OFFICE OF THE SPECIAL INSPECTOR GENERAL FOR IRAQ RECONSTRUCTION

CONSTRUCTION OF PRIMARY HEALTHCARE CENTERS REPORTED ESSENTIALLY COMPLETE, BUT OPERATIONAL ISSUES REMAIN

SIGIR-09-015
APRIL 29, 2009

SIGIR

Special Inspector General for IRAQ Reconstruction

April 29, 2009

CONSTRUCTION OF PRIMARY HEALTHCARE CENTERS REPORTED ESSENTIALLY COMPLETE, BUT OPERATIONAL ISSUES REMAIN

Summary of Report: SIGIR-09-015

Why SIGIR Did This Study

In March 2004, the U.S. Army issued a contract to Parsons Delaware, Inc. Subsequent task orders under the contract provided for the design and construction of 150 primary healthcare centers (PHCs). Two years later, the U.S. government terminated the PHC task orders; the PHCs throughout Iraq were in various construction phases. In our report, *Management of the Primary Healthcare Centers Construction Projects* (SIGIR-06-011, 4/29/2006), we reported on the need for a strong management team, in cooperation with the Iraq Ministry of Health (MoH), to complete the partially constructed PHCs. The U.S. Army Corps of Engineers' Gulf Region Division (GRD) and the U.S. Embassy's Iraq Transition Assistance Office (ITAO) managed the program to complete the PHCs. The objectives of this report are to show the costs and outcomes of efforts to complete the PHCs, the extent to which completed PHCs have been transferred to the MoH, and the operational status of the PHCs.

What SIGIR Recommends

SIGIR recommends that the U.S. Ambassador and the Commanding General, Multi-National Forces-Iraq, jointly direct a U.S. government study—obtaining the Government of Iraq's participation and/or input to the extent possible—to (1) provide transparency on the current status of PHCs and assess the cost and benefits of potential actions to address identified PHC operational and sustainability problems and (2) identify actions the U.S. government could undertake to help ensure that the benefits expected from the PHC program are realized and the investment will not be wasted.

Management Comments

In commenting on a draft of this report, the Embassy concurred with the recommendations and stated that it was working to accomplish them. GRD did not address the recommendations, but disagreed with numerous statements in the report. The comments are addressed where applicable in the report.

For more information, contact SIGIR Public Affairs at (703) 428-1100 or PublicAffairs@sigir.mil

What SIGIR Found

GRD has completed construction of most of the PHCs despite poor security conditions that led to incidents such as bombing of some facilities. GRD awarded follow-on construction contracts to Iraqi contractors to complete the PHCs partially constructed under the Parsons design-build contract and now reports that most construction is complete. GRD estimates the completed facilities will provide outpatient treatment for over 4 million Iraqis annually. However, the program has cost substantially more than planned, taken much longer to complete, and produced fewer facilities. Specifically:

- The program has cost about $345 million or about $102 million more than the $243 million estimate when the Parsons' contract was terminated.
- PHCs have been transferred to the MoH years later than planned.
- The original 150 PHCs were reduced to 142 during the Parsons contract and 9 additional sites were removed, leaving 133.

Management problems significantly burdened the program. GRD did not draft its program management plan until about 6 months after most contracts to complete the partially constructed PHCs were awarded and failed to finalize it. The program had six different managers in three years. ITAO, which had key oversight and coordination responsibilities with MoH, did not have adequate resources to meet these responsibilities.

Although GRD now reports that 133 PHCs have been completed and transferred to the MoH, not all of these PHCs are complete and open to the public. Further, GRD and ITAO experienced problems in transferring PHCs to the MoH, and they do not have accurate data on the number of PHCs actually open and operating. Furthermore, both are aware of operational and sustainability issues at the PHCs, and MoH officials also stated that construction and equipment issues exist with the transferred PHCs. SIGIR's inspections of four open and operating PHCs identified significant uncorrected construction deficiencies and non-operating medical equipment.

In May 2008, a contract was awarded for sustainment of health projects that includes assessing equipment and systems at selected facilities. The contract amount is limited to the $16.5 million of available funds and will not provide for an assessment of all PHCs. GRD reports 6 detailed assessments under review and 28 preliminary assessments completed. GRD and ITAO officials state there are no plans or funds for further action to assess PHCs. GRD further noted that such assessments were not its responsibility.

Conclusions

GRD and ITAO have not provided sufficient accountability and transparency on the status of the PHC program as it nears completion. Millions of dollars were spent on the program; however, available data indicates that the construction, the installation of equipment, and the needed training were not completed for a significant number of PHCs. Without sufficient accountability and transparency on current PHC program status, the U.S. government does not have the information essential for a policy determination as to whether any further U.S. management attention is needed to prevent some or all of its PHC investment from being wasted.

April 29, 2009

MEMORANDUM FOR U.S. SECRETARY OF DEFENSE
U.S. AMBASSADOR TO IRAQ
DIRECTOR, IRAQ TRANSITION ASSISTANCE OFFICE
COMMANDING GENERAL, MULTI-NATIONAL FORCE-IRAQ
COORDINATOR, OFFICE OF PROVINCIAL AFFAIRS
COMMANDING GENERAL, GULF REGION DIVISION, U.S. ARMY CORPS OF ENGINEERS
COMMANDER, JOINT CONTRACTING COMMAND-IRAQ/AFGHANISTAN

SUBJECT: Construction of Primary Healthcare Centers Reported Essentially Complete, but Operational Issues Remain (SIGIR-09-015)

This report is provided for your information and use. It includes the results of the Special Inspector General for Iraq Reconstruction (SIGIR) audit of costs and outcomes of the U.S.-funded effort to complete the partially completed primary healthcare centers (PHCs). These PHCs remained after the termination of task orders with Parsons Delaware, Inc. in March 2006. Our review was done as SIGIR Project No. 9001.

We considered written comments from the Director, Iraq Transition Assistance Office, and the U.S. Army Corps of Engineers, Gulf Region Division, when preparing this report. The comments are addressed in the report, where applicable, and copies of the comments are included in the Management Comments section of the report.

We appreciate the courtesies extended to our staff. For additional information on this report, please contact Mr. Glenn Furbish (glenn.furbish@sigir.mil/703-428-1058) or Ms. Nancee Needham at (nancee.needham@iraq.centcom.mil)/703-343-9275).

Stuart W. Bowen, Jr.
Inspector General

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Construction of Primary Healthcare Centers Reported Essentially Complete, but Operational Issues Remain

SIGIR-09-015 **April 29, 2009**

Executive Summary

In March 2004, the U.S. Army issued a design-build contract to Parsons Delaware, Inc. Subsequent task orders under the contract provided for the design and construction of 150 primary healthcare centers (PHCs) in Iraq. In addition, the task orders provided for the delivery and installation of medical and dental equipment at the PHCs. Two years later, the U.S. government terminated the task orders; the 142 PHCs remaining in the program were in various phases of construction. The Special Inspector General for Iraq Reconstruction (SIGIR), in *Management of the Primary Healthcare Centers Construction Projects* (SIGIR-06-011, 4/29/2006), reported on the need for a strong management team, in cooperation with the Iraq Ministry of Health (MoH), to complete the partially constructed PHCs. In addition to our report on the construction projects, we issued 3 audit reports on concerns related to equipment for the PHCs. The U.S. Army Corps of Engineers' Gulf Region Division (GRD) and the U.S. Embassy's Iraq Transition Assistance Office (ITAO) managed the program to complete the PHCs.

The objectives of this report are to show the costs and outcomes of U.S.-funded efforts to complete the PHCs, the extent to which completed PHCs have been transferred to the MoH, and the operational status of the PHCs.

Results

GRD completed construction of PHCs despite very poor security, which included the bombing of PHC facilities. After the termination of the Parsons' task orders in March 2006, GRD awarded direct construction contracts to Iraqi contractors to complete the partially constructed PHCs. GRD reports most construction is now complete and estimates the facilities will provide outpatient treatment for over 4 million Iraqis annually. However, the program has cost substantially more than planned, taken much longer to complete, and produced fewer facilities than originally planned. Specifically:

- The program has cost about $345 million or about $102 million more than the $243 million estimate of the Parsons contract. The increase came from $57 million for follow-on construction contracts and $56 million for delivering and installing medical equipment and providing training.
- Many PHCs have been transferred to the MoH years later than planned. Under the Parsons contract, all of the PHCs were originally to be completed by December 2005. Under a September 2006 GRD plan, most PHCs were to be completed by early 2007. However, most were reported completed in the last quarter of 2007 and 2008. GRD even

awarded contracts to complete construction of the six PHCs considered complete when the Parsons contract was terminated in March 2006

- During the Parsons contract, the originally slated 150 PHCs were reduced to 142, and 9 additional sites have been removed, leaving 133. Security issues, which were major factors in the cost increases and schedule delays, caused the removal of the nine PHCs. Six of the nine PHCs were not completed because explosives destroyed part or all of the facilities. About $5.18 million was spent on the construction of these nine PHCs.

Management problems have long burdened the program. GRD, which had program management responsibilities, did not draft its program management plan for the follow-on contracts until about 6 months after most contracts to complete the partially constructed PHCs were awarded and never finalized it. It also had six different program managers in three years. Moreover, GRD's award of firm-fixed-price contracts to Iraq contractors for completing construction required assessment of the partially constructed facilities and development of independent government estimates before award of the contracts. However, because GRD did not locate requested project assessments, SIGIR was unable to verify the extent of any site assessments that were made. Also, the data from the Iraq Reconstruction Management System that GRD used for program management was inaccurate and incomplete. ITAO, which had key responsibilities for oversight and coordination with MoH, did not have resources to meet its responsibilities.

GRD reports that 133 of the PHCs have been constructed and transferred to the GOI, but not all of these PHCs are complete and open to the public. In addition, GRD and ITAO experienced problems in transferring PHCs to the MoH. Officials said that, in some cases, they were ready to transfer a facility, but MoH officials were not yet ready to accept the facility because of limited availability of facility protection service personnel and insufficient number of trained and available staff. In 14 cases, GRD transferred facilities to MoH that were incomplete, with plans for continued construction work at just two. (The 14 incomplete PHCs that were transferred included the 9 sites removed from the program after the Parsons termination.) The other incomplete PHCs had no completion plans. In addition to the transfer of incomplete facilities, GRD transferred five PHCs unilaterally, without MoH acceptance. GRD reports that 115 PHCs are open and operational, but MoH reports just 101.

Even more significant than discrepancies in the number of open PHCs is the operational and sustainability status of the PHCs that are open. GRD, ITAO, and the MoH all expressed concerns about operation and maintenance issues at PHCs. The issues include whether PHCs have basic services—such as electricity, water, and sewage—and, whether medical equipment has been provided, installed, and is operating. Health Attaché officials stated that neither the construction nor the materials met expected standards and the facilities did not make a good presentation of a U.S.-funded and managed construction project. MoH officials stated that the PHCs had construction, electrical, mechanical, and equipment deficiencies that will require reconstruction and rehabilitation. SIGIR's inspections have identified operation and maintenance issues at four open PHCs.

Although all parties have concern over PHC operation and maintenance issues, the U.S. government does not have accurate visibility into the overall status of the PHCs. In May 2008, GRD and ITAO contracted with Stanley Baker Hill for the sustainment of health projects funded

by the U.S. government. The scope of work included assessing equipment and system at selected facilities. The contract amount is limited to the $16.5 million of available funds and will not provide assessment of all PHCs. GRD reports 6 detailed assessments under review and 28 preliminary assessments completed; however, the number of assessments to be completed is unknown. Also, because GRD failed to provide the requested assessments, SIGIR has not reviewed these documents. Finally, based on discussions with GRD and ITAO officials, the U.S. government does not plan for future U.S. government roles/responsibilities with regard to the PHCs. Neither organization has any plans or funds for a further effort.

Conclusions

U.S. funds and GRD's and ITAO's management have furnished the Iraq MoH with PHCs that are expected to provide medical care to more than 4 million Iraqis throughout the country. This has been accomplished despite serious security conditions, such as the bombing of facilities. However, GRD and ITAO have not provided sufficient accountability and transparency on current PHC program status. Reports showing that 133 PHCs having been completed and transferred are not complete and accurate. Questions about the completeness of the PHCs relate to far more than those few transferred "as is."

Millions of dollars were spent to finish construction, deliver and install medical and office equipment and consumables, and train Iraqis on PHC equipment. However, some or all of these actions were not completed for a significant number of PHCs. The limited contract effort to assess PHC status is based on funds available, not the amount needed. Further, neither has identified plans and/or funds for additional assessments and/or completion work for PHCs.

The U.S. government's future role regarding the PHCs in Iraq requires a policy decision; however, the U.S. government has not developed the information essential for making that decision. A lack of further management attention by the U.S. government and the Government of Iraq to address the PHCs' operation, maintenance, and sustainability issues places a substantial portion of the U.S. investment in the program at risk of being wasted.

Recommendations

SIGIR recommends that the U.S. Ambassador and the Commanding General, Multi-National Forces-Iraq, jointly direct a U.S. government study—obtaining the Government of Iraq's participation and/or input to the extent possible—to:

1. Provide transparency on the current status of PHCs and assess the cost and benefits of potential actions to address identified PHC operational and sustainability problems.

2. Identify actions the U.S. government could undertake to help ensure that the benefits expected from the PHC program are realized and the investment will not be wasted.

Management Comments and Audit Response

In preparing this report, SIGIR considered written comments from ITAO and GRD. Their complete comments are included in Appendix F.

The Director of ITAO, on April 17, 2009, commented that the Embassy concurs with the recommendations and is working to implement them. ITAO states that the ongoing contract with Stanley Baker Hill will help to identify, prioritize, correct, report, track, and manage facility and equipment deficiencies. ITAO states that its goal is not to assume a long term role in or responsibility for the assets provided to the Government of Iraq. To that end, it notes the shift from reconstruction to boosting the capacity of Iraqis to exercise ownership, control, and operations of the assets-based infrastructure the U.S. government has contributed. It further comments that assessments of near half of the PHC will provide transparency on the status of the facilities and equipment and the information needed to calculate potential operational and sustainability concerns.

We agree that ongoing assessments will help. However, questions remain as to the number of PHCs that will be assessed under the existing contract. ITAO noted that, according to GRD, 42 PHCs have been assessed and funding on the contract will permit an additional 20 PHCs to be assessed. During our audit work, GRD provided different numbers for PHCs that had been and would be assessed, but did not provide documentation on completed assessments or on additional assessments that could be completed with the existing funds. We plan follow up to further verify the number of PHCs that has been and will be assessed under the existing contract. However, assessments of about 50% of the PHCs would be a significant step toward providing accountability and transparency to PHC program status.

The Commanding General sent GRD's comment on April 20, 2009. GRD's comments did not address the recommendations but stated a disagreement with the "basic assumption that GRD and ITAO failed." In addition, GRD stated that the draft report did not fully highlight the difference in responsibilities between GRD, ITAO, and the Health Attaché. GRD also disagreed with other statements in the report and provided 31 specific comments on the draft report. A number of these comments related to a clarification of GRD's responsibilities with regard to the PHC program. GRD emphasized that it is only responsible for tracking the construction management of the projects through physical completion, local turnover to the MoH, and financial and contractual closeout.

GRD's comments regarding its responsibilities highlight the lack of an integrated management structure for contingency reconstruction programs, such as the PHCs, and serve to reinforce our overall conclusion regarding the need for additional program integration and overall accountability.

We believe the information in the draft report is accurate. However, we have revised or deleted some statements based on GRD's comments to improve final report accuracy. Regarding GRD's overall comment, SIGIR did not conclude that GRD and ITAO failed. The first sentence of the Results in the Executive Summary states that "GRD completed construction of PHCs despite very poor security, which included bombing of facilities" and note that the facilities will provide outpatient treatments to over 4 million Iraqis annually. Further, the draft report addressed the responsibilities of GRD, ITAO, and the Health Attaché in the Introduction section and in various subsequent sections when relevant to the subject discussed. For example in the section on MoH transfers, we noted that the GRD management plan stated that the opening and operation of the facilities as well as sustainability were outside the scope of the GRD program. However, we have added GRD's language as appropriate to clarify its stated responsibilities.

SIGIR's responses to GRD's individual comments are presented on a comment by comment basis in Appendix F of the report. These comments identify the changes SIGIR made in finalizing this report.

