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GLOBAL HEALTH

USAID Supported a Wide Range of Child and Maternal Health Activities, but Lacked Detailed Spending Data and a Proven Method for Sharing Best Practices





Highlights of [GAO-07-486](#), a report to congressional committees

Why GAO Did This Study

Every year, disease and other conditions kill about 10 million children younger than 5 years, and more than 500,000 women die from pregnancy and childbirth-related causes. To help improve their health, Congress created the Child Survival and Health Programs Fund. The 2006 Foreign Operations Appropriations Act directed GAO to review the U.S. Agency for International Development's (USAID) use of the fund for fiscal years 2004 and 2005. Committees of jurisdiction indicated their interest centered on the Child Survival and Maternal Health (CS/MH) account of the fund. GAO examined USAID's (1) allocations, obligations, and expenditures of CS/MH funds; (2) activities undertaken with those funds; (3) methods for disseminating CS/MH information; and (4) response to challenges to its CS/MH programs. GAO conducted surveys of 40 health officers, visited USAID missions in four countries, interviewed USAID officials, and reviewed data.

What GAO Recommends

GAO recommends that USAID (1) test accounting system modifications to verify that CS/MH obligation and expenditure data will be recorded and traced back to CS/MH allocation data and (2) assess the effectiveness of existing communication methods for sharing global health best practices across missions. USAID generally concurred with GAO's findings and recommendations.

www.gao.gov/cgi-bin/getrpt?GAO-07-486.

To view the full product, including the scope and methodology, click on the link above. For more information, contact David Gootnick at (202) 512-3149 or GootnickD@gao.gov.

GLOBAL HEALTH

USAID Supported a Wide Range of Child and Maternal Health Activities, but Lacked Detailed Spending Data and a Proven Method for Sharing Best Practices

What GAO Found

In fiscal years 2004 and 2005, Congress appropriated a total of \$675.6 million to the CS/MH account. Individual USAID missions and USAID's Bureau for Global Health—the bureau providing technical support for international public health throughout the agency—were able to provide obligation and some expenditure data on these funds from their separate accounting systems. However, USAID's Office of the Administrator did not centrally track the obligations and expenditures of USAID missions and bureaus. As a result, the Office of the Administrator was limited in its ability to determine whether CS/MH funds were used for allocated purposes during this period. According to USAID officials and GAO's analysis, the agency has recently taken steps to record these data for fiscal year 2007 and beyond, although the modifications to its accounting system are in its early phases and little data had been posted as of February 2007.

Despite the lack of centralized financial data, GAO determined that USAID funded a wide variety of CS/MH efforts in 40 countries. USAID's missions, regional bureaus, and Bureau for Global Health supported programs at the country, regional, and global level. These activities included immunizations, oral rehydration therapy to treat diarrhea, and prevention of postpartum hemorrhage.

USAID used a variety of methods for disseminating information internally concerning CS/MH issues, such as electronic learning courses, biennial regional health conferences, and an online document database. However, USAID has not evaluated these methods' relative effectiveness for disseminating innovations and best practices. GAO identified some drawbacks associated with several of these methods, such as limitations in access and topics covered. As a result, USAID health officers may not learn of new innovations and advances in a timely manner.

USAID is taking steps to respond to numerous challenges to planning and implementing its CS/MH programs. First, responding to a global shortage of skilled health care workers, USAID supports efforts to enhance the skills of current health care workers and to train new health care workers. Second, because newborn and maternal health have typically received less international attention than child health, USAID established programs that focus on the needs of these two populations. Third, in response to numerous barriers to sustaining its CS/MH programs, such as uncertain funding and a lack of technical expertise among host governments and nongovernmental organizations, USAID adopted strategies to provide technical assistance and promote community involvement.

Contents

Letter		1
	Results in Brief	3
	Background	6
	Budget Process and Congressional Directives Guided CS/MH Allocations, but USAID Lacked Centralized Obligation and Expenditure Data	13
	USAID Supported a Wide Range of CS/MH Efforts	21
	USAID Has Not Assessed the Relative Effectiveness of Its Methods of Disseminating Innovations and Best Practices for Internal Use	28
	USAID Is Responding to Certain Child Survival and Maternal Health Program Challenges	32
	Conclusions	41
	Recommendations for Executive Action	41
	Agency Comments and Our Evaluation	42
Appendix I	Objectives, Scope, and Methodology	44
Appendix II	Allocation of Child Survival and Maternal Health Funds within USAID, Fiscal Years 2004 and 2005	47
Appendix III	Allocation of CS/MH Account Funds to Countries, Fiscal Years 2004 and 2005	48
Appendix IV	Mortality Statistics for Countries Receiving CS/MH Funds, Fiscal Years 2004 and 2005	50
Appendix V	Obligations and Expenditures for the Four Missions We Visited, Fiscal Years 2004 and 2005	52
Appendix VI	Comments from the U.S. Agency for International Development	53
	GAO Comment	58

Figures

Figure 1: Congressional Appropriations to the Child Survival and Health Programs Fund, by Account, Fiscal Years 2004 and 2005	9
Figure 2: Global Distribution of USAID's Child Survival and Maternal Health Funds, Fiscal Years 2004 and 2005	11
Figure 3: Organizational Chart of USAID Missions and Bureaus Involved in Supporting Child Survival and Maternal Health Activities, Fiscal Years 2004 and 2005	12
Figure 4: USAID Allocations of Child Survival and Maternal Health Funds, Fiscal Years 2004 and 2005	14
Figure 5: USAID's Allocation and Reporting Process for CS/MH Account, Fiscal Years 2004 and 2005	18
Figure 6: Health Care Worker Training	34

Abbreviations

ACCESS	Access to Clinical and Community Maternal, Neonatal and Women's Health Services
CSH Fund	Child Survival and Health Programs Fund
CS/MH	Child Survival and Maternal Health
NGO	nongovernmental organization
POPHI	Prevention of Postpartum Hemorrhage Initiative
PPC	Bureau for Policy and Program Coordination
RACHA	Reproductive and Child Health Alliance
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development
WHO	World Health Organization

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United States Government Accountability Office
Washington, DC 20548

April 20, 2007

The Honorable Patrick J. Leahy
Chairman
The Honorable Judd Gregg
Ranking Member
Subcommittee on State, Foreign Operations,
and Related Programs
Committee on Appropriations
United States Senate

The Honorable Nita M. Lowey
Chair
The Honorable Frank R. Wolf
Ranking Minority Member
Subcommittee on State, Foreign Operations,
and Related Programs
Committee on Appropriations
House of Representatives

Every year, disease and other mostly preventable conditions, such as diarrhea and malnutrition, kill more than 10 million children younger than 5 years old, including about 4 million infants in the first month of life.¹ Ninety-nine percent of newborn deaths occur in developing countries, and about 75 percent of child deaths occur in sub-Saharan Africa and South Asia.² Mothers in developing regions also face significant health risks—for example, the lifetime risk of maternal death for women in sub-Saharan Africa is 175 times greater than for women in industrialized countries.³ To help lower maternal and child mortality rates globally, in 1997, Congress established the Child Survival and Health Programs Fund (CSH Fund),

¹Robert E. Black, Saul S. Morris, and Jennifer Bryce, “Where and why are 10 million children dying every year?,” *The Lancet*, vol. 361, no. 9376 (2003).

²Save the Children, *State of the World’s Mothers 2006* (Westport, CT: May 2006); and “Where and why are 10 million children dying every year?,” 2.

³World Health Organization, *Facts and Figures from the World Health Report 2005* (2005).

which includes the Child Survival and Maternal Health (CS/MH) account.⁴ The U.S. Agency for International Development (USAID), which administers the fund, currently finances CS/MH programs at headquarters and in 40 countries⁵ to support agency goals to improve global health, including maternal and child health.⁶

In fiscal year 2006, Congress directed GAO to review USAID's use of appropriations to the CSH Fund for fiscal years 2004 and 2005.⁷ We determined, through discussions with staff from the committees of jurisdiction, that congressional interest centered on USAID's use of CS/MH allocations for fiscal years 2004 and 2005—about \$328 million and \$348 million, respectively.⁸ This report reviews USAID's (1) allocations, obligations, and expenditures of CS/MH funds for fiscal years 2004 and 2005; (2) activities undertaken with those funds; (3) procedures for disseminating information related to CS/MH innovations and best practices; and (4) response to challenges in planning and implementing its CS/MH programs.

To address these objectives, we surveyed USAID officials in the 40 USAID countries receiving CS/MH funds to determine how they manage their

⁴Initially titled the Child Survival and Disease Programs Fund and renamed in fiscal year 2001, the CSH Fund includes six accounts: HIV/AIDS; Infectious Diseases; Child Survival and Maternal Health; Family Planning and Reproductive Health; Vulnerable Children; and the Global Fund to fight AIDS, Tuberculosis, and Malaria. In addition, the fund grants money to international partnerships.

⁵For fiscal years 2004 and 2005, USAID allocated CS/MH funds for programs in 41 countries. The U.S. mission in Eritrea, however, closed in December 2005, reducing the total number of countries that received CS/MH funds to 40. USAID also supports child survival and maternal health-related activities in countries through other funding streams, such as the Economic Support Fund, Assistance for Eastern Europe and the Baltics, the Freedom Support Act, and Pub. L. No. 480 Title II accounts. Although these programs follow the same "Guidance on the Definition and Use of the Child Survival and Health Programs Fund," they were outside the scope of our review.

⁶USAID's overall performance goal for health is to "improve global health, including child, maternal, and reproductive health, and the reduction of abortion and disease, especially HIV/AIDS, malaria, and tuberculosis."

⁷The Foreign Operations, Export Financing, and Related Programs Appropriations Act, 2006, Pub. L. No. 109-102, § 522, 119 Stat. 2171, 2203.

⁸The funds appropriated to the CSH Fund in fiscal years 2004 were available to be obligated until the end of the following fiscal year, September 30, 2005. Similarly, the funds appropriated to the fund in fiscal year 2005 were available to be obligated until September 30, 2006.

activities and key challenges they face in the field. In addition, we reviewed documents such as USAID's CSH Fund progress reports, USAID's guidance for managing and implementing its maternal and child health activities, and USAID budget data. We also reviewed literature on interventions for improving maternal and child health, including three separate series from the British medical journal titled *The Lancet*, and reports on global maternal and child health issues from nongovernmental and multilateral sources, such as the United Nations Children's Fund (UNICEF) and Save the Children. At USAID's headquarters in Washington, D.C., we interviewed officials from the Bureau for Policy and Program Coordination (PPC), the Bureau for Global Health, regional bureaus, and the Office of the Controller. We also met with a number of officials representing nongovernmental and multilateral organizations, including the Global Health Council, the World Health Organization (WHO), and UNICEF. In addition, we interviewed USAID staff during visits to USAID missions in four countries—Cambodia, Ethiopia, India, and Mali—in Africa and Asia, the two continents with the highest maternal and child mortality rates. We conducted our work from April 2006 through March 2007 in accordance with generally accepted government auditing standards. (See app. I for more details on our objectives, scope, and methodology.)

Results in Brief

In fiscal years 2004 and 2005, USAID allocated the majority of the CS/MH account to support maternal and child health efforts in Africa, Asia, and Latin America and the Caribbean. However, the agency could not provide a complete accounting for its missions' and bureaus' obligations and expenditures of the allocated funds for this period. Countries in those three geographic regions received about 60 percent (\$405 million) of the approximately \$676 million appropriated to the account, while the Bureau for Global Health and international partnerships it supports received the remaining 40 percent. In making these allocations, USAID was guided both by budgeting procedures, which considered factors such as countries' magnitude of need, and by congressional directives. However, as we also reported in 1996,⁹ due to USAID's approach to tracking and accounting for such funds, it is not possible to determine how much was actually spent on CS/MH activities. Specifically, USAID did not centrally track its missions' and bureaus' CS/MH obligations and expenditures for fiscal

⁹GAO, *Foreign Assistance: Contributions to Child Survival Are Significant, but Challenges Remain*, GAO/NSIAD-97-9 (Washington, D.C.: Nov. 8, 1996), 7.

years 2004 and 2005. Furthermore, the missions and bureaus had their own systems for capturing this information. According to U.S. government standards for internal control, program managers need sufficient data to determine whether they are meeting their agencies' strategic and annual performance plans and their goals for accountability for the effective and efficient use of resources.¹⁰ Because the Office of the Administrator did not require missions and bureaus to report their obligations and expenditures for the CS/MH account, it could not provide these data at our request and is limited in its ability to verify that the allocated CS/MH funds were used for their intended purposes during fiscal years 2004 and 2005. In February 2007, USAID officials informed us of new modifications to its accounting system that are intended to allow the agency to record future maternal and child health obligations and expenditures.

Despite the lack of centralized financial data, our work at USAID headquarters and in the field demonstrated that USAID supported numerous CS/MH efforts with the funds it allocated in fiscal years 2004 and 2005. Missions supported CS/MH activities on the community and national levels—for example, providing funding to train community health workers and providing grants for government-run immunization, polio, and nutrition programs. Regional missions and bureaus conducted regional efforts, such as assessing maternal health activities in two West African countries, and supported regional strategies, for example, by funding the development of a WHO resolution to make newborn health a priority in the Americas. The Bureau for Global Health engaged in numerous CS/MH-related efforts: that is, providing technical support to missions by centrally managing some CS/MH programs at their request; supporting global CS/MH programs by managing partnerships and sharing expertise; administering a grants program for nongovernmental organizations; supporting international research on CS/MH interventions; funding surveys to provide population, health, and nutrition data; and providing global leadership in addressing child survival and maternal health.

