by type of assistance as of March 31, 1979.

	Budget Estimate		Obligations as of March 31, 1979	
Type of Assistance	Amount (thousands)	Percentage	Amount (thousands)	Percent of total
Technical assistance	$ 543	15.4	$ 218	9.3
Participant training	760	21.5	784	33.7
Commodities	779	22.1	607	26.1
Recurring costs	1,448	41.0	572	24.6
Unearmarked a/	-	-	146	6.3
Total	$3,530		$ 2,327	

a/ Mission officials told us that new grant accounting proccedures allow funds to be shifted among the assistance areas as needed. Therefore, the FY 1979 funding was shown as unearmarked until decisions on their dispositions were made.

TECHNICAL ASSISTANCE

According to the project paper and the 1975 program agreement, AID was to provide

--an audiovisual specialist;

--a public health education under a participating agency services agreement with HEW;

--short-term advisors as needed for the Health Education Unit of the National Family Welfare Center;

--contract personnel to conduct courses for certain program staff, such as nurse supervisor/trainer, nurse tutors, and teaching staff at training institutions; and

--the services of an AID population officer.

Planned technical assistance other than the AID population officer were estimated to cost about $543,000; obligations as of March 31, 1979 totaled $218,000--less than half that amount.

The services of the audiovisual specialist were provided early in the project and were charged to the project. His activities included providing some training and advice to the Health Education Unit, plus preparing the original equipment list for the Unit. The public health educator's services were also provided early in the life of the project. Details concerning the type of assistance provided were not available in project records, and the services were charged to an earlier population project.

Only one short-term advisor had been provided to the Health Education Unit through June 1979 to help the Unit's personnel compile the final equipment list for AID commodity procurements. The funds used for the short-term equipment specialist came from a centrally managed AID contract and no longer appear on mission project records as an expenditure. Only, one contract team was provided in 1975 through another centrally managed AID contract; no project funds were used. After that time, the Ministry of Health decided to establish its own training program under the auspices of the National Family Welfare Center. Therefore, no additional outside assistance was requested.

With some interruption, AID has provided the services of a mission population officer to the program. However, none of the population officers' salaries or allowances are charged directly to the project.

Most technical assistan provided by AID: $139,000--was in the form of a contract ith a U.S. firm called Data Use and Access Laboratories (Dualabs). This contract continued assistance which had been provided under a previous population project. The contract was authorized by a second revision to the fiscal year 1976 project agreement. The purpose of the technical assistance was to

--provide services necessary to initiate and expand health and family planning data storage and access

activities in the Ministry of Health's National Family Welfare Center, and

--support the continuing documentation and access of various data files in the Central Bureau of Statistics.

The assistance was to be split 70 percent for the National Family Welfare Center and 30 percent for the Central Bureau of Statistics. This assistance was not mentioned in the project paper, and neither the project agreement nor the implementing paperwork discussed the rationale behind providing this assistance using MCH/FP project funds.

PARTICIPANT TRAINING

The program planning documents identified several types of training needed by Kenyans to meet program goals. These decisions were made several years before the training was scheduled to begin and before the results of other participant training programs were known. Therefore, planners set the program goals, before adequate information was available. All participant training was to have been accomplished by the end of fiscal year 1978, yet very little training was conducted before the donor's mid-term review in March 1977. The project paper estimated training expenditures would be about $760,000, however, as of March 3, 1979, $784,000 had been obligated. The following table shows planned training and actual training at the time of our fieldwork in June 1979.