Introduction

In March 2004, the U.S. Army awarded a design-build contract (W914NS-04-D-0006) to Parsons Delaware, Inc., Pasadena, California, to provide design and construction services in the building, housing, and health care sector in Iraq. The contract had a ceiling of $500 million. The government later issued 14 task orders under the contract, including 3 for the design and construction of 150 primary healthcare centers (PHC) located throughout Iraq and to provide equipment for the centers. In March 2006, after concerns arose about a lack of progress on the contract, the government terminated it. In April and July 2006, the Special Inspector General for Iraq Reconstruction (SIGIR) issued three reports expressing concern about the management of the PHC program. Agencies responsible for the management of the PHC program are the U.S. Army Corps of Engineers Gulf Region Division (GRD), the Iraq Transition Assistance Office (ITAO), and the Joint Contracting Command-Iraq/Afghanistan (JCC-I/A).

Lack of Progress Leads to Termination

The PHC task orders provided for the design and construction of 150 PHCs (41 PHCs in the central region of Iraq, 49 PHCs in the north region, and 60 PHCs in the south region) at a definitized cost of about $88.47 million. Parsons was to provide three standard healthcare center designs: a model center (Type A, about 1,324 square meters), a model center with teaching facilities (Type B, about 1,400 square meters), and a model center with emergency and labor facilities (Type C, about 2,126 square meters). In addition, the three task orders provided for the delivery and installation of medical and dental equipment at each center. The medical equipment to be installed included x-ray equipment, hematology analyzers, examination tables, patient beds, defibrillators, electroencephalography equipment, ventilators, and incubators. The dental equipment to be installed included dental chairs, lights, cabinets, instruments, and supplies. The total definitized cost of the equipment for the 150 PHCs was about $69.12 million.

In June 2005, JCC-I/A, which administered the Parsons contract, began notifying Parsons of concerns about the design and construction of the PHCs. In September 2005, in consultation with Iraq's Ministry of Health (MoH), a decision was made to remove from the requirements for "lack of progress" nine PHCs that were reported to be in the initial stages of construction. One PHC removed from the contract was continued through a direct contract. As of March 2006, about $186 million had been spent on the PHCs over two years, but only six centers had been accepted as completed.

In March 2006, JCC-I/A terminated for convenience the PHC task orders and reduced the scope of work by 121 PHCs. At this time, Parsons was to deliver, by April 3, 2006, 20 PHCs, including 14 that were incomplete and 6 that were considered complete. However, in April 2006, the JCC-I/A decided to accept the 14 PHCs "as is" rather than require completion by Parsons.

Table 1 includes the key dates and summarizes the contract actions for the PHC program under the Parsons' contract.

Table 1—Key Dates and Actions for Contract W914NS-04-D-0022 with Parsons

Date	Contract Action
March 25, 2004	Contract awarded to Parsons, and task order directs mobilization and commencement of work.
May 11, 2004	Notice to proceed issued for task orders to construct 150 PHCs.
October 20, 2004	Task orders to design and construct PHCs are definitized.
June 11, 2005	Stop work order issued for 20 PHCs without agreement between Parsons and U.S. government.
July 18, 2005	Letter of concern issued to the contractor regarding PHC task orders.
July 23, 2005	Stop work order is lifted on 12 PHCs.
September 8, 2005	Bilateral modifications reduce number of PHCs by 9, leaving 141 as a contractual requirement. One PHC is to be completed with a direct contract, leaving a total of 142 in the program.
March 3, 2006	Partial terminations for convenience issued for PHC task orders. Six PHCs are considered complete, and the U.S. government expects Parsons to complete 14 additional PHCs by April 2006. The remaining 122 are to be completed by Iraqi contractors.
April 30, 2006	Fourteen PHCs are accepted "as is," and 142 PHCs require completion: 141 from Parsons (including 6 that are essentially complete) plus the one previously removed for completion under a direct contract.

Source: SIGIR analysis of prior reports and updated data from GRD.

Prior SIGIR Reports

In 2006, SIGIR issued three reports related to the management of PHC construction and concerns about equipment purchased for PHCs. In a report, *Management of the Primary Healthcare Centers Construction Projects* (SIGIR-06-011, 4/29/2006), SIGIR reported that overall management of the PHC construction projects could have been better executed. Because of the strong commitment by the Iraqi and U.S. governments to complete the partially constructed centers, we recommended the development of a strong management team to ensure completion of the PHCs that were in various phases of construction.

In addition to our report on the construction projects, we issued two audit reports on concerns related to equipment for the PHCs. In April 2006, we issued *Interim Audit Report on the Review of Equipment Purchased for Primary Healthcare Centers Associated with Parsons Global Services, Contract Number W914NS-04-D-0006* (SIGIR-06-016, 4/4/2006) to alert responsible U.S. government agencies of our concerns about (1) the lack of written plans for the acceptance, storage, and use of medical equipment that exceeded the current PHC needs as a result of reduced numbers; (2) the need to ensure U.S. government accountability of the equipment upon delivery; and (3) the U.S. government's inability to ensure proper protection and accountability of equipment. In July 2006, we issued *Review of the Medical Equipment Purchased for the Primary Healthcare Centers Associated with Parsons Global Services, Inc., Contract Number W914NS-04-D-0006* (SIGIR-06-025, 7/28/2006). This report noted that the U.S. government had decided not to store any equipment at the Iraqi MoH warehouse but rather to deliver extra

equipment sets to the U.S. government-controlled warehouse. While this decision alleviated our concern over the security of equipment stored in an Iraqi warehouse, we reported additional concerns, including (1) the lack of appropriate actions to ensure that medical equipment delivered to the warehouse was properly accepted, inspected, and inventoried; (2) visible damage to a large number of the equipment shipping crates; and (3) a question about whether the 12-month warranty provided as part of the basic equipment purchase contract would continue to apply given delayed delivery and installation.

A third report, *Status of Medical Equipment and Other Non-construction Items Purchased for Primary Healthcare Centers* (SIGIR-06-030, 1/30/2007), updated the status of the medical equipment and discussed controls over and use of medical consumables and other nonconstruction purchases for the PHC project. GRD had arranged to have the medical equipment sets, furniture, and consumables delivered to storage facilities, thus reducing an extremely high risk of pilferage and susceptibility to damage.

Responsible Organizations

Three U.S. government organizations have primary responsibility for the PHC completion program: GRD, ITAO, and JCC-I/A. In addition, Berger/URS provided program management support to GRD until the fourth quarter of 2007, at which time Stanley Baker Hill, assumed that role. The Iraq MoH is the end user and owner of the facilities.

GRD

GRD provides engineering services to the Multi-National Force-Iraq. These services include planning, design, and construction management support for military and civil infrastructure construction. It is a major subordinate command of the Multi-National Force-Iraq. For the PHC program, GRD has management responsibility to deliver complete, ready-to-operate centers to the MoH. GRD stated that it is only responsible for executing the program funded by its customer, which in the case of the PHC program was ITAO. GRD receives a fee for performing project construction management and contractor quality assurance compliance services. In the case of the follow-on contracts for completing construction of the PHCs, GRD received a fee of 6.5% of the contract costs.

ITAO

ITAO was created by Executive Order on May 9, 2007, as the successor organization to the Iraq Reconstruction Management Office. National Security Presidential Directive 36, "United States Government Operations in Iraq," May 11, 2004, established the Office within the Department of State and directed that it facilitate the transition in Iraq. ITAO reports to the U.S. Ambassador to Iraq. For the PHC program, ITAO is to provide funding, direct program scope and objectives, and coordinate with the MoH. Working with ITAO on the PHC program, but not reporting directly to ITAO, is the Health Attaché, who provides advice to the U.S. Ambassador and others and coordinates the health program with the Iraq MoH.

JCC-I/A

JCC-I/A, the head contracting activity, is responsible for administering contracts. JCC-I/A, established in 2004 to consolidate contracting activities, reports through the Deputy Assistant

Secretary of the Army (Policy and Procurement) to the Assistant Secretary of the Army for Acquisition, Logistics, and Technology. JCC-I/A is responsible for awarding the contracts for medical equipment, training, office equipment and furniture, consumables, and site electrical work. One contactor was responsible for all of the site electrical work at the PHCs.

Objectives

The objectives of this report are to show the costs and outcomes of U.S.-funded efforts to complete the PHCs, the extent to which completed PHCs have been transferred to the MoH, and the operational status of the PHCs.

For a discussion of the audit scope and methodology, see Appendix A. For a detailed list of the PHCs; their status as of March 2006; and the total construction costs, see Appendix B. Appendix C provides the reported dates that PHCs were transferred to MoH and the reported dates they were opened. For a list of acronyms used in this report, see Appendix D. For a list of the audit team members, see Appendix E. Appendix F is the management comments received for this report.

Construction Is Essentially Complete, but Cost, Schedule, and Management Problems Occurred

In March 2006, after the termination of the Parsons contract, GRD undertook a program to complete and transfer PHCs to Iraq's MoH. GRD awarded firm-fixed-price construction contracts to Iraqi contractors to complete the partially constructed PHCs, and it now reports that construction is essentially complete. This construction has been accomplished despite serious security conditions such as the bombing of facilities. Security conditions have affected all aspects of the program, including assessing sites, awarding contracts, and inspecting work done. GRD estimates the facilities will provide outpatient treatment for over 4 million Iraqis annually—a significant accomplishment. However, the final program results, when compared to early plans (1) cost substantially more, (2) took longer to complete, and (3) produced fewer facilities. Specifically:

- The program has cost about $102 million more than the $243 million estimate when the Parsons' contract was terminated.
- PHCs have been transferred to the MoH months and years later than planned.
- The original 150 PHCs were reduced to 142 during the Parsons contract, and 9 additional sites have been removed, leaving 133 constructed.

GRD did not have a timely and finalized management plan and had six different program managers, and ITAO's resources for management and coordination of the program were limited.

Increased Costs and Schedule Delays in PHC Program

Under its contract, Parsons had three task orders that required the design and construction of 150 PHCs. As of March 2006, the total definitized cost of the PHC task orders was $104 million. Parsons was also to procure, deliver, install, and commission medical and dental equipment and provide training to MoH staff. The definitized cost for the equipment was $69 million. The contract also had an administrative task order for the indirect costs of projects under the contract, and we estimate that $70 million of these indirect costs were related to the PHC program.

As shown in Table 2, the total estimated cost of the PHC program has increased by about $102 million—from $243 million at Parsons' termination in March 2006 to $345 million in March 2009—while the number of PHCs to be completed has been reduced from 150 to 133. Although Parsons' construction costs decreased by about $20 million, the costs of follow-on construction contracts added $57 million to program cost. Also, because the PHCs were not complete, Parsons' purchased equipment was delivered to a warehouse instead of PHCs. This resulted in the need for contracts to deliver and install the equipment and provide the planned training. These contracts added another $56 million to program costs.

Table 2—Increase in Estimated Cost of PHC Program from March 2006 to March 2009 ($ millions)

Cost Element	March 2006	March 2009	Increase (Decrease)
Parsons' Construction	$104	$84	($20)
Parsons' Purchased Equipment	$69	$75	$6
Parsons' Administrative Costs including Security and Life Support	$70	$73	$3
Follow-on Construction Contracts	-	$57	$57
Delivering and Installing Equipment and Training	-	$56	$56
Total	**$243**	**$345**	**$102**

Source: SIGIR report, GRD data, and Corps of Engineers Financial Management System data as of March 2009.

Costs for Follow-on Construction Contracts

After Parsons' termination, GRD had program management responsibility to deliver PHCs that were complete and ready-to-operate. According to GRD, in carrying out this responsibility, it was to assess the partially completed PHCs, develop government estimates of the cost to complete construction, and award firm-fixed-price contracts between April and August 2006 to Iraqi contractors to complete construction of the PHCs. GRD awarded firm-fixed-price contracts to Iraqi contractors to complete construction of each of the 142 PHCs. Appendix B shows, by type of PHC, the percentage of PHCs' completion as of the March 2006 termination, Parsons' construction cost, and the additional cost for construction by Iraqi contractors. As shown, GRD awarded construction contracts for all 142 PHCs, even for those identified as complete under the Parsons contract. These additional contracts for about $57 million added to the $84 million spent on construction prior to the Parsons' termination, brings the total cost of construction to $141 million.

Our analysis shows that GRD awarded 128 different contracts to 65 different contractors to complete construction of the PHCs. Accordingly, some contracts were for completions of more than one PHC, and some contractors received more than one contract. For 18 PHCs, more than one contractor was involved in completing construction. This occurred primarily because at least 17 of the follow-on contracts were terminated either for convenience or for default.

Figure 1 shows a completed Type A clinic. PHCs similar to the one shown in Figure 1 have been constructed throughout Iraq and are reported to have the capacity to provide outpatient medical care to more than 4 million Iraqis annually.

Figure 1—Photograph of Completed Type A Clinic in Basrah

Source: GRD photograph.

Costs of Nonconstruction Contracts

In addition to contracts to complete PHC construction, contracts were awarded for tasks that were necessary to complete the facilities and make them operational. As shown in Table 3, these contracts included tasks to provide the PHCs with needed generators and transformers, deliver and install medical equipment and furniture that had been procured under the Parsons' contract, and provide needed training on medical and other equipment.

Table 3—Nonconstruction Contracts for Tasks Needed to Make PHCs Operational
($ millions)

Contract Number	Total Obligated	Completion Date	Work Under Contract
W27P4B-05-C-0015	$24.58	October 2008	Procure and install generators/transformers at PHCs and provide training
W27P4B-05-C-0015	$6.78	October 2008	Electrical work at PHC sites
W27P4B-05-C-0016	$14.38	June 2006	Deliver and install furniture at PHCs
W91GET-06-A-5005	$2.93	March 2009	Install medical equipment and provide training on its use
W91GET-06-A-5006	$2.93	March 2009	Install medical equipment and provide training on its use
W91GET-06-A-5024	$1.40	April 2008	Procure, deliver, and install equipment and provide training
Other contracts	$3.03	Various	Deliver equipment and consumables and other tasks
Total	**$56.03**		

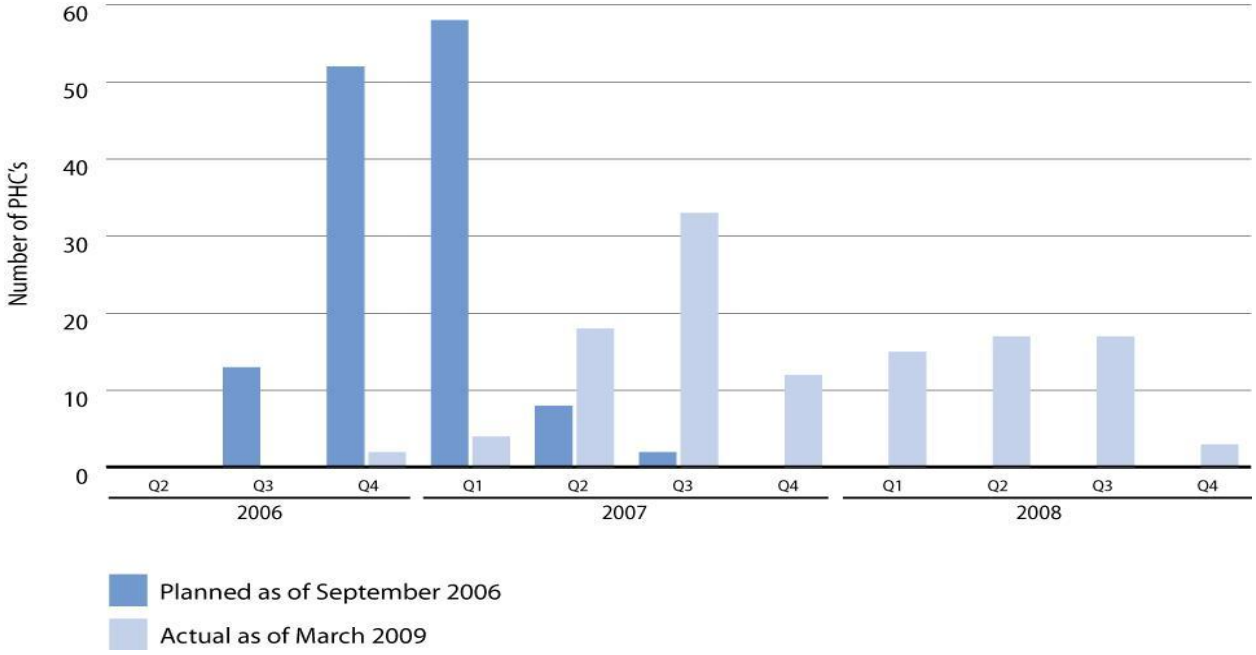
Source: GRD and Corps of Engineers Financial Management System data as of March 2009.

