

PD-AAN-482

ISA 32135

**LIBERIAN PRIMARY HEALTH CARE PROJECT**

(669-0165)

**PROJECT PAPER**

Designed Jointly by the  
Ministry of Health and Social Welfare PHC Committee  
and  
USAID/Liberia

August 1983

PDAA.V 482

<b>AGENCY FOR INTERNATIONAL DEVELOPMENT</b> <b>PROJECT DATA SHEET</b>	<b>1. TRANSACTION CODE</b> <input type="checkbox"/> A = Add <input type="checkbox"/> C = Change <input type="checkbox"/> D = Delete	Amendment Number _____ <b>DOCUMENT CODE</b> 3
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<b>2. COUNTRY/ENTITY</b> Liberia	<b>3. PROJECT NUMBER</b> 669-0165
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<b>4. BUREAU/OFFICE</b>	<b>5. PROJECT TITLE (maximum 40 characters)</b> Liberia Primary Health Care Project
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<b>6. PROJECT ASSISTANCE COMPLETION DATE (PACD)</b> MM DD YY 07 31 88	<b>7. ESTIMATED DATE OF OBLIGATION</b> (Under 'B' below, enter 1, 2, 3, or 4) A. Initial FY <u>83</u> B. Quarter <u>4</u> C. Final FY <u>87</u>
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8. COSTS (\$000 OR EQUIVALENT \$1 = )						
A. FUNDING SOURCE	FIRST FY <u>83</u>			LIFE OF PROJECT		
	B. FX	C. L/C	D. Total	E. FX	F. L/C	G. Total
AID Appropriated Total						
(Grant)	( 3,800 )	(    )	( 3,800 )	(10,751 )	( 4,249 )	( 15,000 )
(Loan)	(    )	(    )	(    )	(    )	(    )	(    )
Other U.S.						
1. Peace Corps					582	582
2.						
Host Country	0	0	0	1,496	19,915	21,411
Other Donor(s)						
<b>TOTALS</b>	<b>3,800</b>		<b>3,800</b>	<b>12,247</b>	<b>24,746</b>	<b>36,993</b>

9. SCHEDULE OF AID FUNDING (\$000)									
A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE		D. OBLIGATIONS TO DATE		E. AMOUNT APPROVED THIS ACTION		F. LIFE OF PROJECT	
		1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan
(1)	530	510		0	0	15,000		15,000	
(2)									
(3)									
(4)									
<b>TOTALS</b>				<b>0</b>	<b>0</b>	<b>15,000</b>		<b>15,000</b>	

<b>10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each)</b> 560      570      580      590	<b>11. SECONDARY PURPOSE CODES</b>
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<b>12. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)</b> A. Code      BR B. Amount      36,993	
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**13. PROJECT PURPOSE (maximum 480 characters)**

1. To increase the proportion of the target population with access to an appropriate balance of PHC services, as described in the project paper.
2. To strengthen the institutional infrastructure, both centrally and in the target areas, in order to achieve GOL long-term goals.

<b>14. SCHEDULED EVALUATIONS</b> Interim    MM YY    MM YY    Final    MM YY 1 2 8 4    0 4 8 6    0 8 8 7	<b>15. SOURCE/ORIGIN OF GOODS AND SERVICES</b> <input checked="" type="checkbox"/> 000 <input type="checkbox"/> 941 <input checked="" type="checkbox"/> Local <input checked="" type="checkbox"/> Other (Specify) 935
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**16. AMENDMENTS/NATURE OF CHANGE PROPOSED (This is page 1 of a \_\_\_\_\_ page PP Amendment.)**

<b>17. APPROVED BY</b>	Signature 	<b>18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION</b> MM DD YY 
	Title    Lois Richards Mission Director USAID/Liberia	Date Signed MM DD YY 0 8 2 9 8 3

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LIST OF ABBREVIATIONS

A&E	Architectural and Engineering
AID	Agency for International Development (US)
AID/W	Agency for International Development/Washington
BA	Bachelor of Arts
BCG	Bacille-Calmette-Guérin (vaccine)
BSc	Bachelor of Science
CCCD	Combatting Communicable Childhood Diseases
CDC	Centers for Disease Control
CHD	County Health Department
CHO	County Health Officer
CM	Certified Midwife
CPA	Certified Public Accounting
CUC	Cuttington University College
DPT	Diphtheria, Pertussis and Tetanus (vaccine)
EPI	Expanded Programme of Immunization
FP	Family Planning
FY	Fiscal Year
GOL	Government of Liberia
HC	Health Center
HI	Health Inspector
HMD	Hospital Medical Director
HMP	Health Management Planning
HP	Health Post
IEC	Information, Education and Communication
IMF	International Monetary Fund

JFK	John F. Kennedy Medical Center
JHPIEGO	Johns Hopkins Program for International Education in Gynecology and Obstetrics
LCRH	Lofa County Rural Health
LRCN	Liberia Rural Communications Network
MCH	Maternal and Child Health
MCH/FP	Maternal and Child Health/Family Planning
MH&SW	Ministry of Health and Social Welfare
MPH	Master of Public Health
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
PA	Physician Assistant
PCV	Peace Corps Volunteer
PHC	Primary Health Care
PIO/C	Project Implementation Order/Commodities
PIO/P	Project Implementation Order/Participant Training
PIO/T	Project Implementation Order/Technical Assistance
PL-480	Public Law 480
PRC	People's Redemption Council
PSA	Procurement Services Agent
PY	Person Year
REDSO/WCA	Regional Economic Development Services Office for West and Central Africa
RFP	Request for Proposal
RHTC	Rural Health Training Center
RN	Registered Nurse
RTC	Regional Training Center
SHDS	Strengthening Health Delivery Systems

TA	Technical Assistance
TBA	Traditional Birth Attendant
TNIMA	Tubman National Institute of Medical Arts
TT	Tetanus Toxoid (vaccine)
UNDP	United Nations Development Programme
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VDC	Village Development Council
VHT	Village Health Team
VHW	Village Health Worker
WHO	World Health Organization

## I. PROJECT AUTHORIZATION DOCUMENTS

### A. Project Summary

#### 1. Project purpose

The purpose of this project is twofold: (1) To increase the proportion of rural Liberians with access to an appropriate mix of preventive, promotive, and curative primary health care (PHC) services; and (2) to strengthen the institutional infrastructure, both centrally and in the project area, in order to support the expansion of the National PHC Program.

#### 2. Project background

Access to basic health care for at least 90 per cent of Liberia's population by the year 2000 is a priority goal of the GOL. To achieve this goal the Ministry of Health and Social Welfare (MH&SW) has developed a National Primary Health Care Program. Recognizing that available resources are insufficient to implement the entire national program at once, the program comprises four phases. In view of the status of the health care delivery system in Liberia, it is clear that meeting this goal will require the close coordination and cooperation of the GOL with AID and other donors in developing projects and programs which will overcome the constraints facing the GOL in the near future.

#### 3. Project description

This project will assist the GOL in refining, implementing, and institutionalizing the National PHC Program in rural Liberia and is expected to continue during at least the first two phases of the program. The project focuses on health care at the village level, and is designed to expand from the village upwards, providing a National PHC system that will impact upon the serious health problems in Liberia while utilizing local resources and participation to the maximum extent. In addition to developing the capability for a coordinated PHC system providing full services in two counties (Grand Gedeh and Sinoe), the project will provide sufficient organizational and managerial capacity to establish the framework for a strong, coordinated, decentralized system that can be expanded nationwide. This is essential in order to attract other donor assistance to support a viable, long-term national effort. In view of Liberia's economic situation, the project has been designed to minimize project-generated recurrent costs. Simple technology and local materials will be used where feasible. A scheme to recover drug costs is incorporated, and remuneration for both VHWS and TBAs will be borne by the communities. AID funds will be used to pay all of certain recurrent costs for a fixed period, with the GOL phasing in its continuing funding of these costs thereafter.

#### 4. Beneficiaries

During the first five years of the project, there will be an increase of more than 115,000 rural Liberians in the full-service counties with access to an appropriate mix of preventive, promotive, and curative PHC services.

In addition, the development of a National PHC Program framework and the strengthening of central/national institutions (logistics, management, training) will benefit the entire population through an improved national PHC delivery system.

5. Host country and other donors

During the first five years of the project the GOL will contribute \$1.8 million toward project-generated recurrent costs, and participating villages will contribute \$0.3 million to support village-level health workers. Approximately \$3.5 million in PL-480 counterpart funds will be programmed to support specified project costs. In addition, Peace Corps will provide the services and support of 15 volunteers at a cost of \$0.6 million. Other donors currently providing PHC support include UNICEF (vaccines, drugs and medical supplies, vehicles); UNFPA (pilot VHW project in Bong County); and WHO (consultants, surveys, training). In addition, the Federal Republic of Germany has initiated a county-level PHC project in Nimba County.

6. Financial summary

The total cost of the first five years of this project will be approximately \$37.0 million, of which the GOL will contribute \$21.1 million in cash and in kind. Participating villages will contribute \$0.3 million, and U.S. Peace Corps will provide \$0.6 million to support 15 volunteers. The AID contribution of \$15.0 million comprises the following major components:

	<u>Life of Project</u> <u>(\$ Thousand)</u>
Technical Assistance	4,281
Training	1,916
Commodities	2,639
Construction	1,052
Other Costs	2,229
Inflation and Contingency	<u>2,883</u>
TOTAL	15,000

# UNITED STATES AID MISSION TO LIBERIA

c/o American Embassy  
Monrovia, Liberia



## B. MEMORANDUM FOR THE MISSION SENIOR REVIEW COMMITTEE

FROM : Glenn L. Post, M.D. *Glenn L Post*  
Health Officer

SUBJECT : Primary Health Care Project (669-0165): Summary of  
Major Project Issues

This memorandum summarizes major project issues and their resolution. GOL and USAID design skills have been enhanced by a wide range of expertise from REDSO/WCA (financial, legal, contract, procurement, and population advisors), and from AID/Washington (health and economic advisors), in addition to outside consultants (project design and public health/financial advisors). With this support, and following the recommendations of several internal Mission project reviews, the USAID Health Office believes that the Primary Health Care Project, although a high-risk undertaking, addresses significant issues adequately and allows flexibility to make the risks manageable. The following major issues have been addressed:

### Project Complexity

In order to facilitate implementation, project components have deleted from earlier drafts and technical assistance has been bolstered. The specific water-and-sanitation component (to have been undertaken with participation of the Ministry of Rural Development) has been deleted in order to simplify implementation and sharpen project focus. Similarly previously proposed nationwide family planning, and nutrition training and service delivery components have been restricted to the two project counties. Central-level inputs, in particular those related to management and logistics, have generally been restricted to whatever is necessary to make PHC work in the two project counties. Although the aim is to establish the framework for a strong, coordinated national PHC effort, overall, sweeping types of reform are beyond the scope of this project.

### Implementation Constraints

To facilitate implementation, technical assistance has been maximized within the \$15-million project ceiling imposed by AID/Washington (Spencer/Ruddy Action Memo of 4/21/83 signed by AA/AFR on May 29, 1982). The duration of County Public Health Physician TA has been increased from 3 to 3½ years in order to reinforce county-level implementation. Three locally-hired administrative officers will support the long-term technicians in an effort to ensure that they will be free to focus on their assigned responsibilities.

Still, the schedule is tight and institution-building can be slow. Several components are relatively untested (e.g., revolving funds and decentralization) and unanticipated difficulties and delays are sure to crop up. The design team considered "stretching out" the length of the project, but this was rejected. In view of the fixed upper limit on AID funding, if the project were extended an additional year or two, project funds in the incremental period would be too heavily depreciated to make sound economic sense. Furthermore, since additional person-years of TA would be required for the extended period, other project elements would have to be relatively short-changed.

Ample funds have been budgeted for operations research, to help refine the village-level system and to investigate implementation problem areas. Moreover, project evaluations will continue to examine conformance to the implementation schedule. The appropriateness of proceeding with the project and need for remedial measures will be continually examined. If necessary and desirable, eventual extension of the project will be considered.

#### Recurrent Costs

This project has been designed to make maximum use of existing resources and of self-financing/cost-recovery mechanisms to reduce recurrent costs. For example, the villagers themselves, through the village development councils, will support the village health team services. Patient charges and revolving-drug funds are eventually expected to assure a continuous drug supply in the project area, without increasing current GOL recurrent drug expenditures. A motorcycle purchase scheme will assure health worker contributions to the purchase of additional motorcycles and spare parts. A certified-public-accounting firm will be contracted to strengthen financial management of the project revenue-generating systems as well as AID-financed local currency expenses. County-level decentralization (of budget, financial responsibility, and planning and management responsibilities) is also expected to lead to more efficient and productive resource utilization.

With these mechanisms, the increase in annual GOL project-generated costs is projected to be only \$709,000 (more than a third of which represents inflation) by the end of the project. This amount is less than 4 percent of the projected annual MH&SW recurrent budget.

While the outlook for economic growth in Liberia during the next five years is not sanguine, there are indications that the GOL can meet incremental recurrent costs related to this project. Improved budgeting and expenditure control assisted by the Economic and Financial Management and Training Project (669-0184), and increased tax recovery, supported through the Increased Revenue for Development Project (669-0132) should enhance GOL ability to meet such costs. Still, economic recovery is largely dependent on world markets for Liberia's exports and therefore cannot be predicted with assurance. For this reason AID is committed to fund significant recurrent costs (notably vehicle operations and maintenance costs), particularly in the early years of the project. The issue of recurrent costs and the GOL's progress in meeting its commitment to assume no less than 90 percent of project-generated recurrent costs by project year 5, will be addressed in each project evaluation.

### Absorptive Capacity

The project design includes a carefully conceived staffing plan that will ensure sufficient mid-level personnel in the project area while minimizing the strain on GOL manpower capabilities. This will be accomplished through expansion of training institutions and redeployment of existing personnel.

### New Interventions

Potential pitfalls in project implementation relate to a range of project components that are not yet well established in Liberia. These include decentralization, self-financing mechanisms, the role of VDCs, and the package of high-impact PHC interventions. A comprehensive plan for training and curriculum development and a well-delineated supervision strategy, along with substantial technical assistance and publicity (e.g., the LRCN) will facilitate implementation of these components. This support will be bolstered by operations research as well as the project evaluations and routine monitoring, all of which will examine potential difficulties in these areas. Evaluations will also examine the continued validity of the project purpose as well as the relevance and appropriateness of expected and actual project outputs and inputs. Findings of research, monitoring, and evaluations will be used to develop modifications as needed to achieve project objectives.

### AID/Washington Concerns

Monrovia 06862 detailed how AID/W concerns about the project (as expressed in the Spencer-Ruddy Memo of April 21, 1982 and various PPC memoranda) have been addressed. See also the memorandum of the Director's conversation of April 1, 1983 with AFR/CCWA concerning this cable.

# UNITED STATES AID MISSION TO LIBERIA

c/o American Embassy  
Monrovia, Liberia



## C. Action Memorandum for the Director

TO: Lois Richards, Director

FROM: Glenn L. Post, M.D., Health Officer *Glenn L. Post*

THRU: John Pielemeier, Deputy Director *John Pielemeier*

SUBJECT: Primary Health Care Project (669-0165)

Problem: Your approval is requested to authorize a grant of \$15,000,000 including \$14,700,000 from the Health Account and \$300,000 from the Population Account (Section 104 of the Foreign Assistance Act of 1961, as amended), to the Government of Liberia (GOL) for the Primary Health Care (PHC) Project. It is planned to obligate \$3,800,000 in FY 1983, including \$3,500,000 from the Health Account and \$300,000 from the Population Account.

### Discussion:

Background: The infant mortality rate in Liberia is estimated to be 154 per 1000 live births, and more than 20 per cent of children die before their fifth birthday. More than half of all the deaths in Liberia occur in the under-five age group, with more than a third of all deaths occurring in the first year of life. The overwhelming majority of infant and child deaths are caused by gastrointestinal illness (especially diarrhea and dysentery), malnutrition, measles, pneumonia (often secondary to measles), malaria, and neonatal tetanus.

Women of reproductive age (15-44) are at high risk of maternal mortality; moreover, poor health in this group also leads to increased infant mortality. Because of their role both in combating infant and child mortality and in contributing to labor productivity, these women are identified as priority targets for health program activities.

Available data indicate that most morbidity and mortality could be prevented through wider access to immunizations and basic health services -- particularly maternal and child health services -- as well as to improved environmental sanitation and nutritional practices. The needed technology is widely known, yet traditional medicine remains a major source of health care for Liberians, with most practitioners untrained in modern preventive and promotive aspects of health care.

Within the government health system, fundamental financial, structural, organizational, and managerial problems and lack of sufficient trained manpower limit the capacity to provide the needed services. According to official estimates, only 35 per cent of Liberians are considered to have access to any form of modern health services. These are mostly facility-based, curative-oriented, and are provided mainly in the urban and peri-urban areas. The health care system is highly centralized, and in general, skilled health personnel and medical supplies are insufficient. Owing to the maldistribution of these resources, they are even more scarce in the rural areas.

An added strain on the health delivery system is the rapid growth and composition of Liberia's population. Approximately 47 per cent of the population is below 15 years of age, while less than 3 per cent has reached the age of 65. Liberia carries a very high child dependency rate; 96 children need to be supported and educated by each 100 adults of working age (15-64).

The total fertility rate is 6.9, which means that the average woman in her reproductive lifetime will bear approximately seven children. At the current growth rate of 3.4 per cent, the population will double in just twenty years. Yet less than one in twenty eligible couples (i.e., with the woman aged 15 to 44 years) practices contraception.

Poor nutritional status in Liberia is related to inadequate food availability and purchasing power, frequent pregnancies, inappropriate food habits including poor weaning practices and food taboos, and inadequate delivery of basic health services leading to debilitating illness.

In recognition of the major financial, manpower, and other constraints facing the Ministry of Health and Social Welfare (MH&SW) and the GOL in the near future, the Ministry has developed a four-phase Primary Health Care Program to meet the national commitment that 90 per cent of Liberia's population will have access to adequate health care by the year 2000.

Project Description: This project supports the long-term goal of the GOL to make adequate health care available to 90 per cent of the Liberian population by year 2000. The project purpose is twofold: to increase the proportion of the target population with access to primary health care services, and to strengthen the institutional infrastructure required to establish the national PHC Program so that the long-term goal can be achieved. The project aims to provide access to low-cost, high-impact, preventive, promotive and curative health services to approximately 115,000 rural Liberians in Grand Gedeh and Sinoe Counties by 1988 -- people who are now effectively beyond the reach of primary health care. At the same time, the project will strengthen the MH&SW capability to manage, implement support and expand the system. The project will build on prior AID involvement in the health sector, as discussed in the Project Paper (PP). This project will assist the GOL in refining, implementing, and institutionalizing the national PHC Program in rural Liberia during at least the first two phases of the program. The project focuses on health care at the village level, and is designed to expand from the village upwards, providing a

national PHC system that will impact upon the serious health problems in Liberia while utilizing local resources and participation to the maximum extent. In addition to developing the capability for a coordinated PHC system providing full services in two counties (Grand Gedeh and Sinoe), the project will provide sufficient organizational and managerial capacity to establish the framework for a strong, coordinated, decentralized system that can be expanded nationwide. This is essential in order to attract other donor assistance to support a viable, long-term national effort. In view of Liberia's economic situation, the project has been designed to minimize project-generated recurrent costs. Simple technology and local materials will be used where feasible. A scheme to recover drug costs is incorporated, and remuneration for both VHWS and TBAs will be borne by the communities. AID funds will be used to pay all of certain recurrent costs for a fixed period, with the GOL phasing in its continuing funding of these costs thereafter.

During the first five years of the project, there will be an increase of more than 115,000 rural Liberians with access to an appropriate mix of preventive, promotive, and curative PHC services in the full-service counties. In addition, the development of a national PHC program framework and the strengthening of central/national institutions (logistics, management, training) will eventually benefit the entire population through an improved national PHC delivery system.

Financial summary: The total cost of the project will be \$37.0 million, of which AID will contribute \$15.0 million in grant funds during the first five years. The GOL will contribute approximately \$21.1 million in cash and in kind; this contribution is expected to include \$3.5 million in PL-480 Title I counterpart funds, based on the annual PL-480 Agreements between the GOL and AID. In addition, the U.S. Peace Corps will support 15 volunteers at an estimated cost of \$582,000, and villages participating in the project will contribute approximately \$274,000 to support their village-level health workers. The cost estimate and financial plan for the project is summarized below (\$000):

	<u>AID</u>	<u>GOL</u>	<u>PEACE CORPS</u>	<u>VIL- LAGES</u>	<u>TOTAL</u>
Technical Assistance	4,281	--	420	--	4,701
GOL Personnel	--	10,500	--	183	10,683
Training	1,916	--	--	--	1,916
Commodities	2,639	1,231	--	--	3,870
Construction/Renovation	1,052	2,350	--	--	3,402
Other Costs	2,229	1,796	--	--	4,025
Subtotal	<u>12,117</u>	<u>15,877</u>	<u>420</u>	<u>183</u>	<u>26,597</u>
Inflation	1,955	3,672	120	73	5,820
Contingency	928	1,588	42	18	2,576
<u>TOTAL</u>	<u>15,000</u>	<u>21,137</u>	<u>582</u>	<u>274</u>	<u>36,993</u>

Other matters: The project is socially, technically, economically, administratively, and financially sound. The PID was approved by STATE 229028, dated August 19, 1980. The project analyses and documentation have been reviewed and approved by USAID and REDSO/WCA officers, as well as several specialists who have participated in the design of the project. A negative determination was made by the IEE and no further environmental analyses are required.

Regarding human rights, since the 1980 revolution the human rights situation in Liberia has steadily improved, and almost all political prisoners have been released. The present government is committed to civilian rule, and has set a target of April 1985 for civilian rule through national elections. The Government also encourages local participation in the expansion of rural services, and this project is consistent with that effort.

There are several conditions precedent in the accompanying project authorization (Section D) and in the proposed Grant Agreement. These will insure, among other things, that a motorcycle purchase scheme is established and the monies thus collected are placed in a fund for the purchase of replacement motorcycles and/or for other recurrent costs of the project; that an evaluation program is established for the project; that revolving drug funds are established and operating in the two project counties; and that decentralized operations have been established and are operating effectively in the project counties. There are also a number of covenants insuring, among other things, that the GOL allocates adequate personnel to the project; that specified committees are established to oversee the project; that the GOL provides adequate office space for project long-term technicians, and at least one counterpart for each long-term technician; and that the GOL will assume at least 90 per cent of project-generated recurrent costs by project year 5.

The following source/origin waivers from AID Geographic Code 000 to Code 935 are required for implementation of this project, and the justifications are included in the PP:

1. One hundred thirty 100-125 cc trail motorcycles.  
Since the value of this procurement exceeds your authority under Delegation of Authority No. 140, Revised, the AA/AFR has been requested to authorize this waiver. His approval was received on August 2, 1983.
2. Two hundred Salter scales for nutrition surveillance activities, and 56 kerosene stoves and spare parts for the rural health facilities in the project area.

The USAID/Liberia Engineer has found that the requirements of Section 611 (a) of the Foreign Assistance Act have been met, and you have signed the certification required by Section 611 (e). The financing, implementation, and engineering plans necessary to carry out the project are contained in the PP. Section III of the PP provides adequate cost estimates of the project to the U.S. Government.

The MH&SW will be the major implementing agency on behalf of the GOL. The USAID/Liberia Health Officer will be the Project Officer for the Mission. AFR/CCWA will be the responsible office in AID/W.

Recommendation: That you sign the accompanying Project Authorization and thereby authorize a grant of \$15,000,000 to the GOL for the PHC Project, as well as a source and origin waiver from AID Code 000 (U.S. only) to Code 935 (Special Free World) for approximately 200 Salter scales and 56 kerosene stoves and spare parts; and certify that exclusion of procurement from Free World countries other than the cooperating country and countries included in Code 941 would severely impede attainment of U.S. foreign policy objectives and objectives of the foreign assistance program.

D. Project Authorization

Name of Country : Liberia  
Name of Project : Primary Health Care  
Number of Project : 669-0165

1. Pursuant to Section 104 of the Foreign Assistance Act of 1961, as amended, and the authority invested in me under Africa Bureau Delegation of Authority No. 140, Revised, I hereby authorize the Primary Health Care ("PHC") Project for Liberia (the "Grantee") involving planned obligations of not to exceed \$15 million in grant funds over a five-year period from date of authorization, subject to the availability of funds and in accordance with the AID/OYB allotment process, to help in financing the foreign exchange and local currency costs of the project.

2. The project will provide commodities, drugs, equipment, construction costs, training, and technical assistance to the Grantee to assist in implementing its PHC Program, which emphasizes the use of both village-level and mid-level health workers, and which is designed to create, from the village up, a national network capable of offering basic health services at a cost the Grantee can afford. This initial funding is designed to provide health services to a limited area of critical need while creating the institutional framework required to support the national program. Under the Grant, AID will provide technical assistance, commodities, construction costs, incountry and overseas training for PHC personnel, and some operating costs. Total project costs are estimated at \$37 million of which A.I.D. will provide \$15 million and the Grantee the remainder in personnel and operating expenses.

3. The project shall be subject to the following essential terms and covenants and major conditions, together with such other terms and conditions as A.I.D. may deem appropriate.

a. Source and Origin of Goods and Services

Goods and services, including ocean shipping, financed by A.I.D. under the Grant shall have their source, origin, and nationality in the United States or Liberia except as A.I.D. may otherwise agree in writing.

b. Conditions Precedent

The Grant Agreement shall contain the following essential conditions:

(1) Prior to disbursement under the Grant, or to issuance by A.I.D. of documentation pursuant to which disbursement will be made for the purchase of motorcycles, the Grantee will, except as A.I.D. may otherwise agree in writing, furnish to A.I.D. in form and substance satisfactory to A.I.D. evidence that the Grantee acting through the Ministry of Health and Social Welfare ("MH&SW") has established a system in accordance with GOL policy whereby (a) employees will pay for at least half the cost of their motorcycles through periodic salary deductions, or other mutually agreed mechanisms, and (b) all monies so

collected are either deposited in a revolving fund from which replacement motorcycles will be financed, or used to support other project-generated recurrent costs as agreed to by the Parties in Project Implementation Letter(s).

(2) Prior to disbursement under the Grant, or to issuance by A.I.D. of documentation pursuant to which disbursement will be made, for each construction activity to be financed by A.I.D. under the Grant, the Grantee shall, except as A.I.D. may otherwise agree in writing, furnish to A.I.D. in form and substance satisfactory to A.I.D. evidence of the Grantee's ownership of the land where the construction is to take place.

(3) Prior to any disbursement of project funds under the Grant in years 2,3, and 4, or the issuance by A.I.D. of documentation pursuant to which disbursement will be made, the Grantee will, except as A.I.D. may otherwise agree in writing, furnish to A.I.D. in form and substance satisfactory to A.I.D.:

(a) Prior to year 2 disbursements, evidence of the establishment of the evaluation program referred to in Section 5.1 of the Grant Agreement;

(b) Prior to year 3 disbursements, (i) evidence that the MH&SW has established a policy in Grand Gedeh and Sinoe Counties to collect funds through user fees for drugs and supplies, which funds are to be retained in a revolving fund within the MH&SW to be used to purchase additional drugs and supplies. This system shall be employed at all three levels of health facilities (health post, health center, and hospital) within the government health care delivery system in at least Grand Gedeh and Sinoe Counties; and, in addition, (ii) evidence will also be furnished that the MH&SW has developed guidelines for decentralized operations (including the budgetary process, and financial, planning and management responsibilities) in Grand Gedeh and Sinoe Counties; and

(c) Prior to year 4 disbursements, (i) evidence that the revolving fund drug system referred to in (b) above has been established and is operating and, in addition, (ii) evidence that decentralized operations referred to in (b) above have been effectively established and implemented in Grand Gedeh and Sinoe Counties. Evidence of the implementation of these policies will be agreed to by the Parties in Project Implementation Letter(s).

#### c. Covenants

The Grant Agreement shall contain the following essential covenants:

(1) The Grantee shall provide staff in at least the minimum numbers as listed in the table below, which numbers may be revised by agreement of the Parties through Project Implementation Letters.

MINIMUM NUMBERS OF STAFF TO BE PROVIDED BY JANUARY<sup>+</sup> OF  
CORRESPONDING PROJECT YEAR, BY HEALTH WORKER CATEGORY\*

<u>COUNTY/CATEGORY</u>	<u>PROJECT YEAR</u>				<u>Total</u>
	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	
<u>Grand Gedeh</u>					
Physician Assistant**	21	21	30	30	30
Certified Midwife**	19	19	32	32	32
Hospital Medical Director	1	1	1	1	1
County Health Officer	1	1	1	1	1
Administrative Officer	1	1	1	1	1
Logistics Officer	1	1	1	1	1
<u>Siное</u>					
Physician Assistant**	-	19	35	35	35
Certified Midwife**	-	17	27	35	35
Hospital Medical Director	1	1	1	1	1
County Health Officer	1	1	1	1	1
Administrative Officer	1	1	1	1	1
Logistics Officer	1	1	1	1	1
<u>Total</u>					
Physician Assistant**	21	40	65	65	65
Certified Midwife**	19	36	59	67	67
Hospital Medical Director	2	2	2	2	2
County Health Officer	2	2	2	2	2
Administrative Officer	2	2	2	2	2
Logistics Officer	2	2	2	2	2

\* It is understood that the health workers provided will fill positions which are required for the effective operation of the PHC Project (i.e., in rural health facilities and county health departments).

\*\* A registered Nurse may serve in this position instead.

+ For example, workers required in project year 2 should be deployed by January 1985; in project year 3, by January 1986, etc.

(2) The Grantee, acting through the MH&SW, shall establish:

- (a) A PHC Project Implementation Committee with representatives of the MH&SW, USAID and project long-term technicians to conduct quarterly meetings to monitor and review project activities and achievements, to examine problems at the field level and recommend appropriate solutions, and to insure that the project conforms to the Grant Agreement;
- (b) A PHC Advisory Committee with representatives of the MH&SW, USAID and other donors to insure a strong, collaborative, coordinated, resource-efficient national PHC Program; and
- (c) A National PHC Steering Committee comprised of the Deputy Ministers for Technical Services or their appointees of the Ministries of Health & Social Welfare, Agriculture, Internal Affairs, Rural Development, Education, Planning & Economic Affairs, and Finance, as well as representatives of the Bureau of the Budget and of the National Housing Authority, to provide general guidelines, resolve major policy issues, and insure necessary resources and intersectoral coordination for the National PHC Program.

(3) The Grantee shall:

- (a) Provide the 5 long-term technicians the use and control (but not ownership) of 4 project jeep-type vehicles, 5 complete sets of project household furnishings/appliances, and 5 complete sets of project office furnishings/equipment as well as office space, during their stay in Liberia;
- (b) Provide project office furnishings/equipment and office space to (i) the locally-hired long-term administrative officers during their association with the Project, and (ii) short-term technical advisors during their stay in Liberia;
- (c) Identify and assign at least one counterpart for each long-term technician; and
- (d) Take measures to insure that the persons receiving training abroad under the project return to Liberia to work in the MH&SW in areas for which they have been trained. A.I.D. shall also take measures within its power to insure that such persons return to Liberia.

(4) The Grantee shall ensure that the fees to be collected and retained by the Ministry of Health and Social Welfare in Grand Gedeh and Sinoe Counties (which may include user fees for drugs and medical supplies as well as registration fees) will be set at necessary levels (and may be further adjusted periodically) so that recipients of drugs and supplies pay sufficient amounts to recover the costs of such drugs and supplies in order to maintain a continuous re-supply.

(5) The Grantee shall maintain expenditures for drugs in project counties at no less than current levels unless otherwise agreed to in writing by the Parties through Project Implementation Letter(s).

(6) The Grantee shall make available sufficient funds to support an increasing proportion of the national PHC system's recurrent costs, so that by the end of the first five years of the project the Grantee will be assuming no less than ninety per cent (90%) of project-generated recurrent costs in the project counties. (Estimated project-generated recurrent costs are shown in Figure H-3 of Annex H-2).

(7) The Grantee shall maintain budgetary allocations for operating expenses of the MH&SW at no less than its current percentage level of the national budget.

d. Waivers

(1) Pursuant to Section 636 (i) of the Foreign Assistance Act, as amended, a procurement source and origin waiver permitting procurement from countries included in A.I.D. Geographic Code 935 (Special Free World) of 130 trail motor-bikes and spare parts for approximate value of \$192,800, was requested in Monrovia 06009, and approved by the Assistant Administrator of the Africa Bureau on August 2, 1983 (State 221924).

(2) The following waiver to A.I.D. regulations is hereby approved:

A procurement source and origin waiver from A.I.D. Geographic Code 000 (United States) to A.I.D. Geographic Code 935 (Special Free World) for kerosene stoves and spare parts and Salter scales in the amount of approximately \$17,600.

I hereby certify that the exclusion of procurement of the above described commodities from Free World Countries other than the Cooperating Country and countries included in A.I.D. Geographic Code 941 would seriously impede the attainment of U.S. foreign policy objectives and objectives of the foreign assistance program.

Date: August 29, 1983



Mission Director  
USAID/Liberia

## II. PROJECT RATIONALE AND DESCRIPTION

### A. Background and Project Rationale

Access to basic health services for at least 90 percent of Liberia's population by the year 2000 is a priority goal of the GOL. In view of the status of the health care delivery system in Liberia, it is clear that meeting this goal will require the close coordination and cooperation of AID and other donors with the GOL in developing projects and programs which will overcome the constraints facing the GOL in the near future.

#### 1. Health status

The infant mortality rate in Liberia is estimated to be 154 per 1000 live births, and more than 20 percent of children die before their fifth birthday. More than half of all the deaths in Liberia occur in the under-five age group, with more than a third of all deaths occurring in the first year of life. The overwhelming majority of infant and child deaths are caused by gastrointestinal illness (especially diarrhea and dysentery), malnutrition, measles, pneumonia (often secondary to measles), malaria, and neonatal tetanus.

Women of reproductive age (15-44) are at high risk of maternal mortality; moreover, poor health in this group also leads to increased infant mortality. Because of their role both in combatting infant and child mortality and in contributing to labor productivity, these women are identified as priority targets for health program activities.

Available data indicate that most morbidity and mortality could be prevented through wider access to immunizations and basic health services -- particularly maternal and child health services -- as well as to improved environmental sanitation and nutritional practices. The needed technology is widely known, yet traditional medicine remains a major source of health care for Liberians, with most practitioners untrained in modern preventive and promotive aspects of health care.

Within the government health system, fundamental financial, structural, organizational, and managerial problems and lack of sufficient trained manpower limit the capacity to provide the needed services. According to official estimates, only 35 percent of Liberians are considered to have access to any form of modern health services. These are mostly facility-based, curative-oriented, and are provided mainly in the urban and peri-urban areas.

The health care system is highly centralized. Skilled health personnel and medical supplies, on the whole, are insufficient. Owing to the maldistribution of resources, they are even more scarce in the rural areas.

An added strain on the health delivery system is the rapid growth and composition of Liberia's population. Approximately 47 percent of the population is below 15 years of age, while less than 3 percent has reached the age of 65. Liberia carries a very high child-dependency rate; 96 children need to be supported and educated by each 100 adults of working age (15-64 years).

The total fertility rate is 6.9, which means that the average woman in her reproductive lifetime will bear approximately seven children. At the current growth rate of 3.4 per cent, the population will double in just twenty years. Yet less than one in twenty eligible couples (i.e., with the woman aged 15 to 44 years) practices contraception.

The rapid population increase dictates a corresponding increase in the need for delivery of health services, particularly to the most vulnerable groups -- mothers, infants, and children. Moreover, high fertility itself correlates directly with both increased maternal mortality and increased infant mortality.

Although organized family planning services have been operating in Liberia for more than 26 years, traditional beliefs are widespread. Accurate, meaningful information is not widely disseminated and contraceptive services are not widely available. Moreover, commitment to population planning at the highest levels of government is lacking.

Poor nutritional status in Liberia is related to inadequate food availability and purchasing power; frequent pregnancies; inappropriate food habits including poor weaning practices and food taboos; and inadequate delivery of basic health services leading to debilitating illness.

Acute protein-energy malnutrition in children is uncommon, but chronic malnutrition is found in approximately one-fifth of children under five, and, maternal malnutrition is found in the same proportion of pregnant and lactating women. These problems are relatively more widespread in the rural, agricultural areas and are associated with poor weaning practices and unsanitary habits. It is believed that the marginal nutritional status of these groups underlies their high mortality rates, as otherwise non-fatal illness such as measles or diarrhea, or the hungry season (the three months preceding the harvest), may be sufficient to cause complications and eventual death.

Continued breastfeeding is undermined by frequent, closely spaced pregnancies. The most common food supplement is rice water, which by itself is not an adequate weaning food. Moreover, 16 per cent of children get no food other than milk up to 11 months of age.

Anemia is also widespread in Liberia, especially in the mothers and children. More than 60 percent of children under five years of age are anemic. Besides low iron intake, anemia is associated with hookworm infestation, malaria, and low socio-economic status.

## 2. The GOL's primary health care strategy

The primary health care concept is not new to Liberia. One county-level project has been in operation for more than five years, and the GOL has been actively planning a national program since 1980. This section summarizes the national long-range program, discusses the PHC experience in Maryland County, and outlines the major areas which require strengthening in order for both the AID-assisted project and the long-term national program to succeed.

### a. The Liberian National Primary Health Care Program

The first formal proposal of the MH&SW for implementing a national PHC Program appeared in the 1979 Draft Plan of "Projects Identified for Implementation under the National Socio-economic Development Plan, 1980-84." In addition, the Maryland County Village Health Workers Project, assisted by the Royal Government of the Netherlands, has been in operation since 1977 and has provided much useful experience (see b. below). In December 1980 the MH&SW held a National Primary Health Care Workshop, which produced recommendations in the form of a draft program plan. Following the workshop, the Ministry's PHC Steering Committee continued to develop and refine the document, and a formal Draft National Primary Health Care Program was prepared in April 1981. Since that time, during the discussions leading to the finalization of this Project Paper, the draft plan has undergone further revision in the PHC Steering Committee to insure that it represents a realistic approach which can be successfully implemented. The detailed description of the AID-assisted project presented below is based on the resulting plan.

In recognition of the major financial, manpower, and other constraints facing the MH&SW and the GOL in the near future, the Ministry has developed a four-phase program to meet the national commitment that 90 per cent of Liberia's population will have access to **basic health care** by the year 2000. The phases and corresponding targets are as follows:

#### Phase I (1983-1988):

- ° Increase the percentage of the population with access to basic health care from 35 to 45 per cent;
- ° Expand existing county health facilities and infrastructure to provide **basic** PHC services to at least 80 per cent of the citizens of Grand Gedeh, Sinoe, Maryland, and Nimba Counties\*;

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\*In addition to the two target counties of this AID-assisted project, the Government of the Federal Republic of Germany is developing a similar PHC project in Nimba County. This effort, as well as those of other donor organizations, are being coordinated under Phase I.