APPENDIX I

Participant Training For Maternal Child Health/Family Planning

Category of staff originally planned:	Long-term Planned	Long-term Trained a/	Short-term Planned	Short-term Trained a/	Total Planned	Total Trained a/
Provincial medical officer	-	c/3	6	-	6	3
District medical officer	25	24	-	b/1	25	25
Provincial matron	-	-	6	5	6	5
Nurse supervisor/trainer	-	-	10	6	10	6
Family planning field office	-	-	12	3	12	3
Health education unit person	3	-	15	1	18	1
Senior level national family welfare center staff	-	-	11	7	11	7
Research and evaluation division personnel d/	2	-	5	-	7	-
Nurse tutors	-	-	11	7	11	7
total	30	27	76	30	106	57
Unplanned but trained						
Nurse trainer/supervisor Nairobi City council	-	-	-	1	-	1
Superintendent public health nurse, Nairobi	-	-	-	1	-	1
Central Bureau of Statistics technicians	-	3	-	b/1	-	4
School of nursing instructors	-	4	-	-	-	4
total	-	7	-	3	-	-
Total	30	34	76	33	106	67

a/Trained or in training as of June 28, 1979.
b/Short-term extensions to long-term training funded under other projects to allow degree to be completed.
c/Received MS in Public Health.
d/Ministry of Health received scholarships for much of this training from UNFPA. training from UNFPA.

The table shows overall that 49 of the originally planned 106 people did not receive any training. The most significant goals not achieved were for short-term training courses for -- Family Planning Field Officers (later called Public Health Education Officers), Health Education Unit personnel, and Research and Education Division personnel. Of 37 persons, originally planned, to receive training in these areas, only 4 persons were trained. A major cause for this situation was the Government of Kenya's preference for degree training over the short-term technical courses. Ministry of Health and AID officials stated that there were often no qualified persons available to attend training, such as Public Health Education Officers. In addition, funds available for short-term training were erroded by unplanned Master degree programs, rapidly rising tuition costs, inflation, and program extensions. Other factors affecting the training goals were the uncertain completion date of the Health Education Unit and the Government's evolving training needs. Further, the short-term training for the Research and Evaluation Division personnel was undertaken by the UNFPA. In addition, unplanned additions to the training program were made.

These unplanned additions were for Masters of Science degree programs for four nurses and three Central Bureau of Statistics technicians. The technicians received degrees in fields related to census-taking, such as surveying and statistical sampling.

The degrees in nursing were necessary to provide instructors for Government-run schools of nursing. Although not in the original plan, such training appeared to be consistent with the overall goals of the project. On the other hand, the advanced degrees for the technicians in the Central Bureau of Statistics did not seem to relate to program goals or objectives.

Kenyan officials informed us that when this particular decision was made to use AID participant training, the technicians were the only people available to attend the training. They stated that the National Family Welfare Center occasionally uses the Central Bureau of Statistics, so that there was some tie-in. Regardless, the officials stated where the trainee worked was less important as long as Kenya could avail itself of the opportunities to obtain advanced degrees for its people.

As in the technical assistance area, the rationale for changes in the original plan was not discussed in the program agreement or the implementing documents. Further, we

believe that the funding of degree programs for Central Bureau of Statistics technicians was improper use of MCH/FP project funds in light of the project goals.

COMMODITIES PROCUREMENT

The AID project paper for MCH/FP estimated $779,000 for the purchase of the following items.

Description	Cost
Audiovisual and production equipment for the National Family Welfare Center's Health Education Unit	$295,000
Small-scale office equipment for the Evaluation and Research Division of the National Family Welfare Center	45,000
Clinical equipment for each of the 400 service delivery points and clinical equipment for the 17 mobile family planning services, and	279,000
U.S. manufactured, colored contraceptives	160,000
Total	$ 779,000

The project paper also provided for closed-circuit TV and other equipment that may be requested during the project.

Obligations for commodities at the end of the project totaled $607,000 for the same categories of equipment as planned, with the exception of the kits for the 400 service delivery points. All the planned contraceptives were provided, but were funded from a source other than the MCH/FP project.

The project paper stated that most commodity purchases would be made early in the project; 88 percent of the funds were to be spent by the end of fiscal 1977. No purchases were authorized before June 1976, however, and the majority of the implementing documents--representing $557,000 of the total $607,000, or 98 percent of the total commodity obligations--were not issued until September 1977 or later. These implementing orders represented the two major commodity purchases of the program: Health Education Unit equipment and clinical equipment.