In addition to program costs identified above, SIGIR reported in March 2006 that the U.S. government cost for managing and administering the PHC program was $7.4 million; we estimate that this cost now would be about $11 million. For example, to recover costs involved in contract supervision and administrative services, GRD charges a fee of 6.5% of the construction contract amount.

Planned Completion Significantly Delayed

In addition to increased costs, completion of the PHCs was significantly delayed from plans under the Parsons' contract and from GRD's September 2006 revised plan. Under the Parsons' contract, all PHCs were to be completed by December 2005. However, no PHCs were completed in 2005, and only two were completed in 2006. In September 2006, GRD developed a projected completion schedule based on the construction contracts awarded in the summer of 2006. Figure 2 compares that schedule with the reported completion dates of the PHCs. GRD's plan was that about half the PHCs would be completed in 2006 and most of the remainder would be completed in early 2007. Figure 2 shows that the completion dates for PHCs slipped significantly from the GRD schedule, as 64 PHCs were reported as complete in the last quarter of 2007 and 2008.

Figure 2—Comparison of GRD Planned Completion with Reported Completion

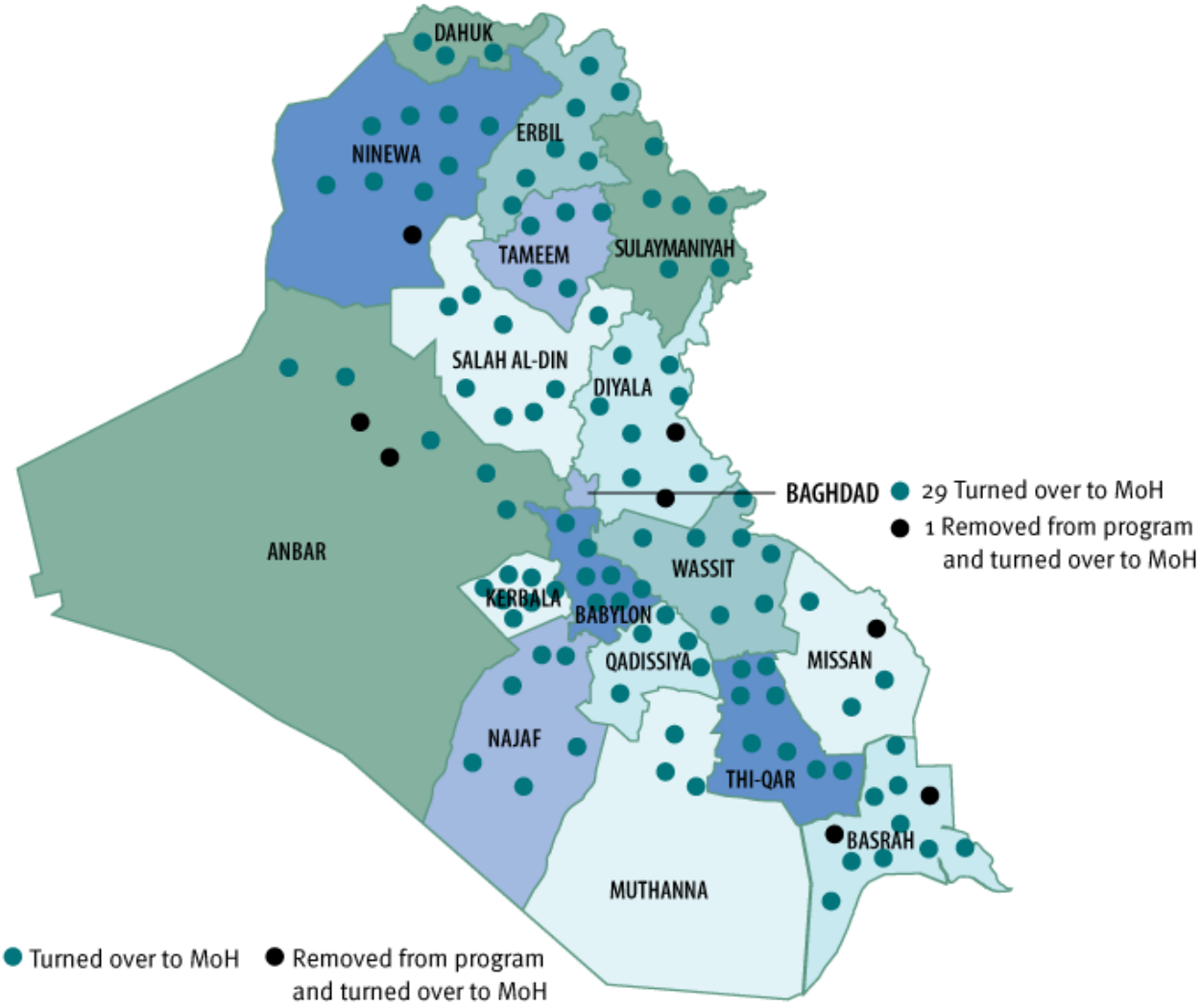


Source: GRD data.

Nine PHCs Not Completed Because of Security Issues

GRD reported that 9 of the 142 PHCs to be completed were removed from the program. A total of about $5.18 million was spent on the construction of these 9 PHCs. Figure 3 shows the location of the 142 PHCs in Iraq and the location of the PHCs removed from the program. Thirty of the PHCs were in Baghdad, with one of those removed from the program. The remaining 112 PHCs are shown in Provinces and 8 of those were removed from the program.

Figure 3—Location of 142 PHCs



Source: GRD February 2009 briefing slide.

Security issues were the major factors in the cost increases and schedule delays in the PHC program, both before and after the March 2006 Parsons' termination, and were the major reasons for removal of the nine PHCs. Six of the nine PHCs were not completed because explosives destroyed portions or all of the buildings during construction. Table 4 identifies the six PHCs removed from the program because of explosives and the amount of funds expended on their construction. The other three were removed for general concerns about security at the locations.

Table 4—PHCs Not Completed Because of Explosives ($ thousands)

Healthcare Center Site Identification Number and Location	% Physical Completion as of March 2006	Construction Cost		
		Parsons	Additional	Total
NA06-Hai Al Intisar, Ninewa	48%	$506	$250	$756
DY04-Al Tahrir, Diyala	38%	$87	$39	$126
AN06-Al Jazeera/Albo Ubeid, Anbar	70%	$367	$0	$367
AN01-Al Hukum Al Mahalli, Anbar	51%	$365	$256	$621
BK10-Al Jami'a, Baghdad	27%	$73	$84	$157
DY08-Bani Sa'ad, Diyala	97%	$43	$888	$931
Total		**$1,441**	**$1,517**	**$2,958**

Source: IRMS and GRD data.

Insurgents bombed the Al Tahrir PHC before a contract to complete construction was awarded in July 2006. Because of the bombing, the contractor was reluctant to sign a contract but was assured that the contract would be amended to include any additional work. In an August 2006 visit, GRD representatives identified substantial damage but reported that the site was salvageable. The next day, three improvised explosive devices detonated in the PHC caused additional damage. This time, the extent of damage was unknown because the area was very volatile and the contractor could not assess the damage.

In October 2006, the contractor notified GRD that he was unable to negotiate with the local sheiks and would be unable to continue at the site. GRD requested that the contractor remain on the site to provide security for materials valued at around $80,000. The contractor agreed and was paid for security services. In April 2007, the contract was terminated for convenience and the PHC was removed from the program. A June 2007 GRD memorandum notes that all measures to identify a point of contact to transfer the PHC to an Iraqi official has been exhausted and that no further actions will be required to close out the project.

The completion contract for the Hai Al Intisar PHC was awarded in July 2006, and, according to GRD, the contractor "worked slowly, but steadily," up to November 15, 2006, when insurgents used explosives to seriously damage the structure, as shown in Figures 4 and 5.

Figure 4-Left Side of Bombed Hai Al Intisar PHC

Figure 5-Right Side of Bombed Hai Al Intisar PHC

Source of Figures 4 and 5: GRD contract files.

GRD was initially uncertain as to whether the PHC would be completed, but for security and other reasons terminated the contract for convenience. In processing the termination, GRD notified the contractor that based on the $278,430 paid, the contractor should have completed 45% of the construction, but the government determined that only 13% had been completed and the contractor therefore owed the government $173,277. This overpayment indicates that the

government was not adequately assessing physical progress as it was making performance payments. Additionally, the government has been unable to recover the overpayment. According to GRD, attempts to locate the contractor have proved unsuccessful.

Table 5 provides information about the three additional PHCs that GRD identified as being removed from the program for security reasons.

Table 5—Additional PHCs Removed from the Program ($ thousands)

Healthcare Center Site Identification Number, Location	% Physical Completion as of March 2006	Construction Cost		
		Parsons	Additional	Total
MN04-Qadha Al Majar Al Kabeer, Missan	51%	$345	$294	$639
BA05-Abdalla Hashim/Qadha' Al Madina, Basrah	55%	$1,069	$0	$1,069
BA08-Janeena, Basrah	65%	$287	$229	$516
Total		**$1,701**	**$523**	**$2,224**

Source: GRD data.

On the PHC at Abdalla Hashim/Qadha' Al Madina (BA05), a follow-on construction contract was awarded in June 2006; however, the contractor was prevented access to the site by a previous subcontractor under the Parsons contract. The subcontractor, believing it was owed for work performed, threatened to attack anyone approaching the site. According to project data, GRD terminated the follow-on contract in March 2008 and removed the PHC from the program.

Management Issues Continued to Impact Program

SIGIR's earlier report[1] on the PHC program identified inadequate U.S. government management as a factor in the failure to complete PHCs as planned and addressed the need for a strong program management team to complete the partially constructed PHCs. Management issues have continued in that

- GRD drafted a management plan for the program about 6 months after critical actions such as assessing sites and awarding construction contracts were taken, but did not finalize it.
- With six program mangers in a three-year period, the program lacked management continuity.
- Documentation of project assessments were not provided
- ITAO did not have resources to fulfill oversight and coordination responsibilities.
- Inaccurate program management data created questions.

[1] *Management of the Primary Healthcare Centers Construction Projects* (SIGIR-06-011, 4/29/2006)

Management Plan Drafted Late and Not Finalized

GRD drafted a management plan in December 2006 to outline its progress and establish a way forward for the successful completion of the PHC program. The document includes a description of the program, its status, and an execution plan. It also identifies potential risks and presents risk mitigation measures. The plan describes various reporting mechanisms for the management of the program, including a detailed list of both internal and external reporting on the program. Reporting included a monthly summary on the cost to complete the program, a list of the 10 most critical PHCs in terms of being behind schedule, and other reports to identify PHCs steadily making progress and those with problems requiring resolutions.

The December 2006 management plan was drafted after completion of some of the most critical early program activities, such as assessing PHCs' status and awarding construction contracts. We asked GRD officials if a management plan existed prior to the December draft and whether the draft plan was officially implemented. GRD officials stated that their archives contained neither a plan drafted before December 2006 nor an officially implemented plan. GRD's management of the PHCs did include some of the reporting mechanisms described in the plan, but some of the reports were discontinued during GRD's construction. For instance, according to a GRD official, the top 10 list of PHCs in jeopardy of being behind schedule was discontinued after the January 6, 2007, report, but at that time, only two PHCs had been turned over to the Iraqi government.

Turnover of Program Managers

In addition, the PHC program had a significant turnover of the PHC Program Manager, an obviously critical position of the program. In the draft plan, the Program Manager was assigned responsbility for overall program scope, schedule and budget, and control over changes in the entire program, including construction and nonconstruction aspects of the program. The Program Manager was also responsible for coordination with other U.S. government offices and consulting with and seeking support from the MoH. The plan notes that the Program Manager has the "ultimate responsibility to complete the program and deliver functional and equipped facilites to MOH."

GRD officials informed us that the postion of Program Manager had been held by six different individuals. The first manager left the position in May 2006, and the next manager held the position for about 15 months until August 2007. Since that time, the program has had four managers; the latest took the position in February 2009. Although GRD officials did not comment on any management issues or problems related to this turnover, such turnover in a critical position would likely present significant continuity challenges and issues throughout the program.

Documentation of Assessments Not Provided

According to GRD officials, their district engineers, in accordance with contracting procedures, conducted site visits in the spring of 2006 to assess the extent of additional construction needed and to develop independent government estimates before award of construction contracts. In response to our request for selected site assessments, GRD officials stated that the assessments could not be located, and they provided no documentation on the assessments. Earlier, when

SIGIR inspected selected PHCs[2] and requested assessments for the sites, GRD was unable to provide them. Moreover, during the inspections, GRD officials had stated that those assessments were to be performed by the contractors. Since GRD has not provided any site assessments, we are unable to verify the extent to which site assessments were done and who did them.

One contract file we examined demonstrates the importance of government assessments and independent government estimates. The contract for the PHC at Al Wihda/Talla'afer, Ninewa (NA07) had been awarded for about $565,000, which seemed like a low price since the independent government estimate was about $100,000 more. However, contract file documents show that (1) the estimate was calculated with limited information and (2) the security situation did not allow time for a full evaluation of the work remaining. The issues surfaced at a preconstruction meeting when GRD discovered that the contractor had visited and bid on the wrong PHC. Through a series of e-mails, the contractor and the government revised and reviewed proposals, and a new proposal of about $881,000 was determined to be fair and reasonable. The new independent government estimate was about $929,000.

For several facilities, two additional contracts were awarded to complete construction. For the PHC at Al Thalith, Baghdad (BR04), Parsons was paid about $387,000 for construction, and GRD considered the PHC 100% complete when the Parsons contract was terminated. GRD awarded a follow-on construction contract for $50,000 in April 2006 to complete the PHC, and the contract was reported complete in May 2006. However, in September 2006, another contract for about $30,000 was awarded. In response to our questions as to why two contracts totaling about $80,000 were awarded on a 100% complete PHC, GRD officials stated that both were to complete punch list items. However, GRD provided no assessment reports to document why the Parsons constructed PHC, which had been accepted as 100% complete, required additional work or why a second contract was needed after the first follow-on contract for about $50,000. We discuss similar situations in a subsequent section of this report.

ITAO Resource Shortages Limited Oversight and Coordination

ITAO officials stated that they did not have the capacity to visit all the facilities for which they were responsible, including the PHCs. According to the Director, ITAO relies on GRD to provide status updates, and ITAO may request that the Provincial Reconstruction Teams or military units visit facilities if they will be in the area. ITAO and GRD held regular meetings, including a weekly strategic-level meeting and a weekly program-level meeting, but these meetings covered all GRD reconstruction projects and were not specific to the PHCs or the health sector. ITAO officials stated that GRD did not always have readily available information on the current status of projects like PHCs because it relied on field personnel to provide updates on projects' status. If GRD's personnel could not easily check on the status of projects, detailed information was not readily available. ITAO officials said that they primarily coordinate through monthly cost-to-complete briefings provided by GRD, but again, the scope of these briefings encompasses all programs and issues. ITAO also relies on the Embassy's Health Attaché to provide subject matter expertise regarding the health sector.

[2] *Heet Primary Healthcare Center Sustainment Assessment* (SIGIR PA 08-133, 1/23/2009) and *Haditha Primary Healthcare Center Sustainment Assessment* (SIGIR PA 08-134, 1/28/2009).

GRD and ITAO officials said that they also rely on the Health Attaché for insight into the operational status of many of the PHCs because the office serves as the primary U.S. government contact with the MoH. According to the Health Attaché, however, he relies extensively on GRD and ITAO for information on the status of the PHCs because his office has only three people. The Health Attaché stated that, despite regular meetings regarding the health sector, coordinating with officials about work needed for the PHC program is difficult.

In commenting on a draft of this report, GRD stated that it held weekly teleconferences with the District Project Managers specific to the Health program to ensure GRD had visibility over the status of the program and possible issues. GRD also stated it participated in teleconferences specific to PHCs, held by the Districts, and distributed a weekly Health Sector Update to ITAO and the DoS Health Attaché.

Management Data Is Inaccurate and Incomplete

One key factor in the PHC program is determining the percentage of PHCs' completion at the time of contract termination and when subsequent contracts are awarded. Percentage completion data is contained in the Iraq Reconstruction Management System (IRMS), which was developed to support the Iraq reconstruction program. In a July 2008 SIGIR report[3], we noted that this IRMS data is entered manually and does not always contain accurate and up-to-date information. In responding to that report, GRD officials acknowledged that IRMS is known to contain inconsistent and incomplete data in several areas. GRD officials also stated that the percentage of completion displayed in IRMS could be incorrect for several reasons, including incorrect estimates, typographical errors, and entries of 100% complete to indicate contract termination rather than actual completion. Furthermore, the draft PHC management plan noted that GRD is required to report "IRMS data even though in most cases the data is suspect."