USAID used a variety of methods for disseminating information concerning CS/MH issues, such as electronic learning courses, biennial regional health conferences, and an online document database. However, we identified drawbacks associated with several of these methods, such as

¹⁰GAO, *Standards for Internal Control in the Federal Government*, [GAO/AIMD-00-21.3.1](#) (Washington, D.C.: November 1999), 19.

limitations in access and topics covered, and USAID has not evaluated the methods' relative effectiveness for disseminating innovations and best practices. As a result, USAID health officers may not learn of new innovations and advances in the maternal and child health fields in a consistent and timely manner. For example, according to USAID's annual employee survey in 2005, approximately 40 percent of mission officials within the three regional bureaus in our review did not agree that their respective regional bureau communicated "clearly, sufficiently, transparently, and in a timely manner." Furthermore, the survey showed that over 40 percent of the mission officials who responded to questions about the Bureau for Global Health did not agree that the bureau provided "quality state-of-the-art training opportunities."

USAID is taking steps to respond to numerous challenges to planning and implementing its CS/MH programs. On the basis of reviews of expert reports, interviews with USAID officials and partner and donor representatives, and the results of our surveys, we identified three key challenges that USAID faces in planning and implementing CS/MH programs. First, responding to a global shortage of health care providers, USAID supports efforts to enhance the skills of current health care workers and to train new health care workers. For example, in Cambodia, USAID funds midwifery training on how to deal with obstetric complications. Second, because newborn and maternal health have typically received less international attention than child health, USAID established programs that focus on the needs of these two populations. For example, in 2004, USAID founded a program that focuses on increasing the coverage, access, and use of maternal and newborn health services; in 2006, the program was supporting interventions in nine countries and launching programs in four additional countries. Third, in response to numerous barriers to sustaining its CS/MH programs, such as uncertain funding and a lack of technical expertise among host governments and nongovernmental organizations, USAID adopted strategies to provide technical assistance and promote community involvement. For example, in India, USAID is funding efforts to help the Indian government develop and implement urban health plans and supporting the use of community volunteers to help implement urban health programs.

We are making two recommendations to the USAID Administrator to improve the agency's administration of the CS/MH account and its implementation of CS/MH programs. First, to strengthen USAID's ability to oversee and record allocations from the CS/MH account to help ensure that those funds are used as intended, we are recommending that the

agency test recent modifications to the principal accounting system to verify that CS/MH obligation and expenditure data will be recorded and properly traced back to the corresponding allocation data. Second, to provide for effective dissemination of information to USAID mission health officers about innovations and best practices in child survival and maternal health in a timely manner, we recommend that the USAID Administrator assess the relative effectiveness of the agency's current methods of disseminating this information through existing tools, such as the annual employee survey.

We provided a draft of this report to USAID. In general, USAID agreed with our recommendations. In its response, the agency emphasized that its accounting system tracked obligations and expenditures at the level of the larger CSH Fund in fiscal years 2004 and 2005. Regarding our first recommendation, USAID agreed to conduct tests to determine whether its modified accounting system captures all CS/MH activities and to verify that the funds are being used for the purposes for which they were appropriated. Furthermore, USAID will verify immediately that the State Department's planning system accurately captures all CS/MH allocated funds. In response to our second recommendation, USAID stated that it plans to conduct a Training Needs Assessment in 2007-2008 that will address our concerns regarding evaluation of information dissemination methods. USAID also provided information regarding the role that grantees and contractors play in disseminating information. Furthermore, the agency provided additional detail on some of the training and information dissemination efforts that we described in the draft. We have incorporated this information in the report, as well as USAID's technical comments, where appropriate. (See app. VI for a reprint of USAID's comments and our response.)

Background

Each year, nearly 10 million children die from preventable diseases and other causes and more than 500,000 women die from causes related to pregnancy and childbirth,¹¹ particularly in developing countries.¹² For

¹¹Another 15 to 20 million women suffer from pregnancy- and childbirth-induced disabilities, including nerve damage, severe anemia, infertility, and obstetric fistula—an injury in which an abnormal opening forms between a woman's bladder and vagina, resulting in urinary incontinence.

¹²"Where and why are 10 million children dying every year?," 2; and *State of World's Mothers 2006*, 3.

example, in sub-Saharan Africa, 1 in 16 women will die as a result of pregnancy or childbirth, compared with 1 in 4,000 women in industrialized countries,¹³ and a mother is 30 times more likely to lose a newborn¹⁴ in the first month of life than a mother in an industrialized country.¹⁵ *The Lancet*, a peer-reviewed British medical journal, estimates that a set of 23 known treatments would cost \$887 for every child's life saved. A subset of those medical treatments targeted for newborns—which includes antibiotics for sepsis, resuscitation, and management of the newborn's temperature—would cost \$784 for every infant's life saved.¹⁶ In addition, the WHO estimates that universal access to maternal and newborn care in 75 developing countries would cost \$0.22 to \$1.18 per person.¹⁷

Maternal health is closely linked to both newborn and child survival. According to a recent United Nations report,¹⁸ motherless newborns are 3 to 10 times more likely to die than are newborns with living mothers. The WHO reports that nearly three-quarters of all newborn deaths could be prevented if women received adequate nutrition and health care during pregnancy, labor, and the postnatal period. Although child mortality in developing countries decreased by about 20 percent between 1990 and 2005,¹⁹ maternal mortality has remained unchanged,²⁰ and newborn

¹³United Nations Children's Fund, *The State of the World's Children 2007* (New York: 2006).

¹⁴The term "newborn" refers to the newborn baby and does not have a specific time period definition, but is often assumed to refer to the first month of life.

¹⁵*State of World's Mothers 2006*.

¹⁶Jennifer Bryce and Robert E. Black, "Can the world afford to save the lives of 6 million children each year?" *The Lancet*, vol. 365, no. 9478 (2005).

¹⁷World Health Organization, *The World Health Report 2005 – Make Every Mother and Child Count*, 1st ed. (Geneva: World Health Organization, 2005).

¹⁸*State of World's Children 2007*.

¹⁹According to UNICEF, child mortality in developing countries decreased from 105/1,000 live births in 1990 to 83/1,000 live births in 2005. *State of World's Children 2007*.

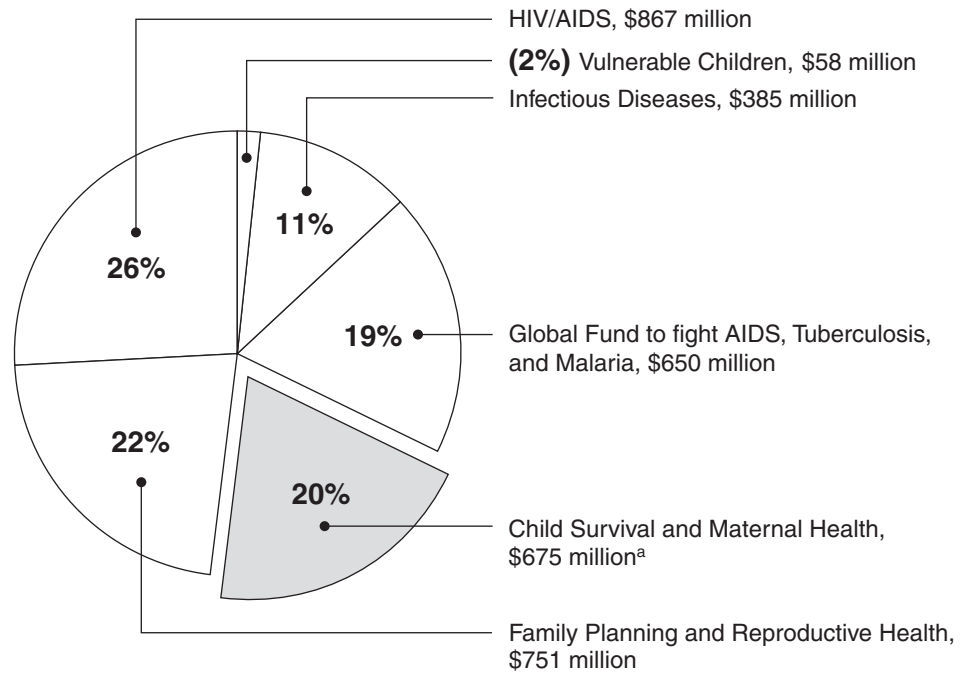
²⁰On the basis of estimates of the maternal mortality ratio for 1990 and 2000, maternal mortality has not improved.

survival has seen less improvement than child survival overall.²¹ Newborn deaths currently account for 38 percent of all deaths in children younger than 5 years old.

In 1997, Congress established the CSH Fund and assigned USAID to administer it. Initially titled the Child Survival and Disease Programs Fund and renamed in fiscal year 2001, the fund includes six accounts, of which the CS/MH account comprised about 20 percent in fiscal years 2004 and 2005. (See fig. 1.)

²¹A *Lancet* series notes that, between 1980 and 2000, child mortality after the first month of life fell by one-third. During that same period, the mortality rate for newborns in the first month of life was reduced by one-quarter. This means that the proportion of child deaths occurring in the first month of life increased. See Joy E. Lawn, Simon Cousens, and Jelka Zupan, "4 million neonatal deaths: When? Where? Why?," *The Lancet*, vol. 365, no. 9462 (2005).

Figure 1: Congressional Appropriations to the Child Survival and Health Programs Fund, by Account, Fiscal Years 2004 and 2005



Total: \$3.4 billion

- All other accounts in the Child Survival and Health Programs Fund
- Child Survival and Maternal Health account

Source: GAO analysis of USAID data.

Note: Appropriated funds for the Global Fund for AIDS, Tuberculosis, and Malaria support the efforts of the Global Fund, which is an international organization that provides funding to programs to fight AIDS, tuberculosis, and malaria in affected countries. Appropriated funds for HIV/AIDS, in contrast, are directed toward USAID's own HIV/AIDS programs and activities.

^aCongressional appropriations to the CS/MH account for fiscal years 2004 and 2005 totaled \$675 million, although the amounts USAID received differed slightly, due to rescission and reprogramming of funds.

Over the years, Congress has continued to support basic child survival interventions, particularly immunizations and oral rehydration therapy,²² and particular initiatives, such as the promotion of breastfeeding. In 2000, the 192-member states of the United Nations, including the United States,

²²Oral rehydration therapy is a treatment for dehydration caused by diarrhea and calls for providing oral rehydration salts—a mixture of water, salt, and glucose—and the recommended amount of fluids.

agreed to work toward achieving the development goals of the Millennium Declaration. These goals include reducing the child mortality rate by two-thirds and reducing the maternal mortality rate by three-quarters from 1990 levels worldwide by 2015.

USAID Support for Child Survival and Maternal Health

USAID has carried out efforts to improve child survival and maternal health since its inception in 1961. In the 1960s, USAID began building health clinics and funding research on treatments for diarrheal disease and malaria prevention. In the 1970s, USAID began focusing on providing the appropriate health interventions for common health problems in communities with the greatest needs. The interventions related to child health included field studies on oral rehydration and vitamin A therapy and malaria research. In the 1980s, USAID focused its efforts on countries with especially high child mortality rates.

One of USAID's current performance goals calls for "improved global health, including child, maternal, and reproductive health." Under this performance goal, child survival activities target the primary causes of child mortality: diarrheal disease, acute respiratory disease, malnutrition, malaria,²³ vaccine-preventable diseases, and newborn diseases and conditions.²⁴ USAID's work in maternal health includes addressing nutritional deficiencies during pregnancy; strengthening preparation for birth, including antenatal care; supporting safe delivery; and improving the management and treatment of life-threatening obstetrical complications. USAID addresses these causes and health issues through country, regional, and global strategies.

As administrator of the CSH Fund, including the CS/MH account, USAID allocated funds for maternal and child health efforts in 40 countries, in Latin America, sub-Saharan Africa, and South Asia. Figure 2 illustrates the global distribution of USAID's CS/MH funds.

²³The CSH Fund guidance notes that most malaria-related activities are supported with funding from the infectious disease account of the fund.

²⁴Newborn diseases and conditions include low birth weight, birth asphyxia and injuries, and postpartum infection.

Figure 2: Global Distribution of USAID's Child Survival and Maternal Health Funds, Fiscal Years 2004 and 2005

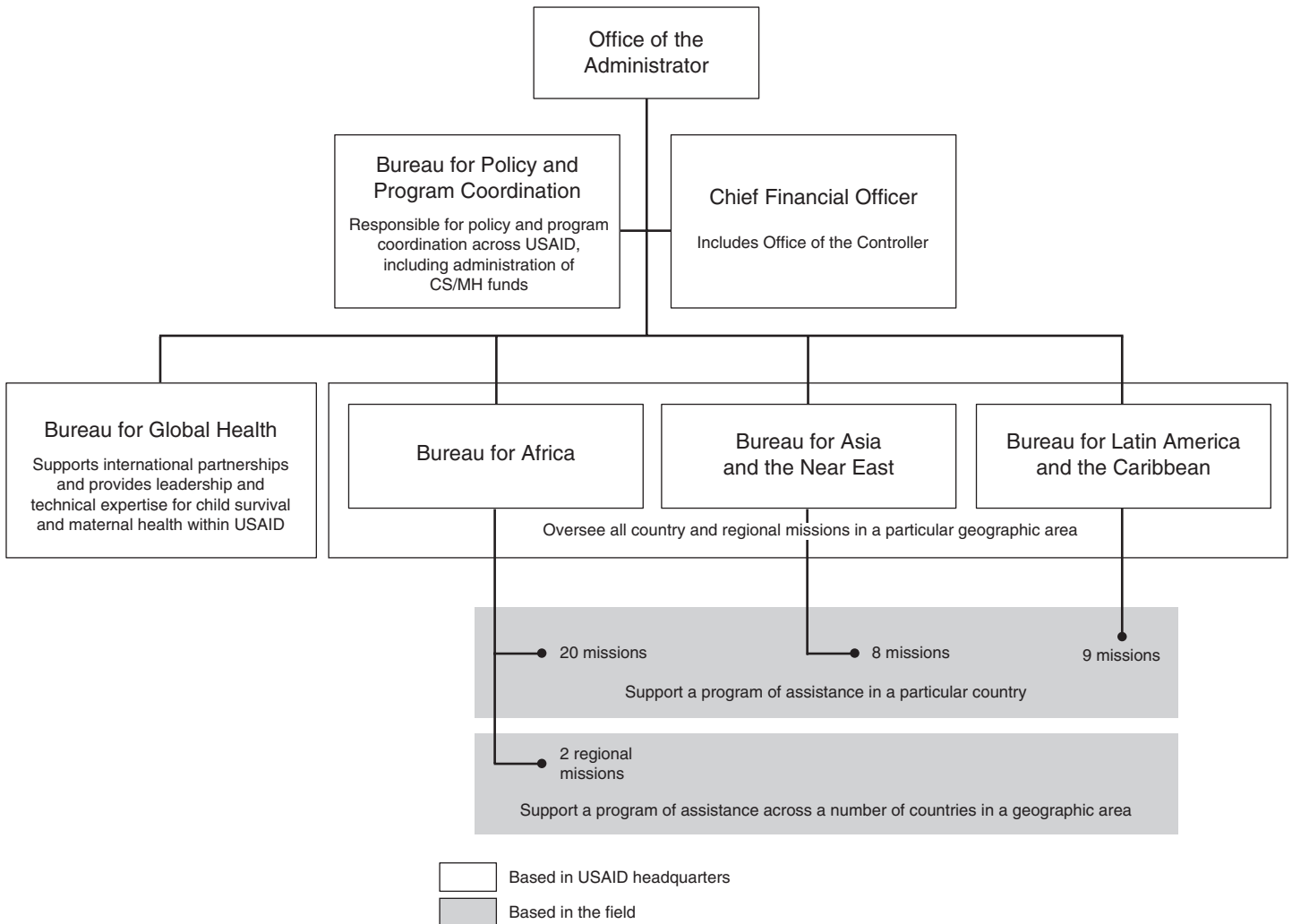


Sources: GAO analysis of USAID data; Map Resources (map).