- ° Create the decentralized managerial, technical and logistical systems necessary to implement the program in the Phase I target areas; and
- ° Rationalize and expand Liberia's health worker training capacity to meet the needs of the PHC Program.

Phase II (1989-1992):

- ° Expand the PHC Program to the remaining five counties, to increase the percentage of the population with access to **basic** health care to at least 60 per cent.

Phase III (1993-1996):

- ° Expand the PHC Program so as to increase the percentage of the population with access to **basic** health care to at least 75 per cent.

Phase IV (1997-2000):

- ° Expand the PHC Program so as to increase the percentage of the population with access to **basic** health care to at least 90 per cent.

As indicated earlier, this project is intended to support at least the first two phases of the Liberian Primary Health Care Program. Thus the overall goals for the Liberian Program and the AID-assisted project are identical.

b. PHC project experience in Maryland County

The Maryland County Village Health Project, jointly financed by the Governments of the Netherlands and Liberia, was the first effort in implementing a PHC program in Liberia -- the results of which have been carefully considered in the design of this new project. From its inception in 1977 until July 1981, the Project Director was a Dutch physician. At the time of his departure, the MH&SW took over the administration and technical supervision of the project; at the county level this became the responsibility of the Liberian County Health Physician, who had been working with the Dutch physician during the previous two years. Dutch financial assistance continued until December 1982, and at the present time the Dutch Government is considering a request from the GOL to extend their assistance for an additional period.

According to a recent project document\*, Maryland County was chosen for this pilot project for three reasons: (1) The county belongs to the most backward and most underdeveloped region in Liberia, so far as economic and infrastructural development are concerned; (2) Maryland is a small county in terms of geographic area; and (3) it is the most distant county from

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\* "A Quick Glance at the Village Health Worker Project " (A Primary Health Care Program), Maryland County, Republic of Liberia, 1981

Mourovia, thus suffering greater impact from the poor transportation and communication systems in Liberia. The document concludes that, given the relative success of the project, "to attempt a community-based National Primary Health Care Program, using the Maryland experience as the model, is a desirable, meaningful and relevant undertaking."

Among the objectives of the Maryland County project, the following emphasize the strong community orientation:

- ° To create an awareness and a sense of responsibility in the communities so that the people understand and appreciate the relationship between preventable disease and the environment as a whole.
- ° To stimulate responsible citizenship, motivation and willingness that will mobilize the people to undertake relevant, viable and meaningful health and development projects at the village level at a cost which both the Government and the people can afford.
- ° To direct development efforts in the rural areas toward improving and developing those areas which directly affect the health status of the people, as health in any given community does not absolutely depend on tablets, injections, and well-kept clinics.
- ° To change from a clinic/hospital orientation in dealing with health problems to a community-based approach in decision-making, planning, implementing and evaluating.

By the end of 1981 the Maryland County project comprised 132 Village Development Councils (VDCs), 132 Village Health Workers (VHWs), and twelve supervisors. Together they serve most of the people in the county, in coordination with the 23 existing health posts.

c. The need for strengthening the Maryland County model in critical areas

The Maryland County Project has accomplished much since the time of its inception. With some modification and expansion, the Maryland County scheme can be used as a model for the national PHC program. In considering areas for strengthening, the following areas have been identified:

- ° County-level supervision, management, and support
- ° Central-level managerial, technical, and logistical support
  - Managerial systems
  - Technical support units
  - Logistics system

- ° Manpower development, with emphasis on mid-level health workers
  - Training institutions
  - Curricula
- ° Increased contribution of people toward their health care services

Each of these areas is discussed in the detailed description which follows. They are also considered as feasibility issues in the corresponding Technical and Administrative Feasibility analyses (Annexes H-1 and H-5, summarized in Section V).

B. Project Description

1. Logical framework narrative

a. Goal and purpose

This project supports the long-term goal of the GOL to make basic health care available to 90 per cent of the Liberian population by year 2000. The project purpose is twofold: to increase the proportion of the target population with access to primary health care services, and to strengthen the institutional infrastructure required to establish the national PHC Program so that the long-term goal can be achieved. The project aims to provide access to low-cost, high-impact, preventive, promotive and curative health services to approximately 115,000 rural Liberians in Grand Gedeh and Sinoe Counties by 1988 -- people who are now effectively beyond the reach of primary health care. At the same time, the project will strengthen the MH&SW capability to manage, implement, support, and expand the system. The project will build on prior AID involvement in the health sector, as discussed in Annex I-1.

The MH&SW has developed its National Primary Health Care Program to achieve its long-term goal. Recognizing that available resources are insufficient to implement the entire program at once, the national program comprises four phases. This project will assist the GOL in refining, implementing, and institutionalizing the PHC Program in rural Liberia. Both the project and the program focus on the community level and are designed to expand from the village upwards, eventually establishing a national PHC delivery system that will have impact on serious health problems while utilizing local resources and participation to the maximum extent. The project will also assist the MH&SW in establishing a strong, coordinated, decentralized system that can be expanded nationwide. This is essential in order to attract other donor assistance to support a viable, long-term national effort.

In order to provide effective support for the institutionalization of the National PHC Program, this AID-assisted project is expected to extend at least through Phases I and II of the Liberian Program as described. This is consistent with AID's March 1983 Policy Paper on Institutional Development, which states that such projects are normally designed and approved for a period of five to ten years; and that some projects may require two or more phases, lasting a total of more than ten years. However, because of the present funding limitation of \$15 million imposed by AID/Washington for this project, it is only possible to fund the first five years now. On the basis of AID's institution building policy, and assuming that funds are available and that the outcome of project evaluations confirms the need for continued AID assistance, then high priority would be given to providing the necessary support in future years.

b. Major assumptions

The following major assumptions underlie the development and success of the project:

- ° Primary health care remains a priority program of the GOL during the life of the project.
- ° Growth of the Liberian economy and Government revenues allow the GOL to meet the recurrent costs of the PHC Program.
- ° The GOL estimate that 35 percent of the population presently has access to adequate health care is accurate.
- ° Sufficient qualified or trainable manpower is available to staff the PHC Program.
- ° The target population participates in the PHC Program.
- ° The MH&SW adopts the improved managerial, administrative, and logistical systems.
- ° The MH&SW implements a policy permitting target-area county health departments to decentralize their planning and operations.
- ° Remuneration and support for the village health teams is sufficient to maintain effective involvement in the PHC Program.
- ° USAID and the GOL deliver project inputs on schedule.
- ° The MH&SW effectively recruits, trains, retains, and deploys staff at all levels to meet PHC needs.

c. End of project status

By the end of the first five years of AID assistance, the established PHC delivery system will provide basic preventive, promotive, and curative health services to approximately 115,000 rural Liberians in Grand Gedeh and Sinoe Counties. Specific indicators include the following:

- ° The proportion of the target-area population with access to a village health team (within one hour walking time) will reach 80 per cent by 1988.
- ° There will be an increase of at least 35 per cent in the utilization of the PHC delivery system by 1988.
- ° There will be a decrease of at least 10 per cent in infant mortality in the target villages by 1988.
- ° The following selected service delivery indicators will be

achieved within the target villages by 1988:

- Contraceptive prevalence among eligible couples of child-bearing age will reach at least 12 per cent.
- 70 per cent of deliveries will be attended by a trained health worker.
- EPI coverage targets will be met for measles vaccina (75%) and tetanus toxoid (50%).
- Nutrition surveillance is being carried out at regular intervals on 50 per cent of children under 3 years of age.
- 60 per cent of mothers of children under 3 will understand how to prepare homemade oral rehydration solution, and 20 per cent have used it.
- Malaria prophylaxis will be given to at least 20 per cent of pregnant women.

In addition to these services being provided within the target counties, the institutional infrastructure of the MH&SW will be strengthened in the following ways in the first five years of the project:

- ° MH&SW central managerial and technical systems, and parallel systems within the target counties, will be operating in a coordinated and effective manner.
- ° Operating within MH&SW policy guidelines, target area county health departments will be effectively carrying out decentralized operations within the counties.
- ° The logistical system will be effectively providing supplies and equipment to the PHC Program throughout the target area.
- ° An increased proportion of health-service costs will be recovered through revenue-generating mechanisms in the target counties.
- ° MH&SW training programs will be providing sufficient numbers of qualified mid-level health workers to support the expansion of the national PHC Program, particularly in the target area.
- ° Central-level MH&SW technical divisions will be providing adequate support to the PHC Program.
- ° The system to provide adequate supervision between the different

levels of PHC workers in the target counties will be effectively implemented.

- o The self-financing village pharmacy program will be effectively regenerating drug costs and supplying the target villages.

d. Project outputs

The major outputs of the project at the village, county, and central levels are as follows:

Village level outputs:

- o 250 village development councils (VDCs) will be organized and operating.\*
- o 250 village health teams (VHTs), comprised of 250 village health workers (VHWs) and 640 traditional birth attendants (TBAs), will be organized, trained, and supported.\*
- o 250 village-level revolving drug funds will be developed and effectively operating.

County-level outputs:

- o Rural health facility staffs will be trained and functioning:
  - 47 health posts (47 PAs,\*\*47 CMs, 24 HIs)
  - 8 health centers (16 PAs,\*\*8 CMs, 8 HIs); plus supervisory staff (4 PAs,\*\*4 CMs)
  - 1 MCH center (2 CMs)
- o Guidelines will be developed, policies and procedures established, and systems developed and implemented to provide effectively functioning decentralized operations at the county level
- o County health department staffs will be recruited, trained, and functioning in each county: County Health Officer, PA Supervisors (2), CM Supervisors (2), HI Supervisor, Logistics Officer, and Administrative Officer.
- o County health department headquarters buildings will be constructed and equipped in Grand Gedeh and Sinoe Counties.
- o Training teams comprised of 2 PAs and 1 HI Supervisor<sup>+</sup> and 3 CMs will be established and functioning in each county to train village-level workers (VHWs and TBAs).

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\* These figures represent a "success rate" of 85 per cent in establishing these village-level resources; that is, the project will attempt to establish 290 VDCs. and so forth for the other categories of village-level outputs.

\*\* A registered nurse may serve in place of a PA.

+ Or other experienced HI (or PA)

- o Health posts and health centers will be constructed or renovated with PL-480 counterpart funds, in accordance with GOL/USAID agreements during the project life; and these facilities will be equipped in accordance with standardized lists.
- o Policies and procedures will be established, and systems developed and implemented, to provide effectively functioning revolving drug funds within the county.
- o Guidelines will be developed, policies and procedures established, and mechanisms developed and implemented for the effective operation of a motorcycle purchase scheme in the target area.

Central-level outputs:

- o Curricula will be developed or revised for PHC health workers to include appropriate PHC content and emphasis:
  - Curricula will be developed for the orientation and training of village-level health workers (VDCs, VHWs, and TBAs).
  - Revised curricula will be developed and implemented in the training programs for PAs, CMs, HIs, and registered nurses (RNs).
- o PHC training institutions will be strengthened through the training of approximately 13 key faculty for TNIMA, RHTC, and the Zwedru Midwifery School; and the development and/or provision of improved training materials.
- o Key MH&SW central-level managerial and technical units will be adequately staffed and functioning to support the PHC Program. These units include Inservice Training, Nutrition, Family Health, and Health Education. Central administrative and management functions will be strengthened to the extent necessary to support decentralization in the two target counties.
- o The central logistics system will be strengthened through the construction of a central warehouse facility; and development and implementation of improved operating systems, including record-keeping and control systems, accounting systems, and transport and distribution systems; and the training of two senior logistics/management personnel.

e. Project inputs

Identified inputs to this project are indicated below by contributor. In addition, inputs from other donor sources, as discussed in Annex I-2, will further strengthen and support the PHC Program.

(1) AID inputs

Technical Assistance: \$4.28 million.

Approximately \$3.54 million will be used to procure and support 17 person-years of long-term technical assistance. This will include the services of a chief of party (4 years), a curriculum/training specialist (3 years), a logistics and management specialist (3 years), and two county public health physicians (3 ½ years each). In addition, three administrative officers will be hired locally -- one to provide administrative support for the long-term TA team (4 years), and two to strengthen the administrative capabilities of the county health departments in the target counties (3½ years each). Furthermore, 62 person-months of short-term technical assistance is budgeted at approximately \$744,000 for selected activities in such areas as health education, inservice training, nutrition, curriculum development, and logistics and management.

Training: \$1.92 million.

The training component is comprised of three parts. Long-term participant training will enable 22 MH&SW staff members to obtain master's degrees in public health and related disciplines. Forty-four person-years of long-term participant training is budgeted at \$968,000. Short-term participant training totalling 86 person-months will cost approximately \$440,000 and will enable 37 MH&SW staff to complete special overseas study programs, especially in training of trainers and management training. Incountry training is a critical project input, estimated to cost \$508,000. It includes about 20 training courses of various lengths (both preservice and inservice training); 24 scholarships to Curran Midwifery School (totalling 48 person-years); and incountry workshops in PHC-related topics.

Construction: \$1.05 million.

AID-funded construction includes the central drug warehouse to be built in Monrovia (\$505,000), and two county health department headquarters buildings to be constructed in Grand Gedeh and Sinoe Counties (\$424,000 for both), plus architectural and engineering fees of approximately \$123,000.

Commodity support: \$2.64 million.

Commodities to be procured under the project fall into three major categories. Vehicles and spare parts (\$858,000) include 130 motorcycles, as well as 21 conventional vehicles (6 jeeps, 10 pickups, 2 delivery trucks and 3 small buses). Drugs and contraceptives totalling \$1.11 million will be provided for the PHC system in the target counties, including funding of \$650 per village health team, \$3,000 for each health post, \$10,000 for each health center, and \$50,000 at the county level. Medical equipment and supplies costing approximately \$665,000 include basic equipment and furniture for the target county health posts, health centers, and county health department; as well as teaching aids and materials for use in the training component.

Other costs: \$2.23 million.

These provide for vehicle operations and maintenance (\$616,000), research and surveys (\$150,000), the private sector study (\$100,000), evaluations (\$150,000), local support costs primarily for AID centrally-funded project support (\$488,000), and local support costs of the long-term TA team (\$725,000).

Inflation and contingency: \$2.88 million.

To protect against escalating costs and unanticipated expenditures, an inflation factor of 8 per cent and a contingency factor of approximately 8 per cent have been used. Based on the estimates of expenditures by project year, the total amount provided for inflation and contingency represents about 19 per cent of overall AID funding.

(2) Government of Liberia inputs: \$21.14 million

Personnel: \$10.50 million.

The GOL will finance the personnel costs of both central- and county-level staff who comprise the PHC service delivery and support system for the project.

Construction: \$2.35 million.

The GOL has agreed to provide PL-480 counterpart funds to cover the costs of constructing and renovating rural health facilities as well as constructing staff housing, in Grand Gedeh and Sinoe Counties; and constructing additional facilities at selected mid-level training institutions. These proposed expenditures are based on the priority guidelines and budgetary estimates for the use of PL-480 counterpart funds, as discussed in Annex I-5.

Commodities: \$1.23 million.

The GOL will continue to provide drugs, medical supplies, and miscellaneous supplies and materials to the PHC Program at their existing levels. This will help insure that there will be sufficient stocks in the system to allow the rotating drug funds to be successfully established during the project life.

Other costs: \$1.80 million.

The GOL will continue to fund vehicle operations and maintenance costs and other miscellaneous project-related costs at current budgetary levels, and will begin to assume project-generated vehicle operation and maintenance costs in year 4 (15% = \$21,000) and year 5 (30% = \$45,000). In addition, PL-480 counterpart funds will be used for the equipment and maintenance of rural health facilities in the target counties, as well as project-generated recurrent costs (see Annex I-5).

Inflation and contingency: \$5.26 million.

As with the AID contribution, the GOL budget incorporates an 8 per cent inflation factor (compounded), as well as a 10 per cent contingency factor based on estimates of expenditures by project year. The total amount provided for inflation and contingency represents 25 per cent of the GOL project budget.

(3) Peace Corps inputs: \$0.58 million.

The Peace Corps will provide the services and support of 15 volunteers, plus inflation (8%) and contingency (10%).

(4) Villages in the target area: \$0.27 million.

The villages are responsible for the remuneration of their VHWs on a continuing basis. Total village contributions during the first five years of the project are estimated to be \$274,000.

## 2. Detailed project description

### a. Village-level health services

Village-level services are the foundation of the primary health care delivery system. First, the need for village-level health services must be understood, accepted, and supported by the villagers. Then if simple, high-impact services are delivered by trained, motivated village-level workers, the villagers will begin to reap the benefits of improved health status.

More than 85 per cent of the population of Grand Gedeh and Sinoe Counties live in remote areas, mainly in villages of less than 500 people. These communities lack modern health services. Local care is provided by traditional practitioners, who generally are ignorant of high-impact primary health care services. Where modern, facility-based services do exist, they are often not used because the health personnel frequently are poorly trained, equipped, and supplied to provide effective services. Experience in Maryland County and elsewhere in Africa shows that, with adequate support, villagers can be trained to deliver high-impact services to their own communities. The PHC project intends to train at least 250 village health teams to provide these services. Each team will consist of a village health worker (VHW) and one or more trained traditional birth attendants (TBAs).

The functions of village-level workers in the project (VDCs, VHWs, and TBAs) are summarized below. Further discussion of their roles, activities, and interactions is provided in Annex J-1.

#### (1) Village development councils

The cornerstone of effective village-based health services is an informed and active village development council (VDC). Although GOL policy promotes the formation of VDCs in all villages, few exist in the project area, and their involvement in health activities is minimal. In the course of the project, at least 250 VDCs, 125 each in Sinoe and Grand Gedeh Counties, will participate in PHC activities.

The VDC will be critical to generating the community involvement that is necessary to initiate, implement, and maintain village-level activities. The council members will need to recognize that the villagers themselves have to take charge of their own development, that they are not passive recipients of health care, but active, self-reliant participants in creating, implementing, and sustaining their own health services.

Where VDCs exist in the project area, they need to be rejuvenated and thoroughly informed of proposed activities. Where VDCs do not exist, they need to be formed. The formation of new VDCs will require intensive discussions during at least three village visits by project staff in order to fully explain and promote the VDC concept, and to convey a clear understanding of the council's role in the project and of the expected benefits to the village. In this way the enthusiastic, active, and appropriate support of the villages can be elicited. VDC membership should include

young as well as old, women as well as men, representatives of local church groups, teachers, students, etc. These individuals should be responsible, respected, and willing to meet regularly to discuss and, in consultation with their villagers, make decisions about relevant health and other development issues. They should be prepared to take the lead in supporting and participating in project activities. Some members should be literate.

To participate in the PHC Project, the VDC members must first determine that project priorities coincide with those of the village. If the VDC wishes to participate, an agreement will be made with the MH&SW that will specify the functions and responsibilities of the VDC as follows:

- o Determines village development priorities.
- o Organizes and mobilizes village resources for development.
- o Selects VHWs and identifies appropriate TBAs for training.
- o Monitors, administratively supervises, and supports VHWs and TBAs.
- o Identifies and implements economic activities in support of PHC.
- o Insures adequate remuneration of the VHW, and determines kind and amount of payment to TBAs.
- o Is responsible for managing the operations of the village pharmacy and its finances.
- o Establishes and enforces rules and regulations to insure proper use and protection of water sources, and good community sanitary practices.
- o Coordinates multisectoral PHC activities.

Local health post (or health center) staff and the health center-based supervisors will be trained to conduct the VDC formation/orientation sessions. As scheduling permits, members of the training teams (to train VHWs and TBAs) and the county health officer will also participate. It is expected that radio programming through the Liberia Rural Communications Network (LRCN) will also support the formation and role of the VDCs.

Further discussion of VDCs, their importance as the foundation for PHC services, and their feasibility in rural Liberia is provided in both the Technical Feasibility Analysis (Annex H-1) and the Social Soundness Analysis (Annex H-4).

#### (2) Village health teams

A village health team (VHT) is comprised of one village health worker (VHW) and one or more traditional birth attendants (TBAs). Although they function on a day-to-day basis as a team, they will be discussed separately in order to emphasize the differences in their functions and orientation.

(a) Village health workers

VHWs will be responsible for delivering primary health care services to a village (or part of a village or combination of villages within an hour's walking distance) of approximately 300 to 500 population (50 to 100 families). The VHW is expected to be available whenever villagers need his/her curative services and will have specific responsibilities to carry out in community organization as well as health, nutrition, and family planning education.

The responsible village council will select the potential VHW for training on criteria such as interest in community activities and service, residence in the village for at least five years, willingness to serve as a VHW, and reputation as a respected and honest person. Literacy is highly desirable, though not essential. Traditional healers, if they conform to other criteria and demonstrate a sincere desire to be VHWs, are to be accorded priority in selection because they have already established their role as health practitioners. This would also avoid potential rivalry. Both men and women are eligible. In Maryland County, most VHWs were men, though women have the advantage of affinity with the most vulnerable target groups -- mothers and young children. In general, people with full-time paid employment should not be chosen. People in their middle years are preferred.

The functions of the village health worker may be summarized as follows:

- ° Promote the adoption by villagers of sound personal and community health practices to prevent and control water-borne and parasitic diseases.
- ° Assist in organizing and implementing village health activities including regular monthly PHC meetings.
- ° Educate and motivate villagers to obtain appropriate vaccinations.
- ° With assistance from the health post staff, organize and conduct the monthly village weighing program.
- ° Promote good nutritional habits through simple messages and demonstrations.
- ° Advise mothers on the proper preparation and use of oral rehydration solution.
- ° Provide child spacing counseling complementary to TBA efforts, and distribute both non-prescription contraceptives and refills of birth control pills.
- ° Provide first aid and treat simple medical conditions including fever, malaria, diarrhea, skin problems, using the following drugs (or others to be determined):

- Aspirin
- Iron (anemic children)
- Chloroquine (malaria)
- Skin antiseptic (gentian violet)
- Benzyl benzoate (scabies)
- Piperazine (worms)
- Cough mixture - expectorant

- o Manage the village medicine supplies, under the supervision of the VDC.
- o Monitor and provide follow-up for TB and leprosy patients to insure they adhere to their treatment regimens.
- o Assist in the implementation of rules and regulations adopted by the VDC on water-source protection and general village sanitation.
- o Keep simple records relating to village health activities.
- o Refer patients to the health post as appropriate.
- o Recognize serious health problems in the village, such as epidemics, and report to health post staff.
- o Participate in surveys and studies in the village, as determined by project needs.

In these ways, a well motivated, trained, and supervised VHW is expected to have significant influence on the major conditions causing serious disability and death, and can improve the quality of life in rural villages.

Fifteen to twenty VHW candidates will be given preservice training at each training session. The VHWs will be trained for five weeks by experienced PA (and HI) trainers at one of the larger local communities that has facilities to accommodate the training. The local health post staff should participate as well. The length and size of the training sessions may be modified according to the curriculum developed and subsequent training experience and field performance. The training will be problem-oriented and competency-based, with emphasis on providing practical experience in the assigned tasks. In addition to regular supervision by the local PA, inservice training will be essential to reinforce and upgrade the VHW skills. Beginning with the year following preservice training, the trainers will provide five days of inservice training annually. By the end of the project, the local PAs will be trained to carry out this responsibility.

(b) Traditional birth attendants

TBAs are already present in the villages of Grand Gedeh and Sinoe Counties and perform the overwhelming majority of deliveries there. However, only a few have had any formal training and most have no concept of a hygienic delivery. Harmful traditional practices abound. For example, the TBA may dress the cord with ash, dirt, or hair.

TBAs have the advantage of already being accepted by the community in their role, but they need to be retrained for their expanded activities in primary health care. The number of practicing TBAs in the project area is unknown. Some individuals consider themselves to be TBAs although they may have done no more than one or two deliveries per year. It is estimated that two or three practicing TBAs may be available in each village and its environs.

The project will fund training of all the TBAs meeting project delivery criteria in a community, if endorsed by the VDC. This is because previous attempts in Liberia to train only one TBA per village have been unproductive owing to hostility and resentment among the untrained TBAs.

The TBAs are already compensated in cash or kind for their services, and previous experience indicates this compensation will probably increase after training. The VDC will have authority to standardize these fees. On completion of training, a TBA will be given a simple midwifery kit with case, to be donated by UNICEF. Provision of the kit will likely be a strong incentive to undertake and complete the training. Other items supplied to the TBAs would be resupplied by health post staff through the same mechanism as for VHW supplies. Under VDC supervision, the VHW would be responsible for distributing these supplies to the TBA. The VDC is responsible for overseeing the financial transactions.

The functions of the traditional birth attendant are as follows:

- o Provide prenatal and postnatal care and counseling including promoting tetanus toxoid immunization and dispensing of iron/folate supplements, and chloroquine.
- o Attend births using proper hygienic techniques.
- o Identify "at risk" patients and refer to health post.
- o Promote good maternal and child nutrition through simple messages (e.g., use of nutritious local foods, and continued breast feeding), and assist in carrying out the village weighing program.
- o Advise mothers in the proper preparation and use of oral rehydration solution.
- o Provide child spacing counseling, and distribute both non-prescription contraceptives and refills of birth control pills.
- o Assist in organizing and implementing village health activities, including monthly PHC sessions.
- o Collect simple information on village births and deaths, and report it to health post staff periodically.

The TBAs will be trained for three weeks by experienced certified midwife (CM) trainers. Up to eighteen to twenty TBAs will be trained per session in the area of one health post or health center. The length and size of training sessions may be modified depending upon the curriculum developed as well as subsequent training and field experience. The local CM who will be TBAs' technical supervisor will also participate in the training.

At first, training emphasis will focus on traditional roles related to midwifery. From there emphasis will shift to encompass other related PHC tasks. TBAs will be taught to carry out an improved, safe village delivery through more hygienic techniques and use of the midwifery kit.

Regular supportive supervision by the local CMs will be critical to maintain the TBAs' new skills. In addition, CM trainers will provide three days of inservice training per year. By the end of the project the local

CMs will be trained to continue this responsibility.

b. Rural health facility services and support

(1) Health posts

The health post is the most peripheral government health facility. On average, each health post covers a population of approximately 3,000, though some may cover up to 5,000. In the project counties, each health post will be staffed by a physician assistant (PA) (or registered nurse) and a certified midwife (CM), with a health inspector (HI) assigned to the area served by two health posts. The health post staff will provide technical supervision and support to the village health team. The PA will have primary responsibility for supervising the VHW, while the CM and the HI have secondary responsibility in areas corresponding to their own functions. The trained TBAs will be supervised by the CM, with assistance from the PA. Each health post will cover five to seven village health teams. More detailed discussions of the functions of health post staff are provided in Annex J-2.

By the end of the project, 21 health posts in Grand Gedeh County and 26 health posts in Sinoe County will be fully staffed and operating. The higher number of facilities in Sinoe reflects the relative scarcity and poor condition of the roads there. No health posts in these counties are currently staffed with CMs and only nine have PAs. A total of ten HIs are assigned to health post areas in Sinoe and Grand Gedeh. Most facilities are staffed only by dressers, nurse aides, or trained TBAs. To provide the proper staff, priority will be given to assigning new graduates to the project area, and training capacity for CMs will be increased. It may also be necessary to transfer staff to the project counties from areas that are relatively overstaffed. The MH&SW is fully committed to meeting these staffing targets for rural health facilities, as evidenced by a project covenant to that effect.

The health post is the point of referral from the village-level services, and as such will offer improved diagnostic, therapeutic, and promotional services. It is estimated that more than 85 per cent of patients can be cared for successfully at the village and health post levels combined. To support the village health team, the health post staff will see all patients referred from the village on priority basis. The health post staff provides immunizations to mothers (tetanus toxoid) and young children (measles, polio, DPT, BCG). Some health posts have refrigerators for vaccine storage. The health post offers more sophisticated treatment for common conditions including malaria, diarrhea/dehydration, intestinal parasites, and injuries; and provides treatment for important conditions that the VHT cannot handle (for example, pneumonia and dysentery). The health post is a center for child-spacing services, including counseling and promotional materials, and oral contraceptives are prescribed. Delivery services will also be provided. Recommended drugs, supplies, and equipment for health posts (and health centers) are listed in Annex N. As described in subsection c.(4) below, the health post will benefit from a strengthened logistical system within the county, and in turn will supply the village-level workers, including the village-level revolving drug schemes.

(2) Health Centers

The health center is the referral point from the health post. Each health center has two to twenty inpatient observation beds (depending upon local needs) and provides a wider range of services than the health post; for example, better diagnostic capability (including a binocular microscope), more comprehensive list of drugs, intravenous therapy (including rehydration), and more family planning services. Each health center will have a refrigerator for vaccine storage. As with the health posts, health centers will be supplied by an improved county-level logistical system. By the end of the first five years of project support, four health centers each in Grand Gedeh and Sinoe Counties will be fully staffed and operating.

Each health center is intended to serve a population of from 5,000 to 20,000 people. Ideally, a physician should be in charge. Since that will not be feasible during the life of this project, an alternative plan has been adopted. Each health center's staff will include two PAs and one CM. They will be responsible not only for health center PHC activities, but also for supervising the village health teams in the area. The designated senior PA is expected to be highly capable and experienced. The additional PA will enable the health center staff to handle the heavy clinical load and to alternate coverage in order to support the VHTs in the field.

In addition, an experienced and specially trained PA supervisor and CM supervisor will be posted to every other health center. They will be responsible for supervising and supplying the 10 to 13 PAs and CMs who are assigned to health posts in their section of the county.

The project area also includes one maternal and child health (MCH) center. This facility, located in Zwedru, Grand Gedeh County, is staffed by two CMs and provides antenatal and well-baby care, including vaccinations as well as family planning.

(3) Construction/renovation of health posts and health centers

Within the target countries, some rural health facilities need to be consolidated and upgraded. Also, a limited number of health posts and health centers should be constructed, either to replace poorly located facilities or those which the MH&SW presently leases rather than owns. PL-480 counterpart funds will be used to accomplish this; the number and location of facilities to be constructed (and renovated) with these funds will be determined in the annual agreements between the GOL and AID for expenditure of PL-480 counterpart funds. Construction in the rural areas will emphasize the use of local materials to conserve costs; for example, it is expected that construction will be based on the use of mud bricks coated with cement -- an effective and common building technique in these rural areas.

c. County-level services and support

The normal chain of referral is from the health post to health center to the county hospital, which has operating and delivery rooms and is typically staffed by two physicians (including the hospital medical director), as well as registered and practical nurses, a laboratory technician, and other supporting staff.

The hospital is under the jurisdiction of the county health officer, who is the responsible MH&SW officer in the county. As shown in Figure II-1, the hospital is the direct responsibility of the hospital medical director, who in turn reports to the county health officer. The figure also shows the proposed organization of all MH&SW operations at the county level. The figure represents the outcome of considerable discussion within the MH&SW's PHC Steering Committee during the project design phase, and the resulting structure is expected to provide the best organizational framework for carrying out the county-level PHC Program.

(1) County-level institution building

The county health department in Grand Gedeh and Sinoe Counties will be responsible for the development and implementation of the county-level PHC services. The project provides for the construction and equipping of a county health department building in each county, as well as the development and implementation of the organizational structure and operational procedures needed to support all county-level PHC activities. Emphasis will be placed on developing and implementing strong supervisory and support systems, to provide needed back-up to both village-level and health post/health center services.

Central to the effective operation of the county health department is the successful design and implementation of county-level decentralization. To be workable in achieving the intended objectives, county-level decentralization implies decentralization in three specific areas: (1) decentralization of the budgetary process, (2) decentralization of financial responsibility, and (3) decentralization of planning and management responsibilities. This means that the target counties will be responsible and accountable for the planning and management of all county-level resources for the delivery of government health care programs and services. A more detailed discussion of these three areas may be found in the Administrative Feasibility analysis (Annex H-5). It is also important to realize that for decentralization to work effectively, it must involve the entire county-level operations of the MH&SW. The institution-building process will emphasize a clear delineation of authority and responsibility between MH&SW Headquarters and the county health officer who is the chief MH&SW official in the county. In turn, the authority and responsibility among the Ministry's health care facilities and programs operating within the county will also be clarified. In this regard, high-priority programs and services, both existing and planned, will be coordinated and integrated within the county-level PHC program, including the three foci of the Combatting Childhood Communicable Diseases Project (immunizations, diarrheal disease, and malaria).

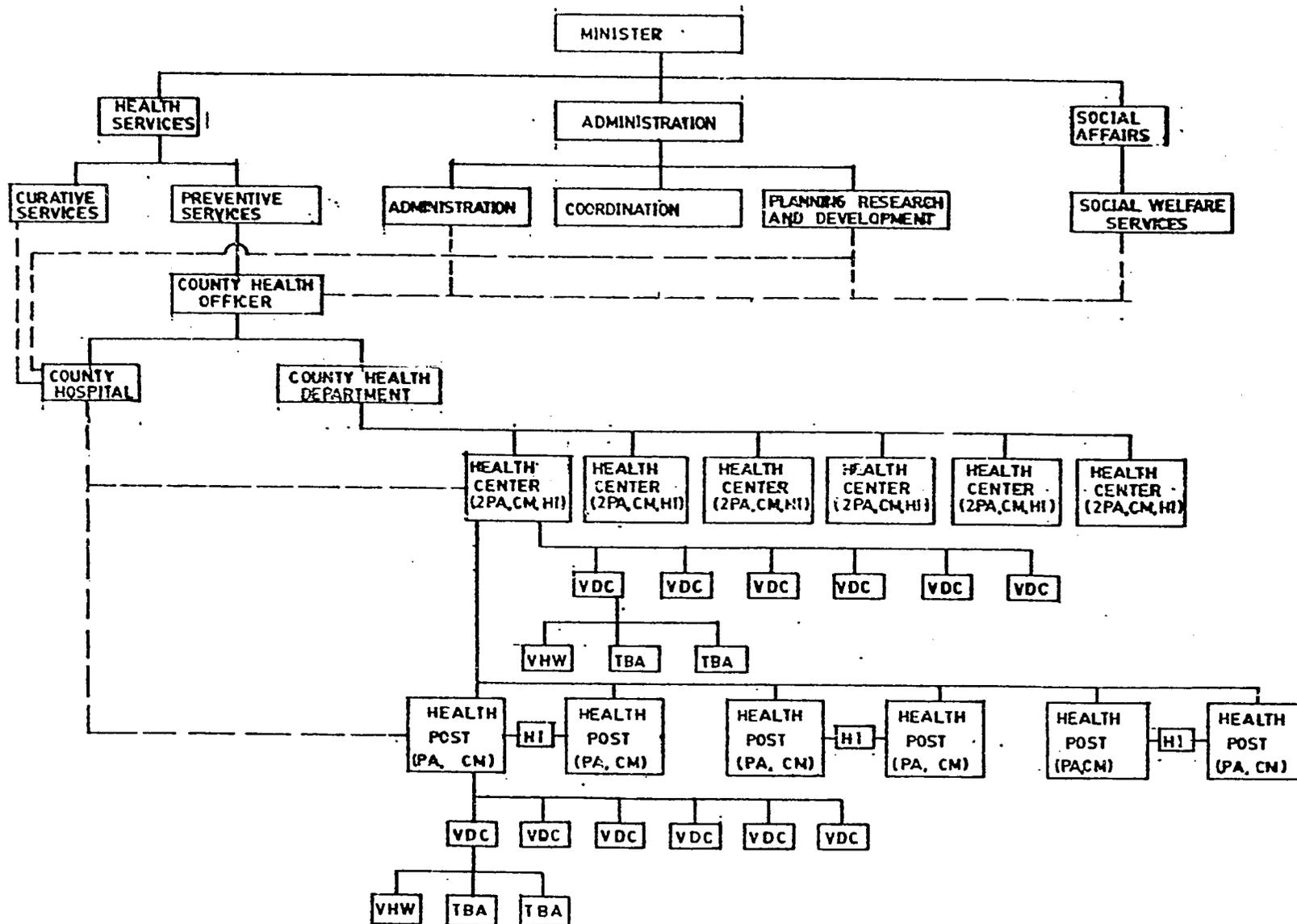


FIGURE II-1: ORGANIZATION OF THE MINISTRY OF HEALTH AND SOCIAL WELFARE, WITH EMPHASIS ON PRIMARY HEALTH CARE

(2) The county health department

In accordance with the proposed county health department organizational structure, the staffing pattern includes the following personnel: county health officer, administrative officer, logistics officer, 2 PA supervisors, 2 CM supervisors, and an HI supervisor. Both the PA and CM supervisors are posted at health centers to improve field activities. The major functions of these officers in relation to county health department operation are summarized briefly below.

The county health officer (CHO) will be a Liberian physician with substantial community health experience and interest. The physician selected for this position will receive master's level training in public health (MPH) at a U. S. institution. During the period of training, another physician with similar background will serve as CHO and counterpart to the long-term TA county public health physician. The interim CHO will undertake a short-term course in mid-level management at the Regional Training Center (RTC) in Lagos. On return from long-term training, the MPH physician will assume the CHO position and the interim CHO will be sent for long-term MPH training, in order to provide sufficient back-up for the CHO position. These additional public health physicians will gain experience in the target counties, but also will be available to serve in other areas as the National PHC Program expands.

The specific duties and responsibilities of the CHO will encompass overall management and supervision of all activities of the county health facilities and health workers, including training activities, supplies, and information. The CHO will manage the community health department and will be expected to serve in a full-time capacity. He/she will be responsible for preparation of annual county work plans and budgets and for execution of the approved work plans and budgets, in line with the guidelines for county-level decentralization.

Both the county administrative officer and logistics officer are expected to be college graduates with degrees in administration. The administrator will have training or experience in financial management. Both officers will attend the mid-level management short-term training course in Lagos.

The logistics officer will be responsible for county-wide management of the supply system including procurement, storage distribution, and inventory control. He/she will establish the supply delivery system as well as the vehicle, building, and equipment maintenance programs. In addition, he/she will manage the drug supply and inventory program. Vehicles will be maintained with the assistance of the county mechanic, who will report to the logistics officer.

The administrative officer will be responsible for financial management and budget procedures. He/she will administer personnel policies and prepare a personnel inventory. Quarterly and annual budget forecasts will be prepared describing proposed resource allocations. These are to be submitted through the CHO for approval at the national level. Under the CHO's direction, the administrative officer will also be in charge of collecting and preparing county statistical data, with the assistance

of the county registrar.

(3) Training at the county level

The successful initiation and continuation of PHC services within the target counties depends on the effective development and implementation of a major training program for county-level health workers and others related to the PHC Program. The courses are primarily designed to introduce new ideas and policies that are essential to an ongoing primary health care program and to give practical training in carrying out relevant new procedures and techniques and in upgrading previously acquired skills. For example, county officials will be introduced to the PHC concept and pertinent new policies. The mid-level workers will be given a four-week orientation to PHC, including training in the new roles and skills expected of them. Other types of training will be provided for different categories of workers at various levels in the system. In addition to teaching PHC technical skills, the training focuses on upgrading the mid-level workers for their roles as supervisors and trainers. Other county-level training courses deal with decentralization and management for senior level staff.