Our analyses of the percentages of PHC completions and their costs support questions about data accuracy. For example, IRMS records for the PHC at Khaleej Al Arabi, Basrah (BA02) show two different percentage completions (26% and 85%) in two different records on the project. In discussing this discrepancy with GRD officials, they stated that they had considered the project 57% complete after about $201,000 had been spent under the Parsons' contract. After GRD had paid a follow-on contractor about $312,000 to complete the PHC, it terminated the contract for default. After this termination, a third contract was awarded for about $338,000, and IRMS data shows the project as 0% complete. Without accurate figures on the percentage of PHC completion, the reasonableness of the dollar amount of follow-on contracts cannot be assessed. A similar situation was identified with the PHC at Hai Al Hussien, Basrah (BA11), and the same two contractors were involved. One IRMS record identifies the Parsons project as 36% complete and the second identifies the Parsons project as 75% complete. For the third contract, IRMS identified the prior project as 0% complete.

Our analysis of data for the completion of the PHCs identified other indicators of IRMS data issues, inadequate assessments, and/or construction management issues. For example, 17 PHCs were identified as being either 100% or 99% complete at termination in March 2006, but significant construction contracts totaling about $1.90 million were awarded for completing these

[3] *Comprehensive Plan Needed to Guide the Future of the Iraq Reconstruction Management System* (SIGIR-08-021, 7/26/2008).

PHCs. For 11 of the PHCs, two separate contracts were awarded to complete the PHCs. For example, GRD data shows that Parsons spent about $407,000 on the PHC at Al Huriya, Baghdad (BK06) and that it was 100% complete. However, two contracts were awarded to complete construction of the PHC: one for about $43,000 in April 2006 and one for about $33,000 in August 2006. For another PHC, GRD data shows that Parsons completed 99% of the construction for about $319,000; however, two follow-on contracts were awarded—the first for about $56,000 and the second for about $208,000. Such data indicates significant assessment and/or construction issues.

PHCs that had a lower percentage rate of completion had similar discrepancies. For example, the PHC at Al Armooshiya, Salah Al-Din (SD02) was identified as 90% complete with about $707,000 expended. The completion contract was for about $567,000; much more than the $70,000 or so that might be expected. Another example is the PHC at Sarawan, Erbil (AR01), which was identified as 69% complete with about $359,000 expended, but about $435,000 was the amount of the completion contract. As noted earlier, without project assessments, we were unable to determine the reasons for apparent discrepancies between completion percentages and follow-on construction costs.

Validity of Geographic Data

SIGIR's attempt to validate the location and conditions of selected PHCs highlights another potential IRMS data deficiency. To identify the project's geographic location, IRMS captures the project's longitude and latitude. We used these IRMS identified coordinates for satellite photographs to validate the location and completeness of 10 randomly selected PHCs. The imagery showed 4 of the 10 selected sites were empty fields. We have referred this data to GRD to further resolve whether the coordinates are incorrect or more serious issues exist.

Transfer and Sustainability Issues Place Program Investment at Risk

While GRD faced security and management challenges in completing construction of PHCs, it and ITAO faced additional challenges in transferring PHCs to the MoH. Furthermore, GRD and ITAO do not have accurate and complete oversight data on the number of PHCs that are open and operating. They and MoH are aware of operational and sustainability issues at open PHCs, and a contract effort was undertaken in May 2008 to identify and address issues at selected PHCs. SIGIR's inspection reports on four PHCs in 2008 identify significant construction and operational issues. GRD and ITAO officials state that they have no future plans and/or funds for additional U.S. government actions related to the PHCs. Difficulties in PHC transfers, incomplete oversight data on unopened PHCs, recognized operational and sustainability issues, and a lack of plans or funds to address these issues leave the overall U.S. investment at risk and subject to waste.

Difficulties in Transfers to MoH

Although progress has been made in completing construction of the PHCs, the lack of coordination about the program among the U.S. government organizations and the MoH has affected the transfer of PHCs to the MoH. According to the Health Attaché and MoH officials, coordination issues about the selection of sites and contractors began early in the program. The Health Attaché stated that many contracts were awarded with great speed and little consultation with the Iraqi government. (GRD, in its comment on the draft report, noted that archived correspondence and reports do not support this statement.) For example, he noted that the Iraqi Regional Director for Health was consulted about the locations of several PHCs built north of Baghdad, but was not consulted about whether new or rehabilitated facilities were preferred.

According to GRD officials, coordination issues hampered the transfer of some sites to the Iraqi government. GRD said that the transfer of PHCs to the Iraqi government involves two letters: one signed at the local level and one signed at the national level. The local-level transfer letter is GRD's responsibility, and the national-level letter is ITAO's responsibility. GRD officials said that in some cases, they were ready to transfer a facility, but MoH officials were not yet ready to accept the facility because of limited available trained staff. According to GRD, at times, the MoH was unable to obtain protection service to secure the site, and as a result, GRD had to arrange for security at the site and the transfer was delayed. Without effective transfer, there are no assurances that the PHCs will be used, maintained and sustained by the MoH. SIGIR has issued several reports on difficulties in transfers of facilities and the latest report was issued in April 2009.[4] SIGIR reports that unless flawed policies, plans, procedures, and accounting for the status of completed and turned over assets is improved, U.S. funded infrastructure projects will remain highly vulnerable to become wasted.

[4] *Asset-transfer Process for Iraq Reconstruction Projects Lacks Unity and Accountability* (SIGIR-09-016, 4/26/2009).

GRD's 2006 draft management plan recognizes that MoH is the end user and owner of the PHCs and that a smooth transfer was the key to a successful program. It states that the opening and operation of the facilities as well as sustainability were outside the scope of the GRD program. GRD states that it is only responsible for tracking the construction management of the projects through physical completion, local turnover to the MoH, financial and contractual closeout. GRD states that it is not responsible for tracking when the MoH staffs the PHC or opens it to the public and relies on the U.S. Embassy – Baghdad for that information.

GRD's plan highlights the need for regular consultation with MoH officials on all aspects of the program and notes that the MoH at each of the Governates is responsible for accepting and staffing the facilities and is to be engaged throughout the projects. In our audit, MoH officials stated that GRD did not consult with them in designing the facilities, in selecting construction contractors, or in overseeing contractors during construction. As a result, they were dissatisfied with many facilities. MoH officials said that they would likely accept any U.S.-funded facilities, even if dissatisfied with the construction outcomes.

In some cases, GRD transferred to MoH some facilities that were incomplete. GRD officials told us that 14 facilities—identified in Appendix C—were transferred "as is." (These 14 facilities include 9 sites that were removed from the program after the Parsons termination.) They noted that construction work continued for two of the "as is" facilities after transfer based on an agreement with MoH. For example, the Al-Atheem PHC in Diyala (DY06) was transferred "as is" to the MoH in October 2008; however, work continued on the facility until February 2009. GRD officials said that they had no completion plans for the other incomplete PHCs transferred to the MoH and that the facilities were accepted with deficiencies.

In addition to the transfer of incomplete facilities, GRD officials stated that five PHCs—identified in Appendix C—were transferred to MoH unilaterally without MoH acceptance. For example, the transfer letter for the Al Badeer, Qadissiya PHC (DI03) states that GRD's south division completed final inspection of the facility with the Diwaniyah Department of Health and accepted the completed facility from the contractor with intent to transfer it to the local MoH representative. According to the letter, GRD south made three unsuccessful attempts to obtain a signature from the Diwaniyah Director General of Health before writing a letter of unilateral transfer.

To verify transfer data reported by GRD, SIGIR requested local and national transfer letters for 12 selected PHCs reported as transferred. GRD was able to provide only two local transfer letters, while ITAO provided seven local transfer letters but did not provide any national transfer letters. In some cases, the letters provided conflicted with information in IRMS, GRD statements and reports, and ITAO status information.

Conflicting Reports on Number of PHCs Open and Operational

GRD and MoH have reported conflicting numbers of open and operational PHCs. A GRD internal report shows that 115 PHCs were open to the public as of late February 2009, with 18 facilities turned over but not yet open to the public. However, GRD officials stated that they do not have visibility over the operational status of the PHCs and that the opening dates listed in their report are based on various sources, including communication from the MoH, news reports, and reports from field staff. Appendix C provides, to the extent data was available, the month

and year a PHC was transferred to MoH, whether GRD identified the transfer as unilateral or as is, and the month and year the MoH opened the PHC.

In response to our request, the Deputy Inspector General for the MoH stated that only 101 PHCs had been opened and 27 facilities had been transferred without yet being opened to the public. Based on this report, the total number to be opened is 5 less that the 133 reported by GRD, and the number open to the public is 14 less than GRD reported. The Iraq Ministry of Planning provided information on the number of transferred and opened PHCs that closely matches the GRD numbers.

Operations and Sustainability Uncertain

Even more significant than discrepancies in the number of PHCs opened is the status of operations and sustainability at the open PHCs. GRD, ITAO, and the MoH have expressed concerns about operational and maintenance issues at PHCs. Specifically, they question whether the PHCs have basic services such as electricity, water, and sewage and whether planned medical equipment has been provided, installed, and is operating. SIGIR's inspections have identified operational and maintenance issues at four open PHCs. While all parties are concerned about PHC operational and maintenance issues, the U.S. government does not have visibility of the PHCs' status.

ITAO and GRD Contracted for Operation and Maintenance Support for PHCs

In May 2008, GRD and ITAO contracted with Stanley Baker Hill to implement a PHC maintenance and operations program that can be transferred to the MoH to assist in its operating and maintaining these facilities. The initial contract was for $7 million, but it was modified in September 2008 to increase the contract amount to $16.5 million. According to the statement of work for the contract, as PHCs were completed and turned over, it became apparent that all facilities were already beginning to have operational and maintenance issues. The document further notes that a number of the facilities have been operational for over 2 years without maintenance and repair contracts. According to the document, GRD saw an obvious need to develop a means to replace and/or repair medical and mechanical equipment that was vital to the effective and safe operation of the facilities. The statement of work notes that structural and/or construction deficiencies can be corrected by the government of Iraq in time, but the immediate need is for operational equipment, preventative maintenance, and capacity building in all of the 133 U.S.-funded PHCs.

Work under the contract includes identification, prioritization, correction, reporting, tracking, and management of facility and equipment deficiencies with a final report due in June 2009. According to GRD, as of February 2009, detailed assessments of 6 PHCs were under review, preliminary assessments were complete for 28, and another 16 were identified for future assessments. However, the number of assessments that can be completed with the available funds is unknown. ITAO, in its April 17, 2009, written response to our draft, stated that GRD reports 42 PHCs have been assessed and an additional 20 PHCs could be assessed with available funds. GRD has not provided us with requested documentation on the assessments that have been completed or on plans for additional assessments. We will follow-up in an attempt to further verify the number of PHCs to be assessed under the existing contract

According to a GRD briefing chart, the preliminary assessment findings were that facilities have substantial issues, including a lack of critical utilities, untrained staff, and missing equipment that was never installed or was transferred to other sites. In addition to conducting assessments, GRD reported that some repair work was ongoing, including repairing water delivery systems; electrical generators; and heating, ventilation, and air conditioning systems. Ongoing challenges include inadequate utility support that precluded the use of medical equipment and delivery of health services.

We requested documents from GRD related to the contract with Stanley Baker Hill. The requested documents include the complete contract, assessments of the PHCs that are ongoing, and lists of reported infrastructure deficiencies since transfer of facilities. At the time we completed our work, GRD had provided only a general statement of work for the contract and no other documentation. In response to our draft report, GRD provided the contract and modifications.

The U.S. funded effort to address the deficiencies in the PHCs will not be sufficient to identify and address all the PHCs deficiencies, according to ITAO and GRD officials in March 2009. According to the Director of ITAO, the current contract value is not enough to complete full assessments of all facilities. The contract amount was not based on an assessment of PHC needs, but was the amount of funds available. In addition, according to the Director of ITAO and GRD officials, no funds or plans are available for further PHC efforts.

MoH Reports Construction, Electrical, Mechanical, and Equipment Deficiencies

In response to our request, the MoH stated in March 2009 that PHCs had construction, electrical, mechanical, and equipment deficiencies that will require reconstruction and rehabilitation. For example, MoH reported that roofs need to be resurfaced on all PHCs accepted, several PHCs have rooms or hallways with major and minor wall cracks and many fire alarm detectors do not work properly. They further reported that for some facilities, the generators have malfunctioned due to extensive use during construction and that generator fuel containers were plastic and began to crack in harsh weather conditions. They also reported that most of the laboratory test tubes and x-ray film development equipment have expired and cannot be used. In addition to deficiencies in the construction and equipping of PHCs, MoH reports that security remains the main challenge for the health sector and that the sector also lacks qualified medical practitioners.

Health Attaché Identifies Operational and Maintenance Issues

Current and former Health Attaché officials said that during visits to selected PHCs over the past 18 months, they had identified construction and equipment deficiencies. During all visits, they identified issues with the construction materials used and contractors' performance. They also reported that equipment was not installed or not operating and that in some cases, electricity, water, and/or sewage were not connected. In general, they stated that neither the construction nor the materials were to the standards expected and that the facilities did not make a good presentation of a U.S.-funded and managed construction project.

In relation to electricity at the PHCs, ITAO reported, as of March 2008, that 76 facilities were receiving power off the grid, 4 were awaiting connection, 31 were operating off generators, and 24 were either under construction or the status was unknown. While we did not identify any

later status report, a November 2008 ITAO memorandum states that connecting the PHCs to the grid remains the biggest challenge. In planning for PHC completion, the Health Attaché, GRD, and the MoH agreed that GRD would be responsible for extending electrical, water, and sewer connections no further than 25 meters from the PHC and that the MoH would be responsible for coordinating, funding, installing, and connecting the remainder. According to the ITAO memorandum, the MoH has not consistently been able to arrange for its portion with Iraq's Ministry of Electricity. In comments about a visit to a Baghdad PHC, the Health Attaché said that although the PHC was in an area with electricity, it was not connected to the grid and was operating with generators provided for emergency use.

SIGIR Inspection Reports Identify Construction and Equipment Deficiencies

SIGIR recently reported on its inspections of four PHCs[5]—Heet (AN05), Haditha (AN07), Shiqaq Hai Musalla (KE02), and Hai Tiseen (KE03)— and noted such problems as lack of documentation on required GRD inspections and identified deficiencies that contractors had not corrected before turnover of the PHCs to the MoH. These deficiencies included damaged air-conditioning units, interior water leaks, poorly insulated duct work, and problems with plumbing. According to one turnover document, the final inspection by GRD noted that it found "no new deficiencies" from the pre-final inspection and that all previously identified deficiencies had been corrected. However, SIGIRs inspection disputed this statement.

Further, during site visits, SIGIR determined that some medical equipment delivered to the PHCs as early as February 2008 was either not connected or not operating. For example, the Heet PHC reverse osmosis unit was still in a crate outside the facility and the dental chair was not connected in the dental room. The Haditha PHC x-ray equipment for the medical and dental units was not connected due to inadequate electrical connections, and the PHC did not have a reverse osmosis unit. Both of these PHCs were connected to the national grid and back-up generators were installed. However, the Heet and Haditha PHCs' automatic transfer switch for the large generator did not work.

SIGIR identified other construction deficiencies, such as damaged heating, ventilation, and air conditioning units; plumbing problems in the bathrooms and the sewer system; non-functioning hot-water heaters; exterior surface cracks; and low-quality door hardware and windows. GRD recognized that, in many cases, the companies awarded the contract to complete the PHCs did not properly install the medical equipment or train the PHC personnel on the use of the equipment. In addition, once the U.S. government turned over the facilities to the Iraqi ministries, little preventive maintenance was performed for items such as generators. Consequently, the facilities and equipment were failing at a rate much faster than expected if preventive maintenance was being performed.

[5] *Heet Primary Healthcare Center Sustainment Assessment* (SIGIR PA 08-133, 1/23/2009); *Haditha Primary Healthcare Center Sustainment Assessment* (SIGIR PA 08-134, 1/28/2009); *Shiqaq Hai Musalla Primary Healthcare Sustainment Assessment* (SIGIR PA 08-157, 4/13/2009); *Hai Tiseen Primary Healthcare Center Sustainment Assessment* (SIGIR PA 08-158, 4/16/2009).