USAID carries out CS/MH activities primarily through its country missions,²⁵ regional missions and bureaus; and the Bureau for Global Health and the international partnerships it supports. Figure 3 shows the organizational structure of USAID entities involved in supporting CS/MH activities.

²⁵USAID does not have missions in Burundi, Eritrea, Sierra Leone, and Somalia. In these cases, the associated regional mission manages the country allocation. For example, the East Africa regional mission is responsible for managing Somalia's allocation.

Figure 3: Organizational Chart of USAID Missions and Bureaus Involved in Supporting Child Survival and Maternal Health Activities, Fiscal Years 2004 and 2005



Source: GAO analysis of USAID data.

Note: In fiscal years 2004 and 2005, the three regional bureaus encompassed seven regional missions, two of which received CS/MH funds. Both of these regional missions are in the Bureau for Africa: the Regional Economic Development Services Office for East and Southern Africa, and the West Africa Regional Program, now known respectively as the East Africa and West Africa regional missions. Furthermore, in the cases of Burundi, Sierra Leone, and Somalia, USAID regional missions managed the assistance programs from a neighboring country.

USAID defines the Bureau for Global Health’s role as providing technical support to the field, state-of-the-art research and innovation, and global leadership in international public health. Included among the bureau’s

functions are centrally managing some of the CS/MH programs that the country missions fund and, along with the agency's regional bureaus, disseminating information on innovations in child survival and maternal health to USAID missions. According to USAID guidance, the bureau is to be the agency's repository for state-of-the-art thinking and innovations in health that can be disseminated and replicated at USAID missions around the world.

Budget Process and Congressional Directives Guided CS/MH Allocations, but USAID Lacked Centralized Obligation and Expenditure Data

In fiscal years 2004 and 2005, USAID allocated the majority of the CS/MH account to countries in Africa, Asia, and Latin America and to the Bureau for Global Health, guided by its budgeting process and congressional directives. However, USAID's Office of the Administrator, through its Office of the Controller, was unable to provide data on agency obligations and expenditures of the allocated CS/MH funds for those years, because such data were not collected from the missions and bureaus. The missions we visited and the Bureau for Global Health were able to provide data showing obligations and some expenditures from their separate accounting systems. According to U.S. government standards for internal control, program managers need financial data to determine whether they are meeting their agencies' goals for accountability for effective and efficient use of resources. Without a process to provide ready access to obligation and expenditure data, USAID has limited ability to report whether it is using the CS/MH funds to fulfill intended purposes. USAID is making changes to its accounting system that may enable it to report such information, but the system is in transition and has not been tested.

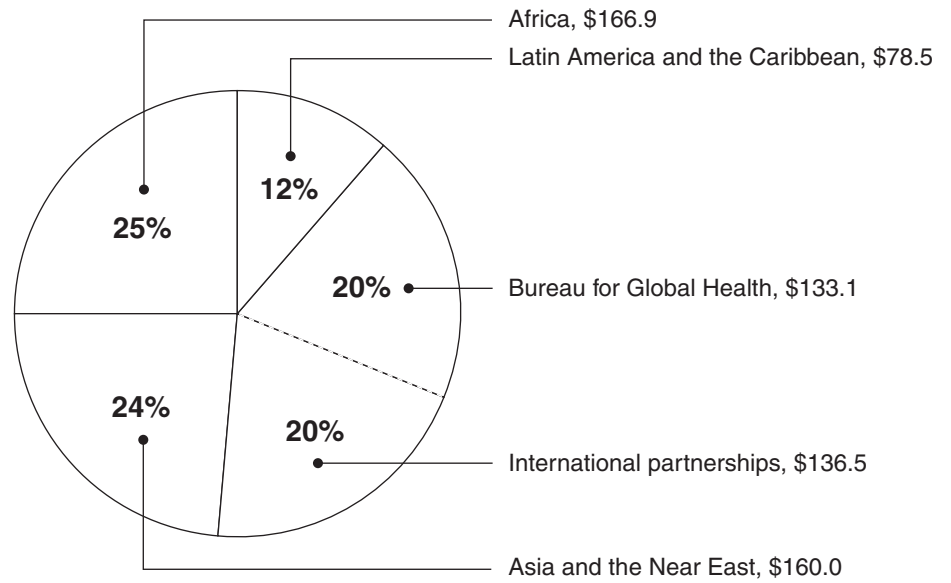
USAID Allocations Followed Budget Process and Congressional Directives

In fiscal years 2004 and 2005, USAID allocated the majority of funds in the CS/MH account to countries in Africa, Asia and the Near East, and Latin America and the Caribbean and to the Bureau for Global Health. In allocating the funds, the agency considered various factors in its annual budgeting process as well as congressional directives.

USAID Allocated Most CS/MH Funds to Africa, Asia, and Latin America and to the Bureau for Global Health

Of the \$675.6 million appropriated to the CS/MH account in fiscal years 2004 and 2005, \$405.3 million (60 percent) was allocated to Africa, Asia and the Near East, and Latin America and the Caribbean. The remaining 40 percent went to the Bureau for Global Health and to international partnerships that the bureau supports. Figure 4 shows the total amounts and percentages of USAID's CS/MH allocations for fiscal years 2004 and 2005. (See app. II for amounts and percentages allocated in each of the 2 years.)

Figure 4: USAID Allocations of Child Survival and Maternal Health Funds, Fiscal Years 2004 and 2005



Total: \$675.6 million^a

----- Bureau for Global Health supported international partnerships that received CS/MH funds

Source: GAO analysis of USAID data.

Note: In addition, USAID allocated funds directly to regions, international partnerships, and the Bureau for Global Health. However, some of the funds allocated to international partnerships and the Bureau for Global Health went to global programs with beneficiaries in the regions. International partnerships included the Global Alliance for Improved Nutrition, the Global Alliance for Vaccines and Immunization, the Kiwanis/UNICEF Partnership for Iodine Deficiency Disorder, and the Health Metrics Network.

^aThe amounts shown in this figure total \$675.0 million. In addition to these amounts, USAID also allocated \$0.6 million, or 0.2 percent of the CS/MH account, to the Bureau for Democracy, Conflict and Humanitarian Assistance, and the Bureau for Policy and Program Coordination in fiscal year 2004. Taken with these amounts, USAID allocated a total of \$675.6 million in fiscal years 2004 and 2005. Percentages in this figure total more than 100 percent due to rounding.

USAID Budgeting Process and Congressional Directives Guided Allocations

USAID's PPC²⁶ allocated CS/MH funds in fiscal years 2004 and 2005 according to its budgeting process and congressional directives.

²⁶PPC reported to the Office of the Administrator.

USAID Budget Allocation Process

PPC used an annual budgeting process to guide its allocation of CS/MH funds. First, missions submitted their budget requests to the regional bureaus, which reviewed the requests and, after discussion with the missions, made any needed adjustments. The regional bureaus then submitted the budget requests to PPC,²⁷ which in turn made final adjustments. Following consultation with the Office of Management and Budget, USAID submitted its budget request to Congress. After receiving an actual appropriation from Congress, PPC then made its decisions on allocations, including for the CS/MH account, throughout the agency. USAID officials told us that the majority of PPC's functions have been transferred to the State Department's Office of Foreign Assistance, which now oversees the budgetary administration of the CSH Fund. PPC's remaining functions have been transferred to USAID's existing Bureau for Management.

As part of the budgeting process, PPC and the regional bureau requested and considered a variety of information from the missions.²⁸ Our analysis showed that some of the factors PPC and the regional bureaus considered included

- the severity of a country's need for CS/MH programs, measured in part by its mortality rates (see apps. II to IV for mortality rate and allocation information, by country);
- the magnitude of a country's need for CS/MH programs, measured, for example, by total number of child deaths or total population of women of reproductive age;
- the potential national-level impact of allocated CS/MH funds;
- a host country government's per capita expenditures for public health;

²⁷The Health Sector Council, which the Bureau for Global Health chairs, also reviewed the budget requests and provided feedback. The council has several subgroups, each with technical representatives, that provided recommendations to the regional bureaus.

²⁸The information requested by PPC differed from that requested by the regional bureaus; in addition, some of the information requested by the regional bureaus differed by region.

-
- the capacity of the USAID mission to absorb funds; and
 - U.S. national interest.

The USAID official who oversaw the CS/MH allocations in fiscal years 2004 and 2005 told us that, as the CSH Fund guidance requires, missions and bureaus reported how they planned to spend their CS/MH funds to a PPC database. According to the official, this database recorded CS/MH allocation information, but not obligation or expenditure information.

Congressional Directives

In addition, USAID's allocation decisions took into account congressional directives—instructions from Congress written into law, or in a committee report, that appropriations should be allocated for a particular purpose. For example, in fiscal year 2004, USAID allocated \$60 million to the Vaccine Fund²⁹ in accordance with a directive in the Consolidated Appropriations Act of 2004.³⁰ Similarly, in fiscal years 2004 and 2005, USAID set aside \$32 million each year for polio in response to congressional interest.³¹ In general, we found that USAID addressed the directives in the committee reports. However, USAID sometimes faced challenges in addressing congressional directives. For example, USAID had difficulty in determining the most effective use of the \$6 million that Congress directed it to use for fistula in Africa, due to a general lack of the necessary human and other resources in African countries. Some USAID officials said that congressional directives for the CS/MH account—also the primary source of funds for general health systems strengthening—had

²⁹The Vaccine Fund, now renamed The GAVI Fund, is the financing arm to support the immunization goals of The GAVI Alliance, an international partnership focused on increasing children's access to vaccines in poor countries.

³⁰Consolidated Appropriations Act, 2004, Pub. L. No. 108-199, 118 Stat. 3, 145. This act did not specify the CSH Fund account that USAID should use for this directive. However, in the accompanying report, the House expressed through a congressional directive that it wanted USAID to use funds from the CS/MH account (*see* H.R. Rep. 108-599, at 8 (2004)).

³¹The fiscal year 2005 conference report (H.R. Conf. Rep. No. 108-792, at 987) states that the House and the Senate "intend that \$32,000,000 be made available to support the multilateral campaign to combat polio." The House and Senate reports for the Consolidated Appropriations Act of 2004 (H.R. Rep. No. 108-222 and S. Rep. No. 108-106) and the House, Senate, and Conference reports for the Consolidated Appropriations Act of 2005 (H.R. Rep. No. 108-599, S. Rep. No. 108-346, and H.R. Conf. Rep. No. 108-792) also demonstrate congressional interest in areas such as providing micronutrients and correcting iodine deficiency.

allowed for the preservation of CS/MH funding over time. However, according to some officials of USAID and organizations implementing programs in cooperation with USAID, other major health initiatives have redirected attention, funding, and staff resources away from the CS/MH congressional directive.

USAID Headquarters Lacked CS/MH Obligation and Expenditure Data Needed for Internal Control in Fiscal Years 2004 and 2005

USAID's Office of the Controller was unable to provide obligation and expenditure data for missions' and bureaus' fiscal years 2004 and 2005 CS/MH programs and, therefore, had limited ability to report on the use of these funds and to exercise internal control³² at the CS/MH account level. According to an official from the Office of the Controller, USAID's primary financial management and reporting system could provide obligation and expenditure data for the CSH Fund³³ and for each mission's strategic objectives.³⁴ However, the official stated that the system could not provide such data for the CS/MH account and that the missions and bureaus were not required to report these data.