In each county, outstanding mid-level workers will be chosen as members of the county training team, and will be trained as trainers of the VHWs and TBAs. Three PAs\* will comprise the VHW training team, and three CMs will train the TBAs. These six trainers will also be involved in the development and presentation of other training courses in the county (working together with other individuals), as described in the In-country Training Plan (Annex J-4). One or two members of each six-person team will attend a short-term training of trainers course in Lagos.

In order to help insure the achievement of project objectives in the target counties, the project staff will work closely with the Liberia Rural Communications Network, which will operate radio stations serving the project counties. Radio programming -- often in local dialects -- will support the development of the PHC system in the counties by presenting information through various methods (radio plays, interviews, etc.). Radio messages will also support and reinforce health education programs (e.g., nutrition, child spacing, oral rehydration), as well as announce specific activities (e.g., immunization sessions, scheduled health meetings, training sessions) in the county.

(4) Logistical system

(a) Drugs and medical supplies

Lack of an adequate supply of drugs will quickly bring health worker activities, and the effectiveness of the PHC system, to a standstill. Experience in Liberia and elsewhere has clearly shown that without drugs, workers cannot maintain the credibility necessary to effectively advocate high-priority preventive health measures. In an effort to prevent this type of program discontinuity, the MH&SW has approved a scheme whereby, throughout the target counties, monies from the sale of drugs

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\* An experienced health inspector (HI) or HI Supervisor may fill one of these positions.

will be kept within the county health department, to be used to purchase more drugs and supplies (as opposed to returning the funds to general revenues, as is presently the case for registration fees). In this way people will increase their direct support of health services, and thereby insure a steady supply of essential expendable items in the county-level system. Naturally, stringent accounting procedures will have to be imposed, along with strict accountability, as discussed in the Administrative Feasibility analysis (Annex H-5). The CPA firm providing financial-monitoring assistance will assist in devising these procedures as described in Annex O. Based on recommendations of the drug procurement and distribution study\*, the MH&SW, with the assistance of the project's long-term logistics technician, will devise appropriate supply, procurement, warehousing, inventory, and distribution procedures, and will establish pricing guidelines. Grant funds will provide much of the initial drug supply for the target counties. Under the revolving-fund mechanism, the charges made to patients for drugs will finance sufficient additional purchases to make the system self-sustaining, so that long-term GOL expenditures for drugs will be drastically reduced. The establishment of the county-level revolving drug funds is a condition precedent to disbursement of funds for drug purchases.

(b) Transportation

The PHC project will finance three vehicles in each county (one jeep and two standard pick-ups) to support CHD activities. These vehicles will be maintained by the county mechanic. In addition, a total of 130 motorcycles will be assigned to mid-level workers and Peace Corps Volunteers in order to carry out various supervisory and support services within the two counties.

The motorcycles will be provided through grant funds. However, the intent is to establish a self-financing fund for motorcycles to be used by mid-level workers in the PHC program\*\*. Such a scheme has already been agreed upon in principle by the GOL under another current AID-assisted project, Increased Revenue for Development (669-0132).

The scheme provides for contributions in installments by the assigned recipients, of at least half the cost of project-financed trail motorbikes. Each recipient will be made to enter into a payment contract with the GOL for a fixed total cost. Equal monthly payments will be spread over a period of approximately two years (or more at the GOL's discretion), most likely through salary deductions. The proceeds of these contracts will be placed in an escrow account, and will be used to purchase additional motorbikes for replacement, or for other expenditures as mutually agreed.

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\* See the discussion in the following subsection (d.(1)(c)) covering this study.

\*\* Note that the Peace Corps Volunteers will not participate in the motorcycle purchase scheme.

(5) Housing

As an incentive to attract and retain qualified health workers in the rural areas, the MH&SW recently established a policy to provide staff housing for employees, within budgetary limitations. Under the project, PL-480 counterpart funds will be used to construct houses for the county health officers in the two target counties. The houses will be rented to the officers at a modest rate, to provide sufficient funds for maintenance and repairs. In view of current MH&SW budgetary limitations, local communities will be encouraged to provide or construct modest housing for mid-level staff at the rural health facilities throughout the counties. PL-480 counterpart funds may be used to purchase required building materials. As indicated in Annex I-5, the estimated expenditure of counterpart funds for staff housing during the first five project years is approximately \$425,000.

(6) Guest house facilities

As just indicated, there will be a wide range of activities taking place within the project counties, from the county health department to the village level. Many of these activities -- especially in the areas of training, decentralization, and project monitoring -- will involve visits and short-term assignments of personnel from the MH&SW, USAID, and other agencies. In turn, these visits will require accommodations at the county headquarters level (Zwedru and Greenville).

In view of the limited public facilities available in these towns for both meals and lodging, USAID will investigate the feasibility of using project funds to rent and furnish modest guest house facilities for the use of visitors on official project business. If feasible, it is anticipated that an existing house will be rented to provide basic accommodations for sleeping and meal preparation. This nominal expenditure may be advisable in order to help insure that adequate facilities will be available to support the inputs of short-term visitors in the county areas.

d. Central-level strengthening and support

The organizational structure of the central MH&SW is shown in Figure II-2, which depicts the relationship of the organizational units to the division level. One can see that health services are divided into curative and preventive services, each headed by a deputy chief medical officer.

The MH&SW PHC Project Manager will be the Deputy Chief Medical Officer for Preventive Services, who will devote a minimum of 25 per cent of his/her time to project management activities. The incumbent is a physician with an MPH and considerable rural public health experience. In addition, the MH&SW will appoint a Deputy Project Manager to assist full time with the implementation of the PHC Project. This individual should also be a public health physician with substantial rural public health administrative experience. The chief of party of the project's long-term technical assistance team will work directly with the Project Manager and his deputy, and will have office space at their locations. The project will fund a vehicle and limited operating expenses for use by the Deputy Project Manager, as well as the Project Manager, on project activities.

(1) Central-level institution building

At the central level, this will include three major foci. The first is the strengthening of planning and management functions, including budget and finance, personnel, and information systems. Second, a review of health worker training programs and their curricula, as well as the corresponding training institutions, will lead to a coordinated, long-range manpower development effort, emphasizing the primary health care orientation of the national health care delivery system. The third major focus at the central level will be the strengthening of the logistical system for drugs and medical supplies.

(a) Planning and management

During the first project year the MH&SW's financial and management systems will be reviewed, and a plan will be developed and implemented to strengthen and coordinate these systems. These efforts will build on the work done under the AID-assisted Health Management Project (669-0126), and will also take into account the special needs of the central-level management functions in relation to county-level decentralization. This will likely involve modifications in the functional areas of budget and finance, personnel, and the various information and reporting systems used to support the planning and management functions. This work will be coordinated with the development of guidelines, policies/procedures, and systems for the decentralized operations in the target counties, which must be established as a condition precedent to disbursement of funds in project year 3. In addition to the involvement of the project Chief of Party, who will be a planning/management expert, there will be assistance in this area from the CPA firm (as described elsewhere), and approximately 10 person-months of short-term technical assistance.

(b) Manpower development

During the first project year, the MH&SW, with the assistance of the project's long-term Curriculum/Training Specialist, will review health

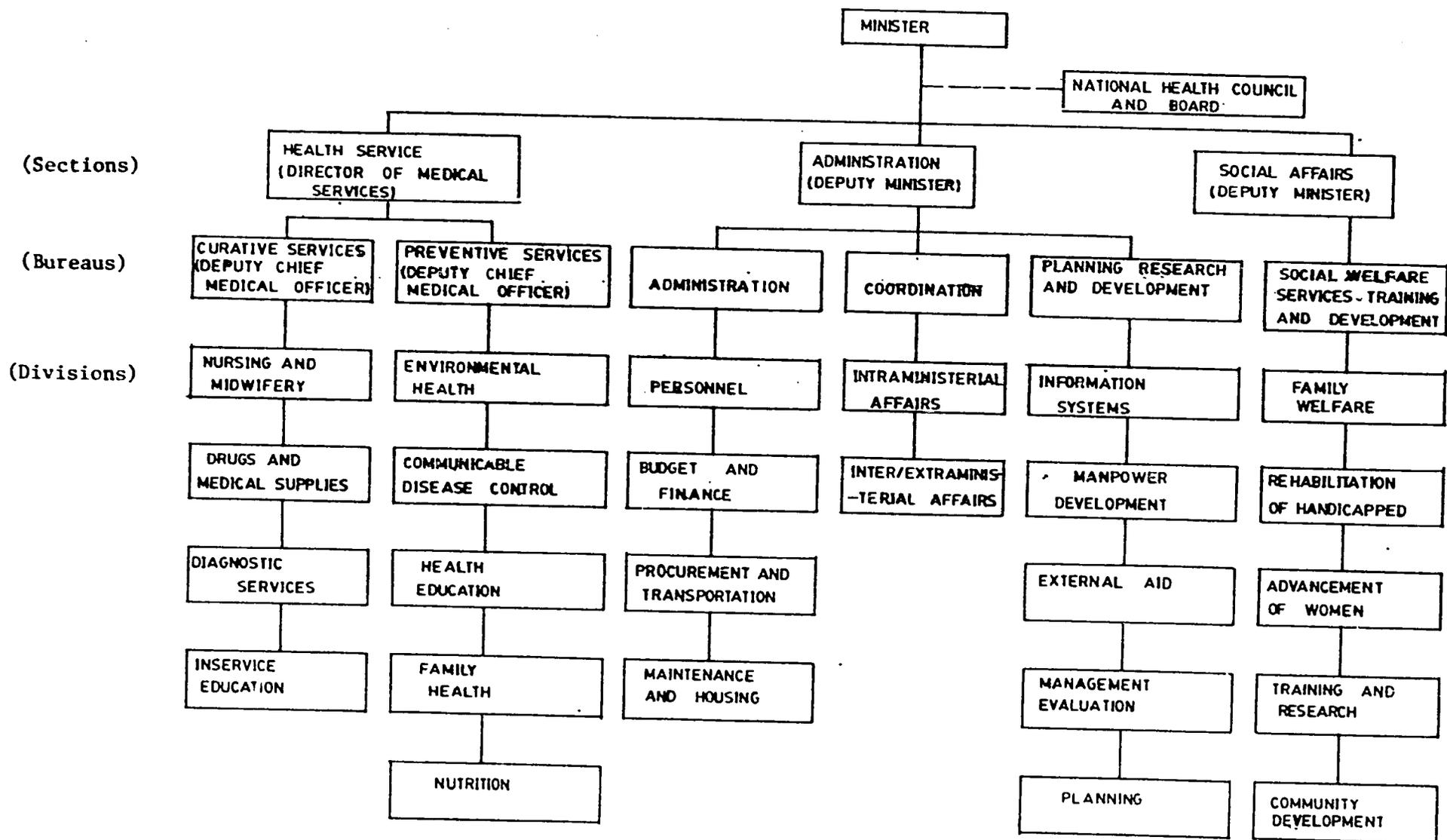


FIGURE II-2: MINISTRY OF HEALTH AND SOCIAL WELFARE CENTRAL ORGANIZATION

worker training programs, considering both the curricula and the respective training institutions. Emphasis will be placed on mid-level training programs for PAs, CMs, and HIs. The mid-level training institutions will include the Tubman National Institute for Medical Arts (TNIMA) in Monrovia, the Rural Health Training Center in Suacoco, the Zwedru Midwifery School, and Curran Hospital. (Further details on these institutions and their training programs are provided in Annex J-4.) From this review detailed plans for strengthening PHC manpower development will be prepared, including the development and implementation of revised curricula for mid-level health workers. Mid-level health worker training institutions will also be strengthened to help insure their ability to provide increasing numbers of qualified health workers to support the national PHC Program. This will be accomplished by several means: training of additional faculty, provision of key faculty members (utilizing Peace Corps Volunteers) until the newly trained faculty are available, provision of three vehicles to insure adequate supervised field work, provision of training materials and supplies, and the physical expansion of training facilities (through the use of PL-480 counterpart funds). Additional project resources in this area will include 15 person-months of short-term technical assistance.

(c) Logistical system

A formal study of the national drug procurement and distribution system will be carried out during the first project year.\* The results of the study will provide the necessary guidance for changes in policy and operation of the system, to improve its effectiveness and insure its capability to meet the needs of the national PHC Program. Specific areas of strengthening include the design and construction of a central warehouse facility in Monrovia; the establishment and implementation of procurement, inventory, issue/transfer, and other record-keeping and control systems; the development of pricing guidelines; and the strengthening of the transport and distribution system to insure adequate support for the project counties and the capability of system expansion to serve the rest of the country. In addition to the long-term project technician (Logistics Specialist), 13 person-months of short-term technical assistance are expected to be used in strengthening the logistical system during the project.

(d) Long-term participant training

An important aspect of institution building that is critical to the long-term viability of the PHC Program is the development of sufficient numbers of well-qualified Liberians to fill key positions in the PHC Program. The project incorporates 4 person-years of long-term participant training to help meet this critical need. The following paragraphs summarize the long-term training planned in order to accomplish the required senior-level manpower development at both the central and county levels.

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\* This study will be funded by the AID-assisted Health Management Planning Project, which supports the development of improved planning and management systems within the MH&SW.

To support the project's manpower development activities, two individuals will be trained at the Master's level in curriculum development and training methodology (4 person-years); one person in maternal and child health (2 PY); and one person in nutrition (2PY). Also, four PAs will obtain BA degrees through the Bachelor's level equivalency program in Nigeria (4PY). It is expected that these PAs will then complete Master's degrees (probably the MPH, 8 PY) to prepare them for faculty positions in the mid-level training institutions, especially those training PAs, where there are currently no PAs as faculty. In addition, to bolster CM training, five PAs will obtain Master's degrees in midwifery or related fields, with emphasis also on maternal and child health as well as general teaching skills (10 PY).

Support for strengthening the logistical system will include the training of two individuals at the Master's level in health services administration, with emphasis on logistical systems development (4 PY). These two staff members will then assume managerial positions in the newly completed central drug and medical supply warehouse.

Central managerial and technical units will be supported by the training at the Master's level of one person in laboratory technology (2 PY); one person in the field of maternal and child health (2 PY); and one individual in the area of public health nutrition (2 PY).

To support the county level, four physicians will obtain MPH degrees (4 PY), and afterwards will assume positions as county health officers in the two target counties. With experience in the target counties, they will be available for other assignments in the PHC Program as it expands.

## (2) Technical support activities

PHC Project and other available resources will be coordinated in order to provide additional support in specific areas of technical program development. These combined resources are summarized below, and the non-project resources are discussed in more detail in Annex I-3.

The MH&SW's Division of Inservice Training has a major role in supporting the inservice training activities of the project. The division will assist in the development and implementation of curricula, courses, and training methodology and materials, and will incorporate appropriate methods and materials into ongoing inservice training programs throughout the country. To enhance the division's long-term capabilities, one of the Master's degree graduates in curriculum development and training methodology will be assigned to the division on his/her return from training. In addition to assistance from the project's long-term Curriculum/Training Specialist, 6 person-months of short-term technical assistance, and limited vehicle operating expenses, are planned to support inservice training activities.

The Ministry's Nutrition Division will benefit from approximately 6 person-months of short-term technical assistance in order to upgrade its capacity to develop and support nutrition-related activities. One of the individuals obtaining a Master's degree in nutrition will return

to the division and provide long-term program continuity. Also, partial use of a vehicle (to be shared with the Family Health Division) and limited operating expenses will be provided to insure the necessary level of field support.

The Division of Family Health will receive a variety of support for carrying out its responsibilities in the project. One of the participants returning from Master's level training in maternal and child health will be posted to the Family Health Division. Also, as noted above, in order to support the division's field activities in the project, use of a vehicle and limited operating expenses will be provided. In addition, support from the following centrally-funded, AID-assisted projects is planned and will be coordinated through the Division of Family Health.

- Assistance from the interregional Population Communication Services Project (936-3004) to assess the need for improved skills in information, education, and communication (IEC) related to family planning, and to develop prototype materials and radio programs (especially in conjunction with the Liberia Rural Communications Network (LRCN) as noted elsewhere).
- Assistance from the centrally-funded project (932-0502) with the Centers for Disease Control (CDC) to support the development of improved logistics, record-keeping, and analysis of contraceptive needs within the division's program.
- Assistance under a centrally-funded project (932-0624) from Westinghouse Health Systems, to design and carry out a PHC baseline survey, with eventual follow-up for evaluation purposes. In addition to other PHC concerns, including utilization of services, the survey will focus on contraceptive prevalence, knowledge of and availability of family planning services, and issues relating to reproductive health status. These issues, which include the age of the mother, birth interval, parity, and obstetrical care, will be examined for their effect on other health conditions, including malnutrition. The survey will oversample in the two project counties, but data will also be collected from representative areas in other counties. In addition to a project baseline, the information will be used for policy development and program guidance.
- Centrally-funded assistance in operations research to investigate the most feasible, cost-efficient, and effective mix of PHC personnel and services, with attention to family planning. One of several potential contractors under this project (923-0632) would be selected in consultation with AID/Washington.
- Consultants from JHPIEGO, through its centrally-funded project (934-0604), will be requested to assist in developing curricula emphasizing reproductive health and management of MCH/FP programs for physicians and registered nurses, to prepare them for their functions in support of the PHC Program.

The Health Education Division, in addition to its direct activities, plays an important coordinating role with other divisions, especially both Nutrition and Family Health. The Health Education Division will receive support for materials development in nutrition education, as well as for IEC materials in relation to family planning and child spacing activities. The division will also provide a link with the LRCN in developing radio programming for the county level. Up to 6 person-months of short-term technical assistance will support these efforts.

A regionally-funded project, Combatting Communicable Childhood Diseases (CCCD), (698-0421), will provide assistance to Liberia in three of the most effective PHC interventions: immunizations, control of diarrheal disease (oral rehydration), and control of malaria (presumptive treatment of fevers, and prophylaxis in pregnant women). Regional assistance will be available in training, development of training materials, health education, information systems, and operations research. In addition, a specific bilateral component of the CCCD Project will provide a full-time resident technical officer for four years, plus substantial commodity assistance and additional support in other technical areas.

(3) Study of potential private sector involvement in the Liberian health care system

The Ministry of Health and Social Welfare is responsible for the provision of health services throughout Liberia. Historically, the Ministry's efforts have been augmented by major service providers representing both the concessions and church-sponsored organizations, as well as a limited number of individual private practitioners and an active private enterprise market in drugs and pharmaceuticals.

Acknowledging these traditional private-sector efforts, as well as the desire to establish a more pluralistic private sector support base for the PHC Program, this project will fund a study to identify additional private sector activities in the health sector. Potential areas include:

- Health services delivery, including the expansion of existing programs (e.g., concession health services) to serve additional people
- Pharmaceutical manufacturing, supply, and distribution
- Medical equipment manufacture, supply, and repair
- Consulting services in the health sector
- Provision of auxiliary health services such as laboratory, x-ray, and medical transport
- Training programs for both mid-level health workers and ancillary personnel

The proposed study will examine market potential, financial projections, and the experience of health care providers, in conjunction with available epidemiological information. The study will describe existing private sector involvement and experience, applicable policies and laws having implications for further development, and possible market responses to new initiatives.

(e) Peace Corps participation

On the basis of discussions and preliminary negotiations with the MH&SW and Peace Corps/Liberia, 15 Peace Corps Volunteers will be assigned to work with the PHC Project. Five volunteers will serve as faculty members of the following mid-level training institutions: The Tubman National Institute of Medical Arts (TNIMA) in Monrovia; the Rural Health Training Center (RHTC) at Suacoco (2 volunteers)\*; Curran Hospital at Zorzor; and the Midwifery Training Center in Zwedru. Three of the five volunteers will teach nursing and midwifery, one will work on curriculum development, and one will teach basic science. The remaining two volunteers will work at the county level. Four will work as training-team coordinators, four as supervisory-team coordinators, and two as county-level laboratory technicians. The volunteers posted to the county level, plus the curriculum development person, will begin in the second project year, while the remaining four volunteers (training institution faculty) will begin in year 3. Their participation is described in more detail in Annex I-4.

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\* The volunteer with curriculum development skills is shown as being posted to RHTC on the assumption that RHTC will begin operations as now anticipated in 1984, and will train PAs, CMs, and HIs. If these plans do not materialize, consideration will be given to posting this volunteer in Monrovia to fulfill the need for curriculum development skills at TNIMA.

### III. COST ESTIMATE AND FINANCIAL PLAN

This section summarizes by source and project year the cost of services and commodities needed to implement planned activities for the project as designed. However, it is important to note that the USAID Mission was constrained by certain AID/Washington limitations, including an upper limit of \$15 million for the AID contribution (see Annex C). This funding limitation has influenced the resulting project design; without the limitation the AID contribution would have funded additional elements and/or funded those still included in different proportions. In view of the major institution-building emphasis of the project, it will clearly take more than five years to achieve this objective; but limited availability of funds has meant that only the first five years can be funded at this time. Thus assuming that funds are available and that the outcome of project evaluations confirms the need for continued AID assistance, then high priority would be given to providing the necessary support in future years.

#### A. Cost Estimate

Cost estimates used in the budget are based primarily on recent USAID experience with other projects in Liberia. Cost estimates for commodities to be purchased in the U.S. are based on catalog prices and Mission procurement experience. Local costs, including construction, are based on costs provided by reliable local sources. Most commodity funds have been budgeted early in the project to offset the eroding effect of inflation on unexpended funds. Inflation has been estimated at 3% compounded annually. Contingency funds were estimated at approximately 8% of total project cost.

The services of a CPA firm will assist in developing proper accounting and financial monitoring mechanisms for overall project management, as well as in preparing annual financial reviews (see Annex O for draft scope of work). These financial control mechanisms will be worked out early in the project in accordance with the implementation schedule, in order to provide a framework for the implementation of the required financial management systems. Consultants from the CPA firm, in conjunction with officials of the Ministry of Finance and the Ministry of Health and Social Welfare, will also assist project technicians in developing training sessions dealing with budget planning, decentralization, and financial management. This activity will not only address recent U.S. Congressional concerns over financial mismanagement of local currency costs experienced in some Sahelian countries, but will provide the necessary training required to improve local financial management. Improved revenue generation and management of the project is needed to enhance its viability.

As indicated in Figure III-1, AID funds will be used to support some of the recurrent costs of the project, most notably for vehicle operations and maintenance. However, as indicated in the Financial Analysis (Annex H-2), and as provided for in a covenant to the project, the GOL will provide increasing recurrent cost funding so that by the end of project year 5, the GOL will be assuming no less than 90 per cent of project-generated recurrent

costs in the project counties.

As set forth in AID's 1982 Policy Paper on recurrent costs, AID will not fund recurrent costs as part of its project assistance except under the following specific criteria:

- That a policy framework for recurrent costs exists or will be developed;
- That the host country is unable to assume the recurrent cost financing at present;
- That the development impact of funding recurrent costs is greater than alternative capital investments; and
- That a carefully phased plan exists for eventually shifting the entire recurrent cost burden to the host country.

In the case of this project, the above criteria are met. Since both the GOL and USAID recognize that eventually the GOL will have to assume the full project-generated recurrent costs -- and the project incorporates a provision that at least 90 per cent will be met by the end of the first five years -- the policy-framework criterion has been resolved. Furthermore, based on the Financial Analysis (Annex H-2), there is no doubt that the GOL presently does not have the resources to meet these costs. Without AID's assistance in meeting recurrent costs during the project, the institution-building process and expansion of basic health services could not take place.

Recognizing the present and near-future economic situation which Liberia faces, it is USAID's policy to minimize the recurrent-cost burden on the government. New investments are being deferred where possible by the GOL, because of the additional cost burden they would impose. Given this situation, recurrent-cost financing under this project will not divert funds from potential new investments, but instead will support USAID's policy of minimizing the GOL's recurrent cost burden during this critical period.

## B. Financial Plan

### 1. Expenditures

The project financial plan is summarized in Figure III-1 through III-6, and of these the first four focus on project expenditures. Figure III-1 indicates the projected expenditure of AID grant funds by project year and major category, as highlighted below. Figure III-2 provides a summary of the expenditure of population grant funds (total \$300,000), and relates these to the overall budget in Figure III-1. Figure III-1 provides a breakdown of expenditure by source and major category, as well as in indicating the foreign exchange (FX) and local cost (LC) components. This figure indicates that the total cost of the project is \$37.0 million; of this, the GOL's contribution represents 57 per cent.

FIGURE III-1: PROJECTED EXPENDITURE OF AID GRANT FUNDS BY PROJECT YEAR (\$000)

CATEGORY	PROJECT YEAR <sup>*</sup>					TOTAL	CATEGORY SUBTOTAL	PER CENT
	1	2	3	4	5			
<b>TECHNICAL ASSISTANCE</b>								
Long-term	286	962	1,011	911	367	3,537		
Short-term	275	243	150	38	38	744		
Subtotal	561	1,205	1,161	949	405		4,281	28.5%
<b>TRAINING</b>								
Long-term	507 (P)	345	58	58	--	968		
Short-term	134	147	86	73	--	440		
Incountry	--	129	110	99	110	448		
Scholarships	10	20	20	10	--	60		
Subtotal	651	641	274	240	110		1,916	12.8%
<b>COMMODITIES<sup>**</sup></b>								
Vehicles	555	--	303	--	--	858		
Equipment and supplies	1,193 (P)	11	577 (P)	--	--	1,781		
Subtotal	1,748	11	880	--	--		2,639	17.6%
<b>CONSTRUCTION</b>								
Central warehouse	505	--	--	--	--	505		
County health dept. buildings	212	212	--	--	--	424		
A&E costs @ 15%	85	38	--	--	--	123		
Subtotal	802	250	--	--	--		1,052	7.0%
<b>OTHER COSTS</b>								
Vehicle operation and maintenance	36	145	145	145	145	616		
Operations research and studies	75	75	50	50	--	250		
Evaluation	--	--	80	--	70	150		
Local support costs	140 (P)	52	132 (P)	72	92	488		
TA local support costs	209	158	161	141	56	725		
Subtotal	460	430	568	408	363		2,229	14.9%
Column Subtotal	4,222	2,537	2,883	1,597	878		12,117	80.8%
<b>INFLATION<sup>***</sup></b>								
	169	313	614	495	364		1,955	13.0%
<b>CONTINGENCY (APPROX. 8%)</b>								
	328	193	219	121	67		928	6.2%
<b>GRAND TOTAL</b>	<b>4,719</b>	<b>3,043</b>	<b>3,716</b>	<b>2,213</b>	<b>1,309</b>		<b>15,000</b>	<b>100.0%</b>

\* Project year 1 is defined as the 12-month period following the signing of the Grant Agreement, and subsequent project years are the corresponding 12-month periods.

\*\* Figures include 40 per cent packing/freight charges for U.S. and other foreign goods.

\*\*\* Inflation has been projected at 8 per cent, compounded annually; average inflation during the first year is calculated at one-half the annual rate.

Note: The symbol "(P)" indicates budget items funded in part with Population funds. See Figure III-2 for summary of Population-funded expenditures.

FIGURE III-2: SUMMARY OF EXPENDITURE OF POPULATION GRANT FUNDS (\$000)

DESCRIPTION	PROJECT YEAR					TOTAL
	1	2	3	4	5	
Long-term Participant Training (1 MPH in MCH/FP)	44	--	--	--	--	44
Contraceptives	30	--	45	--	--	75
Training Materials and Supplies	15	--	15	--	--	30
Local Support Costs (for centrally-funded and regionally-funded project support)	65	--	35	--	--	100
Subtotal	<u>154</u>	<u>--</u>	<u>95</u>	<u>--</u>	<u>--</u>	<u>249</u>
Inflation	6		20			26
Contingency	<u>15</u>		<u>10</u>			<u>25</u>
Total Population Funds	175		125			300

Note: Footnotes for Figure III-1 also apply to this Figure III-2

FIGURE III-3: SUMMARY COST ESTIMATE AND FINANCIAL PLAN (\$000)

	AID GRANT		GOL		PEACE CORPS		VILLAGES		TOTAL	
	FX	LC	FX	LC	FX	LC	FX	LC	FX	LC
Technical Assistance	4,281	--	--	--	--	420	--	--	4,281	420
GOL Personnel	--	--	--	10,500	--	--	--	183	--	10,683
Training	1,407	509	--	--	--	--	--	--	1,407	509
Commodities	2,597	42	1,124	107	--	--	--	--	3,721	149
Construction/Renovation	--	1,052	--	2,350	--	--	--	--	--	3,402
Other Costs	400	1,829	--	1,796	--	--	--	--	400	3,625
Subtotal	8,685	3,432	1,124	14,753	--	420	--	183	9,809	18,788
Inflation *	1,401	554	260	3,412	--	120	--	73	1,661	4,159
Contingency (approx. 8%)	665	263	112	1,476	--	42	--	18	777	1,799
Total	10,751	4,249	1,496	19,641	--	582	--	274	12,247	24,746

\* Inflation has been projected at 8 per cent, compounded annually; average inflation during the first year is calculated at one-half the annual rate.

FIGURE III-4: COSTING OF PROJECT INPUTS/OUTPUTS (\$000)

	DEVELOPED & OPERATING VILLAGE-LEVEL HEALTH SERVICES	IMPROVED HEALTH PLANNING AND MANAGEMENT	IMPROVED MANPOWER DEVELOPMENT	STRENGTHENED MR&SW HEALTH FACILITIES SYSTEM	TOTAL
<b>USAID GRANT</b>					
Technical Assistance	1,070	1,338	803	1,070	4,281
Training	737	407	471	301	1,916
Commodities	872	343	263	1,161	2,639
Construction	--	517	--	535	1,052
Other Costs	962	477	154	636	2,229
Inflation	561	513	289	592	1,955
Contingency	267	243	137	281	928
Subtotal	4,469	3,838	2,117	4,576	15,000
<b>COL INPUTS</b>					
Personnel	188	5,210	580	4,522	10,500
Commodities	--	--	--	1,231	1,231
Construction	--	--	--	2,350	2,350
Other Costs	450	--	--	1,346	1,796
Inflation	42	1,175	130	2,325	3,672
Contingency	18	507	57	1,006	1,588
Subtotal	698	6,892	767	12,780	21,137
<b>VILLAGES</b>					
Personnel	183	--	--	--	183
Inflation	73	--	--	--	73
Contingency	18	--	--	--	18
Subtotal	274	--	--	--	274
<b>PEACE CORPS</b>					
Personnel	126	84	168	42	420
Inflation	36	24	48	12	120
Contingency	13	8	17	4	42
Subtotal	175	116	233	58	582
TOTAL	5,616	10,846	3,117	17,414	36,993
	(15.2%)	(29.3%)	(8.4%)	(47.1%)	(109.0%)

Figure III-4 relates project inputs to four major categories of outputs. In percentage terms, the breakdown is as follows:

Developed and operating village-level health services	15.2%
Improved health planning and management	29.3%
Improved manpower development	8.4%
Strengthened MH&SW health facilities system	47.1%

To add perspective to the tabulated sources of project funding, each source will be reviewed briefly below.

a. AID contribution

As summarized in Figure III-1, AID funds will be used to finance the following project elements. The percentage of each in relation to total AID funding is shown in parentheses. Further details on the derivation of the cost estimate represented by each major category are provided in Annex I-7.

Technical assistance (28.5%): Five long-term technical specialists, representing 17 person-years of technical assistance, will be provided, as well as an additional 11 person-years representing three locally-hired administrative officers. In addition, 62 person-months of short-term technical assistance are planned. Total cost for both long-term and short-term TA is estimated at \$4.28 million.

Training (12.8%): Long-term participant training is comprised of 44 person-years; short-term participant training encompasses 79 person-months. In addition, a major incountry training program, as well as scholarships, will be provided. The total cost of the training program, as well as scholarships, will be provided. The total cost of the training component is \$1.92 million.

Commodities (17.6%): Twenty-one vehicles and 130 motorcycles (including mid-project replacements) will cost \$859,000. Drugs and contraceptives will be purchased for \$1.11 million; an additional \$665,000 will be used for purchasing teaching aids and materials, as well as health facility equipment and furnishings.

Construction (7.0%): Three buildings (one central drug warehouse and two county health department buildings) will cost a total of \$1.05 million including architectural and engineering fees.

Other costs (14.9%): Vehicle operations and maintenance will cost \$616,000. Other activities to be funded in this category include evaluation, \$150,000; operations research and studies, \$250,000; local support costs for the project, \$488,000, and for the TA team, \$725,000.

Inflation and contingency (19.2%):

b. GOL contribution

Personnel (49.7%): The GOL will be responsible for all salaries of both existing and new personnel who are to be involved in the project, at an estimated cost of \$10.50 million over five years. Of this total, only \$1.25 million will be attributable to additional personnel posted in the target area, representing less than 12 per cent of total GOL personnel cost related to the project.

Commodities (5.8%): Based on current expenditure trends, the GOL will be expected to provide commodities, primarily drugs, to the project area at a cost of \$1.25 million over 5 years, or about \$250,000 per year. It should be noted that this is the estimated current level of expenditure, and does not involve any project-generated increment.

Construction (11.1%): Construction and renovation will be undertaken by the GOL under the project in several categories: health posts and health centers, training institutions, and staff housing. PL-480 counterpart funds will be used, totalling approximately \$2.35 million. As indicated in Annex I-5, the annual PL-480 agreements between the GOL and AID will determine the nature and type of expenditure each year.\* In any case, the required architectural and engineering fees are included in the total for construction.

Other costs (8.5%): The GOL will spend approximately \$1.80 million on various other-cost items, including building and equipment maintenance, vehicle operation and maintenance, other project-generated recurrent costs, and subsidies.

Inflation and contingency (24.9%):

c. Peace Corps contribution

The MH&SW is requesting Peace Corps/Liberia to provide a total of 15 skilled volunteers to perform various functions as described in Annex I-4. Peace Corps Volunteers will participate in the project primarily during project years two, three, and four. The estimated total costs to support these volunteers is \$582,000.

d. Contribution of participating villages

Cash and in-kind contributions from an estimated 250 participating villages for payment of VHVs and TBAs is estimated at \$274,000.

2. Obligations of AID funds

Figure III-5 summarizes planned obligations of AID funds by major category and fiscal year. Figure III-6 compares these total obligations with the total planned expenditures by fiscal year. It can be seen that, although the cumulative expenditures approach the cumulative obligations in FY 84 through FY 86, there is a sufficient buffer each year to insure continuity of funding.

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\* Total PL-480 counterpart funds budgeted under this project amount to \$3.5 million -- \$400,000 in the first project year, \$800,000 in each of the next two years, and \$750,000 in each of the last two years.

FIGURE III-5: PLANNED OBLIGATION OF AID FUNDS BY FISCAL YEAR AND APPROPRIATION ACCOUNT (\$000)

CATEGORY	FISCAL YEAR (U.S.)*					TOTAL
	83	84	85	86	87	
Technical Assistance	460	530	850	1,500	941	4,281
Training	540	275	210	865	26	1,916
Commodities	1,300	--	1,339	--	--	2,639
Construction	660	100	292	--	--	1,052
Other Costs	330	170	440	500	789	2,229
Inflation	130	140	311	635	739	1,955
Contingency	<u>380</u>	<u>127</u>	<u>58</u>	<u>--</u>	<u>363</u>	<u>928</u>
TOTAL	<u>3,800</u>	<u>1,342</u>	<u>3,500</u>	<u>3,500</u>	<u>2,858</u>	<u>15,000</u>
<u>APPROPRIATION ACCOUNT</u>						
Health	3,500	1,342	3,500	3,500	2,858	14,700
Population	<u>300</u>	<u>--</u>	<u>--</u>	<u>--</u>	<u>--</u>	<u>300</u>
TOTAL	<u>3,800</u>	<u>1,342</u>	<u>3,500</u>	<u>3,500</u>	<u>2,858</u>	<u>15,000</u>

\* U.S. fiscal year is October 1 through September 30.

FIGURE III-6: SUMMARY OF PLANNED OBLIGATIONS AND EXPENDITURES OF AID GRANT FUNDS (\$000)

TYPE AND SOURCE OF FUNDS	FISCAL YEAR (U.S.)*											
	83		84		85		86		87		88	
	THIS YEAR	TO DATE	THIS YEAR	TO DATE	THIS YEAR	TO DATE	THIS YEAR	TO DATE	THIS YEAR	TO DATE	THIS YEAR	TO DATE
<b>OBLIGATIONS</b>												
HEALTH	3,500	3,500	1,342	4,842	3,900	8,342	3,500	11,842	2,858	14,700	--	14,700
POPULATION	300	300	--	300	--	300	--	300	--	300	--	300
<b>TOTAL</b>	<b>3,800</b>	<b>3,800</b>	<b>1,342</b>	<b>5,142</b>	<b>3,500</b>	<b>8,642</b>	<b>3,500</b>	<b>12,142</b>	<b>2,858</b>	<b>15,000</b>	<b>--</b>	<b>15,000</b>
<b>EXPENDITURES</b>												
HEALTH	130	130	4,562	4,692	3,113	7,805	3,536	11,341	2,142	13,483	1,217	14,700
POPULATION	--	--	175	175	--	175	125	300	--	300	--	300
<b>TOTAL</b>	<b>130</b>	<b>130</b>	<b>4,737</b>	<b>4,867</b>	<b>3,113</b>	<b>7,980</b>	<b>3,661</b>	<b>11,641</b>	<b>2,142</b>	<b>13,783</b>	<b>1,217</b>	<b>15,000</b>

\* The U.S. fiscal year is October 1 through September 30.

Note: It has been assumed that the project will begin in August 1983, in which case the first two project months would be in U.S. fiscal year 1983; and similarly for subsequent project/fiscal years. Thus the expenditure figures in this table have been adjusted to correspond to the fiscal year basis.

#### IV. IMPLEMENTATION PLAN

This section describes the overall implementation plan for the project, including implementation responsibilities, the implementation schedule, procurement of project commodities, disbursement of AID funds, and the monitoring plan.

##### A. Implementation Responsibilities

###### 1. Introduction

This project will be implemented through a grant agreement between the GOL and USAID/Liberia. The GOL's principal agent will be the MH&SW, which will have the major GOL responsibility for project implementation. A Project Manager (the Deputy Chief Medical Officer for Preventive Services) will be appointed by the MH&SW, and will have overall management responsibility on behalf of the GOL. He will report to the Minister of Health and Social Welfare through the Chief Medical Officer.

The project will require the major involvement of USAID/Liberia in management and implementation, in accordance with the provisions of the Grant Agreement and standard AID policies and procedures. USAID's role will be coordinated by the Project Officer. The project will be implemented by an organization selected through a competitive contracting procedure.

The major implementation responsibilities of the GOL, USAID/Liberia, and the technical assistance (TA) contractor are summarized below.

###### 2. GOL responsibilities

- Meet conditions precedent and covenants, as specified in Section VI., in a timely fashion, in accordance with the provisions of the Grant Agreement and the implementation schedule.
- Provide a Project Manager (Deputy Chief Medical Officer for Preventive Services), who will be counterpart to the Chief of Party and will devote at least 25 per cent of his/her time to the project; and a full-time Deputy Project Manager, throughout the life of project. The MH&SW will also provide qualified, experienced counterparts to work with the other long-term project technicians during their entire assignments in the project.
- Assist in the selection of the technical assistance contractor.
- Provide safe transport and storage of project commodities to/ at appropriate project sites after customs clearance.
- Procure local commodities in accordance with the Procurement Plan, with assistance as necessary from the Chief of Party and USAID. Local procurement will be done in accordance with

financial guidelines and systems established with assistance from the CPA firm, to insure conformance with AID policies and procedures.