No Plans for Continued U.S. Government Role and Responsibilities for PHC Program

Both GRD and ITAO have expressed concerns and taken some action to address PHC operational and sustainability issues; however, officials of both organizations state that they have no plans or funds for further involvement with the PHCs. GRD officials informed us that they have no responsibility for a PHC once it is transferred to the MoH. GRD stated that it is only responsible for executing the program funded by its customer, in this case, ITAO. It added that recommendations had been made to ITAO toward the obligation of additional funding to support further assessments, training, and operations and maintenance services.

Conclusions and Recommendations

Conclusions

U.S. funds and GRD's and ITAO's management have furnished the Iraq MoH with PHCs that are expected to provide medical care to more than 4 million Iraqis throughout the country. This has been accomplished despite serious security conditions such as the bombing of facilities. However, GRD and ITAO have not provided sufficient accountability and transparency on current PHC program status. Reports showing 133 PHCs having been completed and transferred are not complete and accurate. Questions about the completeness of the PHCs relate to far more than those few transferred "as is."

Millions of dollars were spent to (1) finish construction, (2) deliver and install medical and office equipment and consumables, and (3) train Iraqis on PHC equipment. However, some or all of these actions were not completed for a significant number of PHCs. ITAO's and GRD's limited contract effort to assess PHC status is based on funds available, not the amount needed. Further, neither has identified plans and/or funds for additional assessments and/or completion work for PHCs.

The U.S. government's future role regarding the PHCs in Iraq requires a policy decision; however, the U.S. government has not developed the information essential for making that decision. A lack of further management attention by the U.S. government and the Government of Iraq to address the PHCs' sustainability, operation, and maintenance issues places a substantial portion of the U.S. investment in the program at risk of being wasted.

Recommendations

SIGIR recommends that the U.S. Ambassador and the Commanding General, Multi-National Forces-Iraq, jointly direct a U.S. government study—obtaining the Government of Iraq's participation and/or input to the extent possible—to:

1. Provide transparency on the current status of PHCs and assess the cost and benefits of potential actions to address identified PHC operational and sustainability problems.

2. Identify actions the U.S. government could undertake to help ensure that the benefits expected from the PHC program are realized and the investment will not be wasted.

Management Comments and Audit Response

In preparing this report, SIGIR considered written comments from ITAO and GRD. Their complete comments are included in Appendix F.

The Director of ITAO, on April 17, 2009, commented that the Embassy concurs with the recommendations and is working to implement them. ITAO states that the ongoing contract with Stanley Baker Hill will help to identify, prioritize, correct, report, track, and manage facility and equipment deficiencies. ITAO states that its goal is not to assume a long term role in or

responsibility for the assets provided to the Government of Iraq. To that end, it notes the shift from reconstruction to boosting the capacity of Iraqis to exercise ownership, control, and operations of the assets-based infrastructure the U.S. government has contributed. It further comments that assessments of near half of the PHC will provide transparency on the status of the facilities and equipment and the information needed to calculate potential operational and sustainability concerns.

We agree that ongoing assessments will help. However, questions remain as to the number of PHCs that will be assessed under the existing contract. ITAO noted that, according to GRD, 42 PHCs have been assessed and funding on the contract will permit an additional 20 PHCs to be assessed. During our audit work, GRD provided different numbers for PHCs that had been and would be assessed, but did not provide documentation on completed assessments or on additional assessments that could be completed with the existing funds. We plan follow up to further verify the number of PHCs that has been and will be assessed under the existing contract. However, assessments of about 50% of the PHCs would be a significant step toward providing accountability and transparency to PHC program status.

The Commanding General sent GRD's comments on April 20, 2009. GRD's comments did not address the recommendations but stated a disagreement with the "basic assumption that GRD and ITAO failed." In addition, GRD stated that the draft report did not fully highlight the difference in responsibilities between GRD, ITAO, and the Health Attaché. GRD also disagreed with other statements in the report and provided 31 specific comments on the draft report. A number of these comments related to a clarification of GRD's responsibilities with regard to the PHC program. GRD emphasized that it is only responsible for tracking the construction management of the projects through physical completion, local turnover to the MoH, and financial and contractual closeout.

GRD's comments regarding its responsibilities highlight the lack of an integrated management structure for contingency reconstruction programs, such as the PHCs, and serve to reinforce our overall conclusion regarding the need for additional program integration and overall accountability.

We believe the information in the draft report is accurate. However, we have revised or deleted some statements based on GRD's comments to improve final report accuracy. Regarding GRD's overall comment, SIGIR did not conclude that GRD and ITAO failed. The first sentence of the Results in the Executive Summary states that "GRD completed construction of PHCs despite very poor security, which included bombing of facilities" and note that the facilities will provide outpatient treatments to over 4 million Iraqis annually. Further, the draft report addressed the responsibilities of GRD, ITAO, and the Health Attaché in the Introduction section and in various subsequent sections when relevant to the subject discussed. For example in the section on MoH transfers, we noted that the GRD management plan stated that the opening and operation of the facilities as well as sustainability were outside the scope of the GRD program. However, we have added GRD's language as appropriate to clarify its stated responsibilities.

SIGIR's responses to GRD's individual comments are presented on a comment by comment basis in Appendix F of the report. These comments identify the changes SIGIR made in finalizing this report.

Appendix A—Scope and Methodology

To determine the costs and outcomes of U.S.-funded efforts to complete the partially constructed PHCs, we contacted officials from GRD, ITAO, and MoH. We discussed and obtained documentation and data about the plans, programs, and activities involved in completing the PHC program. Also, we collected contract and financial data from several databases, including the Iraq Reconstruction Management System (IRMS) and the U.S. Army Corps of Engineers' Financial Management System (CEFMS).

- IRMS is the reporting database for reconstruction projects by U.S. agencies operating in Iraq. Although it provides the most complete data available on projects, both SIGIR and GRD have previously expressed concerns about the accuracy and completeness of its data.
- CEFMS is an automated financial management system that is intended to provide timely, accurate, and comprehensive financial information for all levels of management, especially at the program and project management level, through interface with other information system programs.

SIGIR had direct access to data in IRMS and CEFMS and used this access to identify obligation, expenditure, and completion data on PHC construction projects. If significant differences in data between the systems were identified, we followed up with GRD officials to reconcile the differences. Differences that could not be explained are identified in the report.

After we obtained basic data on the partially constructed PHCs, we judgmentally selected individual PHCs for further review if available data indicated that a PHC encountered potential problems in completion, such as a high total construction cost, terminations of contracts, and more than one contractor to complete a project. Because many of GRD's project files were located throughout Iraq and not easily accessible, the number of project files SIGIR selected for review and obtained from GRD was limited. We requested contract files on 7 PHCs from GRD and received partial files on 3 of those selected projects. During our work, we obtained data from a few PHC contract files that SIGIR had obtained during other audits. Also, GRD provided partial files on other PHCs.

SIGIR performed this audit under the authority of Public Law 108-106, as amended, which incorporates the duties and responsibilities of inspectors general under the Inspector General Act of 1978, as amended. The audit was conducted between December 2008 and April 2009 in accordance with generally accepted government auditing standards. Those standards require that SIGIR plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. SIGIR believes that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Use of Computer-Processed Data

To perform this audit, SIGIR used data taken from IRMS and CEFMS. We examined computer-processed data contained in these databases to identify, verify, and crosscheck information on the PHC projects. As noted in this and in previous SIGIR reports, issues have been identified about the completeness and accuracy of IRMS data. For purposes of this review, we relied greatly on the IRMS data system because it contained the most complete data on PHC projects. However, to the extent possible, this data was crosschecked with CEFMS data and financial and management information from individual project and contract files. The report fully discusses the limitations we noted with the data from these systems. We believe these steps provide assurances that the data presented in this report is reasonable for the purposes for which it is used.

Internal Controls

We reviewed the specific controls used in managing and administering the PHC program. Specifically, we reviewed the plans established for the program and the management controls related to contract award, contract oversight, installation of PHC equipment, and the turnover of completed PHCs to the MoH. Since constructing and equipping the PHCs was largely complete at the time of our audit, we did not monitor progress on these activities. Further, we did not observe the completed PHCs. We also identified various instances where specific records and documents related to the completion and transfer of PHCs were not available. Thus, we relied on available reports, site photographs, transfer documents, and discussions with government officials for insight on the completion of PHCs.

Prior Coverage

We reviewed the following reports and relied on them in conducting this audit:

- *Iraq Reconstruction Project Terminations Represent a Range of Actions* (SIGIR-09-004, 10/27/2008)
- *Comprehensive Plan Needed to Guide the Future of the Iraq Reconstruction Management System* (SIGIR-08-021, 7/26/2008)
- *Review of Outcome, Cost, and Oversight of Iraq Reconstruction Contract, W914NS-04-D-006* (SIGIR-08-010, 1/28/2008)
- *Status of Medical Equipment and Other Non-construction Items Purchased for Primary Healthcare Centers* (SIGIR-06-030, 1/30/2007)
- *Review of the Medical Equipment Purchased for the Primary Healthcare Centers Associated with Parsons Global Services, Inc., Contract Number W914NS-04-D-0006* (SIGIR-06-025, 7/28/2006)
- *Management of the Primary Healthcare Centers Construction Projects* (SIGIR-06-011, 4/29/2006)

- *Interim Audit Report on the Review of Equipment Purchased for Primary Healthcare Centers Associated with Parsons Global Services, Contract Number W914NS-04-D-0006* (SIGIR-06-016, 4/4/2006)

Appendix B—Total Construction Cost of PHCs

($ thousands)

Healthcare Center Site Identification Number, Location, and Province	% Physical Completion as of March 2006	Construction Cost		
		Parsons	Additional	Total
103 TYPE A (MODEL CENTER)				
BK06-Al Huriya, Baghdad	100%	$407	$76	$483
BR08-Al Mashtal, Baghdad	100%	$211	$74	$285
BR04-Al Thalith, Madinat Al Sadr, Sector 46, Baghdad	100%	$387	$80	$467
BR05-Al Guyara Sector 56, Baghdad	99%	$281	$52	$333
BR10-Al Husseniya, Baghdad	99%	$256	$37	$293
BK11-Al Rasheed, Baghdad	99%	$260	$129	$389
BK08-Al Tahaddi, Baghdad	99%	$296	$30	$326
SD08-Al Tooz, Salah Al-Din	99%	$673	$64	$737
NA05-Al Nahrawan, Ninawa	99%	$825	$99	$924
SD05-Tikrit, Salah Al-Din	99%	$823	$119	$942
BK14-Al Noor, Baghdad	99%	$319	$264	$583
BR14-Al Sha'ab 1, Baghdad	99%	$245	$129	$374
BR13-Hai Babil, Baghdad	99%	$312	$180	$492
WA07-Qadha' Al Aziziya, Wassit	99%	$628	$21	$649
BK09-Al Salam, Baghdad	99%	$319	$154	$473
BR02-14 Tammooz, Baghdad	99%	$302	$165	$467
AN02-Al Falluja/Al Hfefi, Anbar	96%	$175	$65	$240
DY10-Nahrawan, Diyala	90%	$363	$127	$490
SD03-Al Razi/Tikrit, Salah Al-Din	90%	$697	$168	$865
SD02-Al Armooshiya, Salah Al-Din	90%	$707	$567	$1,274
SD01-Ibn Rushid, Salah Al-Din	89%	$754	$162	$916
BK03-Al Mahmoudiya, Baghdad	87%	$260	$114	$374
BK02-Al I'lam, Baghdad	87%	$381	$316	$697
BR03-Al Ameen, Baghdad	85%	$255	$159	$414
SD07-Beji, Salah Al-Din	85%	$649	$191	$840
SD06-Al Sharqat / Hajeel Al Kabeer, Salah Al-Din	85%	$571	$392	$963
BR11-Al Thani, Madinat Al Sadr Sector 29, Baghdad	85%	$408	$179	$587
BA02-Al Khaleej Al Arabi, Basrah	85%	$201	$650	$851
NF01-Hai Kinda, Najaf	83%	$557	$166	$723
BR17-Al Sha'ab 2, Baghdad	82%	$333	$246	$579

Healthcare Center Site Identification Number, Location, and Province	% Physical Completion as of March 2006	Construction Cost		
		Parsons	Additional	Total
NF06-Hai Al Jam'Ia (Near Uroba), Najaf	82%	$484	$141	$625
BK01-Al Hadhar, Baghdad	81%	$121	$27	$148
NA09-Hai Nablus, Ninewa	81%	$618	$392	$1,010
BB02-Hai Al Imam, Babylon	78%	$420	$202	$622
BR16-Hai Ur, Baghdad	76%	$382	$150	$532
NA10-Al Mahallabiya, Ninewa	76%	$785	$426	$1,211
DK02-Bahdeenan, Dahuk	75%	$926	$304	$1,230
BA11-Hai Al Hussien, Basrah	75%	$258	$590	$848
KE02-Shiqaq Hai Musalla, Tameem	70%	$315	$303	$618
SU05-Halabjay Taza, Sulaymaniyah	70%	$597	$400	$997
AN06-Al Jazeera/Albo Ubeid, Anbar	70%	$367	$0	$367
AR01-Sarawran, Erbil	69%	$359	$435	$794
SU04-Khormal, Sulaymaniyah	68%	$554	$385	$939
SU06-Ashti Koyseneeq, Sulamaniyah	68%	$357	$414	$771
SU02-Qalawa, Sulaymaniyah	68%	$567	$421	$988
BK15-Al Washhash, Baghdad	67%	$237	$377	$614
KE01-Hai Alhajjaj, Tameem	67%	$320	$374	$694
AR04-Ainkawa, Erbil	66%	$513	$486	$999
KR01-Al Haidariya (Hai Al Askari), Kerbala	65%	$808	$265	$1,073
WA01-Hai Al Shuhada', Wassit	65%	$679	$291	$970
WA06-Hai Al Jamaheer, Wassit	65%	$614	$308	$922
SU03-Cham Chamal, Sulaymaniyah	65%	$554	$453	$1,007
BA08-Janeena, Basrah	65%	$287	$229	$516
BR01-Al Sadis Sector 72, Baghdad	64%	$306	$463	$769
KE05-Hai Alasra Wa Al Mafqoodeen, Tameem	64%	$299	$454	$753
WA03-Al Kut (Zayn Al Qaws), Wassit	63%	$669	$301	$970
KE04-Hai Al Wasity, Tameem	63%	$256	$331	$587
BB06-Al Hadi, Babylon	62%	$381	$250	$631
AR06-Qaraqejeen, Erbil	62%	$466	$463	$929
AR05-Hanjeerok, Erbil	62%	$557	$508	$1,065
AN05-Heet/Hai Al Bakr, Anbar	60%	$198	$412	$610
BA10-Al Mishraq, Basrah	59%	$206	$331	$537
BB04-Al Midhatiya, Babylon	58%	$391	$317	$708
AR07-Harem, Erbil	58%	$581	$546	$1,127
KR06-Hai Al Asra, Kerbala	57%	$412	$302	$714
BA01-Al Aqeel/Qadha' Al Zubair, Basrah	56%	$231	$421	$652
BA09-Hai Al Muhandiseen, Basrah	56%	$234	$356	$590