During our audit work, the four country missions we visited and the Bureau for Global Health provided obligation and some expenditure data, which they recorded in information systems that were not part of USAID's formal accounting system. At the four country missions, we asked mission officials for obligations and expenditures for mission-managed and centrally managed programs for fiscal years 2004 and 2005. For mission-managed programs, officials provided both obligation and expenditure

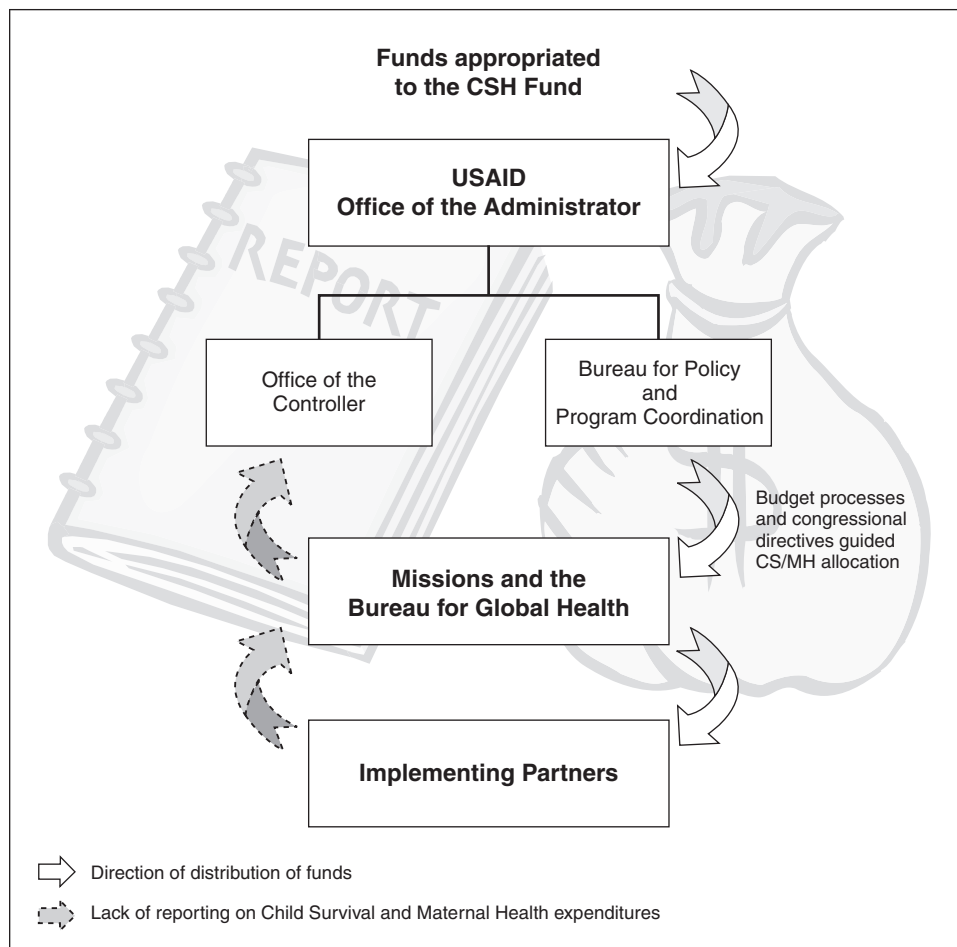
³²Internal control provides an organization with reasonable assurance that key management objectives—efficiency and effectiveness of operations, reliability of financial reporting, and compliance with applicable laws and regulations—are being achieved. See GAO/AIMD-00-21.3.1, 4.

³³According to a PPC official, the accounts within the CSH Fund are not broken out separately when they are allocated. Officials from PPC and USAID's Office of the Controller said that the agency's primary financial management and reporting system tracks obligations and expenditures from the overall fund. Two of the fund's six accounts, the HIV/AIDS and the Family Planning and Reproductive Health accounts, are specifically tracked within the system, but the remaining four accounts are grouped as "other CSH." As of January 2007, USAID was reforming its primary financial management and reporting system.

³⁴Missions' strategic objectives are the areas of measurable change that each mission intends to achieve through its development programs. Objectives may vary among missions, because each mission defines its own. In addition, missions may commingle funding streams to meet their objectives. For example, the Ethiopia mission's Health and Education strategic objective commingled the CS/MH, Basic Education, and Development Assistance Program funding streams.

data. For centrally managed programs, all four missions provided obligation data; however, only one mission provided expenditure data, one mission provided expenditure estimates, and two missions' officials stated that they were unable to provide any expenditure data. (See app. V for mission data.) Although the Bureau for Global Health provided obligation data for these fiscal years for the CS/MH programs it managed, including programs it managed centrally for the missions, bureau officials stated that they were unable to provide expenditure information for any of the programs. (Fig. 5 shows USAID's allocation and reporting process for the CS/MH account in fiscal years 2004 and 2005.)

Figure 5: USAID's Allocation and Reporting Process for CS/MH Account, Fiscal Years 2004 and 2005



Sources: GAO analysis of USAID data; Corel (clip art).

Officials from USAID’s Office of the Controller and the State Department’s Office of Foreign Assistance told us that obtaining fiscal years 2004 and 2005 obligation and expenditure data for the CS/MH account would require a data call to each mission and bureau.³⁵ USAID officials also noted that such a request from headquarters could necessitate a subsequent data request to implementing partners, because missions have not consistently required implementing partners to report at the CS/MH level.³⁶ USAID officials further observed that the agency’s difficulty in providing such information is not unique to the CS/MH account.

Because it did not have a system to collect agencywide obligation and expenditure data for the CS/MH account, USAID’s internal control over its use of the account was limited. According to U.S. government standards for internal control, “Program managers need both operational and financial data to determine whether they are meeting their agencies’ strategic and annual performance plans and meeting their goals for accountability for effective and efficient use of resources.”³⁷ Without ready access to its missions’ and bureaus’ CS/MH obligation and expenditure data, USAID was constrained in its ability to report that these funds were used according to the purposes for which they were allocated.

³⁵The official from the Office of the Controller could not give us an estimate of how long such a data call would take.

³⁶As we reported in 2003, USAID is dependent on international organizations and thousands of partner institutions for data; therefore, it does not have full control over how data are collected, reported, or verified.

³⁷[GAO/AIMD-00-21.3.1, 19.](#)

USAID Is Making Changes to Its Accounting System, but the System Is in Transition and Has Not Been Tested

In a prior report, we found that USAID's approach to tracking and accounting for child survival funds made it difficult to determine precisely how much the U.S. government spent on child survival activities.³⁸ In addition, other GAO work has identified long-standing challenges associated with USAID's financial management and reporting.³⁹

In mid-February 2007, USAID officials told us that they are in the process of instituting changes begun in November 2006 to USAID's primary accounting system. These changes are intended to modify the system so that financial data can be accounted for under new elements⁴⁰ to coincide with the new Foreign Assistance Framework—the road map for foreign assistance resource allocation and implementation.⁴¹ In November 2006, a USAID official from the Office of the Controller told us that the modified system would not be able to separate obligations and expenditures at the CS/MH level. In February 2007, however, USAID officials told us they had recently learned that the system will capture these data at that level from fiscal year 2007 going forward.⁴² In addition, they said that the modified system will be compatible with the State Department's new planning

³⁸GAO/NSIAD-97-9, 7.

³⁹GAO, *Financial Management: Sustained Effort Needed to Resolve Long-Standing Problems at U.S. Agency for International Development*, GAO-03-1170T (Washington, D.C.: Sept. 24, 2003); *Major Management Challenges and Program Risks: U.S. Agency for International Development*, GAO-03-111 (Washington, D.C.: January 2003); *Major Management Challenges and Program Risks: U.S. Agency for International Development*, GAO-01-256 (Washington, D.C.: Jan. 1, 2001); and *Financial Management: Inadequate Accounting and System Project Controls at AID*, GAO/AFMD-93-19 (Washington D.C.: May 24, 1993).

⁴⁰The State Department's Office of Foreign Assistance defines an element as a broad category of program under a particular program area. For example, "Maternal and Child Health" is an element under the "Health" program area in the new Foreign Assistance Framework.

⁴¹The Foreign Assistance Framework concentrates U.S. foreign assistance into five priority objectives: peace and security, governing justly and democratically, investing in people, economic growth, and humanitarian assistance. The Health program area falls within the investing in people objective.

⁴²An October 2006 memorandum from the State Department's Office of Foreign Assistance says that the proposed modification to USAID's accounting system is intended to accommodate State's new Foreign Assistance Framework. Under the modified accounting system, all money would be identified and USAID would be able to separate the sources of funds. USAID officials in the Bureau for Global Health, however, did not know about this memorandum until February 2007. Furthermore, due to a lack of internal communication, the Office of the Controller did not realize that recording information at the element level will, in fact, capture CS/MH data.

system, which records allocation information. The two systems are not integrated, although the USAID officials said that they can trace information between the two because both systems record financial information by element. According to USAID officials, in the future they will be able to verify that CS/MH funds are being used for their allocated purposes by tracing the obligation and expenditure information in their accounting system back to the corresponding allocation information in the State Department's planning system. State's system, however, only records new obligational authority data,⁴³ so CS/MH funds invested in programs that began before fiscal year 2007 cannot be verified in this manner.

USAID's switch to recording financial data by element may address our concern about the lack of agencywide CS/MH obligation and expenditure data. USAID officials told us, however, that the modifications to the accounting system are currently in transition. As of February 2007, the system contained little obligation information at the CS/MH level. For example, the total information on CS/MH obligations to countries was an obligation to Nigeria. The remaining CS/MH obligation information consisted of eight travel authorizations for the Bureau for Global Health and one for the Bureau for Latin America and the Caribbean. The USAID officials said that expenditure information will likely not be included until fiscal year 2008 or 2009, because funds appropriated to the CSH Fund are available for obligation until the end of the following fiscal year. Although USAID officials told us they believe that the modification to the accounting system will address the agency's long-standing financial reporting weaknesses, sufficient time has not elapsed to test whether CS/MH obligation and expenditure data will be properly recorded and traced back to the corresponding allocation data in State's planning system.

USAID Supported a Wide Range of CS/MH Efforts

USAID supported various CS/MH efforts in fiscal years 2004 and 2005 through its country missions, regional missions and bureaus, and Bureau for Global Health. At the community and country levels, USAID missions used CS/MH funds to improve the quality of health services; provide immunizations; and promote basic health care, including essential obstetric care and child health services. Regionally, USAID supported CS/MH activities and strategies over a geographic area, such as fistula

⁴³New obligational authority refers to the funding levels appropriated by Congress in a given year after certain legislatively mandated transfers or rescissions.

repair in West Africa and making newborn health a priority in Latin America and the Caribbean. Finally, the Bureau for Global Health gave technical assistance and administered a grants program; conducted research on CS/MH issues, including treatment of diarrhea and clean cord care during delivery; and provided global leadership.

Country Missions Supported Community- and Country-Level Efforts

USAID's country missions supported CS/MH activities at both the community and the country levels.

Community-Level Activities

Our fieldwork and review of documentation demonstrated that USAID implemented a variety of CS/MH programs at the community level in the four countries that we visited. For example, the Mali mission used its CS/MH funds to support a program that works across the country to improve the quality of government health centers in the community. Similarly, the Afghanistan mission funded nongovernmental organizations (NGO) to train 6,200 community health care workers, about half of which are women, to provide referrals and basic health care to their neighbors.

Country-Level Activities

In addition, 37 of the 40 mission health officials we surveyed told us that they worked on CS/MH activities with their host country's government. Our interviews and fieldwork showed that USAID missions supported host country governments' CS/MH efforts by granting funds directly to governments, providing technical assistance, and participating in government working groups.

- *Grants to governments.* Country missions directly transferred funds from USAID to the host country. In one such agreement, which the Mali mission provided to us, the mission directly funds the government of Mali's immunization, polio, and nutrition programs in response to the government's budget request.
- *Technical assistance.*⁴⁴ In addition to funding their programs, USAID missions provided technical assistance to host country governments. For example, the Afghanistan mission helped the government of Afghanistan's Ministry of Public Health monitor and evaluate the Basic Package of

⁴⁴USAID defines technical assistance as the "provision of goods or services to developing countries and other USAID recipients in direct support of a development objective - as opposed to the internal management of the foreign assistance program."

Health Services Program, which included essential obstetric care and child health and family planning services.

- *Government working groups.* USAID mission representatives participated in host country government donor coordination groups related to health. For example, the India mission chaired a donor group for the Indian government's flagship CS/MH program.

Regional Missions and Bureaus Supported Regional CS/MH Activities and Strategies

USAID's regional missions and bureaus supported CS/MH initiatives in their geographic areas of responsibility. For example, the West Africa Regional Program (now known as the West Africa regional mission) assessed fistula repair activities in two West African countries and identified training, equipment, and cost support as areas of possible future work.

In addition, the regional bureaus supported strategic plans for their areas of responsibility. For example, the Bureau for Latin America and the Caribbean provided funds to the WHO to support the development of a resolution to elevate newborn health as a priority in the Americas.⁴⁵ Similarly, the Bureau for Africa commissioned an in-depth examination of USAID's child survival programs in sub-Saharan Africa, resulting in recommendations for improvement.⁴⁶ Bureau for Africa officials told us that the bureau also reviewed the African missions' strategic plans and provided suggestions to strengthen the missions' community-level programming.

Bureau for Global Health Engaged in Numerous CS/MH Efforts

The Bureau for Global Health engaged in a number of CS/MH-related activities in fiscal years 2004 and 2005. These activities included giving technical assistance to country missions, administering the Child Survival and Health Grants Program, providing global leadership, and supporting international research.

⁴⁵World Health Organization, Pan American Health Organization, *Neonatal Health in the Context of Maternal, Newborn and Child Health for the Attainment of the Millennium Development Goals of the United Nations Millennium Declaration* (Washington, D.C.: 2006).

⁴⁶Support for Analysis and Research in Africa Project, Academy for Educational Development, *Child Survival in Sub-Saharan Africa: Taking Stock*, a report prepared at the request of the United States Agency for International Development (2005).

Technical Assistance

The Bureau for Global Health provided technical assistance to missions by centrally managing CS/MH projects at the missions' request. For example, our fieldwork shows that the bureau managed several projects for the India mission.

- The bureau managed a program for anemia reduction and vitamin A supplementation in the states of Uttar Pradesh and Jharkhand.
- The bureau assisted Indian state governments and the government of India's Ministry of Health and Family Welfare with routine immunization.
- The bureau supported IndiaCLEN, a research organization, to study injection safety. IndiaCLEN found that 74 percent of immunization injections were not administered safely; in response, the government of India introduced the use of autodisable syringes in its national immunization program.