- Through the MH&SW Scholarships Committee or other mechanism acceptable to USAID, identify and select qualified candidates for both long-term and short-term participant training, in accordance with the participant training plan. USAID will have representation on the Scholarships Committee whenever candidates are being considered for project-related training.
- Provide funds for the international travel of long- and short-term participants, in accordance with the participant training plan.
- Provide the 5 long-term technicians the use and control (but not ownership) of 4 project jeep-type vehicles, 5 complete sets of project office furnishings/equipment as well as office space, during their stay in Liberia;
- Provide project office furnishings/equipment and office space to (i) the locally-hired long-term administrative officers during their stay in Liberia, and (ii) short-term technical advisors during their stay in Liberia;
- Identify and assign at least one counterpart for each long-term technician; and
- Take measures to insure that the persons receiving training abroad under the project return to Liberia to work in the MH&SW in areas for which they have been trained.
- Develop and implement incountry training activities in accordance with the implementation schedule, and as described in the incountry training plan.
- Carry out project-related studies and reviews in conjunction with corresponding technical assistance personnel, in accordance with the detailed project description and the implementation schedule.
- Participate fully in project monitoring and evaluation activities, as described in the monitoring and evaluation plans and in accordance with the implementation schedule. The GOL's participation in project monitoring and evaluation will be coordinated by the Project Manager.
- Develop and implement effectively functioning decentralized operations at the county level, in accordance with the detailed project description and the implementation schedule.

- Develop and implement effectively functioning revolving drug funds, as well as the motorcycle purchase scheme, in the target counties.
- Provide sufficient funds to meet budgeted recurrent costs, in accordance with the financial plan.
- Provide sufficient members of qualified staff, both in the target counties and at the central level, to insure the effective implementation of project activities.

### 3. USAID/Liberia responsibilities

As indicated in the detailed project description, this project is relatively complex, and requires the successful execution and performance of a number of contracts in addition to the principal TA contract in order to achieve the project purpose. In view of this requirement, and based on past experience with host country contracting in Liberia, the USAID Mission has decided that this project will be implemented through the direct AID contracting mechanism, with assistance from REDSO/WCA as required.

The USAID/Liberia responsibilities in the project are as follows:

- Provide a Project Officer who will be the principal USAID officer responsible for PHC project implementation and monitoring, and who will coordinate the necessary assistance from other Mission officers and external resources to insure satisfactory progress in project implementation.
- Assist in the selection of the technical assistance contractor.
- Negotiate and execute contracts to provide project inputs as described in the detailed project description:
  - \* study of drug procurement and distribution system (funded through the AID-assisted Health Management Planning Project, 669-0126)
  - \* study of potential private sector involvement in the Liberian health care delivery system.
  - \* Major project evaluation in years 3 and 5.
- Arrange for AID centrally-funded project assistance, as summarized in the detailed project description and described further in Annex I-3.
- Procure offshore commodities. It is anticipated that USAID/Liberia will procure selected commodities for the TA team directly (vehicles, household furniture and appliances), and for the remaining commodities will utilize the services of

a procurement services agent (PSA) who will act on behalf of the GOL.

- Complete customs clearance procedures for offshore commodities.
- Assist in the selection of candidates for participant training, through MH&SW Scholarships Committee or other agreed upon mechanism; and concur with MH&SW staff appointments to key project positions, in accordance with the Project Staffing and Training Annex (Annex J).
- Provide support to the contractor's long-term TA team, in accordance with the provisions of the TA contract and established AID policies and procedures. However, support in relation to housing for long-term technicians will be limited to those based in the Monrovia area.
- Conduct quarterly internal Mission project reviews, through the Mission Project Committee, and participate in all other appropriate aspects of the monitoring plan as described in subsection E. below.

4. REDSO/WCA responsibilities

- Negotiate and execute contracts to provide project inputs as described in the detailed project description, where such contracts exceed the authority delegated to the USAID Mission Director, including the following:
  - \* technical assistance contract
  - \* CPA firm assistance with MH&SW financial systems, and performance of annual financial reviews
  - \* design and construction of central drug warehouse and two county health department buildings
  - \* procurement of project commodities, as specified in the Procurement Plan (Annex M), through a qualified procurement services agent (PSA)
- Provide backstopping as necessary in areas where USAID Mission staffing require consultation and assistance.

5. Technical assistance contractor responsibilities

- Provide long-term technical assistance personnel in accordance with the description in Annex J-3:

Chief of Party (Health Services Management Specialist) (4 years)

Curriculum/Training Specialist (3 years)

Logistics and Supply Officer (3 years)

Two County Public Health Physicians (3 1/2 years each)

In addition, the Chief of Party, on behalf of the contractor, will hire locally three administrative officers -- one to provide the necessary administrative backup for the long-term TA team (4 years), based in Monrovia, and two to provide support in the project counties (3½ years each).

- Through the Chief of Party, identify requirements for short-term technical assistance, in accordance with the detailed project description and with assistance and concurrence from the MH&SW and USAID.
- Prepare annual work plans for review and approval of the MH&SW and USAID, in accordance with the implementation schedule.
- Identify and negotiate suitable housing for the public health physicians in Grand Gedeh and Sinoe Counties, and coordinate needed support services and logistical arrangements.
- Provide detailed descriptions and specifications for equipment and supplies to be ordered in accordance with the procurement plan (Annex M) beginning in project year 2.
- Identify and make arrangements for participant training for all project participants, both long- and short-term, with USAID assistance.
- Participate fully in project monitoring and evaluation activities, as described in the monitoring and evaluation plans and in accordance with the implementation schedule.

#### B. Implementation Schedule

The detailed implementation schedule, presented in Annex I-6, presents the major actions to be taken during the first five years of the project. For convenience, the chronology is shown both by calendar month and year as well as sequential project month. The agency(ies) with responsibility for each action are also indicated. While an attempt has been made to project expected activities throughout the 5-year period, it seems clear certain activities will deviate from the schedule. For example, the timing of the rainy season in relation to the overall project schedule will influence when field activity can be done. The intention of the annual work plans, prepared by the contractor's Chief of Party and approved by the MH&SW and USAID, is to take account of such required shifts in the implementation schedule during the project.

#### C. Procurement

The Procurement Plan is presented in Annex M. The major features are summarized here.

As noted in the previous subsection, USAID will be responsible for off-shore procurement, in part through direct procurement and in part by utilizing the services of a procurement services agent (PSA). Beginning in project year 2, the TA contractor, in consultation with the Project Manager and Deputy Project Manager, will provide detailed descriptions and specifications for equipment and supplies to be ordered, in accordance with the procurement plan.

The MH&SW will be responsible for the local procurement of limited commodities (e.g., office supplies, locally made furniture for health posts/health centers and the two county guest houses), with assistance from the long-term TA team and USAID as required.

All goods and services for the project will be procured from the United States or Liberia, except for 130 motorcycles, 200 Salter scales, and 56 kerosene stoves, all of which will be procured from Code 935 countries. Waivers are being requested for these exceptions, as described in Annex M.

With regard to the contract for long-term technical assistance, key staff members under the contract will include the five principal long-term technicians: Chief of Party, Curriculum/Training Specialist, Logistics Specialist, and two County Public Health Physicians. Each of these technicians will initially be approved as a member of the TA team by both the MH&SW and USAID; subsequent extension and/or replacement of any of these key staff members must also be approved by both the MH&SW and USAID, as provided in the contract.

Regarding the contract for architectural and engineering services, there are several local architectural and engineering (A&E) firms qualified to procure the construction supervision. Since the estimated A&E contract cost exceeds the Mission's authorized level, the A&E contract will be negotiated and executed by REDSO/WCA on behalf of USAID/Liberia. However, the Mission will carry out the tasks related to A&E procurement.

Similarly, for AID-funded construction, there are several local firms capable of carrying out the construction of all three structures. Again, based on the estimated cost of the three potential contracts, REDSO/WCA will negotiate and execute the construction contract(s). USAID/Liberia will oversee and approve the construction at all three sites.

Construction materials and supplies will be purchased according to standard U.S. Government procurement regulations with regard to U.S. and local off-the-shelf procurement. Local procurement under the construction contract(s) is likely to include cement, reinforcing bars, steel shapes, block work, and roofing materials as shelf items of non-local origin.

#### D. Disbursements

Funds under this project will be disbursed in accordance with established AID policies and procedures. The conditions precedent to disbursement at various points in the project implementation are indicated in Section VI.

Funds to meet local-cost commitments will be disbursed directly to the GOL

(through the MH&SW) and the project contractor (through the Chief of Party), as appropriate. Both the MH&SW and the TA Chief of Party will submit requests for advances to USAID, with justification for the funds and an accounting of expenditures and accruals of the previous quarter, in accordance with AID standard provisions for grants. The initial advance will be for a 6-month period (to establish a buffer), with quarterly advances thereafter.

Required procedures will be established with the assistance of the CPA firm, as part of its role in helping to design and implement upgraded financial and accounting systems for the project.

#### E. Monitoring Plan

Project monitoring and evaluation must be closely linked in order to coordinate activities and use available resources effectively. The evaluation plan is considered separately in Section VII. Nevertheless, in practical terms the two plans should be considered to be parts of the same evaluative process.

An adequate monitoring plan requires the timely gathering of information regarding project inputs, outputs, and actions that are critical to project success, and the comparison of this information with the implementation plan and schedule to determine whether or not project activities are proceeding according to plan. The monitoring plan for this project attempts to provide the necessary information and analysis, as indicated below.

##### 1. Monitoring responsibilities

The primary responsibility for project monitoring rests with the USAID Project Officer, who generally will follow all aspects of project implementation and will keep current information on progress being made. Specific responsibilities include the following:

- ° Oversee GOL compliance with AID policies, procedures, and regulations
- ° Monitor contractor adherence to contract, and hence project, requirements and timetables
- ° Insure the timely and coordinated provision of AID and other financing and/or inputs
- ° Assist the GOL to insure the effective utilization of resources and early anticipation of potential problems
- ° Identify and assist in resolving implementation issues
- ° Insure that the evaluation plan is carried out in accordance with the schedule
- ° Develop an historical record of implementation for the official AID project files
- ° Prepare periodic reports for Mission and/or AID/W review

The USAID Project committee has the general responsibility to insure satisfactory progress of the project, and to identify and assist in resolving potential implementation problems. The Project Committee will hold regularly scheduled quarterly meetings, but will meet in the interim as needed, especially during the first project year. These USAID Project Committee meetings will be held no more than a month before the corresponding PHC Project Implementation Committee quarterly meetings (see below), so that any issues raised and not resolved may be referred to the Project Implementation Committee.

As indicated in the detailed project description and specified in the covenants to the project (Section VI), the MH&SW will establish a Project Implementation Committee jointly with USAID and the contractor TA team, to monitor and review project activities and achievements, to examine problems at the field level and recommend appropriate solutions, and to insure that the project conforms to the Grant Agreement. This committee will meet quarterly, and will be the body responsible for conducting the Project Implementation Status Reviews (on a quarterly and annual basis).

Also, as specified in Section VI, the GOL will establish a National PHC Steering Committee, comprised of key Government Ministers and Deputies, to provide general guidelines, resolve major policy issues, and insure necessary resources and intersectoral coordination for the National Primary Health Care Program. Should the need arise, this GOL committee will be able to take action at the policy and resource allocation level to overcome project difficulties.

Finally, the CPA firm will perform annual financial reviews to insure that the improvements in the MH&SW's financial and accounting systems are responsive to the need for documentation of project expenditures.

## 2. Sources of monitoring information

Information and documentation useful in project monitoring will be obtained from at least the following sources:

- ° The Grant Agreement and Project Implementation Letters
- ° Project Implementation Plan
- ° Annual work plans
- ° Project contracts (construction, special studies, etc.)
- ° Project baseline and follow-up studies
- ° Financial reporting system
- ° Contractor's periodic reports

- ° Annual financial reviews
- ° Quarterly Mission Project Committee and Project Implementation Committee meetings
- ° Project evaluations
- ° Consultation with MH&SW, other ministries, Peace Corps
- ° Site visits (particularly with respect to construction, training, county-level decentralization, the revolving drug funds, and village-level activities)

Taking the above information into account in a systematic fashion, the Project Officer and the USAID Mission will be able to identify progress in the project, anticipate problems with its implementation, and resolve problems and issues so that the project, as nearly as possible, will be able to achieve its purpose.

## V. SUMMARY OF PROJECT ANALYSES

This section presents summaries of the five major project analyses that have been carried out to determine the overall feasibility of the project and, in turn, its relative chance for success. The analyses include:

- ° Technical Feasibility
- ° Financial Analysis
- ° Economic Analysis
- ° Social Soundness Analysis
- ° Administrative Feasibility

Each summary in the subsections below highlights the major findings of the corresponding analysis, which may be found in Annex H.

### A. Technical Feasibility

This analysis concludes that the Primary Health Care Project is appropriate for Liberia because it is consistent with the GOL's emphases on rural development, on improving the health of rural residents through the creation and extension of a National Primary Health Care Program, and on self-reliance at the village level. In addition, the project is consistent with AID's health sector policy of promoting the welfare of the poorest segments of the population -- especially women and children -- through community-based health care services (in contrast to hospital-based care).

The PHC Project builds upon existing MH&SW organization, facilities, and personnel by reinforcing positive aspects of the present system while at the same time addressing current needs and weaknesses by maximizing the use of resources at the village level. The project achieves a cost-effective approach to a truly national health care delivery system, and helps to insure that a strengthened PHC Program will remain after AID inputs are terminated. This, in turn, maximizes the probability of maintaining a more effective delivery system, leading to continued improvement in Liberia's health status and the achievement of AID's health sector goals.

#### 1. Emphasis at the village level

The experience gained in the Maryland County Village Health Worker Project, as well as the lessons of other pilot projects in Liberia, show that the PHC strategy is feasible in Liberia. At the same time, these projects also demonstrated several weaknesses in design and implementation. The PHC Project has been designed to overcome these weaknesses in the following ways:

- ° The village development council (VDC) concept\* was very successful in Maryland County, and will become the keystone of the PHC Project's village-level support for PHC activities, but there must be more, and

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\* The role and responsibilities of the VDCs are described in the detailed project description (see Section II.B.2.a.).

more continuous, interaction between the VDCs and the health workers at the county and rural health facility levels in order to insure strong motivation and commitment.

- ° In order to establish and maintain credibility with villagers, VHWs must deliver basic curative services as well as high-impact preventive services.
- ° Supervision and support of village-level workers are critical to their continued effective performance, and must be insured through the provision of adequate numbers of well-trained mid-level workers who have adequate transportation and logistical support.
- ° The village health teams (VHWs and TBAs) should be selected by and remunerated by the communities they serve; otherwise the workers are unlikely to be responsive and responsible to the VDCs. Also, financial and/or in-kind support from the villages themselves will insure the long-term economic viability of service delivery at the village level.

Village health workers. VHWs will be trained to provide simple, safe, and effective methods to alleviate the major causes of morbidity and mortality in rural Liberia through the following specific interventions:

- ° immunization programs
- ° nutrition monitoring and education
- ° oral rehydration therapy
- ° malaria prophylaxis for pregnant women and presumptive treatment for others, especially children
- ° counseling and provision of appropriate contraceptives for child spacing
- ° curative care of injuries, scabies and other skin infections, worms, fever, and anemia

Initial training for VHWs will cover a five-week period, and will have a selective, task-oriented focus and include substantial field experience. Also, annual inservice training will be incorporated in order to provide reinforcement and expansion of knowledge and skills.

Traditional birth attendants. TBAs have long been well accepted in Liberia and have been trained throughout the country since 1949. In conjunction with the PHC Project, the TBA program is being reviewed and refined so that it will better meet the needs of rural Liberians today. The training in this project will be shortened to three weeks, and supplemented both by annual inservice sessions to review and upgrade skills and by regular, monthly village supervisory contact. The training will be simplified in order to focus on improving techniques for deliveries in the village (where TBAs have been practicing

for centuries) as opposed to training for clinic deliveries. In this way, more TBAs can be effectively trained with limited resources.

In addition to hygienic delivery techniques, TBAs will be trained to:

- ° provide prenatal counseling, including provision of iron and folate supplements and referral for specified high-risk factors
- ° work with VHWs to coordinate immunization with tetanus toxoid and to provide chloroquine for malaria prophylaxis
- ° assist in maternal and infant nutrition
- ° complement and reinforce the VHWs with counseling on child spacing and provision of non-prescriptive contraceptives and refills of pills

## 2. Supervisory and logistical support

Previous VHW programs, such as in Maryland County, and TBA training throughout Liberia, have been hampered by inadequate supervision and support. In the PHC Project, supervision will be improved through the commitment of the MH&SW to increase the number of trained mid-level workers in the target counties; by training these workers in VHT supervision; and by providing adequate transport and logistical support.

The development of sufficient numbers of trained mid-level health workers is the key to the success of PHC in Liberia. Village-level workers have only a few weeks of initial training, which is appropriate. However, the lack of continued supportive supervision and inservice training has been the undoing of many PHC schemes. Through a covenant to this project, the MH&SW has demonstrated its commitment to deploy increased numbers of PAs and CMs to the rural health facilities in the target counties, where they will serve as front-line workers, supervisors, and members of the county-level training teams.

As currently envisaged, village-level workers and their mid-level supervisors will have at least two opportunities a month to meet and work together. At least once a month the health post staff (preferably both the PA and the CM) will travel to each village and conduct a session for the villagers, including immunizations, weighing of children, and educational and promotional activities. In addition, the VHWs will be expected to travel to their health post on a monthly basis, in some cases to accompany referral patients but also to attend one-day informal training sessions for the VHWs in the area served by the health post.

At both the village and health post levels, there must be an adequate supply of essential drugs to insure the success of this project. This will be supported not only by establishing and operating revolving drug funds at both the village and county health facility levels, but also through strengthening the transportation and supply system as part of county-level decentralization. AID will fund the construction of a central drug and medical supplies warehouse, as well as county health department buildings which incorporate drug and supplies storage facilities. The project will also provide vehicles for central and county-level distribution. Long-term technical assistance will coordinate the

development of the new systems.

### 3. County-level decentralization

The MH&SW is committed to the concept of decentralizing county-level operations, and has formally agreed that county health departments in the target area will operate with decentralized budgets, financial management, and operational management. This will permit local decision-making, under central guidelines, that should be far more appropriate to meet local needs, and should eliminate the need for unwieldy mechanisms that are presently necessary at the central level.

The analysis undertaken in designing this project indicates that the national PHC program can be accomplished only by strengthening the Ministry's management systems, especially at the county level. In implementing these changes to support the PHC Program, the role of the central MH&SW will shift to program planning, standard setting, evaluating, and providing technical assistance and guidance to the county-level staffs.

In summary, the analysis concludes that the high-priority interventions incorporated into the PHC project, especially at the village level, are both feasible and appropriate for Liberia. These interventions have been identified in AID's Health Sector Strategy as a package of proven, cost-effective technologies which together comprise the most immediately available and, effective means to reduce infant and child deaths.

## B. Financial Analysis

This analysis focuses on the ability of the GOL to effectively contribute to and eventually institutionalize and sustain the activities proposed in this project. The analysis also considers the willingness and ability of the GOL to institute cost-saving and revenue-generating policies to partially finance the system. Finally, the project is assessed in terms of its replicability on a wider scale. A summary of mechanisms to improve the financial viability of the project under prevailing financial conditions is included.

### 1. GOL revenue and financial stability prospects

Since FY 79/80, the GOL has experienced increasing annual deficits. These deficits are the result of two fundamental unresolved problems -- the impact of the current worldwide economic recession on Liberia's revenues, and the cautious investment climate in Liberia since the political events of 1980. Owing to these factors, the outlook for improvement in the GOL's revenue in the short-term future is not encouraging.

Under such stagnant economic conditions, the GOL has entered into a stand-by agreement with the International Monetary Fund (IMF), in an attempt to restore confidence in the Liberian economy. The general principle underlying the objectives and policies adopted in the IMF Standby Agreement is that cuts in government spending will constitute the major instrument in trying to balance the GOL Budget deficits. The specific measures adopted are expected to work towards a balanced budget in the future, and to generate domestic resources for development spending at a revised level of \$60 million for FY 82/83.

### 2. Health sector budget prospects

The data presented indicate that the MH&SW recurrent budget has been within a rather narrow range of between 6.0 and 6.5 per cent of the total GOL budget during the last three years. On the other hand, as a result of the government-wide 15% per cent reduction in FY 82/83, the MH&SW budget is 24.5 per cent below the FY 81/82 level, in nominal terms.

The MH&SW recurrent budget for FY 82/83, \$14.039 million, becomes the base figure for developing estimated budgets for future years. However, given the poor budgetary outlook in the short term, the MH&SW will have to depend primarily on both user financing mechanisms and improved management of current resources to absorb most of the estimated \$1.8 million of project-generated recurrent costs during the first five project years, as well as the corresponding annual increments in future years.

### 3. Health sector absorptive capacity

Estimates of project-generated recurrent costs are provided, and are compared with the total operating budget. One conclusion is that by "project year 6" (the year after this initial AID funding is exhausted), the annual incremental project-generated recurrent cost will represent less than 4 per cent of the MH&SW budget.

This analysis makes two hypothetical projections of the MH&SW budget based on national financial and economic forecasts, and suggests that the less optimistic of the two may be the more realistic basis for assessing the financial impact of the project-generated recurrent costs. If the assumptions underlying this projection prove to be correct, the MH&SW could experience some difficulties in assuming all project-generated recurrent costs exclusively from annual budget increases. Thus it is considered important to consider both planned and potential mechanisms to reduce the pressure on budgetary increases as the source for meeting project-generated costs for which the GOL is responsible.

#### 4. Minimizing GOL recurrent costs in the PHC system

The project design already incorporates three mechanisms which will help to reduce the recurrent cost burden on the GOL as the PHC system develops: (a) remuneration of VHWs and TBAs by villagers; (b) revolving drug funds at both county and village levels; and (c) a motorcycle purchase scheme for MH&SW employees. Furthermore, redeployment of existing personnel to the project area could have an additional effect.

The analysis points out that at least 90 per cent of project-generated recurrent costs are for salaries of new personnel to be deployed in the project area. In principle, if staff already on the MH&SW's payroll is redeployed to the project counties from areas with relative excesses of the corresponding health worker categories, the financial impact on the GOL budget could be minimized. However, the impact of such a redeployment scheme is enhanced if it is implemented early in the project.

This part of the analysis concludes that, taking into account the various additional cost-reduction mechanisms available to the GOL (attrition, early retirement, etc.), it seems clear that the project-generated salary cost can be met.

#### 5. Per capita cost and replicability

The data presented indicate that by project year 5 the annual combined budget for the project counties is \$923,000, yielding a per capita cost of \$4.62 -- that is, the cost of providing health services in the target counties without the PHC Project. If project-generated costs are added, the per capita cost would increase by \$3.51 to a total of \$8.13.

The establishment costs of the PHC system are represented largely by AID funds that are used to provide the technical assistance, commodities, training, and operational costs required to establish the system. Financing both central-level activities and those at training institutions serving all of Liberia make the estimation of per capita establishment costs more complex. However, if it is assumed that two-thirds of AID expenditures will primarily benefit the citizens of the project counties, then the per capita establishment cost over five years is approximately \$50.00. If the \$3.5 million PL-480 counterpart funds are added, the cost increases to about \$68 per capita over five years. These costs are within reason, especially when one realizes that much of what is developed and implemented in these two counties (other than physical infrastructure) will

be transferable to the other counties at a much lower per capita cost. On the question of replicability, the analysis indicates that the GOL cannot afford to expand the PHC Program to the remainder of Liberia in the near future, even if all capital costs were to be financed by international donors. On the other hand, the GOL's current financial situation is too severe to constitute a realistic assessment of the project's eventual replicability.

According to the information presented, GOL expenditures attributable to the PHC Project over the first five years total \$21.14 million. Assuming the economy shows some positive growth by the end of this period, and assuming that health service delivery continues to be a priority area for expansion, then the PHC system developed under the project would be replicable, with foreign financing of major establishment costs in the remaining phases of the GOL's National Primary Health Care Program.

C. Economic Analysis

This analysis indicates that the economic cost of the PHC Project to the GOL during the first five years of the project will be approximately \$5.3 million of combined development and operating expenditures. Of this, \$3.5 million will be derived from PL-480 counterpart funds, which are part of the GOL's development budget; only \$1.8 million represent project-generated recurrent costs to be assumed by the GOL. These are resources that the GOL could use to support other projects and activities, either in health or other sectors. In addition, the AID contribution of \$15.0 million could, at least hypothetically, be used to support other development projects in Liberia -- again, either in health or other sectors.

PL-480 counterpart funds comprise a significant portion of the GOL contribution to the project. The availability of these funds will depend on several interrelated factors: the liquidity position of the GOL over time; the general economic situation; the IMF Standby Agreement; and of course, the continuation of the PL-480 Title I Program in Liberia throughout the first five years of the project. USAID will monitor this aspect closely, will review the availability of GOL funds during each evaluation, and will make changes as necessary.

The analysis concludes that the health, economic, and political benefits to be gained in making these expenditures to support the PHC Project are justifiable under current financial and economic conditions. The analysis also shows that the strategy proposed for achieving project outputs represents the most cost-effective approach under prevailing socio-economic and cultural conditions.

The GOL's stated strategy to concentrate its limited development resources on quick-yield, profit-making projects is in response to current and near-future economic considerations. However, the GOL also recognizes that during this difficult economic period, basic human services must be continued and in some cases expanded. The PHC Project strategy for making basic health services available at the village level represents the lowest-cost strategy for providing health services in the rural areas. In addition, project emphasis on developing human skills reflects a cost-effective strategy for solving both the short- and long-term problems in the health sector.

The decisions by AID, during the project-design process, to reduce the number of project counties and to fund the project entirely with grant funds (i.e., eliminate the loan component) were taken in order to reduce GOL outlays during both the project life and in the longer term.

### 1. Cost-effectiveness of the PHC strategy

The traditional approach to providing more health care services to the population in the two-county project area would have been to train more physicians, build more rural health facilities, and equip them with expensive equipment required to make the physicians functional. Clearly, the expenditure of \$5.3 million to promote this traditional, curative service strategy would not provide the same level of priority services to as many people as will be provided under the PHC strategy. In addition, such a strategy would be unlikely to attract the participation of donor organizations in assisting with financing the expansion of health services.

Discussions during the project design have led to the incorporation of new cost-effective policies and mechanisms that will conserve scarce GOL resources and increase the participation of people in the provision of health services. The revolving drug funds at both village and county level, and the motorcycle purchase scheme, are the major examples of such new policies.

An analysis of cost-effectiveness has been used to provide the economic justification for the project. In view of the complexity of cost-benefit and internal-rate-of-return analyses in health-sector projects with diverse outputs, these have not been done. However, as stressed in the AID Health Sector Strategy Paper, the primary health care approach offers the most cost-effective way to decrease infant and child mortality and maintain a healthy labor force, in the short run. In the long run, health status will also benefit from improvements in income, education and the environment. Primary health care emphasizes increased access to basic and affordable health-related services, community participation, reliance on para-professional workers, adequate referral and support facilities and systems, and intersectoral coordination, as opposed to hospital services, which are dependent on high technology and specialized manpower and available only to a small proportion of the population.

### 2. Recurrent cost implications of PHC

As indicated in the Financial Analysis, AID funds and PL-480 counterpart funds will be used to finance most GOL non-salary recurrent costs during the project life. However, project-generated recurrent costs have been carefully analyzed and budgeted so that the GOL will be able to fund at least 90 per cent during project year 5, and 100 per cent in subsequent years.

Another important recurrent-cost consideration is the payment of village-level health workers. Based on the GOL's policy that people should increase their contribution to the provision of health care, the village health teams (VHWs and TBAs) will be remunerated by the communities they serve. This will have a major impact on conserving GOL resources, especially as the PHC Program expands to a truly national scale.

This analysis concludes that the PHC Project represents the most cost-effective means currently available to achieve the level of health, social, economic, and political benefits anticipated. The overall benefits to be gained from incurring a 4 per cent increase in the MH&SW budget for project-generated recurrent costs far outweigh the costs of not implementing the project. Therefore, the project as designed constitutes a worthwhile investment, even in the current economic and financial climate.

#### D. Social Soundness Analysis

This analysis focuses on the following three areas in order to identify the likely impact and acceptance of the PHC Project in a sociocultural frame of reference:

- ° A determination that the proposed PHC strategy for providing and supporting village-level health services is compatible with and will be feasible within the sociocultural tradition of the ethnic groups of the project area
- ° An assessment of whether the new practices and institutions associated with the project are likely to be diffused into non-project areas
- ° The social impact of benefits and costs of the project, especially among different social groups

The approximately 180,000 inhabitants of Grand Gedeh and Sinoe Counties belong primarily to the Kwa (or Kru) ethnic group, one of three major ethnic groups in Liberia. Within this ethnic group the major linguistic groups are the Krahn and Grebo (Grand Gedeh) and the Sapo, Bassa, and Kru (Sinoe). The population of the area is highly dispersed and consists mainly of small villages isolated in the heavily forested area.

#### 1. Traditional authority and its implications

Traditional organization and authority is hierarchical, beginning with village or town chiefs, then clan chiefs, and finally paramount chiefs at the county level. This traditional organization has been overlain with the GOL administrative organization of district administrators and county superintendents. The chiefs of these traditional units are today appointed by Government, and therefore possess formal authority as well as their traditional power. However, the basis of their traditional power is separate and distinct from their formal authority, and tends to dominate local matters. On the other hand, Government health services within the county are part of the formal administrative system.

The project emphases on community development and self-reliance are critical to its success, but cannot simply be imposed through the formal system. This is why the village development council (VDC) approach is being used, since the village leadership will have to be convinced that village-level health services will benefit the villagers and will be worth what they cost.

Furthermore, there is evidence from other projects and village-level efforts that many villagers are cynical about the potential of "self-help initiatives." This is because there are many examples where self-help projects were begun and then abandoned, through no fault of the villagers but rather resulting from lack of inputs, resources, and follow-up by those initiating the projects. Therefore, the VDCs will have to be convinced that village-level health workers will benefit them, that needed project resources will be forthcoming, and that project staff can be relied upon for needed supervision and support.

Because of the critical importance of successful VDCs and the general acceptance of the self-help approach in the project, a short-term technical assistance specialist in the social and behavioral sciences will be used to review the progress being made in developing the VDCs and in establishing village health teams. This technician will be scheduled to come during project year 3, after there has been some village-level experience in Grand Gedeh County. If this consultation is found to be effective, consideration will be given to arranging periodic visits thereafter.

## 2. Acceptance of project elements at the village level

One difference between the PHC Project and earlier efforts is that the village health workers (VHWs) will be remunerated by the villagers. Although agreement to this arrangement is a prerequisite to participating in the project, it is expected that some villages will drop out. (A "failure rate" of 15 per cent has been incorporated to account for this anticipated phenomenon.)

Similarly, the establishment of village-level revolving drug funds is expected to result in some setbacks and difficulties. The feeling of some villagers -- based on failures in other attempts at self-help -- is that such schemes are not likely to work, and that the villagers will be throwing away funds invested in such ventures. This tendency will have to be overcome on a village by village basis, and likely will be counteracted only by being able to point to successful ventures in other villages. Accountability and use of drug funds may pose special problems, and will have to be addressed during the actual implementation of each village-level system.

All proposed health services will likely not be received with the same level of confidence, enthusiasm, and understanding. Some PHC services will surely be supplemented through the use of traditional practitioners. This should be encouraged where local remedies from herbalists, bone-setters, and others are known to be helpful. However, the project approach will also have to overcome the difficulties inherent in the strong local

belief in the "magic cure" of injections and other curative services that may be inappropriate or that tend to undermine needed preventive services.

In introducing preventive services that may generate controversy in the traditional context, the project staff will explore the possibility of using the so-called traditional societies as a means of educating villagers and gaining their acceptance. Society leadership in the village could make the difference between acceptance and rejection of the proposed service.

For the introduction of village-level services to be successful, it is important that there be a clear understanding at the outset of what the project offers, what the village must do to participate, and if the village accepts, what it can expect in terms of continuous guidance, supervision, and support.

### 3. Social impact of project benefits and costs

The project will provide increased access to an appropriate mix of curative, preventive, and promotive health services for approximately 115,000 rural Liberians in the two project counties. The anticipated benefits will improve the quality of rural life in the project area in different ways for different age and sex groups. Regarding the project emphasis on reducing morbidity and mortality, both women and children will be the principal beneficiaries. However, strong, effective village development councils could lead to an expansion of community development activities beyond those envisioned in the PHC Project. In areas where VDCs do not exist or have not been effective, the impetus of PHC Project activities and benefits to the village may well mean that the councils become more active in promoting general village development.

The achievement of spread effects may take place on two different levels. At the local level, villages not participating in the PHC Project may decide to establish or revitalize their VDCs and begin to achieve benefits similar to those of project villages. This is likely to happen if the village-level PHC activities are perceived by the villagers to benefit them directly. The limiting factor may be a strictly economic one; that is, if inputs are required that the village cannot afford on its own (such as the initial stock of drugs for the revolving drug system).

On a larger scale, spread effects are likely only if and when the GOL decides to expand the PHC delivery system to other areas. As indicated in the detailed project description, an effective system depends on many factors, most especially the supervision and support of village-level services. Unless the necessary elements are in place and operating, one cannot expect a natural spread effect.

More women than men will be involved as health workers, both at the village-level and within the rural health facility system. Approximately 70 per cent of all people trained under the project at the village-level are likely to be women, as will about half of all health post/health center staffing. The active involvement of women and the focusing of project outputs on the needs and problems of women is a key feature of the project.

## E. Administrative Feasibility

This analysis addresses the administrative capabilities of the MH&SW in the areas relevant for the execution of the project, and demonstrates that the project design incorporates the necessary resources to assist the MH&SW in implementing the project and achieving its purposes. In addition, the analysis summarizes the project management capabilities of USAID/Liberia, in view of the Mission's critical role in the project.

### 1. Ministry of Health and Social Welfare

#### a. Organization

On a national scale, the People's Redemption Council (PRC) has provided the leadership for the GOL since April 1980. The PRC has recently pledged to make an orderly return to civilian rule by April 1985. Meanwhile, health care, and especially expansion of health care services in the rural areas, is a stated priority of the PRC.

In the Ministry's Draft Plan for the National Primary Health Care Program, the organization of the PHC Program has been described in some detail. During the project-design process, the joint MH&SW/USAID design team modified this organization in several important ways (as discussed in the detailed project description), in order to insure the successful implementation of the project -- especially in view of the emphasis on county-level decentralization.

The MH&SW's Deputy Chief Medical Officer for Preventive Services will be the PHC Project Manager and the necessary Ministry resources for the project will be coordinated through that office. This will require a good working relationship among the Ministry's principal bureaus that have a key role in the project.

In addition to the day-to-day coordination of activities and resources among these organizational elements of the MH&SW, a PHC Project Implementation Committee will be established. This committee, with representatives of the MH&SW, USAID, and the project long-term TA team, will perform an important role in monitoring and reviewing project activities and achievements, examining problems at the field level and recommending appropriate solutions, and insuring that the project continues to meet the implementation schedule.

Also, a PHC Advisory Committee will be established, with representatives of the MH&SW, USAID, and other donors, to insure a strong, collaborative, coordinated, resource-efficient National Primary Health Care Program. In addition, a National PHC Steering Committee will be created, to be comprised of the Deputy Ministers for Technical Services or their appointees of the Ministries of Health & Social Welfare, Agriculture, Internal Affairs, Rural Development, Education, Planning & Economic Affairs, Finance, and the Budget Bureau. This committee will provide general guidelines, resolve major policy issues, and insure necessary resources and intersectoral coordination for the National Primary Health Care Program.

b. Management

Aside from the organizational implications of county-level decentralization, there are important managerial considerations as well. To be workable in achieving the intended project outcomes, county-level decentralization implies decentralization in three specific areas: (1) decentralization of the budgetary process, (2) decentralization of financial responsibility, and (3) decentralization of planning and management responsibilities. For decentralization to work effectively it must involve the entire county-level operations of the MH&SW -- not only the county health department but the county hospital and rural health facilities as well.

At the central level, MH&SW managers of the principal Headquarters bureaus relating to the project (Preventive Services, Curative Services, Administration, and Planning, Research and Development) are all experienced senior staff members, most having advanced professional degrees. During the first five years of the project, people currently in long-term participant training under the Health Management Planning Project will be returning from their degree programs to fill important positions within those bureaus and divisions of importance in the PHC Program. In addition, the long-term TA team will provide valuable skills and experience to augment those of key MH&SW staff.

At the county level, the establishment of effective county health departments will require a level and breadth of managerial skills that currently does not exist. In addition to the county health officer, who will be responsible for all county-level operations of the MH&SW, the new positions of Administrative Officer and Logistics Officer will be established under the project.

c. Staffing

One concern, in view of the strong project focus on the county mid-level health workers, is the current vacancy rate among PA and CM positions, especially at the rural health posts and health centers. A related problem is the present insufficient capacity of the training institutions which train both PAs and CMs. Both of these weaknesses are being addressed -- the first through the MH&SW's commitment to provide minimal numbers of staff members according to a project covenant (see Section VI), and the second by increasing both facility and manpower resources for the mid-level training institutions (as discussed in the detailed project description).

d. Capacity to fulfill implementation responsibilities

The MH&SW is the primary implementing agent for this project. The series of actions necessary to develop and implement the county-level decentralization are indicative of the importance of a strong implementation capability. The position descriptions of the long-term TA team members have been carefully composed so that the experience and skills of the members, individually and collectively, will complement those of principal MH&SW staff members at both the central and county levels. Similarly, short-term consultants

will be used to provide specialized skills in specific areas. Taken together, these inputs should provide the necessary assistance to the MH&SW so that the project will be effectively implemented.

2. Project management capability of USAID/Liberia

The USAID Health Officer will be the PHC Project Officer and will be assisted by other Health Office staff, the USAID Controller, the USAID Engineer, and other Mission staff, as well as by REDSO/WCA regional specialists in relevant areas.

The Project Officer will have principal responsibility for project monitoring. USAID will convene quarterly internal reviews by the Mission Project Committee, and will participate in all Project Implementation Status Reviews, as well as the annual financial reviews to be conducted jointly by the CPA firm and the MH&SW. USAID/Liberia will also coordinate and participate in all project evaluations, in accordance with the evaluation plan.

The Mission will also develop and execute contracts as needed for locally supplied inputs, and will review and approve construction plans and completed structures in accordance with AID standard procedures.

VI. CONDITIONS AND COVENANTS

In an effort to insure the timely provision of project resources, and in turn to accomplish the implementation of the project in accordance with the implementation schedule, the following conditions and covenants will be included in the grant agreement.