Healthcare Center Site Identification Number, Location, and Province	% Physical Completion as of March 2006	Construction Cost		
		Parsons	Additional	Total
BA03-Al Qurna, Basrah	56%	$529	$523	$1,052
BR19-Al Sabi', Madinat Al Sadr Sector 15, Baghdad	55%	$371	$438	$809
DY02-Al Khalis, Diyala	55%	$59	$532	$591
BR07-Al Karrada Al Awal, Baghdad	55%	$285	$363	$648
BA07-Al Risala, Basrah	55%	$266	$454	$720
WA02-Qadha' Badra, Wassit	54%	$459	$317	$776
BB03-Al Qasim, Babylon	52%	$329	$295	$624
MN04-Qadha' Al Majar Al Kabeer, Missan	51%	$345	$294	$639
KR07-Ayn Tamr, Kerbala	50%	$397	$350	$747
AN04-Qadha'rama, Anbar	50%	$214	$502	$716
SD09-Al Door, Salah Al-Din	49%	$683	$539	$1,222
NA06-Hai Al Intisar, Ninewa	48%	$506	$250	$756
MN02-Hai Al Nida', Missan	48%	$459	$337	$796
BB07-Al Kifil, Babylon	47%	$394	$377	$771
MU03-Qadha' Al Khidhir, Muthanna	46%	$575	$389	$964
BB05-Al Mahaweel, Babylon	45%	$429	$386	$815
BA06-Al Zahrawi/Nahiat Um Qasr, Basrah	44%	$322	$504	$826
NF02-Hai Al Meelad, Najaf	42%	$267	$352	$619
KR05-Qadha'Al Hinidiya Sayid Husseon Al Janib Al Kabeer, Kerbala	42%	$571	$425	$996
BR06-Al Awal Al Mad'in, Baghdad	40%	$158	$844	$1,002
AN07-Hadeetha, Anbar	40%	$117	$538	$655
KR03-Qadha' Al Hindiya, Kerbala	38%	$613	$460	$1,073
DY04-Al Tahrir, Diyala	38%	$87	$39	$126
NF05-Hai Al Askari Near Al Wafa', Najaf	36%	$221	$459	$680
DI05-Hai Al Wihda, Qadissiya	36%	$487	$431	$918
TQ03-Qal'at Sukkar, Thi-Qar	34%	$304	$403	$707
DI04-Al Shannafiya, Al Qadissiya	33%	$452	$451	$903
DY03-Jalowla', Diyala	30%	$73	$790	$863
TQ06-Al Rifa'ee, Thi-Qar	28%	$262	$448	$710
TQ08-Al Nasr, Thi-Qar	27%	$393	$508	$901
TQ01-Suq Al Shyookh/Al Zahra, Thi-Qar	27%	$335	$405	$740
TQ05-Al Duwaya, Thi-Qar	26%	$195	$438	$633
TQ04-Al Gharraf, Thi-Qar	24%	$289	$508	$797
TQ02-Sayyid Dakheel Al Moosawi, Thi-Qar	24%	$182	$515	$697
NA08-Hai Mansoor, Ninewa	23%	$670	$818	$1,488
NA07-Al Wihda/Talla'afer, Ninewa	17%	$475	$1,069	$1,544

Healthcare Center Site Identification Number, Location, and Province	% Physical Completion as of March 2006	Construction Cost		
		Parsons	Additional	Total
20 TYPE B (MODEL CENTER with TEACHING FACILITIES)				
BK05-Al Hibna, Baghdad	99%	$317	$227	$544
BR18-Shaikh Omar, Baghdad	85%	$161	$275	$436
DK03-Barzan, Dahuk	75%	$806	$341	$1,147
AR03-Brayeti, Erbil	72%	$489	$413	$902
BB01-Hai Al Asatiha, Babylon	71%	$492	$217	$709
WA04-Al Haidariya, Wassit	71%	$883	$119	$1,002
NA02-17 Tammooz, Ninewa	65%	$660	$486	$1,146
KR02-Hai Al Wafa', Kerbala	58%	$610	$346	$956
BR12-Family Medicine, Al Thubbat, Baghdad	57%	$305	$721	$1,026
BA04-Mawkee Kul Yat Al Tib Al Kadema, Basrah	56%	$240	$482	$722
KE03-Hai Tiseen, Tameem	54%	$280	$463	$743
AN01-Al Hukum Al Mahalli, Anbar	51%	$365	$256	$621
MN01-Door Al Naft, Missan	44%	$469	$362	$831
MU01-Hai Al Husein, Al Muthanna	39%	$329	$427	$756
NF04-Hai Al Adala, (New Per DG), Najaf	38%	$283	$454	$737
DI02-Al Jadida, Qadissiya	38%	$592	$476	$1,068
BK10-Al Jami'a/Family Medicine, Baghdad	27%	$73	$84	$157
TQ07-Somer, Thi-Qar	17%	$153	$719	$872
DY07-Hai Al Mustafa, Diyala	12%	$152	$510	$662
SU07-Sirchanar, Sulaymaniyah	???	$592	$797	$1,389
19 TYPE C (MODEL CENTERS with EMERGENCY AND LABOR FACILITIES)				
DY08-Bani Sa'ad, Diyala	97%	$43	$888	$931
NA03-Zummar, Ninewa	92%	$1,288	$486	$1,774
NA01-Al Qosh, Ninewa	77%	$578	$442	$1,020
DK01-Sameel, Dahuk	71%	$1,146	$432	$1,578
BR09-Jisir Diyala, Baghdad	67%	$386	$509	$895
AR02-Bnaslawa, Erbil	61%	$734	$862	$1,596
BA05-Abdalla Hashim/Qadha' Al Madina, Basrah	55%	$1,069	$0	$1,069
KR04-Qadha'al Hindiya Al Khayrat, Kerbala	52%	$988	$595	$1,583
AN03-Al Falluja/Al Karma, Anbar	50%	$428	$766	$1,194
DY09-Al Mansooriya, Diyala	44%	$313	$836	$1,149
BK04-Khan Dhari, Baghdad	40%	$381	$483	$864
MN03-Qadha' Ali Al Sharji, Missan	32%	$922	$690	$1,612
DI03-Al Badeer, Qadissiya	30%	$816	$592	$1,408

Healthcare Center Site Identification Number, Location, and Province	% Physical Completion as of March 2006	Construction Cost		
		Parsons	Additional	Total
WA05-Sheikh Sa'ad, Wassit	30%	$507	$569	$1,076
DI01-Ghammas, Qadissiya	26%	$786	$572	$1,358
MU02-Al Warka', Muthanna	19%	$319	$1,133	$1,452
NF03-Suq Sha'alan, Najaf	17%	$484	$868	$1,352
DY05-Al Wajihiya, Diyala	15%	$0	$1,217	$1,217
DY06-Al Atheem, Diyala	9%	$89	$1,691	$1,780
Total Construction Costs		**$60,859[6]**	**$56,809**	**$117,668**

Source: Physical completion data is from IRMS and construction cost data was provided by GRD. The additional construction cost was validated against contract data in CEFMS, and if significant differences existed between the GRD provided data and the CEFMS data, we report the official accounting data from CEFMS.

[6] Although the Parsons construction cost provided by GRD for each of the 142 PHCs adds to $61 million, the financial records in CEFMS shows that $84 million is obligated for Parsons' PHC construction task order as of March 2009. We use this more reliable financial data for total Parsons construction cost.

Appendix C—Reported Dates of Transfer to MoH and Dates PHCs Opened[7]

Healthcare Center Site Identification Number, Location, and Province	Month and Year Transferred to MoH	Identified as a Unilateral or As Is Transfer	Month and Year Opened
103 TYPE A (MODEL CENTER)			
BK06-Al Huriya, Baghdad	Unknown		Unknown
BR08-Al Mashtal, Baghdad	Unknown		Unknown
BR04-Al Thalith, Madinat Al Sadr, Sector 46, Baghdad			May 2006
BR05-Al Guyara Sector 56, Baghdad	Unknown		Unknown
BR10-Al Husseniya, Baghdad	Unknown		Unknown
BK11-Al Rasheed, Baghdad	Dec 2007		Not open
BK08-Al Tahaddi, Baghdad	Oct 2008		Unknown
SD08-Al Tooz, Salah Al-Din	Dec 2006		Unknown
NA05-Al Nahrawan, Ninewa	Sep 2007		Unknown
SD05-Tikrit, Salah Al-Din	Feb 2007		Unknown
BK14-Al Noor, Baghdad	May 2007		Mar 2008
BR14-Al Sha'ab 1, Baghdad	May 2007	Unilateral	Feb 2008
BR13-Hai Babil, Baghdad	May 2007		Unknown
WA07-Qadha' Al Aziziya, Wassit	Sep 2006		Unknown
BK09-Al Salam, Baghdad	Aug 2008		Aug 2008
BR02-14 Tammooz, Baghdad	May 2007		Jul 2008
AN02-Al Falluja/Al Jghefil, Anbar	Jul 2007		Unknown
DY10-Nahrawan, Diyala	Mar 2007		Apr 2008
SD03-Al Razi/Tikrit, Salah Al-Din	Mar 2008		Unknown
SD01-Ibn Rushid, Salah Al-Din	Mar 2008		Unknown
BK03-Al Mahmoudiya, Baghdad	May 2007		Mar 2008
BK02-Al I'lam, Baghdad	Jul 2008		Jul 2008
BR03-Al Ameen, Baghdad	Jul 2007		Unknown
SD07-Beji, Salah Al-Din	May 2007		Sep 2007
SD06-Al Sharqat / Hajeel Al Kabeer, Salah Al-Din	Oct 2008		Oct 2008
BR11-Al Thani, Madinat Al Sadr Sector 29, Baghdad	Dec 2007		Feb 2008
BA02-Al Khaleej Al Arabi, Basrah	Oct 2008		Oct 2008

[7] GRD provides the dates and other data in this Appendix and in most cases, the dates and data were not verified against source documents, as noted in the report.

Healthcare Center Site Identification Number, Location, and Province	Month and Year Transferred to MoH	Identified as a Unilateral or As Is Transfer	Month and Year Opened
NF01-Hai Kinda, Najaf	Jan 2007		Unknown
BR17-Al Sha'ab 2, Baghdad	Sep 2007		Feb 2008
NF06-Hai Al Jam'Ia (Near Uroba), Najaf	Jan 2007		Unknown
BK01-Al Hadhar, Baghdad	Not Completed	As Is	Not open
NA09-Hai Nablus, Ninewa	Apr 2007		Feb 2008
SD02-Al Armooshiya, Salah Al-Din	Sep 2008		Not open
BB02-Hai Al Imam, Babylon	Apr 2008		Feb 2008
BR16-Hai Ur, Baghdad	May 2007		Unknown
NA10-Al Mahallabiya, Ninewa	Apr 2007		Not open
DK02-Bahdeenan, Dahuk	Jul 2007		Oct 2007
BA11-Hai Al Hussien, Basrah	Sep 2008		Nov 2008
KE02-Shiqaq Hai Musalla, Tameem	Jul 2007		Unknown
SU05-Halabjay Taza, Sulaymaniyah	Jun 2007		Nov 2007
AN06-Al Jazeera/Albo Ubeid, Anbar	Not Completed/ Destroyed	As Is	
AR01-Sarawran, Erbil	Sep 2007		Oct 2007
SU04-Khormal, Sulaymaniyah	Aug 2007		Dec 2007
SU06-Ashti Koyseneeq, Sulaymaniyah	Jul 2007		Dec 2007
SU02-Qalawa, Sulaymaniyah	Nov 2007		Mar 2008
BK15-Al Washhash, Baghdad	May 2007		Mar 2008
KE01-Hai Alhajjaj, Tameem	Aug 2007		Jan 2008
AR04-Ainkawa, Erbil	Sep 2007		Feb 2008
KR01-Al Haidariya (Hai Al Askari), Kerbala	May 2008		Jul 2008
WA01-Hai Al Shuhada', Wassit	Jul 2007		Mar 2008
WA06-Hai Al Jamaheer, Wassit	Sep 2008		Sep 2008
SU03-Cham Chamal, Sulaymaniyah	May 2007		Feb 2008
BA08-Janeena, Basrah	Not Completed/ Mar 2008	As Is	
BR01-Al Sadis Sector 72, Baghdad	Oct 2007		Unknown
KE05-Hai Alasra Wa Al Mafqoodeen, Tameem	Jul 2007		Jan 2008
WA03-Al Kut (Zayn Al Qaws), Wassit	Jul 2007		Mar 2008
KE04-Hai Al Wasity, Tameem	Jul 2007		Unknown
BB06-Al Hadi, Babylon	Nov 2007		Dec 2007
AR06-Qaraqejeen, Erbil	Sep 2007		Feb 2008
AR05-Hanjeerok, Erbil	Sep 2007		Oct 2007
AN05-Heet/Hai Al Bakr, Anbar	Jul 2008		Aug 2008
BA10-Al Mishraq, Basrah	Aug 2007		Sep 2007
BB04-Al Midhatiya, Babylon	May 2008		Sep 2008

Healthcare Center Site Identification Number, Location, and Province	Month and Year Transferred to MoH	Identified as a Unilateral or As Is Transfer	Month and Year Opened
AR07-Harem, Erbil	Sep 2007		Feb 2008
KR06-Hai Al Asra, Kerbala	May 2007		Jan 2008
BA01-Al Aqeel/Qadha' Al Zubair, Basrah	Jun 2007		Sep 2007
BA09-Hai Al Muhandiseen, Basrah	Jun 2008		Jul 2008
BA03-Al Qurna, Basrah	Jun 2007		Jun 2008
BR19-Al Sabi', Madinat Al Sadr Sector 15, Baghdad	Nov 2007		Feb 2008
DY02-Al Khalis, Dahuk	Jun 2008		Nov 2008
BR07-Al Karrada Al Awal, Baghdad	Oct 2007		Dec 2007
BA07-Al Risala, Basrah	Jul 2007		Dec 2007
WA02-Qadha' Badra, Wassit	Nov 2007		Mar 2008
BB03-Al Qasim, Babylon	Jan 2008		Jul 2008
MN04-Qadha' Al Majar Al Kabeer, Missan	Not Completed	As Is	
KR07-Ayn Tamr, Kerbala	Jun 2008		Jul 2008
AN04-Qadha'rama, Anbar	Not Completed Sep 2008		Not open
SD09-Al Door, Salah Al-Din	Feb 2008		Jul 2008
NA06-Hai Al Intisar, Ninewa	Not Completed/ Destroyed Jul 2008	As Is	
MN02-Hai Al Nida', Missan	Jul 2007		Mar 2008
BB07-Al Kifil, Babylon	Jul 2008		Oct 2008
MU03-Qadha' Al Khidhir, Muthanna	Aug 2007		Mar 2008
BB05-Al Mahaweel, Babylon	Jan 2008		Jan 2008
BA06-Al Zahrawi/Nahiat Um Qasr, Basrah	Sep 2008		Not open
NF02-Hai Al Meelad, Najaf	Jan 2008		Jan 2008
KR05-Qadha'Al Hinidiya Sayid Husseon Al Janib Al Kabeer, Kerbala	Jul 2008		Jul 2008
BR06-Al Awal Al Mad'in, Baghdad	May 2008		Sep 2008
AN07-Hadeetha, Anbar	Jul 2008		Jul 2008
KR03-Qadha' Al Hindiya, Kerbala	Jul 2008		Aug 2008
DY04-Al Tahrir, Diyala	Not Completed/ Destroyed Jun 2007	As Is	
NF05-Hai Al Askari Near Al Wafa', Najaf	Nov 2007		Feb 2008
DI05-Hai Al Wihda, Qadissiya	May 2008	Unilateral	Jun 2008
TQ03-Qal'at Sukkar, Thi Qar	Feb 2008		Aug 2008
DI04-Al Shannafiya, Qadissiya	Jun 2008	Unilateral	Jul 2008
DY03-Jalowla', Diyala	Jan 2008		Not open

Healthcare Center Site Identification Number, Location, and Province	Month and Year Transferred to MoH	Identified as a Unilateral or As Is Transfer	Month and Year Opened
TQ06-Al Rifa'ee, Thi-Qar	Aug 2008	As Is	Not open
TQ08-Al Nasr, Thi-Qar	Sep 2008		Not open
TQ01-Suq Al Shyookh/Al Zahra, Thi-Qar	Feb 2008		Aug 2008
TQ05-Al Duwaya, Thi-Qar	Aug 2008	As Is	Not open
TQ04-Al Gharraf, Thi-Qar	Sep 2008		Not open
TQ02-Sayyid Dakheel Al Moosawi, Thi-Qar	Sep 2008		Not open
NA08-Hai Mansoor, Ninewa	Apr 2008		Oct 2008
NA07-Al Wihda/Talla'afer, Ninewa	Jun 2008		Not open
20 TYPE B (MODEL CENTER with TEACHING FACILITIES)			
BK05-Al Hibna, Baghdad	Jun 2007		Unknown
BR18-Shaikh Omar, Baghdad	Sep 2007		Feb 2008
DK03-Barzan, Dahuk	Jul 2007		Nov 2007
AR03-Brayeti, Erbil	Sep 2007		Nov 2008
BB01-Hai Al Asatiha, Babylon	Mar 2008		April 2008
WA04-Al Haidariya, Wassit	Apr 2007		Unknown
NA02-17 Tammooz, Ninewa	Jul 2007		Mar 2008
KR02-Hai Al Wafa', Kerbala	Jul 2008		Jul 2008
BR12-Family Medicine, Al Thubbat, Baghdad	Nov 2007		Dec 2007
BA04-Mawkee Kul Yat Al Tib Al Kadema, Basrah	Jul 2007		Feb 2008
KE03-Hai Tiseen, Tameem	Jul 2007		Unknown
AN01-Al Hukum Al Mahalli, Anbar	Not Completed/ Destroyed	As Is	
MN01-Door Al Naft, Missan	Jul 2007		Mar 2008
MU01-Hai Al Husein, Muthanna	Aug 2007		Mar 2008
NF04-Hai Al Adala, (New Per DG), Najaf	Nov 2007		Feb 2008
DI02-Al Jadida, Qadissiya	May 2008	Unilateral	May 2008
BK10-Al Jami'a/Family Medicine, Baghdad	Not Completed/ Destroyed Nov 2007	As Is	
TQ07-Somer, Thi-Qar	Feb 2008		Aug 2008
DY07-Hai Al Mustafa, Diyala	Jun 2008		Aug 2008
SU07-Sirchanar, Sulaymaniyah	Feb 2008		Mar 2008