Country-Level Programs: Community Treatment of Pneumonia, Senegal

The Bureau for Global Health provided "seed funds" to introduce the community treatment of pneumonia in Senegal at the national level. The bureau collaborated with UNICEF, the USAID mission in Senegal, the government of Senegal's Ministry of Health, a local university, and a major pharmaceutical company to introduce and evaluate such an approach. The bureau also provided technical assistance to the ministry and the university to develop an evaluation approach. The bureau ceased funding the program at the close of fiscal year 2006. However, the program will continue with funds from UNICEF, the Ministry of Health, and the USAID mission in Senegal. In addition, at least four other African countries are replicating this approach.

In addition, the Bureau for Global Health may contribute some or all of the funds for a project as "seed funds"—that is, funds to introduce or expand a treatment in a particular country or region. The bureau told us that seed funds may encourage the mission and host country through advocacy, policy dialogue, technical assistance, and development of standards of care and training curricula. (See sidebar.)

Of the 40 missions we surveyed, 34 participated in these centrally managed projects. About one-half of those missions reported that, to a great or very great extent, they had decided to participate in the projects because the bureau provided technical expertise, assisted with procurement, or offered some or all of the funds for the project. According to financial records that we obtained during our fieldwork, the four missions we visited varied in the percentage of CS/MH funds they chose to send to headquarters for centrally managed projects. For example, whereas Cambodia invested very little of its fiscal year 2005 CS/MH funds in centrally managed projects, India sent more than one-half of its funds to headquarters for such projects.

Child Survival and Health Grants Program

The Bureau for Global Health administered the Child Survival and Health Grants Program, which provides 4- to 5-year grants to U.S.-based nongovernmental organizations and private voluntary organizations to improve child survival at the community level in host countries. Of the 40 missions that received CS/MH funds in fiscal years 2004 and 2005, 30 reported that Child Survival and Health Grants projects had been awarded to organizations working in their host countries. In some cases, the grants

**Community-Level Programs:
Community Drug Cabinets, Mali**



Source: GAO.

A recipient of a Child Survival and Health Grants Program grant in Mali is piloting an approach to bring essential drugs to the community level through its Community Drug Cabinets Program. This NGO supplies, initially free of charge, cabinets with essential health supplies to villages throughout the Sikasso region of Mali. The cabinets contain first aid kits and drugs to sustain sick children younger than 5 years old until they can reach a community health center. The cabinets also include preventative malaria treatment and contraceptives for pregnant women and women of reproductive age. Each community selects a primary and a backup manager of the cabinet to provide counseling and distribute the health supplies.

comprised a sizable portion of USAID's child survival funding in a country or region. For example, the Bureau for Africa reported that these grants comprised about one-fifth of USAID's total allocations for child survival across sub-Saharan Africa.

USAID officials told us that grantees may pilot innovations (see sidebar) or work in a country's most rural and hard-to-reach areas. Also, in certain cases, grantees raised additional funds from sources outside the bureau. Of the 30 missions we surveyed that have grantees in their countries, 27 reported that the grantees used the grants to raise additional resources from sources other than the U.S. government. For example, a grantee in Guatemala received funds from the United Nations Development Programme to continue its project with a slightly different scope.

Global Leadership

The Bureau for Global Health's global leadership included managing partnerships, sharing expertise, and helping shape the global CS/MH agenda.

- *Managing partnerships.* The bureau supported international partnerships that received funds from the CS/MH account. For example, to support The GAVI Alliance—an international partnership focused on increasing children's access to vaccines in poor countries, the bureau's immunization advisor served on the GAVI Secretariat's financing task force, technical working group, and coordination group for the Organization for Economic Coordination and Development.
- *Sharing expertise.* The bureau made its global expertise in child survival and maternal health available to global organizations and working groups. For example, a bureau official told us that the director of the bureau's Office of Health, Infectious Diseases, and Nutrition represents USAID on the U.S. delegation to the UNICEF Executive Board. Similarly, the bureau's child health team leader is the interim chair of the Country Support Working Group and serves on the interim steering committee of the international Partnership for Maternal, Newborn and Child Health.
- *Shaping global agenda.* The bureau supported efforts that directly helped shape the global CS/MH agenda for research and interventions. For example, in April 2005, the bureau organized a meeting with the WHO and UNICEF on micronutrients and health. According to a USAID report, this process of bringing together scientists, donors, and policymakers helped shape a global agenda for both clinical and programmatic research for service delivery of micronutrient programs.⁴⁷ In addition, officials from both UNICEF and the Gates Foundation told us that they look to USAID to help set global CS/MH policies and strategies. The bureau also supported the publication of three series of articles on child survival, newborn health, and maternal health in the medical journal titled *The Lancet*, to inform global and national dialogue on these issues. For example, the bureau's maternal health team leader participated in the formal technical reviews of drafts of the maternal health series and hosted its launch in the United States. Similarly, the bureau publicized the launch of the series on newborn health in Nepal, Indonesia, and the United States.

⁴⁷United States Agency for International Development, *Report to Congress: Health-Related Research and Development Activities at USAID* (Washington, D.C.: 2006).

International Research

In fiscal years 2004 and 2005, the Bureau for Global Health supported several CS/MH-focused international research efforts. These efforts included studies of innovative CS/MH interventions and surveys to provide data for use in monitoring and evaluating child survival and health efforts.

- *Studies of CS/MH interventions.* The bureau supported several research efforts that have resulted in internationally recognized measures and interventions for maternal and child health. For example, since 1996, the bureau has been instrumental in supporting research on the use of zinc in the treatment of diarrhea. This research led, in 2006, to the release of WHO and UNICEF policy guidelines recommending 10 to 14 days of zinc treatment for all cases of diarrhea in children between 2 months and 5 years old. Furthermore, the bureau supported research in fiscal year 2005 that contributed to the development of three newborn indicators: essential newborn care,⁴⁸ antibiotic treatment of newborn infection, and postnatal care within 3 days of birth. With respect to the latter, agency officials told us the bureau is working with the Gates Foundation's Saving Newborn Lives Project and other organizations to align the postnatal care indicator with new proposed Millennium Development Goals newborn indicators.⁴⁹ The bureau also supported research on the efficacy of new treatments and their introduction in different countries.⁵⁰ For example, the bureau funded a study in Nepal of an antiseptic that may prevent newborn infections resulting from the cutting of the umbilical cord during delivery. USAID reports that early results show promising impact on reducing newborn deaths.
- *Surveys.* The bureau used CS/MH funds in part to finance the Demographic and Health Surveys—large-scale, nationally representative household surveys that provide population, health, and nutrition data. The survey data comprise such topics as infant, child, and maternal mortality;

⁴⁸Essential newborn care is a package of interventions that includes exclusive breastfeeding, clean delivery, umbilical cord care, warmth, and early recognition of and referral for complications.

⁴⁹The Millennium Development Goals were adopted by the United Nations General Assembly in the 2000 United Nations Millennium Declaration and are supported by the United States. A version of the goals, however, that differs in significant respects from what was agreed to at the United Nations in 2000 is widely in use. The maternal and child health goals, however, are the same in both versions—namely, to reduce maternal mortality by three-quarters, and under-5 child mortality by two-thirds by 2015.

⁵⁰United States Agency for International Development, *Report to Congress: Health-Related Research and Development Activities at USAID* (Washington, D.C.: 2005); and *Health-Related Research and Development Activities at USAID*.

micronutrient deficiencies; health care access issues; vaccination coverage; and percentage of births attended by a skilled health professional. The country surveys take place approximately every 5 years, allowing comparisons across time. As of January 2007, surveys had been completed in more than 70 countries. The WHO, UNICEF, and other donors rely on the survey data for monitoring and gathering statistics. For example, the WHO and UNICEF both use the surveys to supplement their own data. Furthermore, USAID implementing partner officials told us that other donors, as well as country governments, are beginning to contribute more funding to the surveys, recognizing the need for quantitative data as a basis for decisions on programs and policies.

USAID Has Not Assessed the Relative Effectiveness of Its Methods of Disseminating Innovations and Best Practices for Internal Use

The Bureau for Global Health and regional bureaus and missions used several methods to disseminate information within USAID about new CS/MH interventions and best practices. These methods consist of electronic learning courses, State-of-the-Art training, online document databases, Web sites, regional workshops, and other informal methods. In addition, USAID's implementing partners disseminate information on innovations and best practices. However, we identified drawbacks associated with several of these methods. Furthermore, USAID has not assessed the relative efficacy of its methods and, as a result, may not be able to ensure that missions are apprised of innovations in the maternal and child health fields in a consistent and timely manner.

USAID Disseminated Information Internally through Various Methods, Although Several Have Drawbacks

The Bureau for Global Health, along with the regional bureaus and missions, disseminated information on CS/MH innovations and best practices to USAID missions, using several methods.

- *Electronic learning courses.* The bureau instituted an Electronic Learning (eLearning) Center to provide USAID health professionals and external partners with access to technical public health information. The center has offered Internet-based courses on topics such as antenatal care, essential newborn care, and malaria. However, one of the USAID officials in charge of the courses told us that some health officers were still unaware of the availability of the electronic learning courses 3 years after the center's inception. In responding to our draft report, USAID stated that a 2007 priority for the bureau is the marketing and communication of these electronic courses for health officers at field missions.

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- *State-of-the-Art training.* From the early 1990s to 2005, the bureau and regional bureaus and offices⁵¹ held biennial conferences, known as State-of-the-Art training, for USAID health officers in each region to share updated information on population and health developments, including CS/MH issues, and to discuss best practices. According to a 2004 study, this training was an important opportunity for mission staff to regularly interact with one another and network with headquarters staff.⁵² Furthermore, the training provided mission staff with the opportunity for face-to-face exchange on policy updates, programmatic procedures, and new processes. USAID officials in headquarters and in the field told us that this training was crucial for regularly sharing best practices and learning about new health innovations, practices, and policies. Twenty-seven of the 38 health officials who responded to this question on our survey said that the training greatly or very greatly facilitated the sharing of best practices. According to USAID officials, however, the agency canceled the training in 2006 for budgetary reasons related to evolving demands on operating expenses funds. USAID mission officials expressed concern that, since they must pay for travel to conferences out of their operating expenses budget, they would not be able to keep up with the latest innovations without more support for sharing best practices. Although USAID officials told us that they would like to reinstitute the training, its future status is uncertain. In its response to our draft report, USAID stated that discussions are under way to reinstitute the training—beginning with Africa in the near future—but added that decisions regarding the funding and holding of these conferences rest with the USAID Administrator and the leadership of the regional and Global Health bureaus.
 - *Online document database.* USAID maintains an online database of USAID documents called the Development Experience Clearinghouse. The database contains USAID-funded international development technical and program documentation, such as country reports, annual project reports, and strategic plans. In addition, USAID officials are required to submit program evaluation reports to the database. In our survey, however, 18 of the 39 health officers who responded to this question told us either that

⁵¹Geographic offices are located within the regional bureaus and are responsible for coordinating country-related matters, including policy and strategy; project, nonproject, and food aid development, analysis, monitoring, implementation, and review; and personnel and budgeting.

⁵²Public Health Institute, *Best Practices for USAID State-of-the-Art Trainings: Recommendations for PHN Sector State-of-the-Art Planners, Implementers, Presenters and Participants*, a special report prepared at the request of USAID (October 2004).

they do not use the database for sharing best practices or that the database facilitates the sharing of best practices a little or not at all.

- *Web sites.* USAID supports a number of Web sites that disseminate health-related information. For example, the MotherNewBorNet, begun in April 2005, seeks to facilitate translation of maternal and neonatal research into community-level action by fostering dialogue and documentation of learning across projects. However, this forum currently focuses on countries within one regional bureau. Similarly, other health-related Web sites that USAID supports either address a limited number of topics or restrict access to members. USAID also has its own intranet, through which it disseminates health information. Our survey showed that 22 of the 39 health officials who responded to this question believe that USAID's intranet facilitates the sharing of best practices, either moderately or greatly.
- *Regional workshops.* The regional missions hold occasional workshops on health care topics for mission staff. However, these workshops are not held on a regular basis and do not consistently address maternal and child health issues. For example, because the Latin America and Caribbean regional missions do not receive CS/MH funds, their regional workshops do not deal directly with maternal and child health issues.
- *Informal communications methods.* Regional bureaus and the Bureau for Global Health contact USAID missions via telephone conversations and e-mail communications, although the frequency of such communications varies. USAID's Bureau for Global Health also occasionally holds brief, "brown bag" seminars at its offices in Washington, D.C., to provide information on CS/MH-related innovations and best practices to USAID staff members. For example, a returning health officer from the Afghanistan mission recently gave a brown bag seminar on the Rural Expansion of Afghanistan's Community-based Health Care Program. In addition, the bureau occasionally hosts seminars at which USAID partners give presentations on CS/MH innovations and best practices. However, only USAID staff physically present in Washington, D.C., are able to benefit from these brown bags and seminars. Our survey found that 22 of the 37 health officers who responded to this question do not use brown bags at all as a means of gathering information.
- *Implementing partners.* USAID supports some grantees and contractors who develop and disseminate information on CS/MH innovations and best practices. For example, in fiscal years 2004 and 2005, a grantee of the Bureau for Africa produced several publications for health officers, dealing with such topics as child survival in sub-Saharan Africa,

community case management of childhood malaria, and various nutrition briefs.