A. Conditions Precedent to Disbursement.

1. First Disbursement. Prior to the first disbursement under the Grant, or to the issuance by A.I.D. of documentation pursuant to which disbursement will be made the Grantee will, except as the Parties may otherwise agree in writing, furnish to A.I.D. in form and substance satisfactory to A.I.D.:

- a. An opinion of counsel acceptable to A.I.D. that this Agreement has been duly authorized and/or ratified by, and executed on behalf of, the Grantee, and that it constitutes a valid and legally binding obligation of the Grantee in accordance with all of its terms; and
- b. A statement of the name of the person holding or acting in the office of the Grantee specified in Section 8.1 of the Grant Agreement, and of any additional representatives, together with a specimen signature of each person specified in such statement.

2. First Disbursement for Motorcycles. Prior to disbursement under the Grant, or to issuance by A.I.D. of documentation pursuant to which disbursement will be made, for the purchase of motorcycles, the Grantee will, except as the Parties may otherwise agree in writing, furnish to A.I.D. in the form and substance satisfactory to A.I.D. evidence that the Grantee acting through the MH&SW has established a system in accordance with GOL policy whereby, (a) employees will pay for at least half the cost of motorcycles through periodic salary deductions or other mutually agreed mechanisms, and (b) all monies so collected will be deposited in a revolving fund from which replacement motorcycles will be financed or will be used to support other project-generated recurrent costs as agreed to by the Parties in Project Implementation Letter(s).

3. Disbursement for Construction. Prior to disbursement under the Grant, or to issuance by A.I.D. of documentation pursuant to which disbursement will be made, for each construction activity to be financed by A.I.D. under the Grant, the Grantee will except as the Parties may otherwise agree in writing furnish to A.I.D. in form or substance satisfactory to A.I.D. evidence of the Grantee's ownership of the land where the construction is to take place.

4. Subsequent Disbursements. Prior to any disbursement of project funds under the Grant in years 2, 3 and 4, or the issuance by

A.I.D. of documentation pursuant to which disbursement will be made, the Grantee will except as the Parties may otherwise agree in writing, furnish to A.I.D. in form and substance satisfactory to A.I.D.:

- a. Prior to year 2 disbursements, the evaluation program referred to in Section 5.1 of the Grant Agreement:
- b. Prior to year 3 disbursements, (i) evidence that the MH&SW has established a policy in Grand Gedeh and Sinoe Counties to collect funds through user fees for drugs and supplies, which funds are to be retained within the MH&SW to be used to purchase additional drugs and supplies. This system shall be employed at all three levels of health facilities (health post, health center, and hospital) within the government health care delivery system in at least Grand Gedeh and Sinoe Counties; and, in addition, (ii) evidence will also be furnished that the MH&SW has developed guidelines for decentralized operations (including the budgetary process, and financial, planning, and management responsibilities) in Grand Gedeh and Sinoe Counties; and
- c. Prior to year 4 disbursements, (i) evidence that the revolving fund drug system referred to in b. above has been established and is operating and, in addition, (ii) evidence that decentralized operations referred to in b. above have been effectively established and implemented in Grand Gedeh and Sinoe Counties. Evidence of the implementation of these policies will be agreed to by the Parties in Project Implementation Letter(s).

**B. Covenants**

1. The Grantee shall provide staff in at least the minimum numbers as listed in the table below, which numbers may be revised by agreement of the Parties through Project Implementation Letters.

MINIMUM NUMBERS OF STAFF TO BE PROVIDED BY JANUARY<sup>+</sup> OF CORRESPONDING PROJECT YEAR, BY HEALTH WORKER CATEGORY\*

<u>COUNTY/CATEGORY</u>	<u>PROJECT YEAR</u>				<u>Total</u>
	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	
<u>Grand Gedeh</u>					
Physician Assistant**	21	21	30	30	30
Certified Midwife**	19	19	32	32	32
Hospital Medical Director	1	1	1	1	1
County Health Officer	1	1	1	1	1
Administrative Officer	1	1	1	1	1
Logistics Officer	1	1	1	1	1
<u>Sinoe</u>					
Physician Assistant**	-	19	35	35	35
Certified Midwife**	-	17	27	35	35
Hospital Medical Director	1	1	1	1	1
County Health Officer	1	1	1	1	1
Administrative Officer	1	1	1	1	1
Logistics Officer	1	1	1	1	1
<u>Total</u>					
Physician Assistant**	21	40	65	65	65
Certified Midwife**	19	36	59	67	67
Hospital Medical Director	2	2	2	2	2
County Health Officer	2	2	2	2	2
Administrative Officer	2	2	2	2	2
Logistics Officer	2	2	2	2	2

\*It is understood that the health workers provided will fill positions which are required for the effective operation of the PHC Project (i.e., in rural health facilities and county health departments).

\*\* A Registered Nurse (RN) may serve in this position instead.

+ For example, workers required in project year 2 should be deployed by January 1985; in project year 3, by January 1986, etc.

2. The Grantee, acting through the MH&SW, shall establish:

- a. A PHC Project Implementation Committee with representatives of the MH&SW, USAID and project long-term technicians to conduct quarterly meetings to monitor and review project activities and achievements, to examine problems at the field level and recommend appropriate solutions, and to insure that the project conforms to the Grant Agreement.
- b. A PHC Advisory Committee with representatives of the MH&SW, USAID and other donors to insure a strong, collaborative, coordinated, resource-efficient National Primary Health Care Program; and
- c. A National PHC Steering Committee comprised of the Deputy Ministers for Technical Services or their appointees of the Ministries of Health & Social Welfare, Agriculture, Internal Affairs, Rural Development, Education, Planning & Economic Affairs, and Finance, as well as representatives of the Bureau of the Budget and of the National Housing Authority, to provide general guidelines, resolve major policy issues, and insure necessary resources and inter-sectoral coordination for the National Primary Health Care Program.

3. The Grantee shall:

- a. Provide the 5 long-term technicians the use and control (but not ownership) of 4 project jeep-type vehicles, 5 complete sets of project household furnishings/appliances, and 5 complete sets of project office furnishings/equipment as well as office space, during their stay in Liberia;
- b. Provide project office furnishings/equipment and office space to (i) the locally-hired long-term administrative officers during their association with the Project, and (ii) short-term technical advisors during their stay in Liberia;
- c. Identify and assign at least one counterpart for each long-term technician; and
- d. Take measures to insure that the persons receiving training abroad under the project return to Liberia to work in the MH&SW in areas for which they have been trained. A.I.D. shall also take measures within its power to insure that such persons return to Liberia.

4. The Grantee shall ensure that the fees to be collected and retained by the Ministry of Health and Social Welfare in Grand Gedeh and Sinoe Counties (which may include user fees for drugs and medical supplies as well as registration fees) will be set at necessary levels (and may be further adjusted periodically) so that recipients of drugs and supplies pay sufficient amounts to recover the costs of such drugs and supplies in order to maintain a continuous re-supply.

5. The Grantee shall maintain expenditures for drugs in project counties at no less than current levels unless otherwise agreed to in writing by the Parties through Project Implementation Letters.

6. The Grantee shall make available sufficient funds to support an increasing proportion of the national health care system's recurrent costs, so that by the end of the first five years of the project the Grantee will be assuming no less than ninety per cent (90%) of project-generated recurrent costs in the project counties. (Estimated project-generated recurrent costs are shown in Figure H-3 of Annex H-2).

7. The Grantee shall maintain budgetary allocations for operating expenses of the MH&SW at no less than its current percentage level of the national budget.

A. Introduction

The evaluation plan has been designed to provide a measurement of progress toward planned targets, as well as an indication of why the targets are or are not being met. As indicated in the Cost Estimate and Financial Plan (Section III), in view of the major institution-building emphasis of the project, coupled with the funding limitations imposed, serious consideration will be given to extending beyond the initial five years currently being funded. Consequently, it is especially important that each evaluation assess the project's continued feasibility -- specifically, whether the design is still valid, and if not, what changes are required to insure that the purpose will be achieved. The outcome of each evaluation, and especially the mid-project evaluation, will be the basis for deciding whether or not to seek continued project assistance, with or without modifications.

The major baseline survey, and the subsequent follow-up are critical elements of the evaluation plan, in order to provide both socioeconomic and project-specific baseline information and later comparative data. As indicated in the detailed project description, an AID centrally-funded project (932-0624) will be engaged to carry out a health and family planning baseline information survey (including household interviews) in year 1, with a follow-up impact study scheduled to provide further information for the final project evaluation.

Collection and analysis of health status and health service data will be important components of both the baseline study and the overall health information system. However, the survey emphasis of the baseline and follow-up studies will more definitively examine many of the significant health indicators, such as infant mortality, relative utilization of services (including traditional practitioners and "black baggers"), contraceptive prevalence, coverage of regular nutrition surveillance activities among children under three and their nutritional status, deliveries by trained health workers, malaria prophylaxis, and knowledge and use of oral rehydration therapy. Interviews will also indicate health worker knowledge and morale.

The evaluation plan is closely linked with the monitoring plan, as described in Section IV.E. The information that will be collected or otherwise available for monitoring purposes will also be utilized in the evaluation.

B. Evaluation Schedule

Based on the nature and complexity of the project, there will be two major evaluations and one which will be less comprehensive. The major evaluations will occur at mid-project and near the end of the project, while the additional evaluation will take place early in year 2. Each evaluation is summarized briefly below.

1. Interim evaluation: Month 16

This interim evaluation will be an internal one, involving the MH&SW, the contractor TA team, and USAID/Liberia. Other GOL representatives may be

asked to participate as appropriate, in relation to key project issues. The timing of this evaluation is critical, in order to assess the outcome of several studies and reviews that will be completed during year 1, and to determine how the results should be incorporated into the implementation schedule. The key areas to be assessed in this evaluation are as follows (with the month of completion shown in parentheses, if appropriate):

- Annual work plan for year 2, prepared jointly by the MH&SW and the long-term TA team (month 12)
- Annual financial review for year 1, prepared by the CPA firm (month 13)
- Baseline survey (month 12)
- Private sector study (month 12)
- Curriculum design workshop (month 14)
- Effectiveness and timeliness of USAID and GOL in meeting project commitments

## 2. Mid-project evaluation: Month 32

The mid-project evaluation will be carried out by a team that is expected to include representatives of the MH&SW, Ministry of Planning and Economic Affairs, and USAID. It is planned that the services of two external evaluation-team members will also be engaged (one AID health professional from either AID/Washington or another AID mission and one individual under contract, both with relevant evaluation skills). In addition, a Peace Corps/Liberia Staff member will participate in relation to project PCVs.

The mid-project evaluation should yield clear conclusions and recommendations in the following areas, in order to provide sufficient bases for determining whether or not the project should be continued or extended, and if so, what shifts in emphasis should be incorporated in its design. These areas are in addition to the major evaluation components discussed in subsection C below.

- The degree to which the rural population understands, accepts and supports the concept of primary health care in the context of village-level delivery of health services.
- The appropriate balance of curative, preventive, and promotive health services that PHC should achieve.
- The appropriateness and adequacy of training, especially for VHWS and TBAs.
- The success and replicability of decentralized operations at the county level.

- The adequacy of both the supervisory and logistical systems in supporting the rural health facilities and the village health teams.
- The effectiveness of Peace Corps Volunteers in their respective positions.
- The adequacy of contractor performance, with special reference to the technical assistance contractor.
- The effectiveness and timeliness of USAID and GOL in meeting project commitments.
- The validity and achievement of project indicators for goal, purpose, outputs, and inputs.

The timing of the mid-project evaluation is also critical -- not so early that the results are inconclusive, but early enough to allow for mid-course corrections and a preliminary decision on the possible extension of the project.

### 3. Final evaluation: Month 48

The final evaluation will also be a major external evaluation, with an evaluation team similar to that described for the mid-project evaluation, and the participation of Peace Corps/Liberia. The timing will allow for utilization of the data and analyses of the follow-up health and family planning survey as well as the participation of the TA contractor's Chief of Party and remaining team members while they are still involved in the project. In addition to the elements listed for the mid-project evaluation, other important components of the final evaluation are summarized in the following subsection.

#### C. Major Evaluation Components

##### 1. PHC service delivery, coverage and basic health status

The basic source of data on PHC coverage and health status will be the baseline and follow-up surveys, as described above. The follow-up survey will be completed just prior to the final evaluation, to provide quantitative data on the level of achievement of the village-level targets. However, additional sources of information and the corresponding evaluation elements are described below.

Field visits, supervisory reports, and examination of inventory and logistical system records will determine whether the village-level and mid-level health workers are trained and functioning as planned. EPI surveillance data, supplemented by service statistics, inventory and cost data, and baseline survey information will be the basis for assessing the achievement of vaccination coverage targets in the villages.

In addition, service records will be examined to determine the appropriateness of treatment by mid-level health workers. Results of operations research

will be used to determine the best mix of services and health care delivery parameters (e.g., organizing and mobilizing villages, hours of operation, home visits); the desired characteristics of VHWs and TBAs (e.g., age, sex, occupation -- including the effectiveness of those with backgrounds as "country doctors"); patterns of supervision and referral; methods of remuneration; factors that promote community involvement; and other elements of effective village-level service delivery.

2. Institutional strengthening with emphasis on county-level decentralization

Both the mid-project and final evaluations will examine the effectiveness of operational decentralization at the county level, as well as the strengthening of central-level managerial, technical, and logistical support, and manpower development.

Site visits and records will be used to assess the adequacy of the logistical system, and in particular the supply of drugs at all levels of the PHC Program. Field visits, records, and interviews will be utilized to determine if supervisory and support systems are adequate. Site visits and examination of curricula will be used to assess whether training institutions and training teams are carrying out effective and appropriate programs.

In view of the project emphasis to insure the adequacy of budgetary support for PHC and of the budgetary process in relation to county-level decentralization, the evaluations will assess the GCL's performance in the following areas:

- ° Maintaining budgetary allocations for operating expenses of the MH&SW at no less than its current percentage level of the national budget.
- ° Making available sufficient funds to support an increasing proportion of the national health care system's recurrent costs, so that by the end of the project at least 90 per cent of project-generated recurrent costs in the project counties will be covered by the MH&SW.
- ° Maintaining at least the FY 82/83 level of expenditure for drugs in the target counties.

Because of the importance of the revenue-generating mechanisms of the project, the evaluations will give special emphasis to assessing the adequacy and effectiveness of both the revolving drug funds (at county and village levels) and motorcycle purchase scheme.

Decentralized financial and operational management will also be assessed. The evaluations will focus on the guidelines for county level decentralization, and the extent to which decentralized management and control have been achieved.

# Department of State

ANNEX A

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ACTION AID-35

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ACTION OFFICE AFCV-03  
INFO AAAP-01 AFDR-08 PPCF-01 PPPB-02 PPEA-01 AADS-01 DSHE-01  
POP-04 CMB-01 HEW-09 RELO-01 MAST-01 AFDA-01 PDPR-01  
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CAUTIOUS IN THEIR EFFORTS TO AVOID TOO RAPID AN EXPANSION OF THE PRIMARY HEALTH CARE PROGRAM. HOWEVER, AT THIS STAGE OF THE PROJECT'S DEVELOPMENT WE FEEL IT IS BEST TO REACH AGREEMENT ON BASIC CONCEPTS AND APPROACH, LEAVING DETAILS SUCH AS A 7 PCT VERSUS FOR EXAMPLE A 10 PCT RATE OF EXPANSION TO THE FINAL DESIGN PHASE. WE PLAN TO REDOPEN THIS QUESTION WHEN OUR DESIGN TEAM HAS HAD A CHANCE TO DEVELOP AND EVALUATE IN DETAIL POSSIBLE ALTERNATIVES TO THE MINISTRY'S PLAN.

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TO SECSTATE WASHDC 0265

B. ROLE OF VILLAGE HEALTH WORKERS AND HEALTH POSTS: THE DUTIES OF THE VILLAGE HEALTH WORKERS AS ESTABLISHED IN THE MINISTRY'S FOUR YEAR PLAN ARE AS FOLLOWS:

UNCLAS SECTION 01 OF 02 MONROVIA 05350

E.O. 12958: N/A  
SUBJECT: PRIMARY HEALTH CARE PID

1. EXPLAIN PRIMARY HEALTH OBJECTIVES TO THE COMMUNITY.
2. IMPART PROMOTIONAL AND PREVENTIVE ASPECTS OF HEALTH CARE.
3. IDENTIFY BASIC HEALTH PROBLEMS AND SUGGEST IMPROVEMENTS.
4. PROVIDE INFORMATION ON NUTRITION, IMMUNIZATION AND ENVIRONMENTAL SANITATION AND CARRY OUT FOLLOW UP.
5. PROVIDE FIRST AID MEDICAL CARE AND TREATMENT FOR COMMON SIMPLE MEDICAL PROBLEMS, I.E., DIARRHEA, MALARIA, SKIN ULCERS, ETC.
6. PROVIDE FOLLOW UP AND CONTINUING TREATMENT AT HOME FOR TUBERCULOSIS AND LEPROSY AND USE OF ORAL CONTRACEPTIVES.
7. ORGANIZE COMMUNITY PARTICIPATION FOR VISITING VACCINATION AND OTHER HEALTH TEAMS.

REF: SPENCER/GARUF: LTR W/ATTACHMENTS, MAY 14, 1989

1. MISSION APPRECIATES AID/M'S SPEEDY REVIEW OF THE PRIMARY HEALTH CARE PID. THE FOLLOWING ARE THE JOINT GOL/USAID RESPONSES TO THE ISSUES RAISED DURING THE REVIEW OF THE SUBJECT PID:

A. DELIVERY OF PRIMARY HEALTH CARE SERVICES: THE MISSION AND THE MINISTRY HAVE DEFINED THE PRIMARY HEALTH CARE PROGRAM TO INCLUDE SUPPORT SERVICES, I.E., LOGISTICS, PROCUREMENT, HEALTH EDUCATION, IMMUNIZATION, ETC., AS WELL AS THE ACTION UNITS, THE VILLAGE HEALTH TEAMS AND HEALTH POSTS. ONLY BY UPGRADING THE WHOLE SYSTEM CAN WE BE SURE THE VILLAGE HEALTH TEAMS AND HEALTH POSTS WILL HAVE THE SUPPORT THEY NEED TO FUNCTION EFFECTIVELY. FOR THIS REASON EMPHASIS IN FIRST THREE YEARS OF OUR PROJECT IS GIVEN TO THE CREATION OF THE TECHNICAL, MANAGEMENT, AND ADMINISTRATIVE INFRASTRUCTURES NEEDED TO TRAIN, SUPERVISE AND SUPPLY THE HEALTH POSTS AND VILLAGE HEALTH TEAMS. THE EARLY EMPHASIS IN THE AID PROJECT UPON THESE ELEMENTS DOES NOT HOWEVER, MEAN A DEFERRAL IN THE DELIVERY OF HEALTH SERVICES TO THE RURAL POPULATION.

THE MINISTRY'S PRIMARY HEALTH CARE PROGRAM IS BOTH ONGOING AND EXPANDING. WITH THE ASSISTANCE OF THE DUTCH IN SINOE, GRAND GEDEN AND MARYLAND COUNTIES, THE GERMANS IN NIMBA COUNTY, THE UNFPA IN CAPE MOUNT AND BONG COUNTIES, AND OUR SUPPORT, THE MINISTRY PLANS TO INCREASE THE PERCENTAGE OF POPULATION COVERED BY THE PRIMARY HEALTH PROGRAM FROM 33 PERCENT TODAY TO 40 PCT IN 1985 AND 50 PCT IN 1990. THE PROPOSAL DOES REPRESENT AN INCREMENTAL PLAN FOR THE DELIVERY OF PRIMARY HEALTH CARE SERVICES.

EARLY IN THE DEVELOPMENT OF THIS PID THE MISSION QUESTIONED THE PLANNED RATE FOR EXPANDING THESE SERVICES. THE GOL EXPLAINED THAT THE CONSTRAINTS UPON AN IMMEDIATE RAPID EXPANSION ARE: A) BUDGETARY; B) LEAD TIME IN TRAINING PHYSICIAN ASSISTANTS AND CERTIFIED MIDWIVES; C) LIMITED TRAINING FACILITIES, AND D) INADEQUATE LOGISTICAL, PROCUREMENT ADMINISTRATIVE AND MANAGEMENT SYSTEMS. THE MINISTRY EXPRESSED CONCERN THAT UNLESS THE ABOVE PROBLEMS WERE OVERCOME (THEY ARE TARGETED IN THE EARLIEST PART OF OUR PROJECT) AN EXPANSION OF THE PROGRAM WOULD MEAN THE ESTABLISHMENT OF HEALTH POSTS AND VILLAGE HEALTH TEAMS THAT THE MINISTRY COULD NOT ADEQUATELY SUPPORT OR SUPERVISE. THE PLANNED RATE OF EXPANSION, 7 PCT FROM 1980 TO 1985, AND 20 PCT FROM 1985 TO 1990, IS A REFLECTION, AS A RESULT OF OUR ASSISTANCE, OF THE ANTICIPATED INCREASE IN THE MINISTRY'S CAPACITY TO MANAGE THE PRIMARY HEALTH CARE PROGRAM. WHILE AGREEING WITH THE MINISTRY APPROACH WE FEEL THEY MAY BE OVERLY

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8. COLLECT VITAL STATISTICS.

IN ADDITION, THE EMPIRICAL MIDWIVES WILL PROVIDE PRE AND POST-NATAL SERVICES INCLUDING SIMPLE DELIVERIES.

WE BELIEVE THE ABOVE WILL MEET THE MOST COMMON HEALTH NEEDS OF THE VILLAGES AND FULFILL THE DEFINITION OF CURATIVE/PREVENTIVE/PROMOTIVE HEALTH SERVICES DEFINED IN DR GEORGE'S MEMO AS THE PROPER ROLE FOR VILLAGE HEALTH WORKERS. IF IT IS FELT THE CURATIVE ROLE OF THE VILLAGE HEALTH TEAM CAN SAFELY BE INCREASED, WE WILL PROPOSE THIS DURING THE FINAL DESIGN OF THE PROJECT WHEN THE ALLIED HEALTH SCIENCES CURRICULUM SPECIALIST REVIEWS THE TRAINING OF THE VILLAGE HEALTH WORKERS (ANNEX D OF THE PID).

THE HEALTH POST PLAYS A MULTIFACETED ROLE IN BOTH SUPPORTING THE VILLAGE HEALTH TEAM AND PROVIDING FIRST CONTACT SERVICES. IT PROVIDES FIRST CONTACT SERVICES TO PEOPLE IN ITS IMMEDIATE AREA. THIS IS BOTH NATURAL AND UNAVOIDABLE SINCE PEOPLE WHO LIVE CLOSE TO A HEALTH POST CAN BE EXPECTED TO USE THE SERVICES OF THE BETTER TRAINED PHYSICIAN ASSISTANTS AND CERTIFIED MIDWIVES WHO STAFF THE HEALTH POST THAN THOSE OF LESS WELL TRAINED VILLAGE HEALTH TEAMS. THE HEALTH POST HAS A SUPERVISORY AND SUPPORTING RELATIONSHIP TO THE VILLAGE HEALTH TEAMS PROVIDING TRAINING, MEDICAL SUPPLIES, PUBLIC HEALTH INFORMATION, ETC., AS WELL AS OVERSEEING THE FUNCTIONING OF THE TEAM AND ACTS AS THE REFERRAL POINT FOR CASES BEYOND THE SKILLS OF THE VILLAGE HEALTH WORKERS. WE CONSIDER THIS SUPERVISORY/SUPPORT FUNCTION TO BE A CRITICAL LINK IN THE PRIMARY HEALTH CARE DELIVERY SYSTEM AND FEEL THE ROLES OF EACH UNIT APPROPRIATE TO THE LEVEL OF SKILL THEY CONTAIN.

C. REGIONAL PROGRAMS: LIBERIA ALREADY MAKES EFFECTIVE USE OF THE SHOS AND OTHER REGIONAL PROGRAMS FOR SPECIALIZED TRAINING. HOWEVER, AS ONLY ONE OR MORE THAN 20 COUNTIES SERVICED BY SHOS, LIBERIA CANNOT RELY UPON A REGIONAL PROJECT FOR THE DEPTH AND TYPE TRAINING WHICH INCLUDES NON-MEDICAL AS WELL AS MEDICAL TRAINING REQUIRED TO IMPLEMENT THIS PROJECT. WE LOOK UPON SHCS AS AN IMPORTANT RESOURCE CAPABLE, DURING PROJECT IMPLEMENTATION, OF PROVIDING SPECIFIC BUT LIMITED ASSISTANCE AND PLAN TO USE THE REGIONAL PROGRAM AND TRAINING CENTERS WHENEVER POSSIBLE. A DETAILED TRAINING PLAN WILL BE INCLUDED IN THE PP.

D. DECENTRALIZATION: THE THRUST OF THE PRIMARY HEALTH CARE PROJECT IS TO BRING THE SERVICE UNITS CLOSER TO THEIR CLIENTS. THE NATIONWIDE CREATION OF VILLAGE HEALTH TEAMS AND HEALTH POSTS OBVIOUSLY BRINGS HEALTH CARE CLOSER TO THE PEOPLE. THE RESPONSIBILITY OF THE HEALTH POSTS FOR TRAINING AND SUPERVISING THE VILLAGE HEALTH TEAM ILLUSTRATES THE MINISTRY'S EFFORTS TO PLACE

MANAGEMENT FUNCTIONS AT THE LOWEST POSSIBLE LEVEL. THIS EFFORT TO DECENTRALIZE CONTINUES THROUGHOUT THE PROGRAM. COUNTY MEDICAL OFFICES HAVE ALREADY BEEN GIVEN BOTH THE AUTHORITY AND RESPONSIBILITY FOR THE HEALTH PROGRAMS IN THEIR COUNTY. IN PRACTICE, THIS DELEGATION OF AUTHORITY HAS NOT BEEN UNIFORM. BECAUSE OF STAFF SHORTAGES AND THE UNEVEN QUALITY OF COUNTY STAFFS SOME COUNTY MEDICAL OFFICES HAVE MORE AUTHORITY THAN OTHERS. HOWEVER, THE MINISTRY IS CONTINUING TO UPGRADE ITS COUNTY MEDICAL STAFFS AND IS FIRMLY COMMITTED TO DELEGATING AUTHORITY TO THEM AS FAST AS POSSIBLE. OTHER MINISTRY OPERATIONS ARE BEING DECENTRALIZED. OUR PROPOSAL CALLS FOR THE CONSTRUCTION OF REGIONAL WAREHOUSES AND MAINTENANCE SHOPS. THIS TOO IS PART OF THE CONTINUING DECENTRALIZATION EFFORT. THE COMPLETE DETAILS OF THE MINISTRY'S DECENTRALIZATION PLAN WILL BE INCLUDED IN THE PP.

E. DESIGN-TIME FRAME: THE MISSION REALIZES THE PROPOSED DESIGN TIME FRAME MAY AT FIRST APPEAR OVERLY LONG. HOWEVER, AN EFFECTIVE DESIGN OF A PROGRAM OF THIS COMPLEXITY REQUIRES AN UNDERSTANDING OF THE COUNTY AND THE INTERNAL DYNAMICS OF THE MINISTRY, AS WELL AS A PRACTICAL KNOWLEDGE OF PRIMARY HEALTH CARE DELIVERY. GIVEN THE HISTORY OF THIS PROJECT, IT IS ALSO ESSENTIAL FOR OUR DESIGN TEAM AND THE MINISTRY PERSONNEL TO DEVELOP A DEGREE OF MUTUAL UNDERSTANDING AND TRUST IF THE FINAL PROPOSAL IS TO REFLECT REAL UNDERSTANDING AND COMMITMENTS RATHER THAN SURFACE REALITIES. THIS CANNOT BE DONE IN A FEW WEEKS AND IS THE REASON FOR THE DESIGN TIME FRAME PROPOSED IN THE PID.

2. PLEASE ADVISE FINDINGS OF PID REVIEW COMMITTEE SOONEST. SMITH

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RESOURCES OF THE STRENGTHENING HEALTH DELIVERY SYSTEMS PROJECT, 698-0390 (SHOS). HOW THE SERVICES/FACILITIES OF THE SHOS PROJECT WILL BE MAXIMALLY UTILIZED TO BENEFIT THE PROPOSED PROJECT SHOULD BE FULLY DESCRIBED. CHRISTOPHER

INFO OCT-88 /035 R

DRAFTED BY AID/AFR/CLA: SCANDERSON:ED  
APPROVED BY AID/AAA/AFR: WORTH  
AFR/CWA: FJSPENCER (DRAFT)  
AID/AFR/DR/HN: TGEORGES (DRAFT)  
AID/AFR/DP: GCAUVIN (DRAFT)  
AID/AFR/DR/CAVARAP: LBOND (DRAFT)  
PPC/POPR: PFLEURET (DRAFT)  
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E.O. 12065: N/A

AOB:

SUBJECT: RESULTS OF PID REVIEW OF PROPOSED LIBERIA PRIMARY HEALTH CARE PROJECT (669-0165)

REFS: A) SPENCER/GARUFI LTR W/ATTACHMENTS, MAY 14, 1988  
B) MONROVIA 5350

1. THE REVISED VERSION OF SUBJECT PROJECT PROPOSAL (ORIGINAL REVIEWED APRIL 25) AS REVISED PER REF B HAS BEEN APPROVED FOR FURTHER DEVELOPMENT. ISSUES TO BE ADDRESSED DURING DESIGN STAGE PER REF. A SHOULD BE HANDLED ACCORDINGLY. PER AGREEMENT REACHED BETWEEN R. GARUFI, USAID/LIBERIA AND DR. T. GEORGE, AFR/DR/HN DURING JULY 24 MEETING REMAINING OUTSTANDING ISSUES WILL BE ADDRESSED DURING DESIGN OF PROJECT IN THE MANNER DESCRIBED PARA. 2 BELOW.

2. IN ADDITION TO ISSUES CITED REF. A, THE FOLLOWING ITEMS SHOULD BE GIVEN SPECIFIC ATTENTION DURING PROJECT DESIGN:

A. PP SHOULD DESCRIBE IN DETAIL THE SALIENT HEALTH PROBLEMS IN LIBERIA AND THE CURRENTLY AVAILABLE PRIMARY HEALTH CARE SERVICES (GOVERNMENT AND NON GOVERNMENT). IN ADDITION THE FOLLOWING ELEMENTS OF PROPOSED HEALTH CARE PROGRAM SHOULD BE FULLY ELABORATED: (1) NATURE AND SERVICE CONTENT OF PROPOSED PRIMARY SERVICES (2) ADMINISTRATIVE AND GEOGRAPHIC RELATIONSHIPS TO BE ESTABLISHED BETWEEN TERTIARY SECONDARY, AND PRIMARY CARE SERVICES (3) THE TRAINING PROGRAM TO BE ESTABLISHED TO DEVELOP THE NECESSARY MANPOWER RESOURCES REQUIRED FOR THE PLANNED EXPANDED SERVICES (4) DEVELOPMENT OF ADMINISTRATIVE/ LOGISTICS SUPPORT SERVICES (INCLUDING HEALTH INFORMATION SYSTEMS AND MANAGEMENT INFORMATION SYSTEM) (5) THE FACILITY, EQUIPMENT AND COMMODITY SUPPORT NECESSARY FOR THE STRENGTHENING OR DEVELOPMENT OF THE THREE LEVELS OF HEALTH CARE.

B. PPSHOULD DESCRIBE FULLY THE HEALTH PLANNING, HEALTH MANPOWER, EPIDEMIOLOGY, AND OPERATIONAL RESEARCH NEEDS THAT CAN BE MET THROUGH UTILIZATION OF THE SERVICES AND

AFR/DR/HN  
1006433  
15 AUG 1988



REPUBLIC OF LIBERIA  
 MINISTRY OF PLANNING AND ECONOMIC AFFAIRS  
 P. O. BOX 9836  
 MONROVIA

OFFICE OF THE MINISTER

AMPEA-758/D-7.18/'81

August 7, 1981

Mr. Director:

I wish to request USAID assistance through loans and grants for Phase I of Government's National Primary Health Care project.

The main objective of the project is to attain a target health coverage of the country from 35% to 90% by the year 2,000.

It is envisaged that the entire project could be implemented within ten years in two phases each of five years duration. During phase one, covering the period 1981 to 1986, the total project cost is estimated at \$39,355,000. Out of this amount USAID is requested to provide \$28,020,000, of which \$16,042,000 could be provided on a grant basis, whilst the remaining \$11,978,000 would be provided on a major investment loan basis. Our Government contribution to the project is estimated at \$11,335,000.

As this project is of priority to Government, I am herewith forwarding the attached project proposal for your consideration.

IN THE CAUSE OF THE PEOPLE, THE STRUGGLE CONTINUES!

Sincerely yours,

*Paul R. Jeffy*  
 Paul R. Jeffy  
 ACTING MINISTER

The Director  
 USAID/Liberia  
 Monrovia, Liberia.

# memorandum

DATE: April 21, 1982 *701*  
REPLY TO  
ATTN OF: AFR/CWA, Fermino Spencer  
SUBJECT: Liberia Primary Health Care Project (669-0165)  
TO: AA/AFR, F. S. Ruddy  
Refs: (A) Monrovia 01440  
(B) Spencer to Ruddy Memo dated 21 Sept 1981

Problem: Your approval is sought to proceed with redesign of the Liberia Primary Health Care Project and restore it to the list of new projects planned for FY 1982 funding.

Discussion: In reference B, I presented several reasons why I decided not to give CWA's approval to the Liberia Primary Health Care Project at the PP review. In reference (A) USAID/Liberia has made a proposal for redesign of the project which meets a majority of my concerns.

1. High Costs. In reference (B) I expressed concern over the high and escalating costs of the Project. The proposed A.I.D. contribution over the 5-year life of the Project has been decreased from \$31.5 million to \$12 to \$15 million by:
  - a. Reducing the number of counties receiving full services.
  - b. Reducing the number of counties receiving institution building and infrastructure development inputs.
  - c. Sealing down construction plans and vehicle procurement.
  - d. Eliminating inputs to all health activities (e.g. hospitals) which are not essential to operation of primary health care system.
2. Use of ESF Funds. In my original memo I indicated that USAID/Liberia could not rely on the use of ESF funds to help finance the Project. No ESF funds will be used and, at the DA level currently proposed, no mortgage problems will be created.
3. Recurrent Costs. I also indicated in my memo that the recurrent costs of the Project were excessive. Both the reduction in scale and the expansion of the user fee program will reduce recurrent costs. In redesigning the Project, USAID/Liberia will seek to minimize recurrent costs.
4. Early Delivery of Services. Another area of concern I discussed in my original memo was the relatively little emphasis placed on the delivery of services during the early stages of the Project. Redesign will provide for the delivery of health services as early as possible.

*911*

Certain other points need to be considered:

1. Use of Previous Work. The Project will build on previous work in primary health care in Liberia:
  - a. The methodology has already been tested.
  - b. At least one of the counties chosen to receive full services will have an existing primary health care framework developed with foreign assistance.
  - c. Existing facilities will be used as much as possible.
  - d. The Project will work through existing institutions.
  
2. Maintenance of Liberia Program Level. It is unlikely that the approved FY 1982 DA level for Liberia can be reached without this Project. Since health funds are in surplus and other funds are in short supply throughout the Agency, it is unlikely that the \$4 million budgeted for this Project for each of the FYs 1982 and 1983 can be switched to another appropriation category. State will press to maintain the Liberia DA level. If no projects are available, State will probably suggest inclusion of these funds in a program grant.

In addition, the strategy statement given to Congress includes the Project. A draft of this memorandum was shown to Elliott Berg on May 17, 1982 and our plans for redesign of the Project were discussed with him. Berg likes our plans. His only suggestion is that we include a study of the possibility of private sector participation in the delivery of health care services in the project design. We plan to include such a study in the project design.

Recommendation: Based on the above considerations, it is recommended that you approve proceeding with the redesign of the Liberia Primary Health Care Project and its restoration to the list of new projects planned for FY 1982 funding.

Approved: \_\_\_\_\_ ✓

Disapproved: \_\_\_\_\_

Date: \_\_\_\_\_ 5.29

*EAS*  
Drafted by: AFR/DR/CCWAP:ESmith:cel

Clearances:

AFR/DR/CCWAP:LBond *LB*  
 AFR/DR/HN:JShepherd(Draft) *JS*  
 GC/AFR:LDeSoto(Draft)  
 AAA/AFR/DP:ICoker(Draft)  
 DAA/AFR:WHNorth *WH*

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 DISTR: ~~AID CHG~~  
 ECON CHRON  
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AID/W FOR AA/AFR AND AFR/CCWA  
 INFO AFR/TR/EN, ABIDJAN FOR REDSO/WCA

I.C. 12356: N/A  
 SUBJECT: LIBERIAN PRIMARY HEALTH CARE (PHC) PROJECT  
 (669-0165)

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REFS: A) SPENCER/RUDDY MEMO DTD 4/21/82,  
 F) 82 MONROVIA 01440, C) SPENCER/RUDDY MEMO DTD 9/21/81,  
 I) MONROVIA 05854, F) CLOUTIER/POST MEMO DTD 11/17/82  
 (FYI:CLOUTIER IS REDSO/WCA PDO. END FYI), F) BLOOM/BOND  
 MEMO DTE 9/14/81, G) BLOOM/ERIKSSON-ARCHI MEMO DTD 9/29/81,  
 E) LEWIS/ERIKSSON MEMO DTE 9/21/81, I) MONROVIA 06480

1. ON BASIS OF APPROVAL GIVEN BY AA/AFR PER REF A,  
 USAID/LIBERIA HAS BEEN PROCEEDING WITH REDESIGN OF SUBJECT  
 PROJECT. IN ADDITION TO INPUTS FROM USAID STAFF WE HAVE  
 INVOLVED VARIOUS REDSO/WCA PERSONNEL AND LAST DECEMBER,  
 A NUMBER OF OUTSIDE CONSULTANTS. REDESIGNED PROJECT HAS  
 UNDERGONE RECENT REASSESSMENT BY USAID IN RELATION TO  
 OVERALL GOL BUDGETARY SITUATION. MOST RECENT REDESIGN BY  
 MISSION PERSONNEL IS NOW COMPLETE, AND PP IS BEING  
 REVIEWED BY GOL AND MISSION SENIOR REVIEW COMMITTEE.  
 MISSION AUTHORIZATION SCHEDULED FOR AUGUST 1983.

FYI: REF D (CONGRESSIONAL NOTIFICATION CABLE) PROVIDES  
 ADDITIONAL BACKGROUND AND SUMMARY PROJECT DESCRIPTION.  
 SEE ALSO REF I. END FYI.