HEALTH EDUCATION UNIT EQUIPMENT

AID planned to order the Health Education Unit equipment for this project in September 1974 after completion of the annual operational work plan by the Ministry of Health. The Health Education Unit equipment was not authorized for procurement until September 29, 1977. The new building to house this equipment was completed in April, 1978, but because the designated equipment was not available, the Ministry of Health used the building as a depot and distribution center for another project's commodities. When the new equipment began to arrive in the Spring of 1979, it could not be installed until another warehouse was found or constructed. This delayed procurement prevented the Health Education Unit from increasing its production capacity to meet the output goals of the MCH/FP program.

Delays in ordering the Health Education Unit equipment can be attributed, in part, to the absence of a master plan for major procurement actions. This problem is not peculiar to the AID MCH/FP project and will be the subject of our broader review of logistics support of AID projects. Another major cause, in our view, was the absence of donor coordination.

CLINICAL EQUIPMENT

The clinical equipment AID was to provide--sterilizers, refrigerators, kerosene stoves, and family planning kits for the mobile units--was not ordered until December 1977. Some items arrived in the spring of 1979, but they were not distributed to the field clinics where they were needed.

Some equipment was erroneously delivered to the Health Education Unit building. National Family Welfare Center officials in charge of clinical services were unaware that the equipment had been received until we located it during a visit to the Health Education Unit.

During our field visits to project service delivery points and mobile units, we noted shortages of sterilizers, stoves, and refrigerators. In addition, the mobile units appeared to be operating without MCH/FP kits. Although services were being offered, they were of poorer quality than could have been offered with the proper equipment.

Project files did not contain explanations for the delay in ordering clinical equipment. Mission officials assigned at the time of our visit were unable to explain why the equipment was not ordered sooner. We can only

conclude that there was no compelling reason for not ordering the equipment according to the project paper schedule.

NOT ALL PROJECT COSTS APPEARED IN MISSION RECORDS

We were unable to determine the total cost associated with the AID MCH/FP project. Some of the assistance--particularly technical assistance, contraceptives, and participant training--was provided from other fund sources. Often the costs were not listed in project records.

The first project agreement, dated June 16, 1975, contained a section dealing with the U.S. Government contribution to the first year of the Kenyan MCH/FP program. The second part of this section stated

> "With funds from other sources, AID has previously agreed to provide
>
> --one Health Education Specialist through December 31, 1974;
>
> --one Audiovisual Production Specialist through June 30, 1975;
>
> --training for six Nurse Trainer/Supervisors as provided under Letter of Agreement signed August 19, 1974;
>
> --approximately 5,000 gross of U.S. manufactured colored condoms; and
>
> --long-term training grants for three District Medical Officers who began training in September 1974."

Services of the public health educator were provided early in the project and funds were obtained from a previous population project (POPLABS). From available records, we could not determine the amount of these funds used. Similarly, the long-term training was provided under a prior population project, but expenditure records were not available at the mission.

APPENDIX II

SCOPE OF REVIEW

We spoke with officials and examined files and documents at AID headquarters in Washington, the AID mission in Nairobi, Kenya, and at the appropriate divisions of the Kenyan Ministry of Health. Other contacts included World Bank officials in Washington and Nairobi, representatives of the United Nations Fund for Population Activities (UNFPA), the Swedish International Development Agency, Family Planning International Assistance, the Pathfinder Fund, Family Planning of Kenya, and the Population Studies Research Center at the University of Nairobi.

Within the Kenyan Ministry of Health, we visited the National Family Welfare Center, the Health Education Unit, and the Kenyatta National Medical Center in Nairobi. We also visited hospitals, clinics, rural health centers, mobile units, teaching centers, and district and provincial headquarters in the Rift Valley, Nyanza, and Coast Provinces of Kenya.

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