USAID Has Not Assessed Methods' Relative Effectiveness

USAID has not assessed the relative effectiveness of these mechanisms for disseminating innovations to its staff, according to USAID officials. As a result, although it assigned the Bureau for Global Health the role of disseminating health research and innovations, the agency does not know whether the mechanisms used by the bureau and other USAID entities are adequate to keep mission health officers apprised of the most current findings regarding CS/MH innovations. Furthermore, because of shortcomings related to the mechanisms, such as inconsistent use and limited staff access and topics covered, USAID staff may sometimes learn of important advances and innovations haphazardly. For example, according to USAID officials at the Ethiopia mission, the mission decided to institute a community-based health volunteers approach only after learning of it from a health official who had moved to Ethiopia from the Madagascar mission, where the approach had been used successfully. Another health officer who returned from the field in late 2006 said that before arriving at headquarters, she had not heard of USAID's research on using zinc to treat diarrheal illnesses, although it had been building the evidence base since 1996. Within the three regional bureaus in our review, approximately 40 percent of mission officials did not agree that their respective regional bureau communicated "clearly, sufficiently, transparently, and in a timely manner," according to USAID's annual employee survey for 2005.⁵³ Furthermore, over 40 percent of mission officials who responded to questions about the Bureau for Global Health did not agree that the bureau provided "quality state-of-the-art training opportunities."

⁵³ According to USAID, all employees and contractors received their Employee Survey. In total, there were 5,368 responses. USAID only presents response rates for groups of employees. The response rates were 75 percent for foreign service employees, 64 percent for civil service employees, and 51 percent for foreign service national employees.

USAID Is Responding to Certain Child Survival and Maternal Health Program Challenges

On the basis of reviews of expert reports, interviews with USAID officials and partner and donor representatives, and our survey results, we identified three key challenges that affect USAID's CS/MH programs: a global shortage of health care workers; a relative lack of international attention to maternal and newborn health, as compared with child survival; and difficulties in promoting sustainable CS/MH programs. USAID is involved in numerous efforts to respond to these challenges. First, to help address a global shortage of health care providers, USAID is supporting efforts to enhance the skills of current health care workers and to train new health care workers. Second, in response to the comparative lack of international attention to maternal and newborn health, USAID has launched programs that specifically consider the needs of mothers and newborns. Lastly, to help deal with barriers to program sustainability, USAID has adopted various strategies, such as providing technical assistance, leveraging its in-country presence, working with host country health ministries, supporting the development of products with potentially lasting effects, coordinating with the private sector, and promoting community involvement.

USAID Is Supporting Efforts to Address Health Care Worker Shortage

To help address the effects of a global shortage of skilled health care workers, USAID supports the training of midwives and other health care workers. The results of our surveyed identified the health care worker shortage as a challenge for USAID: that is, 38 of 40 health officers in our surveys stated that the shortage of competent health care workers makes it difficult for their maternal and child health program to continue without USAID support.⁵⁴ The WHO estimates a global shortage of almost 2.4 million doctors, nurses, and midwives.⁵⁵ The shortage is due to a variety of factors, including limited investment in health worker education; increasing migration by health workers from the poorest to the richest countries; and the impact of HIV/AIDS, which increases work burdens and health risks for many health workers. Many health workers also face challenges, such as poverty-level wages. According to the WHO, the health worker shortage is especially acute in Africa, because African countries

⁵⁴The term "difficult" refers to the USAID program representatives who replied "Somewhat Difficult," "Moderately Difficult," "Very Difficult," or "Extremely Difficult" to a survey question that also contained the categories "Condition Does Not Exist" and "A Little or Not at All Difficult."

⁵⁵World Health Organization, *The World Health Report 2006: Working Together for Health* (France, World Health Organization: 2006).

have 24 percent of the global burden of disease⁵⁶ but only 3 percent of the world's health workers. For example, Save the Children reports that the majority of Ghana's doctors actually practice overseas, with only an estimated 40 percent of doctors remaining in-country. Also, one-quarter of Malawi's health workers are expected to die from AIDS by 2011. The WHO estimates that Africa requires more than 800,000 additional doctors, nurses, and midwives to meet the Millennium Declaration Goal of reducing child mortality by two-thirds by 2015.

According to a WHO report, evidence shows that rates of maternal, infant, and child survival; immunization coverage; and primary care outreach are linked to the number and quality of health care workers. For instance, an analysis by the Joint Learning Initiative⁵⁷ suggests that a 10 percent increase in the number of health care providers per 1,000 people is correlated with a 5 percent decrease in maternal mortality. Similarly, decreases in the number of health care providers are associated with negative health outcomes—the WHO notes that child malnutrition has been shown to worsen when health sector reform results in staff cuts.

USAID's support of efforts to train midwives and other health care workers includes the following:

- *Midwife training.* In Cambodia, USAID is supporting efforts to upgrade midwives' skills. According to the Cambodian government, 50 percent of the health centers in Cambodia lack a midwife qualified to handle life-threatening obstetric complications.⁵⁸ To help improve maternal health, USAID supports the Life Saving Skills training approach, which emphasizes the needed skills, and as of March 2006, 653 midwives had received this training. The Cambodian Ministry of Health plans to adopt the Life Saving Skills training approach in its national midwifery training programs.

⁵⁶The global burden of disease is an estimate of the effect of disease, and it allows for comparisons across countries and regions. The WHO's Global Burden of Disease Project uses a summary measure—the disability-adjusted life year—to quantify the burden of disease. The number of disability-adjusted life years for a disease is the sum of the years of life lost due to premature mortality in the population and the years lost due to disability.

⁵⁷Joint Learning Initiative, *Human Resources for Health: Overcoming the Crisis* (Washington, D.C.: 2004).

⁵⁸Chan K. Chhuong, Della R. Sherratt, and Patrice White, *Comprehensive Midwifery Review* (Kingdom of Cambodia, Ministry of Health: September 2006).

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- *Other health care worker training.* In Africa, USAID is supporting efforts such as training public health care workers. For example, in Ethiopia, USAID supported the Carter Center's Ethiopia Public Health Training Initiative (see fig. 6). This program develops and provides training materials—such as training modules and lecture notes—for health care workers, and supports training for health instructors in universities and health facilities. As of 2005, the program had developed 100 lecture notes, which are short textbooks that focus on specific health topics, and supported pedagogical training for 382 health instructors.

Figure 6: Health Care Worker Training



Source: GAO.

Carter Center medical library at Awassa University, Awassa, Ethiopia.

USAID Is Working to Increase Attention to Maternal and Newborn Health

USAID has taken several steps to increase attention to maternal and newborn health. Specifically, the agency has established programs that focus on these populations, supported maternal health research, and incorporated maternal and newborn health into mission programs. USAID officials and representatives from implementing partners acknowledged that these areas have not received sufficient attention from the international community. Other donors, such as the United Nations Population Fund and the Gates Foundation, also told us that, relative to

child survival, maternal and newborn health have been neglected. In a series of articles focused on maternal health, *The Lancet* has stated that Millennium Development Goal 5, which calls for a three-quarters reduction in maternal mortality by 2015, is the goal toward which the world has made the least amount of progress.

USAID has established programs that specifically address the needs of mothers and newborns. For example:

- In 2004, USAID established a maternal and newborn health program called Access to Clinical and Community Maternal, Neonatal and Women’s Health Services (ACCESS). By 2006, ACCESS supported interventions in 9 countries and was launching programs in 4 more countries. This program focuses on increasing the coverage, access, and use of maternal and newborn health services, such as antenatal care; treatment of obstetric complications; postpartum care for the mother and newborn; and newborn care, including umbilical cord care and early breastfeeding. For example, in Haiti and Cameroon, ACCESS supported training in essential maternal and newborn care for providers and trainers, while in Nepal, the program helped the government develop a national Skilled Birth Attendance policy.
- In 2002, USAID began a special initiative to address postpartum hemorrhage, one of the major causes of maternal death. According to the WHO, postpartum hemorrhage causes at least 25 percent of all maternal deaths worldwide; in some developing countries, it is estimated to cause up to 60 percent of maternal deaths. USAID has expanded the number of countries with programs that target postpartum hemorrhage from 4 countries to 21. One such program is the Prevention of Postpartum Hemorrhage Initiative (POPPHI), which USAID launched in 2004. POPPHI focuses on the primary intervention for preventing postpartum hemorrhage—that is, active management of the third stage of labor—which has been shown to significantly reduce blood loss and the need for blood transfusions.⁵⁹ POPPHI has supported a number of activities, such as regional workshops for professional associations of obstetricians, gynecologists, and midwives, and is conducting a global survey on the use of the active management of the third stage of labor.

⁵⁹ Active management of the third stage of labor includes the following: administration of a uterotonic agent, such as oxytocin, which helps reduce blood loss; controlled cord traction, or gently pulling on the umbilical cord; and uterine massage after the placenta has been delivered.

USAID has also supported research on maternal health. For example, in 2006, USAID supported the WHO's review of the major causes of maternal death. The study found that the major causes of maternal death vary by geographical region. In Africa, the leading cause of maternal death is hemorrhage, while in Latin America and the Caribbean, the leading cause is hypertension disorders. Prior to the study, one model of maternal mortality causes was used worldwide, without consideration of geographic differences. A USAID official told us that the study will help the agency determine which interventions to use in each region and, thus, allow it to target its maternal health programs more efficiently.

At the mission level, USAID has also begun to include programs that concentrate on maternal and newborn health. For example:

- The Mali mission requested that one of its major implementing partners, Assistance Technique Nationale, increase its program's focus on maternal health.
- In Cambodia, the mission supports a national program of "maternal death audits"—investigations into the causes of specific maternal deaths—to gather information to help prevent future deaths.
- The India mission supported the promotion of newborn care practices—such as the immediate drying and wrapping of the newborn and early breastfeeding—through CARE, an implementing partner.
- The missions in Ethiopia and India support new interventions for newborn health. The mission in India is supporting research on both newborn disease surveillance and the government of India's introduction of a new health protocol—the Integrated Management of Newborn and Childhood Illness.⁶⁰ The Ethiopian mission is also supporting the development of this protocol in Ethiopia.

⁶⁰The Integrated Management of Newborn and Childhood Illness strategy is an adaptation of the Integrated Management of Childhood Illness approach, which is based on studies that show that sick children often have more than one disease and emphasize the importance of considering other health factors, such as immunizations, when a sick child receives health care. This strategy incorporates the newborn, and includes home visits by health workers to educate mothers and families on (1) detecting newborn and child illnesses and (2) caring for sick or low birth weight newborns.

USAID Has Taken Steps to Support Sustainability

USAID has undertaken several efforts to address challenges to the sustainability of its CS/MH programs. These efforts include providing technical assistance, using its presence and connections in countries, working with host country governments, helping to develop products with potentially lasting effects, and promoting community involvement in CS/MH efforts.

In our survey results and interviews with USAID officials, we found that although challenges to the sustainability of CS/MH programs varied among countries, officials commonly cited challenges such as a lack or uncertainty of funding and a lack of technical expertise. For example, our survey showed that all 40 of the health officers surveyed found uncertainty over future funding levels to be a hindrance to their ability to effectively implement their maternal and child health programs.⁶¹ Likewise, a 2004 report prepared for USAID's Bureau for Africa also cites funding uncertainty as a challenge to sustainability. The report states that reductions and rapid shifts in funding levels for child survival and other health programs made it difficult for missions to plan and implement programs. Health officers at the USAID mission in Cambodia cited the Cambodian government's failure to devote sufficient funding to health as a challenge to sustainability. Our survey also indicated that 16 of 39 health officers were not confident that their maternal and child health programs would continue at their current level of quality without additional USAID assistance.⁶² In India, USAID officials told us that a lack of technical expertise was a major challenge to implementing and sustaining programs. In addition, out of 40 health officers, 35 or more cited corruption and the local populations' low educational level as factors that would make it difficult for their maternal and child health programs to continue without USAID support. Thirty-seven of 39 health officers also cited a lack of other resources for the health system as a challenge. For example, the USAID mission in Mali told us that the population's low educational level is a challenge for sustainability because people must be educated about planning and budgeting for their own health needs.

⁶¹The term "a hindrance" refers to the USAID program representatives who replied "Some Hindrance," "A Moderate Hindrance," "A Great Hindrance," or "A Very Great Hindrance" to a survey question that also included the categories of "Condition Does Not Exist" and "Little or No Hindrance."

⁶²The term "not confident" refers to the USAID program representatives who replied "Hardly Confident or Not At All Confident" in response to a survey question that also included the categories of "Extremely Confident," "Very Confident," "Moderately Confident," and "Somewhat Confident."

USAID's efforts to address such challenges to program sustainability include the following:

- *Providing technical assistance.* USAID provides technical assistance to build and strengthen the local expertise needed for program sustainability.
 - In India, the Urban Health Resource Center, a USAID implementing partner, is coordinating the government of India's efforts to develop and implement urban health plans for cities of different sizes. These plans will help guide national and state governments in developing urban health programs for other cities. Also, the Urban Health Resource Center is helping the state government of Uttar Pradesh to develop models of public-private sector partnerships that can be replicated and expanded to reach a larger population. One such partnership mobilizes NGO volunteers to interact with community members to increase their use of public health services.
 - Similarly, the Ethiopian mission funded a project providing technical assistance to the Ministry of Health to develop a proclamation for health reform. The proclamation allows local health centers to retain user fees. It has been ratified in four regions, affecting 90 percent of the Ethiopian population. We visited one health center that has plans to increase drug availability with the new funds it has retained under the proclamation.
- *Working with implementing partners.* USAID uses its in-country presence to develop relationships with implementing partners. For example:
 - According to a USAID report, the mission in Nigeria has cultivated relationships with all of the country's ethnic groups and requires its implementing partners to select local staff from all ethnic groups and geographic regions of the country. As a result, 99 percent of USAID-support project staff in Nigeria is local, which helps create a sense of local ownership.