2. SUMMARY OF MAJOR ISSUES AND THEIR RESOLUTION FOLLOWS,  
 BASED ON REF A FORMAT:

A. HIGH COSTS: THE PROPOSED AID CONTRIBUTION DURING THE  
 FIRST FIVE YEARS OF THE PROJECT HAS BEEN DECREASED FROM  
 DOLS 31.5 MILLION TO DOLS 15 MILLION IN THE FOLLOWING  
 WAYS:

- (1) THE NUMBER OF COUNTIES RECEIVING FULL SERVICES HAS  
 BEEN REDUCED FROM 4 TO 2.
- (2) THE NUMBER OF COUNTIES RECEIVING INFRASTRUCTURE  
 DEVELOPMENT INPUTS AND INSTITUTION BUILDING HAS BEEN  
 REDUCED FROM 8 TO 2; THAT IS, THE 2 FULL-SERVICE  
 COUNTIES.

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- (3) AID-FUNDED CONSTRUCTION HAS BEEN LIMITED TO 3 STRUCTURES -- A CENTRAL DRUG AND MEDICAL SUPPLY WAREHOUSE IN MONROVIA AND COUNTY HEALTH DEPARTMENT HQ BUILDINGS IN THE 2 FULL-SERVICE COUNTIES. CORRESPONDING CONSTRUCTION COST HAS DROPPED FROM DOLS 7.06 MILLION (22 PERCENT OF AID FUNDING) TO DOLS 1.05 MILLION (7 PERCENT). SIMILARLY, COMMODITIES HAVE BEEN REDUCED FROM DOLS 7.31 MILLION (23 PERCENT) TO DOLS 2.84 MILLION (18 PERCENT). SPECIFICALLY, VEHICLE PROCUREMENT HAS DROPPED FROM DOLS 3.1 MILLION TO DOLS 0.86 MILLION.
- (4) PROJECT INPUTS TO HOSPITALS HAVE BEEN ELIMINATED. INPUTS ARE FOCUSED ON THOSE AREAS OF THE M&SW HEALTH DELIVERY SYSTEM WHERE STRENGTHENING IS ESSENTIAL TO THE IMPLEMENTATION OF AN EFFECTIVE PHC SYSTEM -- NAMELY, DECENTRALIZATION TO COUNTY LEVEL, INCLUDING STRENGTHENING OF SUPERVISORY AND SUPPORT SERVICES TO RURAL HEALTH FACILITIES AND TO VILLAGE-LEVEL HEALTH WORKERS; STRENGTHENING OF TRAINING PROGRAMS FOR MID-LEVEL AND VILLAGE-LEVEL WORKERS, AND STRENGTHENING OF CENTRAL-LEVEL UNITS AND SERVICES (WITH EMPHASIS ON DRUG SUPPLY AND DISTRIBUTION SYSTEM) REQUIRED TO ESTABLISH A FRAMEWORK FOR THE NATIONAL PHC PROGRAM AND TO SUPPORT PHC SERVICES IN THE TARGET COUNTIES.

F. USE OF ESF FUNDS: PHC PROJECT IS PROPOSED TO BE FULLY FUNDED FROM GRANT DA, NOT ESF, FUNDS.

C. RECURRENT COSTS: SPECIAL ATTENTION HAS BEEN GIVEN TO MINIMIZING PROJECT-GENERATED RECURRENT COSTS. AS A RESULT, ANNUAL PROJECT-GENERATED RECURRENT COSTS AT THE PACD ARE PROJECTED TO BE ONLY DOLS 700,000 (35 PERCENT OF WHICH REPRESENTS INFLATION). THIS IS EQUIVALENT TO LESS THAN 4 PERCENT OF THE PROJECTED M&SW ANNUAL RECURRENT BUDGET. COMPARED WITH 36 PERCENT FIGURE GIVEN IN REF C, THIS 4 PERCENT FIGURE REPRESENTS A MAJOR REDUCTION IN GOL RECURRENT COSTS ATTRIBUTABLE TO THE CURRENT PHC PROJECT REDESIGN. PER CONCERNS RAISED IN REFS F AND G, THE PROJECT DESIGN INCORPORATES THREE FINANCING MECHANISMS WHICH WILL HELP TO MINIMIZE THE RECURRENT COST BURDEN ON THE GOL AS THE PHC SYSTEM DEVELOPS: (1) PAYMENT OF VHWS AND TRAS BY

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THE VILLAGERS THEMSELVES, THROUGH THE VILLAGE DEVELOPMENT COUNCILS; (2) REVOLVING DRUG FUNDS BOTH AT THE VILLAGE LEVEL AND WITHIN THE MH&SW FACILITIES IN THE PROJECT COUNTIES, SO THAT PATIENT CHARGES WILL HELP MAKE THE SYSTEMS SELF-SUSTAINING, AND (3) A MOTORCYCLE PURCHASE SCHEME WHEREBY MH&SW EMPLOYEES WILL PURCHASE PROJECT FUNDED MOTORCYCLES, THEREBY REDUCING THE GOL EXPENDITURE FOR LOCAL TRANSPORTATION IN THE COUNTY-LEVEL SYSTEM. THUS RECURRENT COSTS HAVE BEEN MINIMIZED AS MUCH AS REALISTICALLY POSSIBLE. IN ADDITION, THE GOL IS COMMITTED, INCLUDING THROUGH A COVENANT TO THE PROAG, TO MEET NO LESS THAN 90 PERCENT OF PROJECT-GENERATED RECURRENT COSTS BY PROJECT YEAR 5. THE ISSUE OF RECURRENT COSTS, AND THE GOL'S PROGRESS IN MEETING ITS COMMITMENT, WILL BE ADDRESSED IN EACH PROJECT EVALUATION. ALTHOUGH IT IS DIFFICULT TO ESTIMATE THE MAGNITUDE OF FUNDS FROM THE PROJECT'S REVENUE-GENERATING MECHANISMS, THIS ASPECT WILL BE CAREFULLY MONITORED IN THE ANNUAL FINANCIAL REVIEWS, AND WILL ALSO BE ADDRESSED IN EACH PLANNED IN THE PREVIOUS PHC DESIGN. THE LONG-TERM TECHNICAL ASSISTANCE CONTRACTOR WILL BE SELECTED AND WILL FIELD ITS TA TEAM AS SOON AS POSSIBLE AFTER PROJECT AUTHORIZATION TO HELP INSURE EFFECTIVE IMPLEMENTATION OF THE STEPS LEADING TO SERVICE DELIVERY IN THE TARGET COUNTIES.

F. USE OF PREVIOUS WORK: THE PROJECT STRESSES THE USE OF EXISTING RESOURCES AND TESTED PHC METHODOLOGIES. THE DUTCH-ASSISTED MARYLAND COUNTY VHW PROJECT AND THE LESSONS LEARNED THEREFROM ARE THE BASIS FOR THE COUNTY-LEVEL PHC DELIVERY SYSTEM. DESPITE MODESPHC EFFORTS IN OTHER AREAS OF LIBERIA, THE MARYLAND COUNTY PROJECT IS THE ONLY SYSTEMATICALLY DESIGNED AND IMPLEMENTED VILLAGE-LEVEL SERVICE DELIVERY SYSTEM. PER THE CONCERNS VOICED IN REFS I AND G, MISSION'S ASSESSMENT OF THE MARYLAND COUNTY PROJECT IS THAT IT IS A REALISTIC MODEL FOR THE NATIONAL PHC SYSTEM, PROVIDED THERE IS SUFFICIENT STRENGTHENING IN THE FOLLOWING KEY AREAS: (1) COUNTY-LEVEL SUPERVISION, MANAGEMENT, AND SUPPORT; (2) CENTRAL-LEVEL MANAGERIAL, TECHNICAL AND LOGISTICAL SUPPORT; (3) MANPOWER DEVELOPMENT, WITH EMPHASIS ON MID-LEVEL WORKERS; AND (4) INCREASED CONTRIBUTION OF PEOPLE TOWARD THEIR HEALTH CARE SERVICES. ALL OF THESE AREAS ARE SYSTEMATICALLY ADDRESSED IN THE PHC PROJECT.

THE GOL IS STILL HOPEFUL THAT THE DUTCH WILL RENEW THEIR SUPPORT FOR MARYLAND COUNTY, SO IT HAS NOT BEEN INCLUDED IN THE AID-ASSISTED PROJECT. EXISTING FACILITIES AND INSTITUTIONS WILL BE USED AS MUCH AS POSSIBLE. AS NOTED ABOVE, THE ONLY AID-FINANCED CONSTRUCTION IS LIMITED TO 3 HIGH-PRIORITY STRUCTURES REQUIRED TO SUPPORT EXPANSION OF THE PHC SYSTEM. IT IS PLANNED TO ALLOCATE APPROXIMATELY DOLS 2.35 MILLION IN PL-482 COUNTERPART FUNDS TO THE GOL DEVELOPMENT BUDGET FOR CONSTRUCTION/ RENOVATION OF RURAL HEALTH POSTS AND HEALTH CENTERS; FOCUSING FOR COUNTY HEALTH OFFICERS (A MUCH-NEEDED INCENTIVE FOR RURAL SERVICE) AS WELL AS THE SELF-HELP CONSTRUCTION OF HOUSING FOR MID-LEVEL STAFF OF THE RURAL

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HEALTH POSTS AND HEALTH CENTERS, AND MODEST CONSTRUCTION/RENOVATION OF FACILITIES AT EXISTING MID-LEVEL TRAINING EVALUATION. WHILE THE OUTLOOK FOR RENEWED ECONOMIC GROWTH IN LIBERIA IS NOT VERY PROMISING DURING THE NEXT 5 YEARS, IMPROVED BUDGETING AND EXPENDITURE CONTROL, ASSISTED BY THE ECONOMIC AND FINANCIAL MANAGEMENT AND TRAINING PROJECT (669-0184), AND INCREASED TAX RECOVERY, SUPPORTED THROUGH INCREASED REVENUE FOR DEVELOPMENT PROJECT (669-0132), SHOULD HELP SIGNIFICANTLY IN OVERALL IMPROVEMENT IN GOL ABILITY TO MEET SUCH COSTS. SINCE 1978 THERE HAS BEEN A GROWING COMMITMENT BY THE GOL TO INCREASE REVENUES. FOR EXAMPLE, REVENUE COLLECTION IN INCOME TAX, REAL ESTATE TAX, AND BUSINESS TRADE LEVY HAS INCREASED AN AVERAGE OF 12 PERCENT PER YEAR SINCE 1978 AND IS PROJECTED TO INCREASE TO APPROXIMATELY 75 PERCENT OF BILLED TAXES BY 1985.

SIMILARLY, THE GOL'S BUDGET DEFICIT HAS FALLEN SOMEWHAT LARGELY THROUGH THE INFLUENCE OF THE IMF STANDBY AGREEMENTS. THE DEFICIT IN GOL FY 81/82 WAS DOLS 118 MILLION, AND IN FY 82/83 IS ESTIMATED TO BE DOLS 109 MILLION. THE IMF TARGET FOR FY 83/84 IS DOLS 42.4 MILLION. UNTIL WORLD MARKETS FOR LIBERIA'S EXPORTS IMPROVE, IT IS NOT POSSIBLE TO PREDICT WHEN THE GOL WILL BE ABLE TO PAY ITS OWN WAY. THIS IS THE REASON, AS STATED IN THE PP.

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WHY THE AID CONTRIBUTION IS FUNDING MOST RECURRENT COSTS IN THE EARLY YEARS OF THE PROJECT.

FINALLY, IN VIEW OF THE CRITICAL NEED TO EXPAND PHC SERVICES TO RURAL LIBERIANS, THE OVERALL BENEFITS OF THE PROJECT FAR OUTWEIGH THE COSTS OF NOT BEGINNING THE INTRODUCTION OF A COST-EFFECTIVE PHC SYSTEM NOW.

D. EARLY DELIVERY OF SERVICES: AN EFFORT HAS BEEN MADE TO INSURE THE DELIVERY OF SERVICES IN THE TARGET COUNTIES AS EARLY AS POSSIBLE. IN CONTRAST TO THE AUGUST 1981 PP, DEVELOPMENT OF THE PHC SERVICE DELIVERY SYSTEM BEGINS WITHOUT DELAY; THERE IS NO LAG PERIOD DURING WHICH ONLY CONSTRUCTION TAKES PLACE. FOR EXAMPLE, COUNTY MID-LEVEL STAFF PHC TRAINING AND VILLAGE HEALTH WORKER TRAINING ARE NOW SCHEDULED TO BEGIN IN PROJECT YEAR 2, RATHER THAN FIVE MONTHS LATER, IN PROJECT YEAR 3, AS INSTITUTIONS TO SUPPORT NEEDED INCREASES IN CAPACITY. FURTHERMORE, THE PROJECT FOCUSES ON WORKING WITH AND STRENGTHENING EXISTING INSTITUTIONS IN LIBERIA RATHER THAN CREATING NEW ONES WHICH WOULD ONLY DILUTE SCARCE RESOURCES.

F. MAINTENANCE OF LIBERIA DA PROGRAM LEVEL: THIS ISSUE PER REF A WAS CONCERNED ONLY WITH THE FY 1982 OYE. IT HAS BEEN OVERTAKEN BY EVENTS. PER THE FY 1985 ABS, FUNDING FOR THE PROJECT IS INCLUDED WITHIN PLANNED PROGRAM LEVELS.

G. PRIVATE SECTOR PARTICIPATION: FOLLOWING ELLIOT BERG'S SUGGESTION, THE PROJECT INCORPORATES A STUDY OF POTENTIAL PRIVATE SECTOR INVOLVEMENT IN THE LIBERIAN HEALTH CARE SYSTEM. THE STUDY WILL BE CARRIED OUT IN PROJECT YEAR 1, AND ITS CONCLUSIONS AND RECOMMENDATIONS WILL BE CONSIDERED FOR APPROPRIATE FOLLOW-UP THEREAFTER.

E. ADDITIONAL CONCERNS RAISED:

(1) ADEQUATE FINANCIAL MONITORING: PER CONCERNS EXPRESSED REF I, PROJECT REDESIGN INCORPORATES STRENGTHENED FINANCIAL MONITORING CAPABILITIES THROUGH A PROJECT-FUNDED CONTRACT WITH AN INDEPENDENT ACCOUNTING FIRM IN ORDER TO ADEQUATELY MONITOR BOTH THE REVOLVING DRUG FUNDS AND AID-FINANCED LOCAL CURRENCY EXPENDITURES. IN ACCORDANCE WITH THE DRAFT SCOPE OF WORK INCLUDED AS A PP ANNEX, THE FIRM WILL ALSO CARRY OUT ANNUAL REVIEWS OF PROJECT MANAGEMENT ISSUES AND FUNDS CONTROL.

(2) GOL/MBSSW ABSORPTIVE CAPACITY: REFS C, F, AND G INDICATE CONCERNS ABOUT THE GOL'S ABSORPTIVE CAPACITY IN TERMS OF BOTH THE AVAILABILITY OF TRAINED MANPOWER AND THE RANGE OF SERVICES TO BE PROVIDED BY VILLAGE-LEVEL WORKERS. THE PROJECT REDESIGN INCORPORATES A CAREFULLY DELINEATED STAFFING PLAN SO AS NOT TO OVERBURDEN THE MANPOWER CAPABILITIES OF THE GOL, THROUGH BOTH EXPANSION OF MID-LEVEL TRAINING INSTITUTION CAPACITY AND POTENTIAL REDEPLOYMENT OF EXISTING WORKERS. FURTHERMORE, THE TASKS OF VHWS AND TBAS FOCUS ON THOSE HIGH-PRIORITY INTERVENTIONS IDENTIFIED IN AID'S HEALTH SECTOR STRATEGY AS A PACKAGE OF PROVEN, COST-EFFECTIVE

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TECHNOLOGIES. TOGETHER THESE COMPRISE THE MOST IMMEDIATELY AVAILABLE, EFFECTIVE MEANS TO REDUCE INFANT AND CHILD DEATHS.

(3) PER CAPITA COST: THE REVISED FINANCIAL AND ECONOMIC ANALYSIS INDICATE THAT BY 1982 THE GOL WOULD BE SPENDING AN ESTIMATED DOLS 4.62 PER CAPITA ANNUALLY TO DELIVER HEALTH SERVICES IN GRAND GEDEH AND SINOE COUNTIES THROUGH ITS EXISTING DELIVERY SYSTEM. NOTE THAT THIS ESTIMATE DOES NOT CONSIDER THE PHC PROJECT AT ALL, BUT REPRESENTS A PROJECTION OF EXISTING RECURRENT COSTS. IF PHC PROJECT-GENERATED RECURRENT COSTS ARE ADDED, THE ANNUAL PER CAPITA COST WOULD INCREASE BY DOLS 3.51 TO A TOTAL OF DOLS 8.13. LOCKING AT TOTAL COSTS, AND INCLUDING ALL AID FUNDING AS WELL AS ANTICIPATED PL-482 COUNTERPART FUNDS, THE PER CAPITA ESTABLISHMENT COST OVER 5 YEARS IS ABOUT DOLS 63 FOR PROJECT AREA BENEFICIARIES. THIS COST IS WITHIN REASON, ESPECIALLY WHEN ONE REALIZES THAT MUCH OF WHAT IS DEVELOPED AND IMPLEMENTED DURING THE FIRST FIVE PROJECT YEARS WILL BENEFIT THE EXPANSION OF THE NATIONAL PHC PROGRAM TO THE REST OF THE COUNTRY. SPECIFIC PROJECT OUTPUTS WHICH WILL STREAMLINE SUCH EXPANSION INCLUDE (A) STRENGTHENED NATIONAL LOGISTIC AND SUPPLY SYSTEM, (B) STRENGTHENED AND EXPANDED MID-LEVEL TRAINING INSTITUTIONS USING STANDARDIZED AND IMPROVED CURRICULA, (C) EFFECTIVELY OPERATING REVENUE-GENERATING MECHANISMS, AND (D) EFFECTIVE,

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DECENTRALIZED SYSTEMS OPERATING IN TWO COUNTIES. THE PROJECT ALSO PROPOSES TO UTILIZE CENTRALLY-FUNDED ASSISTANCE IN OPERATIONS RESEARCH TO INVESTIGATE THE MOST FEASIBLE, COST-EFFICIENT, AND COST-EFFECTIVE MIX OF PHC PERSONNEL AND SERVICES. RESEARCH RESULTS WILL BE USED TO DETERMINE MODIFICATIONS REQUIRED TO ACHIEVE OPTIMAL RESULTS.

3. IN SUMMARY, THE PHC PROJECT REDESIGN REPRESENTS THE MOST COST-EFFECTIVE COMBINATION OF ELEMENTS TO ACHIEVE THE LEVEL OF HEALTH, SOCIAL, ECONOMIC AND POLITICAL BENEFITS ANTICIPATED. DESPITE THE CURRENT LIBERIAN ECONOMIC AND FINANCIAL CLIMATE, THE PROJECT CONSTITUTES A WORTHWHILE INVESTMENT. WE HAVE PROVIDED ABOVE INFORMATION TO AID/WIC ADVISE ON STEPS TAKEN IN REVISING PROJECT DESIGN AS DIRECTOR RICHARDS INDICATED LAST SUMMER. ASSUMING POSITIVE REVIEW BY USAID SENIOR REVIEW COMMITTEE AND POSITIVE OUTCOME OF FINAL NEGOTIATIONS ON PROJECT WITH GOL (WHICH BEGAN JULY 15), WE STILL ANTICIPATE AUTHORIZATION AND AGREEMENT SIGNING WELL BEFORE END OF FY. SHURTLEFF  
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PROJECT DESIGN SUMMARY  
LOGICAL FRAMEWORK

ANNEX D

PRIMARY HEALTH CARE PROJECT 669-0165

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p><u>Program or Sector Goal:</u></p> <p>To make basic health care accessible to 90 percent of the population of Liberia by the year 2000.</p>	<p><u>Measures of Goal Achievement:</u></p> <p>Portion of population with access to adequate health care, by year:</p> <p>1988: 45 percent 1992: 60 percent 1996: 75 percent 2000: 90 percent</p>	<p>Government reports Independent evaluations and assessments</p>	<p>A. Primary health care remains a priority program of the GOL during the life of the project.</p> <p>B. Growth of the economy and Government revenues allow the GOL to meet the recurrent cost of this program.</p> <p>C. The GOL estimate that 35 percent of the population presently has access to adequate health care is accurate.</p>
<p><u>Project Purpose:</u> The project purpose is twofold:</p> <p>1. To increase the proportion of the target population with access to an appropriate balance of PBC services, as described in the Project Paper.</p>	<p><u>Conditions that will indicate purpose has been achieved:</u></p> <p>1.a. Proportion of population with access to a village health team (within one hour walking time) will reach 80 percent by 1988.</p> <p>b. Increase of 35 percent in utilization of PBC system by 1988.</p> <p>c. Decrease of 10 percent in infant mortality in target villages by 1988.</p> <p>d. Selected service delivery indicators achieved within target villages by 1988:</p> <p>(1) Contraceptive prevalence among eligible couples of childbearing age reaches 12 percent.</p> <p>(2) 70 percent of deliveries attended by trained health worker.</p>	<p>Government reports (including GOL Annual Reports and GOL project reports)</p> <p>M&amp;SW National and county-level budgets and expenditure summaries</p> <p>County work plans</p> <p>Procurement, inventory, and distribution records</p> <p>Appropriate training program curricula for integrated PBC delivery</p> <p>Records of training</p> <p>Supervisor records</p> <p>Service/activity reports</p> <p>Project evaluations</p> <p>Special studies</p> <p>Observation</p>	<p>A. Sufficient qualified or trainable manpower is available to staff the PBC Program.</p> <p>B. Target population participates in PBC Program.</p> <p>C. M&amp;SW adopts improved managerial, administrative, and logistics systems.</p> <p>D. M&amp;SW implements policy permitting target area county health departments to decentralize their planning and operations.</p> <p>E. Remuneration and support for the village health teams is sufficient to maintain effective involvement in the PBC Program.</p>

ANNEX D

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PROJECT DESIGN SUMMARY  
 LOGICAL FRAMEWORK  
 PRIMARY HEALTH CARE PROJECT 669-0165

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p><u>Project Purpose (cont'd):</u></p>	<p><u>Conditions that will indicate purpose has been achieved (cont'd):</u></p> <ul style="list-style-type: none"> <li>e. Training programs providing sufficient numbers of qualified personnel to support the expansion of the national PBC Program, particularly in the target area.</li> <li>f. Central-level MB&amp;SW technical divisions adequately supporting the PBC Program.</li> <li>g. System to provide adequate supervision between different levels of PBC workers in the target counties effectively implemented.</li> <li>h. Self-financing village pharmacy program effectively supplying target villages.</li> </ul>		
<p><u>Outputs:</u></p> <p>1. <u>Village level:</u> Increased access to curative, preventive, and promotive health services for 115,000 rural Liberians through:</p> <ul style="list-style-type: none"> <li>a. Village Development Councils (VDCs) organized, trained and functioning.</li> <li>b. Village health teams (VHTs) organized, trained and functioning.</li> <li>c. Village revolving drug funds functioning.</li> </ul>	<p><u>Magnitude of Outputs:</u></p> <ul style="list-style-type: none"> <li>1.a. 250 VDCs organized and operating</li> <li>b. 250 village health workers (VHTs) trained and supported</li> <li>640 traditional birth attendants (TBAs) trained and supported.</li> <li>c. 250 drug funds developed and effectively operating</li> </ul>	<p>Government reports</p> <p>Project monitoring, site visits, and evaluations</p> <p>MB&amp;SW personnel records</p> <p>Procurement, inventory, and distribution records</p> <p>Training institution records, revised curricula</p> <p>Special studies</p>	<ul style="list-style-type: none"> <li>A. USAID and GOL deliver project inputs on schedule.</li> <li>B. MB&amp;SW effectively trains, recruits, retains and deploys staff at all levels to meet PBC needs.</li> </ul>

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PROJECT DESIGN SUMMARY  
LOGICAL FRAMEWORK  
PRIMARY HEALTH CARE PROJECT 669-0165

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>Outputs (cont'd):</p> <p>2. <u>County level:</u></p> <p>a. Rural health facility staffs trained and functioning</p> <p>b. County-level decentralization developed and implemented</p> <p>c. County health department staffs trained and functioning</p> <p>d. County health department facilities completed and equipped</p> <p>e. Training teams established and functioning in each county to train village-level workers (VDCs, VHAs, and TBAs)</p> <p>f. Health posts and health centers constructed/renovated and equipped</p> <p>g. County-level revolving drug funds functioning</p> <p>h. Motorcycle purchase scheme developed and functioning</p>	<p><u>Magnitude of Outputs (cont'd):</u></p> <p>2.a. 47 health posts (47 PAs, 47 CHs, 24 HIs); 8 health centers (16 PAs, 8 CHs, 8 HIs, plus supervisory staff of 4 PAs, 4 CHs); 1 MCH center (2 CHs)</p> <p>b. Guidelines developed; policies and procedures established; and systems developed and implemented to provide effectively functioning decentralized operations at county level.</p> <p>c. Supervisory and support staff in each county: County Health Officer, 2 PA Supervisors, 2 CH Supervisors, HI Supervisor, Logistics Officer, Administrative Officer</p> <p>d. County health department headquarters buildings in Grand Gedeh and Sinoe Counties constructed and equipped</p> <p>e. Training team in each county: 3 PAs, 3 CHs</p> <p>f. Facilities constructed/renovated with PL-480 Counterpart Funds, in accordance with USAID/GOL agreements during project life</p> <p>Facilities equipped in accordance with standardized lists</p> <p>g. Policies and procedures established, and systems developed and implemented to provide effectively functioning revolving drug funds at county level</p> <p>h. Guidelines developed; policies and procedures established; and mechanisms developed and implemented for effective operation of motorcycle purchase scheme in the target area</p>		

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PROJECT DESIGN SUMMARY  
 LOGICAL FRAMEWORK  
 PRIMARY HEALTH CARE PROJECT 669-0165

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>3. <u>Central level:</u></p> <p>a. Curricula developed for all PHC health workers to include appropriate PHC content and emphasis</p> <p>b. MHSW central-level managerial and technical units adequately staffed and functioning to support PHC</p> <p>c. Central logistics system strengthened</p> <p>d. Training institutions strengthened</p>	<p>3.a. Curricula developed for orientation/training of village-level health workers (VDCs, VHWs, TBAs)</p> <p>Revised curricula developed and implemented in training programs for FAs, CHs, and HIs</p> <p>b. Key staff member in each of following disciplines trained and functioning in corresponding MHSW support units: MCH, nutrition, health education and inservice education</p> <p>Central-level planning and administrative systems coordinated with and supportive of county-level decentralized operations</p> <p>c. Central warehouse facility constructed</p> <p>Improved systems developed and implemented to support logistical system</p> <p>Two senior logistics/management personnel trained</p> <p>d. Key faculty for TNIMA, RHTC and Zwedru Midwifery School trained and functioning</p> <p>Training materials developed and/or provided</p>		

PROJECT DESIGN SUMMARY  
 LOGICAL FRAMEWORK  
 PRIMARY HEALTH CARE PROJECT 669-0165

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<u>Inputs</u>			
1. <u>USAID inputs:</u>			
Technical assistance	<u>Technical assistance: \$4.28 million</u> 28 person-years long-term, including 11 person-years for 3 locally-hired individuals 62 person-months short-term		
Training	<u>Training: \$1.92 million</u> 44 person-years long-term participant training 79 person-months short-term participant training In-country training program (initial and inservice, workshops, etc.)		
Construction	<u>Construction: \$1.05 million</u> Central drug and medical supplies warehouse Two county health department buildings		
Commodities	<u>Commodity support: \$2.64 million</u> Vehicles; medical equipment; drugs, medical supplies and contraceptives; office equipment and supplies; teaching aids and materials; shipping costs		
Other costs	<u>Other costs: \$2.23 million</u> Vehicle operation and maintenance; research and surveys; evaluations; private sector study; local support costs		
	<u>Inflation: \$1.96 million</u>		
	<u>Contingency: \$0.93 million</u>		

PROJECT DESIGN SUMMARY  
 LOGICAL FRAMEWORK  
 PRIMARY HEALTH CARE PROJECT 669-0165

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p><u>Inputs (cont'd):</u></p> <p>2. <u>GOL inputs:</u></p> <p>Personnel</p> <p>Commodities</p> <p>Construction</p> <p>Other costs</p> <p>3. <u>Village-level inputs:</u></p> <p>4. <u>Peace Corps inputs:</u></p>	<p><u>\$10.50 million</u> personnel costs</p> <p><u>\$ 1.23 million</u> commodities</p> <p><u>\$ 2.35 million</u> construction/renovation (FL-460 Counterpart Funds)</p> <p><u>\$ 1.80 million</u> other costs</p> <p><u>\$ 3.67 million</u> inflation</p> <p><u>\$ 1.59 million</u> contingency</p> <p><u>\$0.27 million</u> to support village-level services</p> <p><u>\$0.58 million</u> to provide 15 Peace Corps Volunteers</p>		

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STATUTORY CHECKLIST

5C(1) - COUNTRY CHECKLIST

Listed below are statutory criteria applicable generally to FAA funds, and criteria applicable to individual fund sources: Development Assistance and Economic Support Fund.

A. GENERAL CRITERIA FOR COUNTRY ELIGIBILITY

1. FAA Sec. 481. Has it been determined that the government of the recipient country has failed to take adequate steps to prevent narcotic drugs and other controlled substances (as defined by the Comprehensive Drug Abuse Prevention and Control Act of 1970) produced or processed, in whole or in part, in such country, or transported through such country, from being sold illegally within the jurisdiction of such country to U.S. Government personnel or their dependents, or from entering the U.S. unlawfully? NO
  
  2. FAA Sec. 620(c). If assistance is to a government, is the government liable as debtor or unconditional guarantor on any debt to a U.S. citizen for goods or services furnished or ordered where (a) such citizen has exhausted available legal remedies and (b) the debt is not denied or contested by such government? No such case exists for Liberia.
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assistance to the government, has it (including government agencies or subdivisions) taken any action which has the effect of nationalizing, expropriating, or otherwise seizing ownership or control of property of U.S. citizens or entities beneficially owned by them without taking steps to discharge its obligations toward such citizens or entities?

No, the GOL has taken no such action.

4. FAA Sec. 532(e), 620(a), 620(f), 620D; FY 1982 Appropriation Act Secs. 512 and 513. Is recipient country a Communist country? Will assistance be provided to Angola, Cambodia, Cuba, Laos, Vietnam, Syria, Libya, Iraq, or South Yemen? Will assistance be provided to Afghanistan or Mozambique without a waiver? NO
5. ISDCA of 1981 Secs. 724, 727 and 730. For specific restrictions on assistance to Nicaragua, see Sec. 724 of the ISDCA of 1981. For specific restrictions on assistance to El Salvador, see Secs. 727 and 730 of the ISDCA of 1981. N/A
6. FAA Sec. 620(j). Has the country permitted, or failed to take adequate measures to prevent, the damage or destruction by mob action of U.S. property? NO

7. FAA Sec. 620(l). Has the country failed to enter into an agreement with OPIC? No, Liberia has an Investment Guaranty Agreement with the U.S.
8. FAA Sec. 620(o); Fishermen's Protective Act of 1967, as amended, Sec. 5. (a) Has the country seized, or imposed any penalty or sanction against, any U.S. fishing activities in international waters? NO
- (b) If so, has any deduction required by the Fishermen's Protective Act been made?
9. FAA Sec. 620(q); FY 1982 Appropriation Act Sec. 517. (a) Has the government of the recipient country been in default for more than six months on interest or principal of any AID loan to the country? (b) Has the country been in default for more than one year on interest or principal on any U.S. loan under a program for which the appropriation bill appropriates funds? (a) NO (b) NO
10. FAA Sec. 620(s). If contemplated assistance is development loan or from Economic Support Fund, has the Administrator taken into account the amount of foreign exchange or other resources which the country has spent on military equipment? (Reference may be made to the annual "Taking into N/A

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 "Yes, taken into account by the Administrator at time of approval of Agency OYB." This approval by the Administrator of the Operational Year Budget can be the basis for an affirmative answer during the fiscal year unless significant changes in circumstances occur.)

11. FAA Sec. 620(t). Has the country severed diplomatic relations with the United States? If so, have they been resumed and have new bilateral assistance agreements been negotiated and entered into since such resumption? NO
12. FAA Sec. 620(u). What is the payment status of the country's U.N. obligations? If the country is in arrears, were such arrearages taken into account by the AID Administrator in determining the current AID Operational Year Budget? (Reference may be made to the Taking into Consideration memo.) Liberia is not in arrears in UN obligations.
13. FAA Sec. 620A; FY 1982 Appropriation Act Sec. 520. Has the country aided or abetted, by granting sanctuary from prosecution to, any individual or group which has committed an act of international terrorism? Has the country aided or NO

abetted, by granting  
sanctuary from  
prosecution to, any  
individual or group which  
has committed a war crime?

14. FAA Sec. 666. Does the  
country object, on the  
basis of race, religion,  
national origin or sex,  
to the presence of any  
officer or employee of  
the U.S. who is present  
in such country to carry  
out economic development  
programs under the FAA? NO
15. FAA Sec. 669, 670. Has  
the country, after August  
3, 1977, delivered or  
received nuclear  
enrichment or  
reprocessing equipment,  
materials, or technology,  
without specified  
arrangements or  
safeguards? Has it  
transferred a nuclear  
explosive device to a  
non-nuclear weapon state,  
or if such a state,  
either received or  
detonated a nuclear  
explosive device, after  
August 3, 1977? (FAA  
Sec. 620E permits a  
special waiver of Sec.  
669 for Pakistan.) NO
16. ISDCA of 1981 Sec. 720.  
Was the country  
represented at the  
Meeting of Ministers of  
Foreign Affairs and Heads  
of Delegations of the  
Non-Aligned Countries to  
the 36th General Session  
of the General Assembly  
of the U.N. of Sept. 25  
and 28, 1981, and failed NO
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to disassociate itself from the communique issued? If so, has the President taken it into account? (Reference may be made to the Taking into Consideration memo.)

17. ISDCA of 1981 Sec. 721. N/A  
See special requirements for assistance to Haiti.

B. FUNDING SOURCE CRITERIA FOR COUNTRY ELIGIBILITY

1. Development Assistance Country Criteria.

a. FAA Sec. 116. Has the Department of State determined that this government has engaged in a consistent pattern of gross violations of internationally recognized human rights? If so, can it be demonstrated that contemplated assistance will directly benefit the needy? NO

2. Economic Support Fund Country Criteria

a. FAA Sec. 502B. Has it been determined that the country has engaged in a consistent pattern of gross violations of internationally recognized human rights? If so, has the country made such significant improvements in its human rights record that furnishing such assistance is in the national interest? NO

b. ISDCA of 1981, Sec. 725(b). If ESF is to be furnished to Argentina, has the President certified that (1) the Govt. of Argentina has made significant progress in human rights; and (2) that the provision of such assistance is in the national interests of the U.S.?

N/A

c. ISDCA of 1981, Sec. 725(b). If ESF assistance is to be furnished to Chile, has the President certified that (1) the Govt. of Chile has made significant progress in human rights; (2) it is in the national interest of the U.S.; and (3) the Govt. of Chile is not aiding international terrorism and has taken steps to bring to justice those indicted in connection with the murder of Orlando Letelier?

N/A

## 5C(2) PROJECT CHECKLIST

Listed below are statutory criteria applicable to projects. This section is divided into two parts. Part A. includes criteria applicable to all projects. Part B. applies to projects funded from specific sources only: B.1. applies to all projects funded with Development Assistance Funds, B.2. applies to projects funded with Development Assistance loans, and B.3. applies to projects funded from ESP.

CROSS REFERENCES: IS COUNTRY CHECKLIST UP TO DATE? HAS STANDARD ITEM CHECKLIST BEEN REVIEWED FOR THIS PROJECT?

A. GENERAL CRITERIA FOR PROJECT1. FY 1982 Appropriation Act Sec. 523; FAA Sec. 634A; Sec. 653(b).

(a) Describe how authorizing and appropriations committees of Senate and House have been or will be notified concerning the project;  
 (b) is assistance within (Operational Year Budget) country or international organization allocation reported to Congress (or not more than \$1 million over that amount)?

(a) a CN has been forwarded to Congress, and the 15-day waiting period has elapsed without response.

(b) Yes

2. FAA Sec. 611(a)(1). Prior to obligation in excess of \$100,00, will there be

- (a) engineering, financial or other plans necessary to carry out the assistance and (b) a reasonably firm estimate of the cost to the U.S. of the assistance? (a) Yes  
(b) Yes
3. FAA Sec. 611(a)(2). If further legislative action is required within recipient country, what is basis for reasonable expectation that such action will be completed in time to permit orderly accomplishment of purpose of the assistance? N/A
4. FAA Sec. 611(b); FY 1982 Appropriation Act Sec. 501. If for water or water-related land resource construction, has project met the standards and criteria as set forth in the Principles and Standards for Planning Water and Related Land Resources, dated October 25, 1973? (See AID Handbook 3 for new guidelines.) N/A
5. FAA Sec. 611(e). If project is capital assistance (e.g., construction), and all U.S. assistance for it will exceed \$1 million, has Mission Director certified and Regional Assistant Administrator taken into consideration the country's capability effectively to maintain and utilize the project? N/A
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6. FAA Sec. 209. Is project susceptible to execution as part of regional or multilateral project? If so, why is project not so executed? Information and conclusion whether assistance will encourage regional development programs. NO
7. FAA Sec. 601(a). Information and conclusions whether project will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; and (c) encourage development and use of cooperatives, and credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions.
- (a) minimal effect  
 (b) will encourage a village-level initiative in solving their health care problems.  
 (c) minimal or no effect  
 (d) no effect  
 (e) will improve human resources efficiency by decreasing number of idle days due to illness  
 (f) no effect
8. FAA Sec. 601(b). Information and conclusions on how project will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise).
- The project will provide U.S. technical assistance and commodities. Most of these inputs will be obtained in the U.S.

9. FAA Sec. 612(b), 636(h);  
FY 1982 Appropriation  
Act Sec. 507. Describe  
steps taken to assure  
that, to the maximum  
extent possible, the  
country is contributing  
local currencies to meet  
the cost of contractual  
and other services, and  
foreign currencies owned  
by the U.S. are utilized  
in lieu of dollars. GOL contributions to this  
activity will be assured  
through normal budget  
allocations.
10. FAA Sec. 612(d). Does  
the U.S. own excess  
foreign currency of the  
country and, if so, what  
arrangements have been  
made for its release? NO
11. FAA Sec. 601(e). Will  
the project utilize  
competitive selection  
procedures for the  
awarding of contracts,  
except where applicable  
procurement rules allow  
otherwise? YES
12. FY 1982 Appropriation Act  
Sec. 521. If assistance  
is for the production of  
any commodity for export,  
is the commodity likely  
to be in surplus on world  
markets at the time the  
resulting productive  
capacity becomes  
operative, and is such  
assistance likely to  
cause substantial injury  
to U.S. producers of the  
same, similar or  
competing commodity? N/A
13. FAA 118(c) and (d).  
Does the project comply  
with the environmental  
procedures set forth in  
AID Regulation 16? Does YES

the project or program take into consideration the problem of the destruction of tropical forests?

N/A

14. FAA 121(G). If a Sabel project, has a determination been made that the host government has an adequate system for accounting for and controlling receipt and expenditure of project funds (dollars or local currency generated therefrom)?