19 TYPE C (MODEL CENTERS with EMERGENCY AND LABOR FACILITIES)

DY08-Bani Sa'ad, Diyala	Not Completed/ Destroyed Feb 2008	As Is	
NA03-Zummar, Ninewa	Sep 2007		Unknown
NA01-Al Qosh, Ninewa	Jun 2007		Apr 2008
DK01-Sameel, Dahuk	Sep 2007		Nov 2007
BR09-Jisir Diyala, Baghdad	Nov 2007		Feb 2008
AR02-Bnaslawa, Erbil	Sep 2007		Feb 2008
BA05-Abdalla Hashim/Qadha' Al Madina, Basrah	Not Completed Mar 2008	As Is	
KR04-Qadha'al Hindiya Al Khayrat, Kerbala	Apr 2008		Jun 2008
AN03-Al Falluja/Al Karma, Anbar	Apr 2008		Not open
DY09-Al Mansooriya, Diyala	Jan 2008		Not open
BK04-Khan Dhari, Baghdad	Feb 2008		Jul 2008
MN03-Qadha' Ali Al Sharji, Missan	Sep 2007		May 2008
DI03-Al Badeer, Qadissiya	Jun 2008	Unilateral	Jun 2008
WA05-Sheikh Sa'ad, Wassit	Feb 2008		Feb 2008
DI01-Ghammas, Qadissiya	Jul 2008		Sep 2008
MU02-Al Warka', Muthanna	Mar 2008		Not open
NF03-Suq Sha'alan, Najaf	Jul 2008		Sep 2008
DY05-Al Wajihiya, Diyala	Oct 2008	As Is	Not open
DY06-Al Atheem, Diyala	Oct 2008	As Is	Not open

Source: GRD provided data as of March 2009

Appendix D—Acronyms

Acronym	Description
CEFMS	U.S. Army Corps of Engineers Financial Management System
GRD	Gulf Region Division
IRMS	Iraq Reconstruction Management System
ITAO	Iraq Transition Assistance Office
JCC-I/A	Joint Contracting Command-Iraq/Afghanistan
MoH	Ministry of Health
PHC	primary healthcare center
SIGIR	Special Inspector General for Iraq Reconstruction

Appendix E—Audit Team Members

This report was prepared and the review was conducted under the direction of David R. Warren, Assistant Inspector General for Audit, Office of the Special Inspector General for Iraq Reconstruction.

The staff members who conducted the audit and contributed to the report include:

Ziad Buhaissi

David Childress

Whitney Miller

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Appendix F—Management Comments
Iraq Transition Assistance Office

Embassy of the United States of America
Baghdad, Iraq

April 17, 2009

Mr. David R. Warren
Assistant Inspector General for Audit
Special Inspector General for Iraq Reconstruction

Dear Mr. Warren:

We appreciate the effort and research that has gone into the SIGIR Draft Audit Report 09-015: *Construction of Primary Healthcare Centers Reported Essentially Complete, But Operational Issues Remain.* Our responses to the recommendations are as follows:

Recommendations (1) and (2): Jointly direct a U.S. government study to (1) provide transparency on the current status of PHCs and assess the cost and benefits of potential actions to address identified PHC operational and sustainability problems, and (2) identify actions the U.S. government could undertake to help ensure that the benefits expected from the PHC program are realized and the investment will not be wasted.

The Embassy concurs with both parts of this recommendation and is working to accomplish these goals. As noted in the audit report, in May 2008, ITAO contracted Stanley Baker Hill through GRD to initiate a PHC maintenance and operations program that can ultimately be transferred to the Ministry of Health (MoH) to help it operate and maintain these facilities. The $16.5 million program will help identify, prioritize, correct, report, track, and manage facility and equipment deficiencies.[1] According to COL George Wright, GRD worked jointly with the local MoH Director General for Infrastructure to identify and prioritize the most heavily used PHCs for the assessment.

This assessment will review approximately half of the USG-funded PHCs. The SIGIR report states that as of February 2009, GRD anticipated reviewing only 48 PHCs; however, in April GRD told ITAO and Health Attaché Officials that 42 PHCs have already been assessed and that available funding will permit an additional 20 PHCs to be assessed. Assessment of 62 of 133 PHCs represents 46%—a considerable statistical and logistical effort that should provide sufficient transparency to allow the MoH to assume responsibility.

[1] The initiative also includes training and hands-on exercises on maintaining facilities, bio-medical systems, medical laboratories, and dental and x-ray equipment. Many of the facilities have modern, more effective or more technical equipment that may be new to local staff. The assessment will include recommendations to the MoH on training necessary

In the audit, SIGIR states that ITAO does not have resources to meet its responsibilities and does not plan for future roles/responsibilities with regard to the PHCs. It has never been the goal of ITAO to assume a long term role in or responsibility for the assets it has provided to the GOI, but to transfer those assets and the responsibility for them to the GOI. To that end ITAO has shifted from reconstruction to boosting the capacity of Iraqis to exercise ownership, control and operation of the assets-based infrastructure the USG has contributed. ITAO does this by providing Iraqi ministries with initial access to the expertise that 30 years of international isolation has denied them, such as providing the information necessary to budget and plan for operation and maintenance and some training as well. ITAO's current sustainment, training and capacity development programs are intended to assist the various ministries as they themselves take responsibility for the maintenance, sustainment, and overall use of capital assets. Continuous long-term USG involvement would contradict our ultimate strategy of transition from USG to the GOI and undermine its fledgling initiatives.

The assessments of near half the USG-funded PHCs built, including the most heavily used facilities, will provide transparency on the status of the facilities and equipment and the information needed to calculate the potential operational and sustainability concerns[2]. The completed assessment will provide the Embassy and MoH with enough information about the status of the PHCs to identify any actions the USG or GOI could take to help maximize the benefits of the PHC program and protect the USG investment. ITAO and the Health Attaché will make recommendations to the MoH for capacity development and sustainability initiatives using GOI or, if available, USG or other donor funds.

Recommendation (3): Ensure steps are taken to obtain the Government of Iraq's participation and/or input into the above actions to the extent possible.

The Embassy concurs with this recommendation. The Health Attaché Office will ensure transparency on the current status of PHCs by working with the MoH to share assessment findings including the cost and benefits of potential operations and maintenance requirements. Through diplomatic engagement the Health Attaché's Office will work to ensure that the MoH is aware of any requirements and the actions

[2] The PHC draft audit states that preliminary findings show that "facilities have substantial issues, including a lack of critical utilities, untrained staff, and missing equipment that was never installed or was transferred to other sites…" In contrast, the SIGIR Inspection reports of PHCs use a different tone. For example, the SIGIR Inspections reports for Hai Tiseen PHC (PA-08-158) found only minor issues that it believed would be corrected using the sustainment contract and the conclusion from the report states:

> *"During the site visit, SIGIR observed doctors attending to patients and pharmacists dispensing medication. According to the administrator, the PHC facility has been operating for 15 months and serves approximately 200 patients daily. Overall, the facility was moderately clean and well organized, and the personnel were performing minor maintenance functions, such as cleaning and repairing minor items."*

that can be undertaken to ensure that the benefits for which the PHC program was designed are realized.

Sincerely,

Karen Aguilar
Director
Iraq Transition Assistance Office

Management Comments
U.S. Army Corps of Engineers - GRD

DEPARTMENT OF THE ARMY
U.S. ARMY CORPS OF ENGINEERS
GULF REGION DIVISION
BAGHDAD, IRAQ
APO AE 09348

REPLY TO
ATTENTION OF

CEGRD-CG

20 April 2009

MEMORANDUM FOR Special Inspector General for Iraq Reconstruction, US Embassy Annex II, Room 1013, APO AE 09316

SUBJECT: SIGIR Draft Audit Report – Construction of Primary Healthcare Centers Reported Essentially Complete, but Operational Issues Remain (09-015)

1. The Gulf Region Division reviewed the subject draft report and provides comments in the enclosure.

2. Thank you for the opportunity to review the draft report and provide our written comments for incorporation in the final report.

3. If you have any questions, please contact Mr. Robert Donner at (540) 665-5022 or via email Robert.L.Donner@usace.army.mil.

Michael R. Eyre

MICHAEL R. EYRE
Major General, USA
Commanding

Encl
as

GULF REGION DIVISION
COMMAND REPLY
to
SIGIR Draft Audit Report – Construction of Primary Healthcare Centers Reported Essentially Complete, but Operational Issues Remain
SIGIR Report Number 09-015
(SIGIR Project 9001)

Overall Comment. GRD does not agree with the basic assumption that GRD and ITAO failed. Although both organizations could have done a few things better, the protracted nature of the Iraqi insurgency, poor performance by contractors, and lack of responsibility taken by the Ministry of Health are significant factors that the report failed to address and explore.

In addition, the draft report does not fully highlight the difference in responsibilities between GRD, ITAO and the Health Attaché.

GRD disagrees with some statements in the report as discussed in our comments.

SIGIR Response. *SIGIR did not conclude that GRD and ITAO failed. The first sentence of the Results in the Executive Summary states that "GRD completed construction of PHCs despite very poor security, which included bombing of facilities" and notes that the facilities will provide outpatient treatments to over 4 million Iraqis annually.*

The draft report addressed the responsibilities of GRD, ITAO, and the Health Attaché in the Introduction section of the report and various subsequent sections such as the section on transfers to the MoH where we note that the GRD management plan states that the opening and operation of the facilities as well as sustainability were outside the scope of the GRD program. We believe the report clearly discusses the responsibilities of GRD, ITAO, and the Health Attaché.

Overall SIGIR believes the information provided in the draft report is accurate. However, we agree that certain statements could be revised or deleted to improve the final report accuracy and have done so where appropriate. SIGIR specific responses to the individual GRD comments are presented below in italics on a comment by comment basis.

1. **Draft Report, summary page, third paragraph.** Further, GRD and ITAO experienced problems in transferring PHCs to the MoH, and they do not have accurate data on the number of PHCs actually open and operating.

Command Comment. GRD is responsible for tracking the construction management of the projects through physical completion, local turnover to the MoH, and financial and contractual closeout. GRD is not responsible for tracking when the MoH staffs the PHC or opens it to the public. Problems experienced by GRD and ITAO during turnover were related to MoH staffing shortages.

SIGIR Response. *GRD notes that is it not responsible for tracking the staffing and opening of PHCs. As noted above, this was discussed in the body of the draft report. Also, the section on transfers in the report includes GRDs comments about MoH staffing shortages creating difficulties in transfer of facilities. However, the report also notes that GRD did have internal reporting on the number of PHCs and the limitations GRD identified with the reported data.*

2. **Draft Report, summary page, fourth paragraph.** In May 2008, a contract was awarded to assess equipment and systems at selected facilities.

Command Comment. The scope of this contract is not limited to assessments. The scope of work includes the following primary objectives: (1) Implement an Effective Facilities Management & Operations Program at USG-Funded Healthcare Facilities; (2) Develop a Comprehensive Maintenance Management Plan; (3) Implement a Maintenance Management Program at USG-Funded Healthcare Facilities; (4) Establish a Centralized Maintenance Data Collection Capability; and (5) Enhance Operational and Life-Cycle Facilities Management Capabilities; which includes completing assessments at the selected facilities.

SIGIR Response. *We have added information to the final report's summary page and executive summary to clarify the contract was awarded for sustainment of health projects and includes assessing equipment and systems. The additional details about the contract's scope were included in the text of the draft report.*

3. **Draft Report, summary page, fifth paragraph.** GRD and ITAO have not provided sufficient accountability and transparency on the status of the PHC program as it nears completion.

Command Comment. GRD is unclear what SIGIR means by this statement or if it fully understands GRD program responsibilities. SIGIR implies that GRD has information that it has not provided. Some SIGIR information requests did not follow the prescribed process to permit a proper response or allow a reasonable response time. All 133 IRRF funded PHCs have been completed and transferred to the Government of Iraq. In addition, GRD provided contact information related to achieved records shipped to the United States.

SIGIR Response. *SIGIR concluded that more information is needed about the status and condition of the PHCs. The additional information is needed to more fully detail the status of PHCs than is provided by a summary statement that 133 PHCs have been completed and transferred to the Government of Iraq. We believe the additional information includes the number of PHCs (1) open and serving the public, (2) with construction deficiencies, (3) without basic services, (4) without required equipment, and (5) without training staff to operate equipment. We believe such additional information will provide sufficient accountability and transparency on the PHCs.*

As discussed in response to the overall comment above, the draft report discussed GRD's responsibilities. In the Introduction section of the report, we state that GRD has management responsibility to deliver complete, ready-to-operate centers to the MoH.

4. **Draft Report, page i, second bullet in results section.** GRD even awarded contracts to complete construction of the 6 PHCs considered complete when the Parsons contract was terminated in March 2006.

Command Comment. The source of this information is unknown, as GRD did not provide it as part of their response to information requests.

SIGIR Response. *In December 2008, we requested a listing of the contractors and contracts for each PHC, showing award date, completion date, and cost. GRD provided this data in mid-January, as part of SIGIR's requests for data on all 142 PHCs remaining in the program after Parsons termination. The data provided on the 142 included the 6 considered complete.*

5. **Draft Report, page ii, first paragraph.** Management problems have long burdened the program. GRD, which had program management responsibilities, did not draft its program management plan for the follow-on contracts until about 6 months after contracts to complete the partially constructed PHCs were awarded and never finalized it. It also had six different program managers in three years. Moreover, GRD's award of firm-fixed-price contracts to Iraq contractors for completing construction required assessment of the partially constructed facilities and development of independent government estimates before award of the contracts. However, because GRD failed to provide the assessments, we are unable to verify the extent of any site assessments that were made.

Command Comment. This paragraph contains misleading statements. For example:

For the period of May 06 to February 09, GRD averaged one contractor Program Manager per year. The only exception has been one short-term Program Manager who supported the program for one month. For the last two years, Feb 07 to March 09, while the program was nearing completion and closeout, there was only one GRD Programs Directorate Department of the Army Civilian assigned as the government lead of the program.

It is not unusual for the program management plan to be drafted after contract award. GRD could not locate signed copies in the three year old project file; thus, it is unconfirmed the plan was never finalized.

GRD could not locate copies of the assessments in its project files.

SIGIR Response. *GRD, in a written response to a SIGIR request, provided the names of the PHC program managers and the dates they served. That is the data included in the draft report. The GRD statement about a GRD Programs Directorate Department of the Army Civilian appears to be referring to someone other than the individuals GRD had previously identified as "PHC Program Manager."*

GRD states that it is not unusual for a program management plan to be drafted after contract award. SIGIR's point is that this practice created risk since drafting a plan after completion of some of the most critical program actions—assessing PHCs construction status and awarding

firm-fixed-priced contracts for construction completion—were completed without the benefit of a management plan.

During our audit, we were not told that the assessment files could not be located. However, based on this GRD statement, we have revised the final report language to reflect GRD's position. It should be noted that this statement conflicts with GRD comment number 17 which states that "GRD informed SIGIR that the assessments were archived and that GRD recommended an alternate contact to obtain the requested information.

6. **Draft Report, page ii, second paragraph.** In 14 cases, GRD transferred facilities to MoH that were incomplete, with plans for continued construction work at just two.

Command Comment. This paragraph misleadingly suggests all 14 were part of the 133 PHCs completed and turned over to MoH. In reality, nine of the 14 referenced cases were deprogrammed from the original 142 PHCs under the Parsons contract. A deprogrammed PHC is a PHC that ITAO and GRD collectively determined are no longer beneficial to complete from a cost perspective. Both base this determination on cost to complete, scope, schedule, or other risk factors. GRD then cancels or terminates any contracts for work on that site and removes it from the program.