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- USAID has developed long-standing relationships with some implementing partners. For example, in Bolivia, USAID has worked with PROSALUD, a nonprofit health services provider, for about 18½ years.⁶³
 - Some USAID-funded programs have transitioned into local NGOs. For example, the Cambodian staff of two USAID-funded projects later became local NGOs themselves—the Reproductive Health Association of Cambodia and the Reproductive and Child Health Alliance. A USAID official at the Cambodia mission told us that the mission targets support to local NGOs, rather than international NGOs, because the local organizations’ programs build capacity.
 - USAID’s presence in the field enables it to coordinate with implementing partners. For example, in India, the mission told us that the USAID coordinator for the maternal and child health activities in the state of Jharkhand visits project sites about once a month, and works with implementing partners’ representatives as well as local government officials. Furthermore, in addition to holding regular meetings for its partners, the mission has developed a partners’ guide, which is a publication containing brief descriptions of all USAID health partners and their activities. According to one health officer, the meetings and the guide have helped to foster a sense of a “USAID community” among the partners.
 - *Working with host governments.* USAID works with the countries’ health ministries to coordinate CS/MH efforts. In our survey, 37 of 40 health officers reported working with their host country’s health ministry to implement their maternal and child health programs. Also, in all four of the countries we visited, USAID supported the national governments’ development of health policies. In Ethiopia, India, and Mali, the missions have chaired the governments’ donor coordination groups. The Cambodian Ministry of Health chairs donor coordination groups, but according to mission staff and representatives from other donors, these groups are not an effective means for coordination.
 - *Developing potentially lasting products.* USAID seeks to support the development of products that can have long-lasting effects on maternal and child health. For example, USAID helped support the creation of a Family Health Card in Ethiopia. This pamphlet, which is meant to be used

⁶³According to a USAID official, PROSALUD currently has a 92 to 95 percent cost recovery rate, and USAID hopes that it will reach 100 percent cost recovery by December 2007.

**Community-Level Programs:
Community Volunteers, Cambodia**



Source: GAO.



Source: GAO.

The USAID mission in Cambodia works with several implementing partners who use a community-based approach to improving health. For example, the Reproductive and Child Health Alliance (RACHA), a USAID partner and local nongovernmental organization, works with community volunteers to provide health education and outreach activities, such as vitamin A distribution for children younger than 5 years old. Studies have shown that vitamin A supplementation, if received every 4 to 6 months, can reduce child mortality from all causes by as much as 23 percent. The photographs above show RACHA community volunteers distributing vitamin A supplements and educating fellow villagers on good health practices in the Pursat province.

by parents and community health workers, includes information on topics such as antenatal care, immunizations, nutrition, treatment of diarrhea, and hygiene. The Family Health Card is being used by several implementing partners as well as the Ethiopian Ministry of Health. Also, USAID supported the development of a Child Survival Message Guide in Ethiopia. This guide, developed with the Ministry of Health and other partners, seeks to ensure that organizations working in health provide the public with consistent messages about child survival. The guide can also serve as the basis for other health efforts, because organizations can use the guide as a starting point for developing their own materials.

- *Working with the private sector.* USAID works with private sector entities to promote the use of maternal and child health interventions. In our survey, 26 of 40 health officers reported working with for-profit businesses to implement their CS/MH programs. For example, the Point of Use Water Disinfection and Zinc Treatment Project, a USAID implementing partner in India, works with pharmaceutical manufacturers to promote the production of oral rehydration solution and zinc for the treatment of diarrhea, a leading cause of child mortality.
- *Promoting community involvement.* USAID also promotes community involvement to strengthen program sustainability (see sidebar). Community volunteers play major roles in USAID's CS/MH programs in the four countries we visited. Community members may perform a variety of activities, such as encouraging families to get their children immunized, urging pregnant women to obtain antenatal care, and referring others to government health centers for treatment and other services. For example, the India mission supports the use of community volunteers as part of its urban health program. These volunteers help organize outreach "camps," during which certain health services, such as antenatal care, are offered in the local community. The volunteers also assist in setting up women's health groups, which are composed of women from the community. Among their other activities, these groups create and manage a "community health fund" that provides loans to community members to pay for emergency health services; the women's groups also encourage attendance at outreach camps. USAID policy urges the use of community members to promote health. For example, according to USAID officials, the Bureau for Africa asks missions to incorporate community involvement in their countries' work plans.

Conclusions

USAID's allocations from the Child Survival and Maternal Health account in fiscal years 2004 and 2005 helped fund wide-ranging efforts to lower maternal and child mortality in Africa, Asia and the Near East, and Latin America and the Caribbean. The agency's country and regional missions and bureaus conducted numerous local and regional CS/MH activities. The Bureau for Global Health, in addition to serving as a global leader of CS/MH efforts, provided technical support for these activities, supported CS/MH research, and disseminated innovations and best practices to the missions and regional bureaus. However, because the Office of the Administrator did not require its missions and bureaus to report their obligations and expenditures of CS/MH allocations, the office had limited ability to account for and report on the use of the funds. To oversee and determine whether the CS/MH account is being used for the purposes for which it is allocated, including addressing congressional directives, the Office of the Administrator needs improved access to this information. USAID officials told us that the agency is making changes to its accounting system to record obligations and expenditures in the CS/MH account. However, the system currently contains little CS/MH data, and USAID has not tested how these data are traced back to the corresponding allocation data in the State Department's planning system to determine if CS/MH funds are obligated and expended for their intended purposes.

USAID has used various methods of disseminating health care innovations and best practices to its staff in the field to facilitate their efforts to improve maternal and child health. These methods have included, for example, electronic learning courses, biennial regional health conferences, an online database, and regional workshops. However, USAID has not assessed the relative effectiveness of its methods, some of which have drawbacks that may limit their usefulness. Given the urgent need to improve maternal and child health in developing countries, as well as the challenges confronting such efforts, it is essential that USAID use proven methods to ensure that staff at its missions and regional bureaus learn of CS/MH innovations and best practices in a timely and consistent manner.

Recommendations for Executive Action

To enhance USAID's administration of the Child Survival and Programs Fund and implementation of CS/MH programs, we are making the following two recommendations to the USAID Administrator:

- To strengthen USAID's ability to oversee and determine whether the Child Survival and Maternal Health account is used for the purposes for which the agency allocates it, including responding to congressional directives, the USAID Administrator should test recent modifications to the principal

accounting system to verify that CS/MH obligation and expenditure data will be properly recorded and traced back to the corresponding allocation data in the State Department's planning system.

- To provide for effective dissemination of information to USAID mission health officers about innovations and best practices in child survival and maternal health in a consistent and timely manner, the USAID Administrator should assess the relative effectiveness of the agency's current methods of disseminating this information using existing tools—for example, by including appropriate questions in the annual employee survey.

Agency Comments and Our Evaluation

USAID provided written comments and technical suggestions and clarifications on a draft copy of this report. (See app. VI for a reprint of USAID's comments and our response.) Consistent with our report's discussion, the agency emphasized that while its accounting system did not track obligations and expenditures at the CS/MH level in fiscal years 2004 and 2005, it did capture obligation and expenditure information for the larger CSH Fund. Regarding our first recommendation, USAID stated that once its modified accounting system has captured sufficient funding information, the agency will conduct tests to determine whether this information captures all CS/MH activities, thus allowing for verification that the funds are being used for the purposes for which they were appropriated. USAID also said it will immediately verify that the State Department's planning system correctly captures all CS/MH allocated funds, including CS/MH funds that might not fall under the maternal and child health element or health program area.

With respect to our second recommendation, USAID stated that it plans to conduct a Training Needs Assessment in 2007-2008 that will address our concerns and recommendation regarding evaluation of information dissemination methods. USAID also provided information regarding the role that grantees and contractors play in disseminating information on innovations and best practices. Furthermore, the agency provided additional detail on training and information dissemination efforts that we described in the draft, such as its electronic learning courses and state-of-the-art training. We have incorporated this information in the report, as well as USAID's technical comments and suggestions, where appropriate.

We are sending copies of this report to interested congressional committees and the USAID Administrator. Copies of this report will be made available to other interested parties upon request. In addition, the report will be available at no charge on the GAO Web site at <http://www.gao.gov>.

If you or your staffs have any questions about this report, please contact me at (202) 512-3149 or GootnickD@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. Key contributors to this report are listed in appendix VII.

A handwritten signature in black ink, appearing to read "David Gootnick". The signature is stylized with a large, looping initial "D" and a cursive "Gootnick".

David Gootnick
Director, International Affairs and Trade

Appendix I: Objectives, Scope, and Methodology

The fiscal year 2006 Foreign Operations Appropriations Act directed GAO to review the U.S. Agency for International Development's (USAID) use of child survival and health funds for fiscal years 2004 and 2005. Discussions with staff from committees of jurisdiction indicated that congressional interest focused on the Child Survival and Maternal Health (CS/MH) account within the Child Survival and Health Programs Fund.

As part of our efforts to obtain information to address our four objectives, we conducted two surveys between August and December 2006. The surveys included questions on financial reporting, the types of activities funded with CS/MH funds, coordination with host country governments, methods for sharing best practices, and challenges to implementing CS/MH programs. Both surveys were sent to all 40 USAID health officers who currently manage CS/MH programs. To develop the questions for both surveys, we reviewed documents from USAID's Bureau for Global Health and conducted interviews with mission health officers. We pretested both questionnaires with mission health officers. For the first survey, we conducted three pretests; for the second, we conducted two. We refined our questions on the basis of the feedback we obtained from the pretests. We achieved a 100 percent response rate for both surveys. We took steps in collecting and analyzing the survey data to minimize errors that might occur during these stages of the surveys.

To examine USAID's financial data on CS/MH funds for fiscal years 2004 and 2005, we reviewed budget data provided by the Office of the Controller, which provided data from USAID's primary financial management and reporting system; the Bureau of Policy and Program Coordination; the Bureau for Global Health; and the regional bureaus for Africa, Asia and the Near East, and Latin America and the Caribbean. We also conducted interviews with officials from those units, as well as the Office of the Inspector General, to understand how USAID accounted for its CS/MH funds. Finally, we reviewed financial data from USAID missions in Cambodia, Ethiopia, India, and Mali. We conducted field visits to these four countries from October to November 2006. We selected these countries based on criteria that included (1) receipt of CS/MH account funding; (2) representation of Africa and Asia, the two geographic regions with the highest maternal and child mortality rates; (3) recommendations by USAID officials of some countries that faced "challenges" and others that had achieved "successes"; and (4) consideration of travel restrictions.

To describe USAID's activities funded by the CS/MH account, we reviewed documentation from the Bureau for Global Health; the regional bureaus for Africa, Asia and the Near East, and Latin America and the Caribbean;

and the USAID missions in our four field countries. We also interviewed USAID officials at each of these entities. In the four field countries, we observed some of USAID's CS/MH activities and interviewed host country government officials at both national and local levels, representatives from USAID implementing partners (including international and local nongovernmental organizations and faith-based organizations), and program beneficiaries. Lastly, to further develop our understanding of current CS/MH interventions and indicators, we attended global health conferences in Washington, D.C.

To examine USAID's methods for sharing best practices, we reviewed USAID policies and documents and analyzed data from our two surveys. To familiarize ourselves with the electronic resources USAID uses to disseminate best practices, we accessed USAID's external Web site as well as other sites on the World Wide Web. We also interviewed USAID officials of the Bureau for Global Health, the regional bureaus, and the missions that we visited.

To describe USAID's response to challenges in planning and implementing its CS/MH programs, we first identified key challenges by using data from our first survey and interviewing officials representing (1) USAID's three regional bureaus, the Bureau for Global Health, and our four field countries; (2) USAID's implementing partners; and (3) other donor organizations, such as the United Nations Children's Fund (UNICEF), United Nations Population Fund, and Gates Foundation. To obtain additional information on the global health worker shortage, we reviewed reports from nongovernmental and multilateral sources, such as Save the Children and the World Health Organization. In our examination of the challenges associated with maternal and newborn health, we reviewed reports, such as UNICEF's *State of the World's Children 2007*, and articles from the British medical journal titled *The Lancet*. To determine what steps USAID is taking to address the identified challenges, we interviewed USAID officials at the Bureau for Global Health, the three regional bureaus, and missions in our four field countries. We also reviewed USAID documentation, including work plans, annual reports, and program reports, such as the Bureau for Africa's *Child Survival in Sub-Saharan Africa – Taking Stock*.

We assessed the reliability of financial data compiled and generated by USAID's Office of the Controller in Washington, D.C., and by the missions in our four field countries. We determined that the survey and financial data were sufficiently reliable for our analysis.

**Appendix I: Objectives, Scope, and
Methodology**

We conducted our work from April 2006 through March 2007 in accordance with generally accepted government auditing standards.

Appendix II: Allocation of Child Survival and Maternal Health Funds within USAID, Fiscal Years 2004 and 2005

Dollars in millions

Country/Entity	Fiscal year				Total	
	2004		2005		Amount	Percent
	Amount	Percent	Amount	Percent		
Africa	\$78.6	24.0%	\$88.3	25.4%	\$166.9	24.7%
Asia and the Near East	79.6	24.2	80.5	23.2	160.0	23.7
Latin America and the Caribbean	39.0	11.9	39.3	11.3	78.4	11.6
International Partnerships	64.2	19.6	72.3	20.8	136.5	20.2
Bureau for Global Health	66.0	20.1	67.1	19.3	133.1	19.7
Other	0.6	0.2	n/a	n/a	0.6	0.1
Total	\$328.0	-	\$347.5	-	\$675.6	-

Source: GAO analysis of USAID data.