N/A

## B. FUNDING CRITERIA FOR PROJECT

### 1. Development Assistance Project Criteria

a. FAA Sec. 102(b), 111, 113, 281(a). Extent to which activity will (a) effectively involve the poor in development, by extending access to economy at local level, increasing labor-intensive production and the use of appropriate technology, spreading investment out from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using the appropriate U.S. institutions; (b) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward better life, and

- (a) The project is intended to increase the number of rural Liberians having access to adequate health care. The project will adopt a community - based approach in decision-making, planning, implementing and evaluating.
- (b) By adopting a community-based approach, the project will stimulate the motivation of rural people to undertake projects at the community level and thus foster the cooperative spirit, which is fundamental to developing cooperative organizations.

otherwise encourage democratic private and local governmental institutions; (c) support the self-help efforts of developing countries; (d) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (e) utilize and encourage regional cooperation by developing countries?

- (c) The project will encourage village-level people to undertake projects to which they themselves contribute financially and "in-kind".
- (d) The project will promote the extension of health care services to all people in the rural counties covered by the projects including women.
- (e) No effect.

b. FAA Sec. 103, 103A, 104, 105, 106. Does the project fit the criteria for the type of funds (functional account) being used?

YES

c. FAA Sec. 107. Is emphasis on use of appropriate technology (relatively smaller, cost-saving, labor-using technologies that are generally most appropriate for the small farms, small businesses, and small incomes of the poor)?

d. FAA Sec. 110(a). Will the recipient country provide at least 25% of the costs of the program, project, or activity with respect to which the assistance is to be furnished (or is the latter cost-sharing requirement being waived for a "relatively least developed" country)?

YES

100

e. FAA Sec. 110(b). Will grant capital assistance be disbursed for project over more than 3 years? If so, has justification satisfactory to Congress been made, and efforts for other financing, or is the recipient country "relatively least developed"? (M.O. 1232.1 defined a capital project as "the construction, expansion, equipping or alteration of a physical facility or facilities financed by AID dollar assistance of not less than \$100,000, including related advisory, managerial and training services, and not undertaken as part of a project of a predominantly technical assistance character.

f. FAA Sec. 122(b). Does the activity give reasonable promise of contributing to the development of economic resources, or to the increase of productive capacities and self-sustaining economic growth?

g. FAA Sec. 281(b). Describe extent to which program recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage

The project is intended, ultimately, to increase health care coverage to rural Liberians and thus increase the productive capacity of the Liberians themselves.

Liberia is characterized by a high infant/child death rate and inadequate provision of health services to the rural poor. The project will focus on one of Liberians' major concerns - health - by working with the country's trained health officials to develop a better health care system. The project will also support training of community health workers.

institutional development;  
and supports civil  
education and training in  
skills required for  
effective participation in  
governmental processes  
essential to self-government.

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## memorandum

DATE: June 23, 1983

REPLY TO  
ATTN OF:

Robert C. Braden, Engineer *RCB*

ANNEX F

SUBJECT:

Project 669-0165, Primary Health Care, Foreign Assistance  
Act of 1961, as amended, Section 611(a)

TO:

Lois Richards, Director

I have examined the information contained in the project paper and find it meets the requirements of Section 611(a) of the Foreign Assistance Act of 1961, as amended.

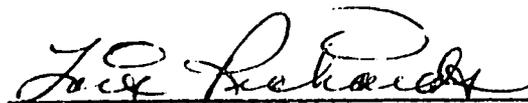
I certify that the construction cost breakdown of the construction elements, i.e., the two county administrative buildings and the central warehouse, as shown in Annex K, are reasonable.

The final plans, specifications and bid documents will be reviewed and approved by the USAID engineer prior to obligation, and competitive bids will be received from local contractors for construction.

CERTIFICATION PURSUANT TO SECTION 611(e) OF THE FOREIGN  
ASSISTANCE ACT OF 1961, AS AMENDED

I hereby certify to the Administrator of the Agency for International Development that the Government of Liberia (GOL) possesses both the financial and human resources to effectively maintain and utilize the Primary Health Care (PHC) Project to be undertaken pursuant to the terms of the A.I.D. grant between the Government of Liberia and the United States of America for the purpose of increasing the proportion of the rural population with access to PHC services, and strengthening the institutional infrastructure required to establish the national PHC Program. In so certifying I have taken into account the maintenance and utilization of projects in Liberia financed and assisted by the United States of America, and I have more particularly taken into account the demonstrated capability of the GOL to effectively utilize development projects of this nature.

Date: August 29, 1983

  
\_\_\_\_\_

Lois Richards  
Director, USAID/Liberia

TECHNICAL FEASIBILITYA. Introduction

The Primary Health Care Project is appropriate for Liberia because it is consistent with the GOL's emphasis on rural development, on improving the health of rural residents through the creation and extension of a national primary health care program, and on self-reliance at the village level. Moreover, the project is consistent with AID's intention of promoting the welfare of the poorest segments of the population -- especially women and children -- through community-based health services (in contrast to hospital-based care).

In 1980 at the National Primary Health Care Workshop, prior to the design of this project, the MH&SW demonstrated its full commitment to PHC, with the emphasis to be placed at first on the underserved southwestern counties. The commitment was followed through during 1981 with the draft National Primary Health Care Program, on which the discussions leading to this project were based.

The Primary Health Care Project builds existing MH&SW organization, facilities, and personnel by reinforcing positive aspects of the system while at the same time addressing current needs and weaknesses by maximizing the use of resources at the village level. The project achieves a cost-effective approach to nationally available health care, while insuring that a strengthened PHC system can remain viable after AID inputs are terminated. This, in turn, maximizes the probability of maintaining better health services leading to continued improvement in Liberia's health status and achievement of AID/s health sector goals.

B. Emphasis at the Village Level1. Prior Experience

The experiences gained in the Maryland County Village Health Workers program, which served as the model for this PHC Project, as well as the lessons of other pilot projects in Liberia, show that the primary health strategy is feasible in Liberia; however, these projects also demonstrated the weaknesses in PHC design and implementation that had to be considered in formulating the PHC project.

Both the UNFPA Bong County Project and the USAID-funded Lofa County Rural Health Project showed that community participation and the development of improved village health care cannot be sustained in the absence of an effective village-level organization. Because of the success of the village development councils in Maryland County, a million-dollar UNDP self-help project has been initiated there with VDCs as the foundation for expanded community development activities. Nevertheless, more continued interaction between VDCs and motivated health workers who are skilled in community development is needed to sustain the self-help orientation. In the PHC Project, the health post staff will be trained to provide orientation, and will make regularly scheduled visits to each village to meet with council members as well as with the village health team. Village health workers in Bong County were trained by the local physician assistants, some of whom lacked sufficient interest or ability to conduct an effective training program. The VHW skills in Bong were preventive only; without the curative component the workers quickly lost their

credibility with villagers. Supervision was weak owing to insufficient trained mid-level workers and lack of transport. Moreover, VHW selection by 'passer' the community. VHWs were paid through the county hospital, which resulted in inadequate local control over the workers. Furthermore, there were no funds to pay VHWs once the project ended. In Maryland, as the VHW project progressed, the substantial financial implication of the MH&SW paid VHW program became difficult to bear. Yet VDC-led communities can effectively support their own health activities, as shown by projects in Lofa, Grand Cape Mount (Bendaja), and Nimba Counties. In the UNDP-funded Women in Health Development Project in Bendaja, villages are successfully regenerating the major costs of drugs sold in the "mind pharmacy".

The PHC Project is designed to address the major weaknesses identified in these projects. The training team concept, already utilized effectively in Maryland, will be strengthened to permit health post level training rather than training only at the county seat. This will facilitate increased village-level field practice that is felt to be needed. The MH&SW is committed to increasing the number of mid-level supervisors for the project area and to insuring their community contact by regularly scheduling community work on weekdays. In addition, the GOL-approved scheme to systematically transfer ownership of motorcycles to the health workers should insure improved vehicle care and maintenance, as have similar arrangements in The Gambia, Mali, and Sierra Leone. A scheme whereby workers pay half of the motorcycle purchase price has worked well in Lofa County.

The MH&SW also endorses the plan for VDCs\* to be responsible for payment for VHW services as well as paying the cost of drugs to sustain the revolving drug fund. This will not only decrease requirements for scarce GOL funds, but will also enhance the worker's accountability to the community. It is considered to be feasible because of a strong historical precedent in Liberia whereby people have traditionally paid for health care services. Villages have long been accustomed to paying fees (often exorbitant) to traditional practitioners, "black baggers", and private pharmacies, as well as to paying for care at both government and mission-operated facilities. While drugs are supposed to be free at government facilities, they have rarely been available. Interviews with villagers in Maryland, Sinoe, and Grand Gedeh Counties, as well as evidence from the Bendaja experience, also support the contention that villagers will contribute financially to their own health care. Ministry support and project technical and financial assistance should insure that the funds collected produce a steady pipeline of drugs available at the village level. Information about the new policy of charging for drugs at health facilities will be widely disseminated via local officials and the LRCN. This should help to allay health worker concerns that patients will believe the workers are "eating" the money.

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\* The role and responsibilities of the VDCs is described in the detailed project description (see Section II.B.2.a).

## 2. PHC training and skills

### a. Village health workers

The VHW training will be strengthened not only by increasing the field experience, but also by developing a more selective, task-oriented focus. The initial training will encompass five weeks. In addition, annual intensive inservice training will be programmed in order to provide reinforcement and expansion of knowledge and skills. The strategy is to build incrementally on a basic core of training skills. The training will be aimed at providing the VHWs with the most effective and safe methods to alleviate the major causes of morbidity and mortality in rural Liberia.

VHWs, along with the VDCs, have been effective in educating and organizing their communities for immunization, which will diminish the incidence of measles, neonatal tetanus, and other childhood diseases. These skills will be expanded to include organization of regular village-level nutrition monitoring and education activities, as part of well-baby/MCH clinics that will be carried out with the assistance of health post staff. The nutrition component will utilize focused nutritional messages, weight charts, and scales that will be provided by the project. Experience with the Pathfinder-funded preventive Medical Services Project in rural Liberia demonstrates that mothers readily accept the weight charts and monitoring process. Village-level workers have successfully carried out monitoring activities in many countries, such as Ghana, Kenya, and Tanzania, and have effected marked reductions in malnutrition. VHWs will also provide treatment of ascariasis; this treatment is not only simple, effective, and dramatic, but also leads to improved nutritional status of the child.

Oral rehydration therapy (ORT) is well recognized as the most simple, safe, effective, and inexpensive method of preventing deaths from diarrhea. VHWs will provide education and distribute oral rehydration solution (ORS) packets, or if packets are unavailable, will review and demonstrate treatment with homemade ORS (locally referred to as "special water"). Distribution of ORS packets is well established in Liberia. However, a practical mechanism for villagers to correctly dilute the packets remains to be worked out. Operations research is planned to address this issue. Some VHWs have been effectively teaching therapy with homemade solutions in Maryland County; however, it is important to standardize the solutions, and to deemphasize sulfonamide treatment of diarrhea, which all too often is the chief means of therapy dispensed by both the VHWs and their supervisors.

Because of widespread misuse and abuse of sulfonamides and antibiotics, it has been decided not to distribute these drugs to village-level workers. As the training and supervisory system becomes firmly established, it may be possible to introduce these drugs in the future. For now, the most important condition that could be treated with these drugs, pneumonia in children, will be handled by speedy referral to the health post, along with symptomatic treatment, and by increased efforts to immunize against measles, which often precipitates fatal pneumonia in young children. The credibility of the VHWs will be maintained through training them in the curative care of injuries, scabies and other skin infections, worms, fever, malaria, and anemia. Moreover, in accordance with the AID-recommended strategy on the most cost-effective

control of malaria in endemic areas of sub-Saharan Africa, chloroquine for malaria prophylaxis will be distributed to pregnant women. Presumptive curative therapy will be available for others, especially children. The tendency to overtreat suspected cases of malaria, observed in Maryland County, will be guarded against in this project. The possibility of emerging chloroquine resistance in Liberia will be carefully monitored, and the malaria strategy will be modified accordingly. Assistance from the regionally-funded Combatting Childhood Communicable Diseases (CCCD) Project is expected to strengthen the implementation of PHC strategies for immunizations, ORT, and malaria, and to coordinate these strategies at all levels.

While early treatment of malaria is expected to decrease anemia in young children (as well as to decrease mortality), the provision of iron for most children also will be required until their iron stores return to normal and they can maintain normal hemoglobin levels through dietary adjustment.

VHWs, in coordination with TBAs, also will be responsible for counseling on the health benefits of child spacing and for providing "non-prescription" contraceptives and refills of oral contraceptives at the village level. The initial history and exam for orals would be performed by the CM or PA, either at the health post or at the monthly village sessions. It might appear that population activities have little chance of success in southeastern Liberia, owing to sparse population density, poorly educated women, and strong, traditional cultures. However, child spacing activities can succeed when presented as an effective and needed health intervention, which indeed they are. As shown in an FPIA project in Sinoe County, well trained and motivated village-level workers can successfully promote child spacing and distribute contraceptives. The experience of the Preventive Medical Services Project in southeastern Liberia also supports this, particularly when family planning activities are closely tied to MCH, and not perceived as an isolated program.

#### b. Traditional birth attendants

Traditional birth attendants have long been well accepted in Liberia and have been trained throughout the country since 1949. In conjunction with the design of the PHC Project, the TBA program is being reviewed and refined so that it will be better able to meet the needs of rural Liberians today. TBA training in this project will be shortened to three weeks, though supplemented by yearly inservice sessions to review and upgrade skills, and by regular, monthly village supervisory contact. The MH&SW had already been planning to develop shorter, more focused training sessions for TBAs.

The training will be simplified in order to focus mainly on improving techniques for deliveries in the village, where TBAs have been practicing for centuries, as opposed to training for clinic deliveries. In this way many more TBAs can be effectively trained. As an incentive, trained TBAs will be provided with a simple delivery kit (donated by UNICEF). These kits are already used elsewhere in Liberia, and are viewed by both TBAs and villagers as a "credential" indicating their job. More importantly, as shown in the Lofa County Project, trained TBAs can command higher fees than their untrained counterparts.

In addition to hygienic delivery techniques, TBAs will be trained to provide prenatal counseling, including provision of iron and folate supplements and

referral for specified high-risk factors. However, it is expected that at some point during pregnancy, almost all pregnant women will be examined by health post staff, either at the health post or during the monthly village MCH clinics.

The TBAs will work with VHWs to coordinate immunization with tetanus toxoid and to provide chloroquine for malaria prophylaxis. TBAs will also assist in maternal and infant nutrition education by communicating a few simple messages. The TBAs will complement and reinforce the VHWs with child spacing counseling and provision of non-prescription contraceptives.

The VHWs and TBAs will establish credibility through providing curative care and safer deliveries, and will also deliver improved preventive and promotive services. The initial range of village health team functions is based upon available epidemiological data and experience with the most high-import, simple, safe, established, and cost-effective approaches. Admittedly, the statistical base is imprecise, but the broad range of causes is clear. Surveys at the start of the PHC project will yield a better, community-based statistical foundation. If these data indicate different approaches to village-level care are needed, these will be explored.

Operations research studies will investigate the effectiveness of preservice and inservice training modules and the degree to which all the proposed health worker activities are accepted and effectively carried out. Based on the results, the mix of health worker activities will be adjusted as the program develops. Similarly, three different parameters of VHW and TBA training will be considered: (1) length and content of preservice training, (2) length, frequency, and content of periodic inservice training, and (3) the desirability of splitting the preservice training into two parts.

### 3. Supervisory and logistical support

Previous VHW programs, such as in Maryland County, and TBA training throughout Liberia have been hampered by inadequate supervision and support. In the PHC Project, supervision and support will be improved through the MH&SW's commitment to increasing the number of trained mid-level workers in the target counties, training these workers in VHT supervision, and providing adequate transport and supplies.

#### a. Coverage

Poor accessibility of health services has hindered many pilot projects in Liberia. Under the PHC Project, sufficient village-level workers will be recruited and trained in Grand Gedeh and Sinoe Counties so that villagers will be within approximately one hour walking distance.

TBAs have been available and accepted in rural Liberia for centuries. The Maryland Project demonstrated that sufficient numbers of people qualified to become VHWs are available and will be well accepted by their communities. Moreover, attrition was less than five percent over five years. Only two of the Maryland VHWs came from the ranks of traditional healers, and only two were women. However, since the traditional healers were found to be effective VHWs and they are already well respected and established in their communities, their selection will be encouraged in the PHC project. Women VHWs will also

be given preference because of their natural affinity for and access to the most vulnerable target groups and because of their demonstrated success in other projects in Liberia.

With the planned number of 47 fully staffed health posts and health centers, the PAs and the CMs will typically cover an area with a radius of about seven miles. With motorcycles, participation in village MCH clinics and other village-level activities should be easily accomplished. Experience in Lofa County indicates that female workers are unlikely to drive motorcycles on their own. Consequently, two-seat motorcycles will be provided so that the CMs can travel with the PAs or HIs.

b. Mid-level health workers

The development of sufficient numbers of mid-level health workers is the key to the success of PHC in Liberia. Village-level workers have only a few weeks of initial training, which is appropriate. However, the lack of continued supportive supervision and inservice training has been the undoing of many PHC schemes. Through a covenant to this project, the MH&SW has demonstrated its commitment to deploy increased numbers of PAs and CMs to the rural health facilities in the target counties, where they will serve as front-line workers, supervisors, and members of the county-level training teams.

As currently envisaged, village-level workers and their mid-level supervisors will have at least two opportunities a month to meet and work together. At least once a month the health post staff (preferably both the PA and CM) will travel to each village and conduct a session for the villagers including immunizations, weighing of children, and educational and promotional activities. In addition, the VHWs will be expected to travel to their supervising health post on a monthly basis, in some cases to accompany referral patients but also to attend one-day informal training sessions for the VHWs in the area served by the health post.

In addition to inservice workshops to train deployed mid-level workers in their new role and functions, the project provides for the review and strengthening of the curricula for the preservice training of the mid-level workers. A curriculum workshop in year 3 will review the initial impact of the new curriculum. The project will also fund long-term participant training to improve the curriculum development and training methodology skills of two Liberians; and will support the training institutions with provision of training aids, transportation for field work, long-term training for several faculty members, and posting of Peace Corps Volunteers to assist in key training areas while the Liberians are in training.

c. Supplies

At both the village and health post levels, there must be an adequate supply of essential drugs to insure the success of this project. This will be insured not only by establishing and operating revolving drug funds at both the village and county health facility levels, but also through strengthening the transportation and supply system as part of county-level decentralization. AID will support the construction of a central drug and medical supplies warehouse, as well as county health department buildings which incorporate drug and

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supplies storage facilities. Project funds will also provide vehicles for central and county-level distribution. Long-term technical assistance will coordinate the development of the new systems.

#### 4. County-level decentralization

The MH&SW is committed to the concept of decentralizing county-level operations, and has formally agreed that county health departments in the target area will operate with decentralized budgets, financial management, and operational management. This will permit local decision-making, under central guidelines, that should be far more appropriate to meet local needs, and will eliminate the unwieldy mechanisms that are presently controlled at the central level.

The analysis undertaken in designing this project indicates that the national PHC Program can be accomplished only by strengthening the Ministry's management systems, especially at the county level. In implementing these changes to support the PHC Program the role of the central MH&SW will shift to program planning, standard setting, evaluating, and providing technical assistance and guidance to the county-level staffs.

In summary, the analysis concludes that the high-priority interventions incorporated into the PHC project, especially at the village level, are both feasible and appropriate for Liberia. These interventions have been identified in AID's Health Sector Strategy as a package of proven, cost-effective technologies which together comprise the most immediately available, effective means to reduce infant and child deaths.

## FINANCIAL ANALYSIS

### A. Introduction

This analysis focuses on the ability of the GOL to effectively contribute to and eventually institutionalize and sustain the activities proposed in this project. The analysis also considers the willingness and ability of the GOL to institute cost-saving and revenue-generating policies to partially finance the system. Finally, the project is assessed in terms of its replicability on a wider scale. A summary of mechanisms to improve the financial viability of the project under prevailing financial conditions is included.

### B. GOL Revenue and Financial Stability Prospects

Figure H-1 summarizes GOL recurrent expenditures and revenues for the past eight fiscal years.\* Beginning in FY 80/81, the GOL has experienced an increasing annual deficit. The current world economic recession has severely affected prices for Liberia's major exports such as rubber, iron ore and wood products and has resulted in decreased revenues for these products. Also, political events in the country since 1980 have contributed to the poor economic performance to date. Remaining local and prospective foreign investors are cautious about investing in Liberia at this time.

The outlook for improvement in the GOL's revenue in the short-term future is not encouraging. In FY 78/79, 84 per cent of total revenue collections came from three sources: taxes on international trade (39 per cent), taxes on domestic production (10 per cent), and taxes on income and profit (35 per cent). By comparison, in FY 81/82 only 75 per cent of total revenues were derived from these sources (taxes on international trade, 31%; taxes on domestic production, 9%; and taxes on income and profits, 35%).

For two consecutive years, FY 80/81 and FY 81/82, the gross domestic product is estimated to have declined by 5 per cent per capita per year. Under these deteriorating economic conditions, the GOL has entered into a series of standby agreements with the International Monetary Fund (IMF), in an attempt to restore fiscal stability and therefore confidence in the Liberian economy. The objectives and policies adopted by the GOL as part of the IMF Standby Agreement include the following fiscal measures, which address development projects and overall revenue prospects of the GOL. Although these measures were adopted specifically for FY 82/83, they probably constitute the best indicator of GOL fiscal and economic performance for the next four to five years.

1. Cuts in government spending will constitute the major instrument in trying to balance the GOL budget deficits.

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\* The GOL fiscal year is July 1 through June 30.

FIGURE H-1: SUMMARY OF GOL RECURRENT EXPENDITURES AND REVENUES FOR SELECTED FISCAL YEARS (\$ MILLION)

	<u>74/75</u>	<u>75/76</u>	<u>76/77</u>	<u>77/78</u>	<u>78/79</u>	<u>79/80</u>	<u>80/81</u>	<u>81/82</u>	<u>82/83</u>
Budgeted Expenditure	89.3	96.1	117.0	138.8	180.8	195.3	246.5	304.2	272.8
Actual Expenditure	79.8	87.6	117.7	137.2	156.5	196.8	241.0	287.1	270.0*
Actual Revenues	125.3	149.8	172.7	190.6	204.1	222.4	223.0	237.9	220.0*
Actual Surplus or (Deficit)	45.5	62.2	55.2	53.4	47.6	25.6	(18.0)	(49.2)	(50.0)*

\* For FY 82/83 actual expenditure and actual revenues are estimated; thus the corresponding deficit is approximate.

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2. For FY 81/82, the GOL ordered the freezing of all hiring and salaries in order to meet the terms of its standby agreement with the IMF, and it is likely to do the same in the near future.
3. For FY 82/83, in order to control rising recurrent costs and meet the IMF obligations, the GOL ordered a 15 per cent reduction in recurrent costs in all government ministries and public corporations. The reductions were expected to result from stricter enforcement of the hiring freeze, eliminating unfilled positions, implementing an early retirement program, and making selective reductions in operating expenses. In fact, the major reduction resulted from a program of salary reductions of from 16.67% to 25%\*, for all GOL and public corporation employees earning more than \$200/month. This measure was announced in December 1982, and went into effect in January 1983.

These measures are expected to work towards a balanced budget in the future, and to generate domestic resources for development spending. However, the fundamental causes of the GOL's financial problems, low investor confidence and low prices for Liberia's major export commodities, remain unresolved. Although the PRC Government is instituting measures to improve internal financial management, it is likely that the current unfavorable GOL financial situation will persist for the next 3 to 5 years.

The GOL has indicated that it will curtail commitments to support development projects because of its financial problems. The GOL has also stated that development spending in FY 83/84 would be selective, favoring projects nearing completion and those with quickly maturing and profitable returns. Although the PHC Project does not meet these criteria, it represents an important long-term investment in expanding needed services to the rural population. As such it has the strong support and commitment of the GOL.

### C. Health Sector Budget Prospects

Figure H-2 summarizes GOL health sector budgetary allocations for the past three years.\*\* Note that in GOL budgetary terms, the health sector budget has two components: the JFK Medical Center and MH&SW. Of particular interest to the PHC Project are MH&SW allocations as a function of the total GOL budget in order to assess the GOL's financial commitment to the MH&SW. The percentages are indicated in parentheses.

The figure indicates that the MH&SW recurrent budget has been within a rather narrow range of between 6.0 and 6.5 per cent during the three year time period. On the other hand, as a result of the government-wide 15 per cent reduction in FY 82/83, the MH&SW budget is 24.5 per cent below the FY 81/82 level, in nominal terms.

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\* December 1982 salary reduction scale:

\$1500 or more monthly salary:	25% cut
\$750 --\$1499 monthly salary:	20% cut
\$200 -- \$749 monthly salary:	16.67% cut

\*\* Expenditure data would better illustrate GOL health sector priorities, but these data are not available for the entire period.

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FIGURE H-2: SUMMARY OF GOL HEALTH SECTOR BUDGETARY ALLOCATIONS FOR THE PERIOD FY 80/81 THROUGH FY 82/83 (\$000)

	FY 80/81		FY 81/82		FY 82/83		
	RECURRENT COSTS	DEVELOPMENT COSTS	RECURRENT COSTS	DEVELOPMENT COSTS	RECURRENT COSTS	DEVELOPMENT COSTS	ADJUSTED RECURRENT COSTS*
MH&SW	16,049 (6.5%)	1,463 (5.4%)	18,580 (6.1%)	1,020 (0.8%)	16,516 (6.0%)	8,098 (5.5%)	14,039 (6.0%)
JFK	<u>10,830</u>	<u>1,234</u>	<u>12,382</u>	<u>4,900</u>	<u>9,832</u>	<u>122</u>	<u>8,357</u>
TOTAL FOR HEALTH SECTOR	26,879 (10.9%)	2,697 (2.1%)	30,962 (10.2%)	5,920 (4.5%)	26,348 (9.7%)	8,220 (5.6%)	22,396 (9.6%)
TOTAL FOR GOL	246,500	126,000	304,200	126,900	272,900	147,200	231,965

\* The adjustment reflects the Government-wide reduction of 15 per cent of the original FY 82/83 budget.

Note: Figures in parentheses indicate the corresponding percentage of the total GOL budget.

Source: MH&SW Budgets

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The recurrent MH&SW FY 82/83 budget of \$14,039 million, which incorporates the 15 per cent Government-wide cut, becomes the base figure for developing estimated budgets for FY 83/84 and future years. It is reasonable to assume that the MH&SW budget growth will parallel the overall GOL budget growth for the future. In fact, as a covenant to this project the GOL has agreed to maintain budgetary allocations for MH&SW operating expenses at no less than its current percentage level of the national budget. As indicated earlier, the budgetary outlook in the short term is poor. This means that MH&SW will have to depend primarily on both user financing mechanisms and improved management of current resources to absorb most of the estimated \$1.8 million of project-generated recurrent costs, as well as for the corresponding annual increments in future years.

#### D. Health Sector Absorptive Capacity

Figure H-3 provides an estimate of the project-generated recurrent costs that the MH&SW will have to incorporate into its annual operating budgets\*, and indicates that by "project year 6" (the year after this initial AID funding is exhausted), the annual incremental project-generated recurrent cost will represent less than 4 per cent of the MH&SW budget. Projections of the MH&SW budget based on national financial and economic forecasts are presented in Figures H-5 and H-6. Each figure is based on a different set of assumptions, to help assess the probability that the MH&SW will be able to absorb the project-generated recurrent costs.

The assumptions underlying Projection A of the MH&SW budget are as follows:

1. During the first two project years\*\*, the MH&SW budget will experience a negative real growth of about 8 per cent, equal to the estimated rate of inflation.
2. During the third year, the negative real growth will be reduced from -8 per cent to -4 per cent by a projected 4 per cent budget increase.
3. In the last two project years, the budget will experience no growth, with the rate of inflation equalling the amount of budgetary increase.

The assumption underlying Projection B is that after the FY 1982/83 cuts, the MH&SW budget will experience a real growth of zero. This means that budgetary increases will only keep pace with the rate of inflation at least until the end of project year 5. Budget increases forecast in Projection B would probably permit the MH&SW to absorb project recurrent costs. However, if one

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\* For illustrative purposes, the total MH&SW budget projections follow the assumptions for budget project A, as described below.

\*\* For simplicity, project years are equated to GOL fiscal years in this discussion. However, as shown in the implementation schedule it is expected that the project years will lag behind the GOL fiscal years by one month.

FIGURE H-3

PROJECTED MH&SW INCREMENTAL RECURRENT COSTS FOR THE PROJECT AREA

CATEGORY	PROJECT YEAR						T O T A L	(6)
	1	2	3	4	5			
PERSONNEL	-	140,000 94%	282,000 97%	401,000 93%	430,000 90%	1,253,000 93%	430,000 93%	
VEHICLE MAINTENANCE & OPERATION	-	-	-	21,000 4%	44,000 7%	64,000 4%	27,000 6%	
OTHER MISCELLANEOUS	-	10,000 6%	11,000 3%	12,000 3%	13,000 3%	47,000 3%	3,000 1%	
Subtotal	-	150,000	293,000	434,000	487,000	1,364,000	460,000	
INFLATION AT 8% COMPOUNDED ANNUALLY	-	21,000	69,000	145,000	215,000	451,000	249,000	
TOTAL		171,000	362,000	579,000	702,000	1,815,000	709,000	

FIGURE H-4

PROJECT-GENERATED RECURRENT COSTS AS A PROPORTION OF MH&SW RECURRENT COSTS (\$000)

CATEGORY	PROJECT YEAR						T O T A L	(6)
	1	2	3	4	5			
MH&SW RECURRENT BUDGET	14,039	14,039	14,600	15,769	17,030	75,477	18,392	
PHC PROJECT-GENERATED RECURRENT COSTS	-	171 (1.2%)	362 (2.5%)	579 (3.7%)	702 (4.1%)	1,815 (2.4%)	709 (3.9%)	

H-2  
(6)

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FIGURE H-5: PROJECTED MH&SW BUDGET FOR FISCAL YEARS 82/83 THROUGH 87/88 (\$000)

PROJECTION A

	FY 82/83 (ADJUSTED)	FY 83/84 (0%)	FY 84/85 (0%)	FY 85/86 (+4%)	FY 86/87 (+8%)	FY 87/88 (+8%)
Personnel	9,217	9,217	9,217	9,586	10,353	11,181
Other Services	505	505	505	525	567	613
Materials/Supplies	1,083	1,083	1,083	1,126	1,216	1,314
Equipment	93	93	93	97	104	113
Subsidies/Grants	3,141	3,141	3,141	3,267	3,528	3,810
TOTAL	14,039	14,039	14,039	14,601	15,768	17,031

Note 1: The percentages shown in parentheses in the column headings indicate the net change in the budgetary figures from year to year (see text discussion for Projection A).

Note 2: The FY 82/83 budget was adjusted by reducing personnel costs by 19% (to reflect the overall salary cuts), and then making necessary reductions in other line items so that the total reflects a 15% decrease from the original MH&SW budget.

FIGURE H-6: PROJECTED MH&SW BUDGET FOR FISCAL YEARS 82/83 THROUGH 87/88 (\$000)

PROJECTION B

	FY 82/83 (ADJUSTED)	FY 83/84 (+8%)	FY 84/85 (+8%)	FY 85/86 (+8%)	FY 86/87 (+8%)	FY 87/88 (+8%)
Personnel	9,217	9,954	10,751	11,611	12,540	13,543
Other Services	505	545	589	636	687	742
Materials/Supplies	1,083	1,170	1,263	1,364	1,473	1,591
Equipment	93	100	108	117	127	137
Subsidies/Grants	3,141	3,392	3,664	3,957	4,273	4,615
<b>TOTAL</b>	<b>14,039</b>	<b>15,161</b>	<b>16,375</b>	<b>17,685</b>	<b>19,100</b>	<b>20,628</b>

Note 1: The percentages shown in parentheses in the column headings indicate the net change in the budgetary figures from year to year (see text discussion for Projection B).

Note 2: The FY 82/83 budget was adjusted by reducing personnel costs by 19% (to reflect the overall salary cuts), and then making necessary reductions in other line items so that the total reflects a 15% decrease from the original MH&SW budget.

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assumes that budgetary increases are normally distributed equitably among all nine counties, then the two project counties would benefit at the expense of activities in other counties. Unfortunately, Projection B is considered to be too optimistic under Liberia's current economic conditions, and will not be considered further in this analysis.

Projection A is less optimistic, and is considered to provide a fairly realistic basis for assessing the financial impact of the project-generated recurrent costs. Nonetheless, it would be unrealistic to assume that most of the annual budget increase would be used only for recurrent costs in the two project counties. Thus if the assumptions underlying Projection A prove to be correct, the MH&SW could experience some difficulties in assuming all project-generated recurrent costs exclusively from annual budget increases. Therefore, it is important to consider both planned and potential mechanisms to reduce the pressure on budgetary increases as the source for meeting project-generated costs for which the GOL is responsible.

#### E. Minimizing GOL Recurrent Costs in the PHC System

The project design already incorporates three mechanisms which will help to reduce the recurrent cost burden on the GOL as the PHC system develops. In addition, redeployment of existing personnel to the project area could have an additional effect. Each of these mechanisms is discussed in the subsections which follow, with references to more detailed descriptions where appropriate.

##### 1. Remuneration of VHWs and TBAs by villagers

As discussed in the detailed project description, the villagers themselves will remunerate both VHWs and TBAs. Traditionally this has been the case for TBAs, but by extending it to VHWs as well it will cover the cost of all village-level workers in the project area, for an estimated total of \$274,000 during the first five project years.

##### 2. Revolving drug funds at both county and village levels

These two funds are also discussed in the detailed project description, and in each case the importance of regenerating sufficient funds for purchasing replacement drugs is emphasized. If the revolving funds work as expected, the charges made to patients for drugs will finance sufficient additional purchases to make the systems self-sustaining, so that the long-term requirement for GOL expenditures for drugs will be drastically reduced.

##### 3. Motorcycle purchase scheme

The motorcycle purchase scheme involves the sale of project-funded motorcycles to MH&SW staff at lower than market cost. Payments will be made via a monthly installment plan, or other mutually agreed mechanism, based on a contract with each employee (see detailed project description for further discussion). Although the MH&SW will ultimately provide limited funds for operating expenses, the scheme will eventually allow for a major reduction in the GOL expenditure for necessary local transportation in the county-level system. However, the MH&SW will

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have the authority to use the funds generated by the scheme either to purchase more motorcycles or to support other mutually agreed project-generated recurrent costs. Based on the recent approval of a similar motorcycle purchase scheme for another AID-funded project, the principle has already been accepted by the GOL.

#### 4. Redeployment of existing personnel

At least 90 per cent of project-generated recurrent costs are for the salaries of personnel to be deployed in the project area -- to provide adequate staffing of health posts, health centers, and the county health department in order to support the PHC system. In principle, if staff already on the MH&SW's payroll are redeployed to the project counties from areas with relative excesses of the corresponding health worker categories, the impact on the GOL budget could be minimized.

The impact of such a redeployment scheme is enhanced if it is implemented early in the project. For example, at the beginning of project year 2 approximately 34 additional mid-level personnel (PAs, CMs, HIs) will be required in Grand Gedeh County to complement the 15 existing staff in these categories. If these 34 staff members would be redeployed from elsewhere in the delivery system at the beginning of year 2, the resulting saving in project-generated recurrent cost would be \$540,000, or 41 per cent of the total project-generated recurrent costs.\* However, if the redeployment program were delayed for two years, the savings from redeployment (instead of new hiring) would be cut in half -- only \$280,000, or about 20 per cent of total project-generated recurrent costs.

It is important to note, in relation to the redeployment concept just indicated, that there is a general MH&SW policy committing the Ministry to employ all new graduates of GOL health worker training programs. Assuming that this policy continues, then insofar as such new graduates are assigned to work in the PHC Project target counties, their salaries would be counted as project-generated recurrent costs; whereas if they were assigned elsewhere, Their salaries would not. If one makes an argument similar to that for redeployment -- that newly hired graduates are not project-generated costs (since they would become part of the Ministry's budget anyway) - then the potential "savings" in either case are not real.

In any case, taking into account the various additional cost reduction mechanisms available to the GOL (attrition, early retirement, etc), it seems clear that the project-generated salary cost can be met. To the extent necessary, PL-480 counterpart funds can be applied to meet the remaining costs.

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\* The annual cost of these 34 personnel in year 2 is \$140,000 (Figure H-3), and similarly for the next three years, for a total of \$560,000.

### F. Per Capita Cost and Replicability

Figure H-7 indicates the estimated combined budget for the project counties during the first five project years, as well as the base year (FY 82/83). Note that by project year 5 (FY 87/88) the annual cost is \$923,000, yielding a per capita cost of \$4.62 -- that is, the cost of providing health services in the target counties without the PHC Project. If project-generated costs are added (Figure H-3), the per capita cost would increase by \$3.51 to a total of \$8.13.

The establishment costs of the PHC system are represented largely by AID funds that will be used to provide the technical assistance, commodities, training, and operational costs required to establish the system. Financing both central-level activities and those at training institutions serving all of Liberia make the estimation of per capita establishment cost more complex. However, if it is assumed that two-thirds of AID expenditures will primarily benefit the citizens of the project counties, then the per capita establishment cost over five years is approximately \$50.00. If the \$3.5 million PL-480 counterpart funds are added, the cost increases to about \$68 per capita over five years. These costs are within reason, especially when one realizes that much of what is developed and implemented in these two counties (other than physical infrastructure) will be transferable to the other counties at a much lower per capita cost.

On the question of replicability, this analysis indicates that the GOL cannot afford to expand the PHC Program to the remainder of Liberia in the near future, even if all capital costs were to be financed by international donors. It is worth noting that there are major manpower development constraints in addition to financial ones. On the other hand, the GOL's current financial position is too constrained to provide the basis for a fair assessment of the project's replicability. As discussed in the Economic Analysis (Annex H-3), the project constitutes a low-cost, affordable strategy for achieving the principal health sector goal.

Figure H-8 projects total GOL expenditures attributable to the PHC Project over the first five years, indicating a total contribution of \$21.14 million. Note that the personnel category contributes \$10.5 million, or about half of the total expenditure.

Assuming the economy shows some positive growth by the end of this period, and assuming that health service delivery continues to be a priority area for expansion, then the PHC system developed under the project would be replicable, with foreign financing of major establishment costs in the remaining phases of the GOL's National Primary Health Care Program.