SIGIR Response. *We have included the suggested wording in the final report. We also note that Appendix B of the draft report provided the information about the 14 incomplete PHCs.*

7. **Draft Report, page ii, second paragraph, last sentence.** GRD reports that 115 PHCs are open and operational, but MoH reports just 101.

Command Comment. GRD is not responsible for tracking when the MoH staffs the PHC or opens it to the public. GRD does not report the "open" or "operational" status of PHCs.

SIGIR Response. *As stated above in response to GRD's overall comment, the report states that GRD's management plan states that GRD is not responsible for tracking opening and operation of facilities. However, GRD's internal reports did show that 115 PHCs were open and operational. Our reports further notes that GRD officials have no visibility on the operational status.*

8. **Draft Report, page iii, top of page.** Also, because GRD failed to provide the requested assessments, SIGIR has not reviewed these documents.

Command Comment. GRD has no record of a data request for assessments.

SIGIR Response. *We requested details about the Stanley Baker Hill contract in our initial questions to GRD in December 2008 and continued to pursue such data throughout the audit. On March 12 an e-mail was sent to GRD specifically requesting any assessments available and other related data. We received no response.*

9. **Draft Report, page iii, second paragraph.** Reports showing 133 PHCs having been completed and transferred are not complete and accurate.

Command Comment. GRD provided SIGIR a table showing all 133 IRRF funded PHCs were completed and transferred.

SIGIR Response. *This is a SIGIR conclusion. As noted above in response to GRD's comment 3, we believe that accurate and complete reporting would provide additional information on PHCs, including the number (1) open and serving the public, (2) with construction deficiencies, (3) without basic services, (4) without required equipment, and (5) without training staff to operate equipment.*

10. **Draft Report, page iii, third paragraph.** Millions of dollars were spent to (1) finish construction, (2) deliver and install medical and office equipment and consumables, and (3) train Iraqis on PHC equipment. However, some or all of these actions were not completed for a significant number of PHCs. ITAO's and GRD's limited contract effort to assess PHC status is based on funds available, not the amount needed.

Command Comment. This paragraph begins by addressing the original IRRF program goals and then tries to associate the intent of the follow-on O&M program of Task Order 36. This approach leaves a false and negative impression of the intent and a limited view of the scope of the O&M program.

SIGIR Response. *Again the cited statement is a part of SIGIR's conclusions. We are noting that despite the expenditure of millions of dollars, the job is not complete and the ongoing contract effort will not fully address questions about what is not complete. These SIGIR conclusions lead to the recommendation for further study to provide transparency to the current status of PHCs.*

11. **Draft Report, page iii, third paragraph, last sentence.** Further, neither has identified plans and/or funds for additional assessments and/or completion work for PHCs.

Command Comment. The SIGIR statement is misleading. GRD is only responsible for executing the program funded by its customer, in this case, ITAO. GRD has made recommendations to ITAO towards the obligation of additional funding to support further assessments, training, and operations & maintenance services.

SIGIR Response. *This statement is based on information obtained during our audit. To clarify the point we added information to reflect GRD's position. However, we do note that GRD's comment regarding the recommendations it made to ITAO indicates GRD had some interest in this issue.*

12. **Draft Report, page 3, third paragraph.** In addition, Stanley Baker Hill, a contractor, provides management support to GRD for the program.

Command Comment. Berger/URS provided program management support for GRD until the fourth quarter of 2007 at which time SBH transitioned into the role.

SIGIR Response. *We have added the suggested language to the final report.*

13. **Draft Report, page 3, fourth paragraph.** GRD provides engineering services to the Multi-National Force-Iraq and the Iraqi government.

Command Comment. The SIGIR statement is misleading because GRD does not provide engineering services to the Iraqi government.

SIGIR Response. *We deleted the reference to the Iraqi government from the final report.*

14. **Draft Report, page 5, fourth paragraph.** As shown in Table 2, the total estimated cost of the PHC program has increased by about $98 million—from $243 million at Parsons' termination in March 2006 to $341 million in March 2009—while the number of PHCs to be completed has been reduced from 150 to 133.

Command Comment. This statement is misleading as it suggests the estimate to complete the program in March 2006, at the time of Parson's termination was $243 million. In reality, it was the original, $67.1M (IRRF) & $0.7M (CERP) definitized construction cost for the program, under Parson's as reported by GRD. In addition, the PHC count had reduced to 142 by termination in 2006 rather than 150 as represented in this report.

SIGIR Response. *We clearly state that we are comparing the expected cost under the Parsons contract at the time of termination, to the current cost. Likewise, we are also comparing the original 150 planned PHCs to the current number. In our final report, we have updated the amount of obligations for construction under the Parsons' contract to March 2009 and the increase is reported at $102 million—from $243 million to $345 million.*

15. **Draft Report, page 8, first paragraph.** For the nonconstruction costs that were awarded by JCC-I/A, the GRD fee for contract administrative services is 4% of the contract amount.

Command Comment. This statement is inaccurate since GRD did not provide it in response to a data request. In addition, JCC-I is not aware of any occasion where GRD receives an administrative fee on procurement contracts. GRD does not know the source of this inaccurate information.

SIGIR Response. *We have deleted the statement from the final report. Also, the final report shows the estimated government cost of managing and administering the PHC program as $11 million.*

16. **Draft Report, pages 11 - 13.** The completion contract for the Hai Al Intisar PHC was awarded in July 2006, and, according to GRD, the contractor "worked slowly, but steadily," up to November 15, 2006, when insurgents used explosives to seriously damage the structure, as shown in Figures 4 and 5. GRD was initially uncertain as to whether the PHC would be completed, but for security and other reasons terminated the contract for convenience. In processing the termination, GRD notified the contractor that based on the $278,430 paid, the contractor should have completed 45% of the construction, but the government determined that only 13% had been completed and the contractor therefore owed the government $173,277. This overpayment indicates that the government was not adequately assessing physical progress as it was making performance payments. Additionally, financial records do not indicate that the government has recovered the overpayment. In our follow-up to determine whether the funds were recovered, a GRD official said that they were still seeking information about the potential refund.

Command Comment. The pictures show the kinetic activity associated with this PHC. The Gulf Region North district office notified the contractor by email in 2007 of the overpayment. The district did not receive a response from the contractor and could not locate the contractor. Subsequent attempts to contact the contractor *proved* unsuccessful. The total amount involved is less than one percent of the PHC program.

SIGIR Response. *We added to the final report GRD's statement that its attempts to contact the contractor proved unsuccessful.*

17. **Draft Report, page 14, last paragraph.** GRD provided no documentation in response to our request for selected site assessments.

Command Comment. While this statement is true, it fails to indicate that GRD informed SIGIR that the assessments were archived and that GRD recommended an alternate contact to obtain the requested information.

SIGIR Response. *We were not informed during our audit work that the assessments were archived. This statement also seems to conflict with GRD's statement in comment number 5 that the assessments could not be located in its files.*

18. **Draft Report, page 15, first paragraph.** Moreover, GRD had stated that those assessments were to be performed by the contractor, not by the district engineers.

Command Comment. GRD did not make this statement response to a request for information; the source is unknown. GRD and its Districts practice standard USACE procedures. GRD district engineers, in accordance with contracting procedures, conducted site visits in the spring of 2006 to assess the extent of additional construction needed and to develop independent government estimates before award of construction contracts.

SIGIR Response. *The statement is from SIGIR inspection reports on PHCs that were issued in January 2009. The final report reflects the source of this information.*

19. **Draft Report, page 15, third paragraph.** For several facilities, two additional contracts were awarded to complete construction. For the PHC at Al Thalith, Baghdad (BR04), Parsons was paid about $387,000 for construction, and GRD considered the PHC 100% complete when the Parsons contract was terminated. GRD awarded a follow-on construction contract for $50,000 in April 2006 to complete the PHC, and the contract was reported complete in May 2006. However, in September 2006, another contract for about $30,000 was awarded. When we asked GRD why two contracts totaling about $80,000 were awarded on a 100% complete PHC, they responded that one was to complete construction, and the other was to complete a punch list.

Command Comment. GRD's response to this question, both verbally and in writing, was that both follow-on contracts were to complete punch list items. Based upon its thorough review of all RMS and IRMS data, GRD determined that contract W917BG-06-D-0005 was not terminated as previously reported in its response to a SIGIR data request.

SIGIR Response. *While the cited information was provided to us during the audit, we have revised the final report based on GRD's current statements. SIGIR's data on contracts show that the cited contract was not terminated.*

20. **Draft Report, page 15, last paragraph.** ITAO officials stated that GRD did not always have readily available information on the current status of projects like PHCs because it relied on field personnel to provide updates on projects' status. If GRD's personnel could not easily check on the status of projects, detailed information was not readily available.

Command Comment. The SIGIR statement is misleading. GRD held weekly teleconferences with the District Project Managers specific to the Health program to ensure GRD had visibility over the status of the program and possible issues. GRD also participated in teleconferences specific to PHCs, held by the Districts, and distributed a weekly Health Sector Update to ITAO and the DoS Health Attaché.

SIGIR Response. *This cited statement was made by ITAO officials. While GRD cites various efforts to have program details, the comments by ITAO officials was that GRD did not always have readily available data on project status. GRD comments were added to the report.*

21. **Draft Report, page 16, first paragraph.** GRD and ITAO officials said that they also rely on the Health Attaché for insight into the operational status of many of the PHCs because the office serves as the primary U.S. government contact with the MoH. According to the Health Attaché, however, he relies extensively on GRD and ITAO for information on the status of the PHCs because his office has only three people.

Command Comment. Again, GRD is only responsible for tracking the construction management of the projects through physical completion, local turnover to the MoH, and financial and contractual closeout. For related information, GRD would be the appropriate resource. GRD is not responsible for tracking when the MoH staffs the PHC or opens it to the public, and relies on the U.S. Embassy – Baghdad for that information.

SIGIR Response. *SIGIR statement is that GRD and ITAO officials stated that they rely on the Health Attaché. It neither states nor implies that GRD is responsible for tracking when the PHC is open. As noted in a number of earlier comments, the draft report stated that GRD does not track when the MoH staffs or opens the PHCs.*

22. **Draft Report, page 16, second paragraph.** Furthermore, the draft PHC management plan noted that GRD is required to report "IRMS data even though in most cases the data is suspect.

Command Comment. The referenced management plan was written in 2006. Integrity of the IRMS data is a command priority, has improved significantly, and GRD continually scrubs it for discrepancies. The majority of the IRMS data involving PHCs is District construction management data reported in the USACE Resident Management System (RMS) which is imported into IRMS.

SIGIR Response. *We agree with GRD points and also note that IRMS data problems are not limited to 2006 data. In the same paragraph cited by GRD, the draft report noted that GRD officials, in response to a July 2008 SIGIR report, stated that IRMS is known to contain inconsistent and incomplete data in several areas.*

23. **Draft Report, page 16, third paragraph.** Our analyses of the percentages of PHC completions and their costs support questions about data accuracy. For example, IRMS records for the PHC at Khaleej Al Arabi, Al Basrah (BA02) show two different percentage completions (26% and 85%) in two different records on the project.

Command Comment. The report does not identify the date or name of the IRMS report allegedly containing this data. GRD continually scrubs data accuracy and could not find the situation described.

SIGIR Response. *The cited percentages were taken from project tracking data for the URIs in March 2009.*

24. **Draft Report, page 16, fourth paragraph.** Our analysis of data for the completion of the PHCs identified other indicators of IRMS data issues, inadequate assessments, and/or construction management issues. For example, 17 PHCs were identified as being either 100% or 99% complete at termination in March 2006, but significant construction contracts totaling about $1.90 million were awarded for completing these PHCs. For 11 of the PHCs, two separate contracts were awarded to complete the PHCs.

Command Comment. The 17 sites were not part of any information requests for this audit. Depending on the data field selected, either the 100% or 99% data could accurately reflect the termination of the project. The re-award for completion is an entirely separate record. Again, the situation is unknown. Of note, the punch list contracts targeted ten PHCs. In addition, based upon its thorough review of all RMS and IRMS data, GRD determined that contract W917BG-06-D-0005 was not terminated as previously reported in its response to a SIGIR data request.

SIGIR Response. *In December 2008, we requested a listing of the contractors and contracts for each PHC, showing award date, completion date, and cost. GRD provided this data in mid-January, including data on the 17 PHCs. Appendix B of the draft report shows percentage completion and construction costs for each of the 142 PHCs and is based on the GRD provided data.*

25. **Draft Report, page 18, first paragraph.** Furthermore, GRD and ITAO do not have accurate and complete oversight data on the number of PHCs that are open and operating.

Command Comment. Again, GRD is only responsible for tracking the construction management of the projects through physical completion, local turnover to the MoH, financial and contractual closeout. GRD is not responsible for tracking when the MoH staffs the PHC or opens it to the public and relies on the U.S. Embassy – Baghdad for that information.

SIGIR Response. *The GRD language has been inserted in the final report and the GRD comment has been addressed in a number of previous comments.*

26. **Draft Report, page 18, second paragraph.** The Health Attaché stated that many contracts were awarded with great speed and little consultation with the Iraqi government.

Command Comment. Archived correspondence and reports do not support this statement. On the contrary, documentation indicates active MoH-PCO discussion specific to site selection, type (new construction/rehabilitation), and priority via written and in-person communication.

SIGIR Response. *The statement is attributed to the Health Attaché. Also, included in the draft report were comments by MoH officials that GRD did not consult with them in designing facilities, in selecting construction contractors, or in overseeing contractors and that this resulted in dissatisfaction with many facilities. We have added GRDs comment to the final report but without the GRD documents, SIGIR cannot verify the validity of the statements.*

27. **Draft Report, page 19, second paragraph.** GRD officials told us that 14 facilities—identified in Appendix C—were transferred "as is." They noted that construction work continued for two of the "as is" facilities after transfer based on an agreement with MoH.

Command Comment. Nine of the 14 sites were those deprogrammed from the 142 PHC program. GRD an ITAO deprogrammed one when insurgent activity severely damaged it. The Iraqi government used another to complete the facility and GRD delivered GFE to a MoH warehouse for installation. The medical equipment went to the warehouse instead of the site because MoH did not yet have available staff or security dedicated for the location (BK01). Two other facilities were still on-going at the time of turnover (DY05 & DY06). Two were near complete when they were terminated (TQ05 & TQ06) and MoH agreed to accept the sites and complete construction themselves.

SIGIR Response. *We have added to the final report the statement that 9 of the 14 facilities transferred "as is" were removed from the PHC program. As cited in the draft report, Appendix C identified the 14 facilities and provides additional information.*

28. **Draft Report, page 19, fourth paragraph.** To verify transfer data reported by GRD, SIGIR requested local and national transfer letters for 12 selected PHCs reported as transferred.

Command Comment. All local letters requested from GRD were located and delivered to SIGIR. ITAO is responsible for executing and tracking national transfer letters.

SIGIR Response. *We requested 12 local transfer letters from GRD. GRD provided us with 2 letters as stated in the report. We did not receive transfer letters from GRD for the other 10 PHCs. However, ITAO provided us some of the local transfer letters, but no national transfer letters.*

29. **Draft Report, page 22, third paragraph.** GRD recognized that, in many cases, the companies awarded the contract to complete the PHCs did not properly install the medical equipment or train the PHC personnel on the use of the equipment.

Command Comment. GRD did not make this statement in response to any information requests. The source is unknown.

SIGIR Response. *This statement comes from the SIGIR inspection reports on PHCs issued in January 2009 and is included in a section where the results of the inspections are being discussed.*

30. **Draft Report, page 22, last paragraph.** Both GRD and ITAO have expressed concerns and taken some action to address PHC operational and sustainability issues; however, officials of both organizations state that they have no plans or funds for further involvement with the PHCs.

Command Comment. GRD only executes the program funded by its customer, in this case, ITAO. GRD does not formulate plans unless it receives a statement of requirements from its customer, also in this case, ITAO.

SIGIR Response. *As noted in response to comment number 11, this statement is based on information obtained during our audit. To clarify the point we added information to reflect GRD's position. However, we do note that GRD's comment regarding the recommendations it made to ITAO indicates GRD had some interest in this issue.*

31. **Draft Report, page 22, last paragraph, last sentence.** GRD officials informed us that they have no responsibility for a PHC once it is transferred to the MoH.

Command Comment. GRD is responsible for tracking the construction management of the projects through physical completion, local turnover to the MoH, and financial and contractual closeout. GRD is not responsible for tracking when the MoH staffs the PHC or opens it to the public and relies on the U.S. Embassy – Baghdad for that information.

SIGIR Response. *As noted in response to comment 25, this GRD language has been inserted into the report.*

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