Appendix III: Allocation of CS/MH Account Funds to Countries, Fiscal Years 2004 and 2005

Country	Fiscal year		
	2004 (actual)	2005 (actual)	2006 (planned)
Afghanistan	\$16,870	\$19,870	\$21,005
Angola	2,700	1,200	1,483
Bangladesh	10,800	9,412	6,683
Benin	1,350	1,250	1,977
Bolivia	4,475	4,752	5,787
Burundi	200	300	692
Cambodia	4,690	5,100	5,148
Democratic Republic of the Congo	8,025	8,600	8,601
Dominican Republic	4,000	3,861	3,237
El Salvador	2,700	2,970	2,970
Eritrea	1,600	5 ^a	0 ^a
Ethiopia	4,600	6,090	7,257
Ghana	3,200	3,200	2,719
Guatemala	4,150	4,215	4,158
Guinea	2,150	2,150	2,200
Haiti	8,550	8,839	9,207
Honduras	3,142	3,143	3,377
India	12,600	14,222	12,852
Indonesia	11,400	13,800	14,157
Jamaica	544	539	497
Kenya	1,000	1,000	989
Liberia	1,200	1,200	1,582
Madagascar	2,825	3,475	3,287
Malawi	2,200	2,200	2,175
Mali	2,900	3,780	3,658
Mozambique	3,500	4,500	4,350
Nepal	5,040	5,340	4,951
Nicaragua	3,000	3,242	3,210
Nigeria	7,000	8,650	3,856
Pakistan	11,600	7,600	13,652
Paraguay	0	0	1,102
Peru	5,450	5,164	4,653
Philippines	4,700	4,550	4,356
Rwanda	1,100	1,400	2,224

**Appendix III: Allocation of CS/MH Account
Funds to Countries, Fiscal Years 2004 and
2005**

Country	Fiscal year		
	2004 (actual)	2005 (actual)	2006 (planned)
Senegal	2,500	2,600	2,422
Sierra Leone	100	100	297
Somalia	100	100	0
South Africa	2,000	2,000	1,780
Sudan	7,200	8,200	8,809
Tanzania	2,500	3,500	3,312
Uganda	2,260	2,260	2,135
Zambia	4,420	4,420	4,271

Source: GAO analysis of USAID data.

Note: We conducted site visits to the countries that are noted in bolded text.

^aUSAID closed its activities in Eritrea on December 31, 2005, in response to the Government of Eritrea's request that USAID terminate development assistance programs in the country.

Appendix IV: Mortality Statistics for Countries Receiving CS/MH Funds, Fiscal Years 2004 and 2005

Country	Under 5 Mortality Rate (2003) ^a	Neonatal Mortality Rate (2000) ^b	Maternal Mortality Ratio (2000) ^c
Afghanistan	257	60	1,900
Angola	260	54	1,700
Bangladesh	69	36	380
Benin	154	38	850
Bolivia	66	27	420
Burundi	190	41	1,000
Cambodia	140	40	450
Democratic Republic of the Congo	205	47	990
Dominican Republic	35	19	150
El Salvador	36	16	150
Eritrea	85	25	630
Ethiopia	169	51	850
Ghana	95	27	540
Guatemala	47	19	240
Guinea	160	48	740
Haiti	119	34	680
Honduras	41	18	110
India	87	43	540
Indonesia	41	18	230
Jamaica	20	10	87
Kenya	123	29	1,000
Liberia	235	66	760
Madagascar	126	33	550
Malawi	178	40	1,800
Mali	220	55	1,200
Mozambique	158	48	1,000
Nepal	82	40	740
Nicaragua	38	18	230
Nigeria	198	53	800
Pakistan	103	57	500
Peru	34	16	410
Philippines	36	15	200
Rwanda	203	45	1,400
Senegal	137	31	690
Sierra Leone	283	56	2,000

**Appendix IV: Mortality Statistics for
Countries Receiving CS/MH Funds, Fiscal
Years 2004 and 2005**

Country	Under 5 Mortality Rate (2003)^a	Neonatal Mortality Rate (2000)^b	Maternal Mortality Ratio (2000)^c
Somalia	225	49	1,100
South Africa	66	21	230
Sudan	93	29	590
Tanzania	165	43	1,500
Uganda	140	32	880
Zambia	182	40	750

Source: GAO analysis of WHO and UNICEF data.

Note: We conducted site visits to the countries that are noted in bolded text.

^aUnder-5 Mortality Rate = Probability per 1,000 live births of child dying before age 5.

^bNeonatal Mortality Rate = (Neonatal deaths / live births) x 1,000.

^cMaternal Mortality Ratio = Maternal deaths per 100,000 live births.

Appendix V: Obligations and Expenditures for the Four Missions We Visited, Fiscal Years 2004 and 2005

Country	Fiscal year			
	2004		2005	
	Obligations	Expenditures	Obligations	Expenditures
Mission-managed programs				
Cambodia	\$3,971,330	\$3,573,002	\$5,020,120	\$4,019,403
Ethiopia	2,531,597	2,469,984	4,684,941	2,417,957
India ^a	4,295,000	8,445,506	4,858,000	5,300,141
Mali	2,620,000	2,617,154	3,486,766	2,513,190
Centrally managed programs				
Cambodia	718,610	-	150,000	-
Ethiopia	400,000	400,000	570,000	570,000
India ^a	8,731,000	-	9,942,000	-
Mali	330,000	320,000	493,000	318,000

Source: GAO analysis of USAID mission data.

Note: Cambodia and India were unable to provide expenditure data for centrally managed programs. Ethiopia estimated its expenditures for centrally managed programs. The Bureau for Global Health, which managed these programs, was able to provide obligation data, totaling over \$90 million in fiscal years 2004 and 2005, but was unable to provide expenditure data.

^aIndia carried over unexpended funds from previous fiscal years, which caused greater expenditures than obligations in fiscal years 2004 and 2005.

Appendix VI: Comments from the U.S. Agency for International Development

Note: GAO comment supplementing those in the report text appears at the end of this appendix.



USAID
FROM THE AMERICAN PEOPLE

APR 3 2007

Mr. David Gootnick
Director
International Affairs and Trade
U.S. Government Accountability Office
441 G Street, N.W.
Washington, D.C. 20548

Dear Mr. Gootnick:

I am pleased to provide the U.S. Agency for International Development's (USAID) formal response to the draft GAO report entitled USAID Supported a Wide Range of Child and Maternal Health Activities but Lacked Detailed Spending Data and Proven Methods for Sharing Best Practices [GAO-07-486].

I would like to clarify that USAID tracks obligations and expenditures at the account level, e.g., the Child Survival and Health (CSH) account. In FY 2004 and FY 2005, the Agency accounting system did not track obligations and expenditures at the sub-account level, including Child Survival and Maternal Health (CS/MH) funds. Congress was aware of this situation and the Agency never presented its accounting system as reporting below the account level. Starting in FY 2007, changes in the accounting system will allow tracking of the CS/MH funds.

Thank you for the opportunity to respond to the GAO draft report and for the courtesies extended by your staff in the conduct of this review.

Sincerely,

A handwritten signature in black ink, appearing to read "Mosina H. Jordan".

Mosina H. Jordan
Counselor to the Agency

Enclosure: USAID Comments

cc: Rob Portman, Director, OMB

USAID COMMENTS ON DRAFT GAO 07-486

1. In response to your first recommendation, USAID will carry out the following longer term and immediate tests:
 - A. Once there is sufficient obligation and expenditure information in Phoenix, reconcile the FY2007 CS/MH “sub-account” and cross-walk it over to the corresponding allocation information in the Foreign Assistance Coordination and Tracking System (FACTS). This test will determine whether the modifications in the Phoenix system to record obligations and expenditures by the elements¹ of the Foreign Assistance Framework, as set out in FACTS, capture all the CS/MH activities and allow for verification that these funds are being used for the purposes for which they were appropriated and allocated. This testing process might take a year and a half in order to have sufficient data, making it possible to close out the recommendation in the three-year window allowed.
 - B. In addition to this longer term testing process, USAID will verify immediately that FACTS correctly captures all of the CS/MH funding information, as the CSH guidance requires, including CS/MH funds in the Maternal and Child Health (MCH) element and CS/MH funds in other elements and in non-health areas.
2. In response to your second recommendation, we would like to note the large amount of information about innovations and best practices in child survival and maternal health disseminated by the grantees and contractors of the Bureau of Global Health and the Regional Bureaus.²

¹ Maternal and Child Health (MCH) is one of the eight elements of the health area in the Foreign Assistance Framework.

² In FY2004 and FY2005, grantees and contractors in the BGH included: Basic Support for Institutionalizing Child Survival (BASICS III); Access to Clinical and Community Maternal, Neonatal and Women’s Health Services (ACCESS); the Prevention of Postpartum Hemorrhage Initiative (POPPHI); the A2Z Micronutrient Project; LINKAGES (Breastfeeding, Lam, and Related Maternal and Young Child Nutrition); FANTA (Food and Nutrition Technical Assistance); Quality Assurance/Workforce Development; Hygiene Improvement, the Child Survival and Health Grants Program, The World Health Organization, UNICEF, and Country and Global Research Activities. In FY2004-2005, the Africa Bureau, through its grantee, the SARA project, provided Health Officers the following publications on innovations and best practices: 1) A Guide to Research on Care-Seeking Childhood Malaria; 2) Child Survival in Sub-

This information is not fully covered in the draft report. Grantees and contractors develop and disseminate innovations and best practices in their respective fields of maternal and child health. Their dissemination activities are monitored and routinely evaluated. BASICS, for example, carried out a survey among key decision-makers in developing countries to determine the most effective means to deliver key information on new child survival approaches.

In addition to the development and dissemination of innovations and best practices through the core-supported grantees and contractors described above, BGH, as the report observes, has activities specifically targeting Mission Health Officers. These activities are routinely monitored and evaluated, as described below.

A. Electronic Learning Courses. The GAO report notes that some health officers were still unaware of the eLearning Courses. The report cites three courses relevant to CS/MH: Antenatal Care, Essential Newborn Care, and Malaria. Ten other courses, however, are available or near completion that also are relevant to CS/MH: Essential Newborn Care, Preventing Postpartum Hemorrhage, Diarrheal Disease, Pneumonia, Immunization Essentials, Preventing Mother-to-Child Transmission of HIV, Reduction of Maternal Mortality and Disability, Sick Newborn Care, Emergency Obstetrical Care, and Newborn Care. All eLearning courses are authored by USAID staff and contractors expert in the subject area and reviewed by and vetted with technical experts outside the agency. Each course describes current best practice and state-of-the-art research.

The Agency tracks who is taking a given course, where the person is located, the person's role at USAID, and their score on the final exam (85% correct is required to pass). Each course requires a learner action plan and end-of-course evaluation to get a certificate of course completion. The evaluation data collected provides detailed feedback to the eLearning Administrator in the BGH and course authors on the appropriateness, usefulness, and timeliness of topics covered. Course

Saharan Africa - Taking Stock, An Overview; 3) Improving Community Case Management of Childhood Malaria; 4) Lives at Risk: Malaria and Pregnancy; 5) Nutrition Briefs; 6) Post abortion Care in Francophone Africa; 7) Utilizing the Potential of Formal and Informal Private Practitioners.

content is updated annually, and an Administrator Mailbox installed in 2006 allows users to communicate feedback and follow on questions directly to the BGH and course authors. In addition, the bureau regularly receives comments from other international health organizations on the quality, accessibility and usefulness of eLearning courses and website.

As of March 2007, BGH had recorded 6,151 USAID users of its eLearning courses. The bureau set a 2007 priority for the marketing and communication of these courses to Population, Health, and Nutrition (PHN) Officers and Foreign Service Nationals (FSN) in USAID missions. The bureau is exploring ways to: 1) make the eLearning courses part of the professional development requirements for people both in Washington and the missions; 2) garner mission leadership support (time/incentives/rewards) for PHN and FSN health staff to take the courses; and 3) continue funding development of courses in CS/MH areas to further address the needs in the field.

B. State-of-the-Art-Trainings (SOTAs) The GAO report notes that a reduction of funds in USAID Regional Bureau budgets resulted in postponing SOTAs in 2006. In 2007 two Regional Bureaus, Asia and Near East and Europe and Eurasia are pursuing plans to hold regional trainings with support from the BGH. An ANE regional mini-university will include presentations and training on relevant “best practices” as well as increased access to e-learning courses. The E&E Regional Bureau Health team is working with the Social Transition team to develop cross-sectoral and health-related training sessions. Discussions are underway in the BGH on re-instituting bi-annual SOTAs and holding a SOTA (or equivalent) in Africa in the near future. The decision regarding funding and holding SOTAs rests with the USAID Administrator, the leadership of the Regional Bureaus, and BGH.

C. Assessing the Relative Effectiveness of the Agency’s Current Methods USAID/BGH uses a range of methods to address different communications and learning requirements for diverse audiences in highly dispersed areas around the world. Consequently, information sharing, training, and communication methods are multiple and varied. Using a separate contractor, The BGH conducts a Training Needs Assessments of Washington and field health staff to capture

See comment 1.

information about their learning requirements, preferred training methods, and resources available to meet their needs. The information is captured through surveys, interviews, and focus groups. This information serves as a basis for new professional development and organizational development activities. BGH will conduct a Needs Assessment in the 2007-2008 time period that will address the information sharing, dissemination of best practices, and training concerns raised in the GAO report.

The following is GAO's comment on the U.S. Agency for International Development's letter dated April 3, 2007.

GAO Comment

1. USAID commented that the Bureau for Global Health conducts a Training Needs Assessment of Washington and field health staff to gather information about learning requirements and resources as well as training preferences. While we acknowledge that a second Needs Assessment in the 2007-2008 time frame could address our concerns regarding evaluation of information sharing methods, we also note that the first Training Needs Assessment was conducted in 2003 and concentrated mainly on Washington-based staff. For such an assessment to be effective, we encourage USAID to widely solicit input from its field health staff as well as to include relevant evaluation questions in its annual employee survey.

Appendix VII: GAO Contact and Staff Acknowledgments

GAO Contact

David Gootnick, (202) 512-3149

Staff Acknowledgments

In addition to the individual named above, Audrey Solis (Assistant Director), Judith Williams, Theresa Chen, Heather MacDonald, Susan Tieh, Jeanette Franzel, Joel Grossman, Keith Kronin, Reid Lowe, and Grace Lui made key contributions to this report. Claude Adrien, J. Robert Ball, Etana Finkler, and B. Patrick Hickey also made technical contributions.

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