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FIGURE H-7: PROJECTION OF ESTIMATED COMBINED BUDGET FOR SINOE AND GRAND GEDEH COUNTIES  
FOR FY 82/83 THROUGH FY 87/88 (\$000)

	FY 82/83 (ADJUSTED)	FY 83/84 (0%)	FY 84/85 (0%)	FY 85/86 (4%)	FY 86/87 (8%)	FY 87/88 (8%)
PERSONNEL	619	619	619	644	695	751
MATERIALS/SUPPLIES	19	19	19	20	21	23
SUBSIDIES	86	86	86	89	97	104
OTHER COSTS	<u>37</u>	<u>37</u>	<u>37</u>	<u>38</u>	<u>42</u>	<u>45</u>
TOTAL	761	761	761	791	855	923

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FIGURE H-8: ESTIMATED GOL ANNUAL EXPENDITURES ATTRIBUTABLE TO THE PHC PROJECT (\$000)

CATEGORY	PROJECT YEAR					TOTAL
	1	2	3	4	5	
<b>PERSONNEL:</b>						
County	427	567	734	904	989	3,621
National	1,293	1,293	1,337	1,429	1,527	6,879
DRUGS	209	209	217	235	254	1,124
PL-480 COUNTERPART FUNDS	400	800	800	750	750	3,500
VEHICLE OPERATION AND MAINTENANCE	14	14	15	37	61	141
MATERIALS AND SUPPLIES	20	20	21	22	24	107
SUBSIDIES	86	86	89	97	104	462
OTHER COSTS	-	10	10	11	12	43
SUBTOTAL	<u>2,449</u>	<u>2,999</u>	<u>3,223</u>	<u>3,485</u>	<u>3,721</u>	<u>15,877</u>
INFLATION	112	363	676	1,081	1,440	3,672
CONTINGENCY	<u>280</u>	<u>295</u>	<u>317</u>	<u>349</u>	<u>347</u>	<u>1,588</u>
TOTAL	<u><u>2,841</u></u>	<u><u>3,657</u></u>	<u><u>4,216</u></u>	<u><u>4,915</u></u>	<u><u>5,508</u></u>	<u><u>21,137</u></u>

Note 1: Project-generated recurrent costs (Figure H-3) have been incorporated in the overall estimates.

Note 2: National personnel costs represent an estimate of central-level administrative overhead attributable to the two project counties (i.e., two-ninths of total estimated overhead).

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ECONOMIC ANALYSIS

The economic cost of the PHC Project to the GOL during the first five years of the project will be approximately \$5.3 million of combined development and operating expenditures. Of this, \$3.5 million will be derived from PL-480 counterpart funds, which are part of the GOL's development budget; only \$1.8 million represents project-generated recurrent costs to be assumed by the GOL. These are resources that the GOL could use to support other projects and activities, either in health or other sectors. In addition, the AID contribution of \$15.0 million could, at least hypothetically, be used to support other development projects in Liberia -- again, either in health or other sectors.

PL-480 counterpart funds comprise a significant portion of the GOL contribution to the project. The availability of these funds will depend on several interrelated factors; the liquidity position of the GOL over time; the general economic situation; the IMF Standby Agreement; and of course, the continuation of the PL-480 Title I Program in Liberia throughout the first five years of the project. USAID will monitor this aspect closely, will review the availability of GOL funds during each evaluation, and will make changes as necessary.

A. Benefits and Strategy

The GOL's stated strategy is to concentrate its limited development resources on near-future economic considerations. However, the GOL also recognizes that during this difficult economic period, basic human services must be continued and in some cases expanded. The PHC Project strategy for making basic health services available at the village level represents the lowest-cost strategy for providing health services in the rural areas. In addition, project emphasis on developing skills reflects a cost-effective strategy for solving both the short- and long-term problems in the health sector.

As discussed in the Financial Analysis (Annex H-2), the per capita establishment costs (estimated at \$68 for project area beneficiaries) for rendering the system functional at the village level are relatively high. These costs result from the following combination of factors; the high cost of technical assistance, the widely dispersed population, the remoteness of the project area, and the consideration of some traditional recurrent costs (such as drug costs) as capital costs in structuring the financing schemes of the project.

When the PHC system is established, the recurrent transportation costs required to sustain the supervisory and technical support systems for these village-based health systems are minimal and are estimated during what would be project year 6 at less than \$30,000, or \$0.25 per capita beneficiary. In economic terms, the GOL expenditures will go primarily towards maintaining existing physical infrastructure and supporting the costs of those elements necessary to make better use of existing manpower

resources. This is a prudent strategy under current financial and economic circumstances.

The decisions by AID, during the project design process, to reduce the number of project counties and to fund the project entirely with grant funds (i.e., eliminate the loan component) were taken in order to reduce GOL outlays during the project life.

The adoption by the MH&SW of the PHC approach as the strategy for providing health services to most Liberians implies the adoption of new cost-effective policies in the organization, financing, and provision of health services. The key cost-effective policies which the GOL will implement in conjunction with the project include the provision of a scheme whereby health workers purchase motorcycles in installments (the regenerated funds to be used for replacing motorcycles), the primary use of village- and mid-level personnel to provide basic health services; and a mechanism to generate the recurrent costs for VHWS, TBAs, and drugs at the local level (i.e., outside of the regular MH&SW budget).

### B. Cost Effectiveness of the PHC Strategy

The traditional approach to providing the same level of services to project area inhabitants would have been to use the \$5.3 million to train more doctors, build more fixed facilities, and purchase all the sophisticated supporting equipment and services required to make the traditionally trained physicians functional. The use of \$5.3 million under such a curative strategy would not provide the same level of services to as many people as will be provided under the PHC approach. Such an approach is unlikely to enlist the participation of donors in financing complementary capital expenditures.

It is recognized that the PHC strategy will not constitute an instantaneous cure for the scarce resource problems of the GOL and MH&SW. The need exists to select the most appropriate mix of personnel, facilities, and technologies based on information on relative cost-effectiveness and trade-offs, between capital and recurrent costs within the Liberian political and administrative context. The project will undertake various studies including operations research to assist the MH&SW to find appropriate solutions with which to implement the long-range National Primary Health Care Program.

An analysis of cost-effectiveness has been used to provide the economic justification for the project. In view of the complexity of cost-benefit and internal rate of return analyses in health sector projects with diverse outputs, these have not been done. However, as stressed in the AID Health Sector Strategy Paper, the primary health care approach offers the most cost-effective way to decrease infant and child mortality and maintain a healthy labor force, in the short run. In the long run, health status will also benefit from improvements in income, education and the environment. Primary health care emphasizes increased access to basic and affordable health-related services, community participation, reliance on paraprofes-

sional workers, adequate referral and support facilities and systems, and intersectoral coordination, as opposed to hospital services dependent on high technology and specialized manpower and available only to a small portion of the population.

### C. Central and National Level Efficiencies and Economies

During the design of this project, it was realized that greater efficiencies and economies can be achieved by the MH&SW at the central level and for the benefit of the entire health system by reviewing and revising planning, management and programming practices in the following areas:

#### 1. Salaries

At the mid-level and below, MH&SW personnel salaries often bear little relationship to the kind and amount of training required for the job, and to the actual effort required on the job. The salary of a night watchman, an unskilled worker, is \$2400 per year, and approximately the same amount is earned by certified midwives, who receive two years of intensive training. These salary distortions constitute one of the causes of low morale in the work force. However, the problem of wage scale distortions is not limited to the MH&SW but exists throughout the GOL, and is therefore beyond the scope of this project.

#### 2. Deployment of Personnel

The majority of the Ministry's work force is not deployed where its services are needed the most. Most of Liberia's rural physicians currently are foreigners because few Liberian physicians are willing to accept rural assignments and corresponding compensation. Montserrado County, because of its urban attractions, has more than its share of all categories of health personnel.

#### 3. Administrative Overhead

A review of the MH&SW budget indicates that the cost of administration and supervision of the central MH&SW are high, resulting in reduced county allocations.

#### 4. Service Financing and Subsidization Policies

There are currently some inconsistencies between GOL policy and practice concerning the contribution by service users to regenerate some of the costs of maintaining the system. A fee for service schedule is on the books but appears to be very loosely applied. Moreover, the system requires that fees are not retained by the MH&SW but deposited in the central treasury. Accountability within this system is also a major problem.

#### 5. Discipline

Because of longstanding practice, the MH&SW suffers from a lack of discipline among many employees with respect to the services they are being

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paid to perform. Technical assistance and other project resources have been budgeted to assist the MH&SW at the Central level in finding solutions to make the national system more productive.

#### D. Quantification of Benefits

Savings to the GOL in adopting the PHC strategy can be estimated by comparing the per capita cost of health care provided by the present delivery system with that of the PHC system. Currently, rural health services are delivered via static health facilities serving a rather restricted geographical area surrounding them. Because of the widely dispersed population, the cost-effectiveness of these static facilities is low, since patients must come to the health unit for service. If it is assumed that the present facilities are serving 25 per cent of the population in Grand Gedeh and Sinoe Counties, and since in round numbers there are approximately 50 health posts and health centers operating in these counties now, then the cost of expanding the present facility-based system can be estimated. To reach 90 per cent of the population of these counties -- even ignoring the fact that people not now being served are in more sparsely populated areas -- then it will take an additional 130 health facilities to provide the same level of services to 90 per cent of the population. If all of these new facilities were to be health posts, each costing \$40,000 to construct and equip, this represents a new capital cost burden of \$5.2 million. Recurrent costs for these new facilities would include both salaries of the new staff (\$4,000 x 260 = \$1.04 million) and additional support costs (building maintenance, supplies, etc., at \$3,000 per health post, or \$390,000). Thus to summarize, expanding the traditional facilities-based system would increase GOL expenditures by an additional \$5.2 million in capital costs, and an annual recurrent cost of about \$1.4 million.

By comparison, as shown in the Financial Analysis (Annex N-2), the annual project-generated recurrent costs in the two counties in what would be project year 6 are estimated to be \$709,000. Even ignoring the capital cost requirement and focusing only on annual recurrent costs, it can be seen that the facility-based system would cost twice as much. Thus using the PHC strategy, adequate health care services can be made accessible to 90 per cent of the population at approximately half the cost of the traditional, facility-based system. It is acknowledged that this analysis is oversimplified, and that variations in the situation from county to county might change the analysis in making a national projection. However, the figures are generally representative of the costs of the two systems, and clearly point out the cost advantages of the PHC system.

In summary, the project represents the most cost-effective means currently available to achieve the level of health, social, economic and political benefits anticipated. The overall benefits to be gained from incurring approximately a 4 per cent increase in the recurrent MH&SW budget far outweigh the costs of not implementing the project. Despite the current economic and financial climate, the project constitutes a worthwhile investment.

SOCIAL SOUNDNESS ANALYSISA. Introduction

This analysis focuses on the following three areas:

- A determination that the proposed PHC strategy for providing and supporting village-level health services is compatible with and will be feasible within the socio-cultural traditions of the ethnic groups of the project area
- An assessment of whether the new practices and institutions associated with the project are likely to be diffused into non-project areas
- The social impact of benefits and costs of the project, especially among different social groups

In all three areas, the approach of the analysis is to identify potential problem areas and suggest solutions.

The 180,000 inhabitants of Grand Gedeh and Sinoe Counties belong primarily to the Kwa (or Kru) ethnic groups, one of the three major ethnic groups in Liberia. The major linguistic groups within this ethnic group are the Krahn and Grebo (Grand Gedeh) and the Sapo, Bassa, and Kru (Sinoe). The population of the area is highly dispersed and consists of mainly small villages isolated in the heavily forested area. Larger towns tend to be either administrative centers of concession farms, or the location of plants for processing local resources such as lumber, rubber or palm products. Southeastern Liberians are traditionally forest hunters who farm a little rice and cassava for their subsistence needs. With the advent of plantation farms and lumbering activity in the area, most of the able-bodied men who have not migrated away from the area are employed as laborers in these establishments.

B. Traditional Authority and its Implications

Village organization is primarily on a kin basis in both counties. Often, a town or large village with its satellite hamlets belong to the same chiefdom with members tracing their identity to a common ancestry. Chiefdoms were traditionally very small (less than 5,000 people) but have been organized by the central government into large administrative units (clans) headed by clan chiefs. Clan chiefs are themselves under the jurisdiction of a paramount chief, who is responsible to the District Commissioner.

This traditional organization has been overlain with the GOL administrative organization. Each county is divided into administrative districts headed by a district commissioner. District commissioners are responsible to the county superintendents who represent the central government in the county. The organization of the project area in these administrative units is summarized in the table below. Grand Gedeh County is comprised of four districts, while Sinoe County consists of three districts and the municipality of Greenville. Sasstown territory with its eight clans will also be part of the project area.

Grand Gedeh County (4 districts)

Gbarzon District	7 clans
Gheapo District	8 clans
Konobo District	11 clans
Webbo District	11 clans

Sinoe County (3 districts + 1 municipality)

Bloni Sinoe River District	2 clans
Juarzon District	7 clans
River Sinoe District	7 clans
Greenville Municipality	3 townships

Sasstown Territory (1 district)

Jloh District	8 clans
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The chiefs of these administrative units (village/town, clan), which coincide closely with the traditional ethnic groups, are today appointed by the central government and therefore, possess fiscal authority. The basis of traditional power is not loyalty to the central government, but tends to be a combination of the ability to trace one's ancestry directly to a well known common ancestor; individual prestige based on family, competence and wealth; and membership in one of the secret societies, such as the Poro and Sande Societies, which wield local political and religious power.

Most health centers are located at the district headquarters and come under the power and influence of the District Commissioner, while health posts tend to be located at clan headquarters and fall under the power and influence of clan chiefs. Village development councils (VDCs) will be organized in the approximately 6 to 7 villages in the catchment areas of the health posts and centers, and will be sustained through a supervisory and support system under the county health department. The Governmental structure, whose support is critical for the success of the project's community development and policy initiatives, is represented by the Ministry of Internal Affairs at the county level, and the County Superintendent. Although the PHC project will be implemented by the MH&SW, new policy initiatives such as user fees for drugs will be introduced in the project area through the formal GOL organizational hierarchy, from the County Superintendent to the District Commissioners and then to the VDCs.

The project emphasis on community development and self-reliance are critical to its success, but cannot simply be imposed through the formal system. This is why the village development council (VDC) approach is being used, since the village leadership will have to be convinced that village-level health services will benefit the villagers and will be worth what they cost.

Furthermore, there is evidence from other projects and village-level efforts that many villagers are cynical about the potential of "self-help initiatives." This is because there are many examples where self-help projects were begun and then abandoned, through no fault of the villagers but rather resulting from lack of inputs, resources, and follow-up by those initiating the projects. Therefore, the VDCs will have to be convinced that village-level health workers will benefit them, that needed project resources will be forthcoming, and that project staff can be relied upon for needed supervision and support.

The PHC Project will have to plan carefully to restore confidence in those villagers who have had bad experiences with self-help projects. The VDCs will constitute the motivational and authoritative force for project activities at the village level. The concept and implications of the project for the village will be discussed with each VDC. In order to benefit from the sanction of the project by the GOL, local Ministry of Internal Affairs officials will be involved in finalizing the agreement between the VDC and the county health department (in a capacity to officially approve of the policies and procedures of the project). The agreements will reinforce the point that all material and-in-kind contributions from a village will be used only in that village.

Because of the critical importance of successful VDCs and the general acceptance of the self-help approach in the project, a short-term technical assistance specialist in the social and behavioral sciences will be used to review the progress being made in developing the VDCs and in establishing health teams. This technician will be scheduled to come during project year 3, after there has been some village-level experience in Grand Gedeh County. If this consultation is found to be effective, consideration will be given to arranging periodic visits thereafter for follow-up.

### C. Acceptance of Project Elements at the Village Level

One difference between the PHC Project and earlier efforts is that the village health workers (VHWs) will be paid directly by the VDCs. Although agreement to this arrangement is a condition to participation in the project, it is expected that some villages will drop out. (A "failure rate" of 15 per cent has been incorporated to account for this anticipated phenomenon. (This means that at least 250 of the proposed 290 VDCs will be successfully established.)

Similarly, the establishment of village-level revolving drug funds is expected to result in some setbacks and difficulties. The feeling of some villagers -- based on failures in other attempts at self-help -- is that such schemes are not likely to work, and that the villagers will be throwing away funds invested in such ventures. This tendency will have to be overcome on a village-by-village basis, and likely will be counteracted only by being able to point to successful ventures in other villages. Accountability and use of drug funds may pose special problems, and will have to be addressed during the actual implementation of each village-level system.

One potential accountability problem for the project that has been observed in a PHC setting is that the person responsible for the drug funds (usually a VDC member or the VHW) would lend these funds to villagers facing a

financial crisis, as an expression of kinship solidarity. Interest is not usually charged, and repayment deadlines are not always enforced. The result is that when it is time to repurchase drugs, the VDC may discover that there are not enough funds on hand. This situation and others like it will be anticipated in advance, and guarded against insofar as possible through discussions with the VDCs.

All proposed health services will not be received with the same level of confidence, enthusiasm, and understanding. Some PHC services will surely be supplemented through the use of traditional practitioners. This should be encouraged where local remedies from herbalists, bone-setters, and others are known to be helpful. However, the project approach will also have to overcome the difficulties inherent in the strong local beliefs in the "magic cure" of injections and other curative services that may be inappropriate or that tend to undermine needed preventive services.

In introducing preventive services that may generate controversy in the traditional context, the project staff will explore the possibility of using the traditional societies as a means of educating villagers and gaining their acceptance. Society leadership in the village could make the difference between acceptance and rejection of the proposed service.

The family planning (child spacing) services in the project is one area where the approach to delivering the services must be carefully developed and implemented. For example, the introduction of family planning at the village level will take into account traditional male proprietorship attitudes over female procreation by introducing and discussing the subject to both husband and wife. The consent of husbands of married women will be required to accept these women into the family planning program so as to avoid serious family disputes.

In general, for the introduction of village-level services to be successful, there should be a clear understanding at the outset of what the project offers; what the village must do to participate; and if the village accepts, what it can expect in terms of continuous guidance, supervision, and support.

The technical and financial analysis of this project indicates that this project offers a low-cost strategy to providing health services to the inhabitants of a relatively remote and underprivileged portion of Liberia. Remoteness, infrastructural deficiencies, and current financial and economic conditions limit the replicability of project activities at this time, without additional external support.

### C. Social Impact of Project Benefits and Costs

The project will provide increased access to an appropriate mix of curative, preventive, and promotive health services for approximately 115,000 rural Liberians in the two project counties. The anticipated benefits will improve the quality of rural life in the project area in different ways for different age and sex groups. In view of the project emphasis on reducing morbidity and mortality, both women and children will be the principal recipients. Strong, effective village development councils could lead to an expansion of community development activities beyond those envisioned in the PHC Project. In areas

where VDCs do not exist or have not been effective, the impetus of PHC Project activities and benefits to the village may well mean that the councils become more active in promoting general village development.

The achievement of spread effects may take place on two different levels. At the local level, villages not participating in the PHC Project may decide to establish or revitalize their VDCs and begin to achieve benefits similar to those of project villages. This is likely to happen if the village-level PHC activities are perceived by the villagers to benefit them directly. The limiting factor may be a strictly economic one; that is, if inputs are required that the village cannot afford on its own (such as the initial stock of drugs for the revolving drug system).

On a larger scale, spread effects are likely only if and when the GOL decides to expand the PHC delivery system to other areas. As indicated in the detailed project description, an effective system depends on many factors, most especially the supervision and support of village-level services. Unless the necessary elements are in place and operating, one cannot expect a natural spread effect.

One immediate beneficial impact of the project will be the ability of VHWS to provide first aid treatment of lacerations and other injuries acquired by farmers. The shifting cultivation method used for food crops in the project area requires that families must annually fell trees, cut and clear the forest underbrush, and burn the bush in order to plant their crops. The process is not mechanized, although portable power saws are occasionally used (and cause at least their share of injuries). Health statistics confirm that lacerations are a common problem in the area. Because of the long distances involved in reaching health posts, most farmers treat themselves as best they can, and the lacerations usually end up as infected wounds. VHWS will be provided with gauze, bandages and antiseptic to provide first aid care, and will refer patients as necessary to the nearest health post. The VHW will also treat non-occupationally acquired infections and infestations -- those acquired in and around the home.

Current morbidity and mortality risks to mother and child, arising from inadequate delivery practices and inadequate maternal and child nutritional practices, will be reduced by training the village's traditional birth attendants and providing them with supplies to provide their services more safely.

The traditional women in the project area are by necessity hard-working and most have diverse skills to cope with family responsibilities. A recent study on the problems of Liberian women in development confirm this impression. In the project area in particular, female labor inputs into the cultivation of rice are higher than those of their counterparts in the rest of the country, where farming is a firmly established tradition for both sexes. The women's farming duties have to be considered along with her childbearing and household obligations, and more recently the need to generate supplementary cash through the sale of foodstuffs for payment of school fees and school uniforms. The burden of these ongoing duties of rural women may make it difficult either to add on new roles as a TBA or VHW or to drop existing duties to take on the TBA/VHW job.

More women than men will be involved as health workers, both at the village level and within the rural health facility system. Approximately 72 per cent of all people trained under the project at the village level will be women, and about half of all health post/health center staff members. The active involvement of women and the focusing of project outputs on the needs and problems of women is a key feature of the project.

ADMINISTRATIVE FEASIBILITY

This analysis assesses the administrative capabilities of the MH&SW in the areas relevant for the execution of the project, and demonstrates that the project design incorporates the necessary resources to assist the MH&SW in implementing the project and achieving its purpose. In addition, the analysis summarizes the project management capabilities of USAID/Liberia, in view of the Mission's critical role in the project.

A. Ministry of Health and Social Welfare

1. Organization

a. Leadership and commitment

On the national scale, the People's Redemption Council (PRC) has provided the leadership for the Government of Liberia since April 1980. The PRC has recently pledged to make an orderly return to civilian rule by April 1985. Meanwhile, health care, and especially the expansion of health care services in the rural areas, is a stated priority of the PRC.

The Minister of Health and Social Welfare, who is a professional nurse by training, has held that office since August 1981. The MH&SW leadership is expected to remain stable because of the strong professional and technical orientation among the key positions. Because of the nature of the Ministry's activities, its policies and resources are not likely to shift in a way which would impact negatively on the PHC Project even if some of the members of the leadership should change over time. Senior MH&SW officials realize both the political and humanitarian importance of expanding rural services, and have devised the National PHC Program as the system by which this expansion will be carried out.

b. Legal status

The MH&SW has the legal responsibility for carrying out policies, laws, and regulations in the broad area of health and social welfare, as well as the delivery of health care services throughout the country. The MH&SW operates within the GOL framework and is subject to normal interministerial relationships and operating procedures.

c. Financial status

The MH&SW has the authority to commit and disburse budgeted funds. Under the budgetary controls currently in operation, the MH&SW receives quarterly allocations from the Ministry of Finance, based on the actual annual budget for the MH&SW.

It is clear that considerable financial resources will be required from the GOL to help support the project. In recognition of this, and as reflected

in Section VI, the GOL has agreed through covenants that (1) the GOL will make available sufficient funds to support an increasing proportion of the national health care system's recurrent costs, so that by the end of the project the GOL will be assuming no less than 90 per cent of the project-generated recurrent costs; and (2) the GOL will maintain budgetary allocations for recurrent costs of the MH&SW at no less than its current percentage level of the national budget.

d. Pattern of organization

In the Ministry's Draft Plan of the National Primary Health Care Program, the organization of the PHC Program has been described in some detail. Since the time of the draft plan, as an outcome of the series of meetings of the joint MH&SW/USAID design team, this organization has been modified in several ways. The revised organizational structure is shown in Figure H-9. Figure H-10 indicates the organizational relationships among the central Ministry's bureaus and divisions, many of which have strong links with the project.

(1) Central level

The MH&SW's Deputy Chief Medical Officer for Preventive Services will be the PHC Project Manager, and the necessary Ministry resources will be coordinated through that office. The Project Manager will spend at least 25% of his time on the project. In addition, to insure adequate project direction, there will be a full-time Deputy Project Manager. To support their activities, a vehicle and limited operating expenses will be provided for the use of the Deputy Project Manager, to be used also by the Project Manager for project-related activities.

In addition to the day-to-day coordination of activities and resources among these organizational elements of the MH&SW, a PHC Project Implementation Committee will be established. This committee, with representatives of the MH&SW, USAID, and the project long-term TA team, will perform an important role in conducting quarterly meetings to monitor and review project activities and achievements, examining problems at the field level and recommending appropriate solutions, and insuring that the project continues to meet the implementation schedules.

Also at the national level there will be a National PHC Steering Committee, comprised of the Deputy Ministers for Technical Services of the Ministries of Health and Social Welfare, Agriculture, Internal Affairs, Rural Development, Education, Finance, and Planning and Economic Affairs, as well as a representative of the Budget Bureau. This Governmental committee will provide general guidelines, resolve major policy issues, and insure necessary resources and intersectoral coordination in support of the National PHC Program.

A third important national-level committee, the PHC Advisory Committee, will also be established under the project. This committee, with representatives from the MH&SW, USAID, and other donor agencies providing PHC inputs, will help to insure a strong, collaborative, coordinated, resource-efficient national PHC program.

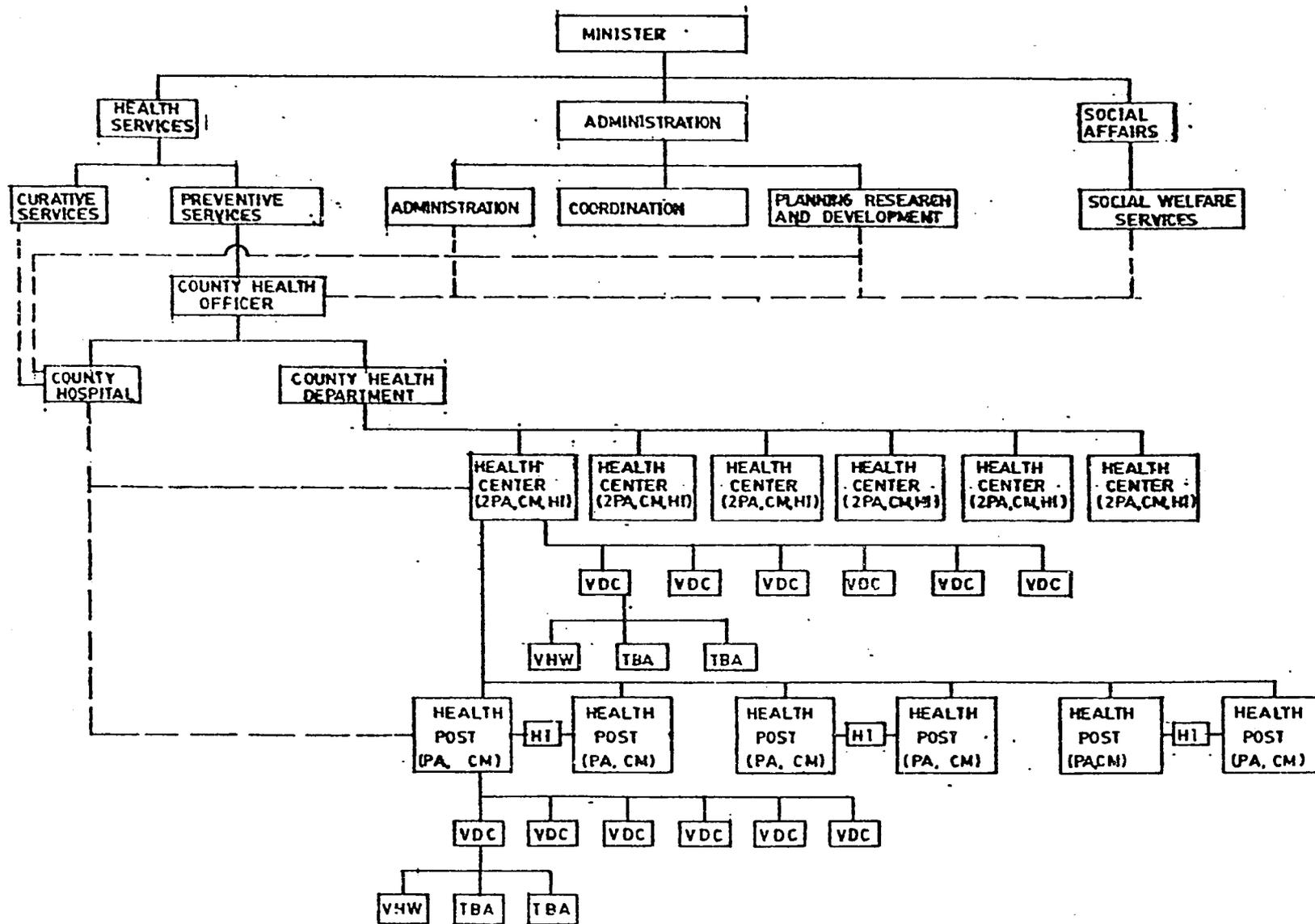


FIGURE H-9: ORGANIZATION OF THE MINISTRY OF HEALTH AND SOCIAL WELFARE, WITH EMPHASIS ON PRIMARY HEALTH CARE

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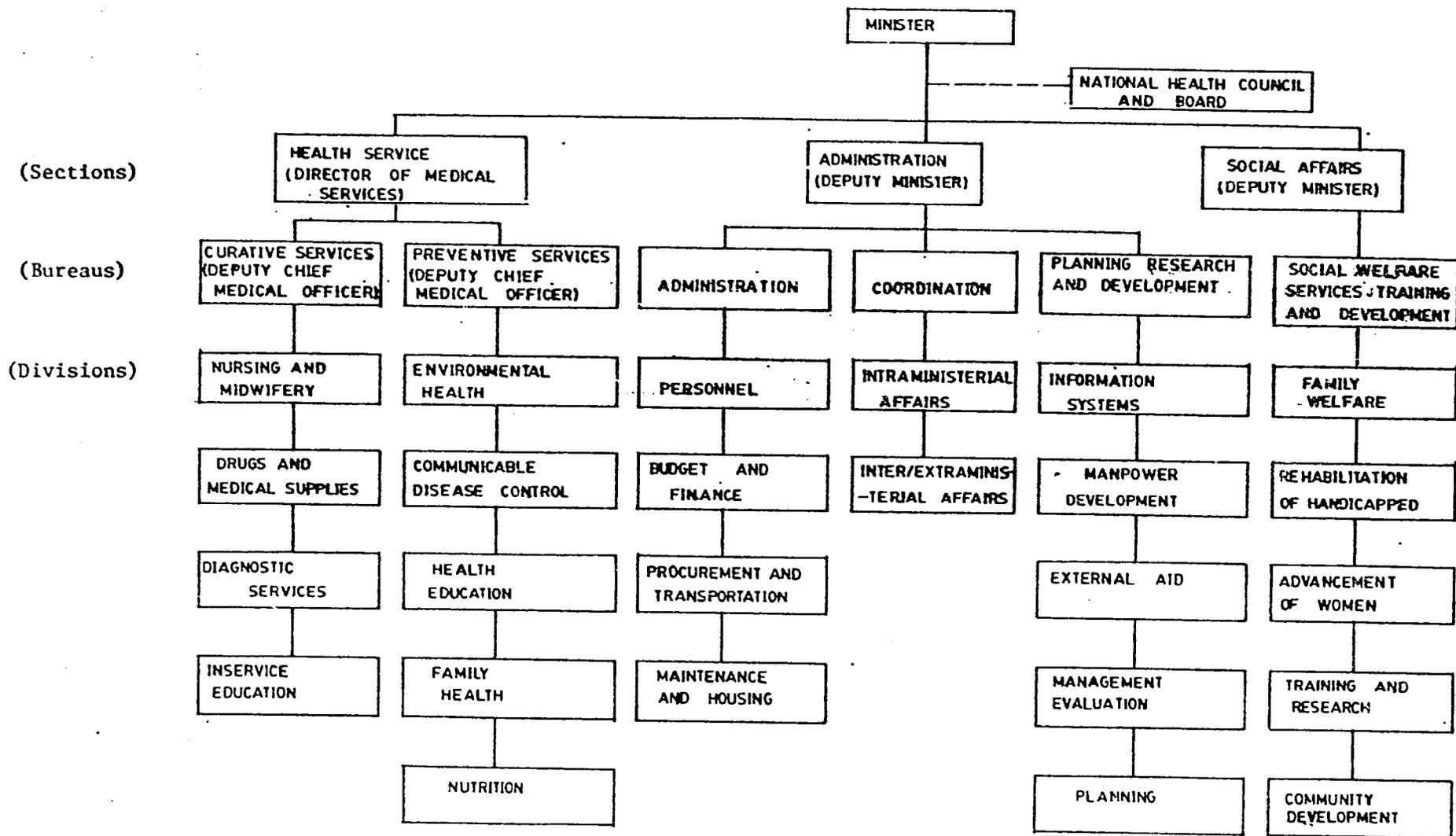


FIGURE H-10: MINISTRY OF HEALTH AND SOCIAL WELFARE CENTRAL ORGANIZATION

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(2) County level

The county-level organizational structure has been discussed in the detailed project description, and will not be repeated here. The county-level structure and organizational links with the central MH&SW can be seen in Figure H-9. The managerial implications of this decentralized structure are discussed in the following subsection.

2. Managementa. County-level decentralization

To be workable in achieving the intended objectives, county-level decentralization implies decentralization in three specific areas: (1) the budgetary process, (2) financial responsibility, and (3) management responsibility. The following sections summarize the important aspects within each area.

It is also important to realize that for decentralization to work effectively, it must involve the entire county-level operations of the MH&SW. As shown in Figure H-9, the responsible MH&SW officer at the county level is the county health officer. He or she is responsible for both the county hospital (headed by the hospital medical officer) and the county health department. There must be a clear delineation of authority and responsibility between MH&SW Headquarters and the county, and between these two officers within the county. This delineation of authority and responsibility, taken together with effective information and record-keeping systems, will allow the county-level decentralization concept to be implemented successfully.

(1) Decentralization of the budgetary process

To decentralize the budgetary process effectively, the following steps should be taken in a carefully planned and coordinated manner:

- ° The MH&SW should prepare and publish a manual for the use of both hospital medical directors and county health officers in the preparation of annual county budgets. The development of this manual should involve both central and county-level personnel, as well as the appropriate project technicians (Chief of Party and County Public Health Physician), so that there is a mutual understanding of the system and its objectives as it is developed in detail. The manual should include policies and procedures covering at least the following areas:
  - Purpose of the document
  - How the budgetary process should be performed at the county level
  - Discussion of the recurrent and development budgets (differences)

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- Budget categories (line items) discussed in detail
  - Comparison figures for previous years (to show variations of budgetary components as a function of shifting priorities)
  - Costing of annual work plans
  - Schedule of the county-level budgetary process, including deadlines for submission of the proposed county budget and for return of the approved budget
  - Procedures for handling county expenses (banking arrangements, etc.)
- ° Once the budgetary manual has been prepared and approved for use, training programs should be carried out so that everyone involved in the process is prepared to fulfill their respective roles. The training sessions should include assistance and participation from the appropriate project technicians and central MH&SW officials.
  - ° The initial implementation of the county-level budgetary process should include assistance from and involvement of the relevant project technicians and central MH&SW personnel, to insure that the initiation and operation of the system will be as smooth as possible.
  - ° The county budgetary preparation cycle should be phased so that it fits in with the overall Ministry budgetary cycle. The initial county-level cycle should begin earlier than in the normal schedule, to allow sufficient time for thorough, careful development.

## (2) Decentralization of financial responsibility

There are currently great differences among the counties regarding the level of financial responsibility and flexibility delegated to the county-level. For the purpose of the PHC Project, and to insure a viable, standardized model for the future expansion of the National PHC Program, the authority and responsibilities to be delegated to the county level must be clearly delineated. In general, the system already in effect in Bong County appears to be the model on which the county-level system should be based.

The MH&SW budget at the county level is currently comprised of a limited number of categories, or line items. In view of the expanded authority and responsibilities at the county level envisioned under the PHC Project, these categories may be inadequate for proper budgetary and financial control. Thus, the decisions on delegation of authority and responsibility to the county-level should allow for the restructuring of county-level budgets and

financial operations in accordance with needs, including the implications of the initiation of county work plans. One example of such a need involves the budgetary and accounting aspects of the revolving fund for drugs, to be implemented at the county-level. The delegation of authority and responsibility at the county-level should be clear on the division between the responsibilities of the county medical director and the county health officer. This would logically include the provision of separate budgetary components and accounting records, so that each officer has control over his or her respective areas of responsibility.

(3) Decentralization of Planning and Management Responsibility

Generally speaking, sufficient authority and responsibility must be delegated to the county health officer and hospital medical director so that they can carry out their respective annual work plans. A clear delineation must be made between the responsibilities of the county-level officials and the central-level officials. Operational management of all resources which are required to implement the annual plan -- both human and material resources -- should be the responsibility of the county officials. The steps necessary to accomplish this delegation of responsibility are similar to those described in the budgetary responsibility section above. These steps are: (1) preparation of a policy and procedures manual (including purpose and method of developing the annual work plan), (2) training of county-level staff in the use of the manual, and (3) development and implementation of the initial plan (in accordance with a schedule which takes into account the budgetary schedule). As with the initial budgetary cycle, the initial work plan submission cycle should allow extra time to insure adequate development of the plan.

b. Experience and capability of managers

(1) Central level

MH&SW managers of the principal Headquarters bureaus relating to the PHC Project (Preventive Services, Curative Services, Administration, and Planning, Research and Development), and their respective divisions are all experienced senior staff members, most having advanced professional degrees. The TA Chief of Party will work not only with the Project Manager and Deputy Project Manager but also the other key Ministry managers to insure the necessary coordination of responsibilities and functions within the Headquarters bureaus and divisions. Recognizing this, the qualifications for the Chief of Party emphasize the need for a senior, experienced individual with a professional background in health planning and management. During the first five years of the project, several people who are currently in long-term participant training under the Health Management Planning Project will be returning from their degree programs to fill leadership positions within those bureaus and divisions of importance in the PHC system.

However, it is clear that there will be a need within the project to strengthen and coordinate the existing financial and management systems to insure they

are adequate to provide needed project support. These efforts will build on the work carried out under the Health Management Planning Project, and will take into account the special needs of the central-level management functions in relation to county-level decentralization. This will involve revisions of policies and procedures in the functional areas of budget and finance, personnel and the various information and reporting systems used to support the planning and management functions. In addition to the TA Chief of Party and the key MH&SW staff already discussed, short-term consultants will provide specialized skills in expanding MH&SW capabilities in these areas.

In the area of manpower development, the MH&SW has a core group of experienced professionals who are responsible for both the planning and training functions. Overall planning responsibility in the health manpower area is within the Bureau of Planning, Research, and Development, while the centrally-based training programs are carried out at the Monrovia-based Tubman National Institute of Medical Arts (TNIMA). So far as PHC mid-level health workers are concerned, TNIMA offers training programs for PAs, CMs, and HIs. The project's long-term Curriculum/Training Specialist will augment the skills of the existing Ministry staff to help insure the strengthening and coordination of existing training programs, and will assist in developing and expanding curricula for both VHWs and TBAs. In addition, short-term TA will be relied upon to provide specialized assistance in both curriculum and training. In order to help insure that these manager-level skills will be available by the end of the project life, two MH&SW staff members will be selected for and enrolled in long-term participant training programs to improve curriculum development and teaching skills.

During the first project year a study will be carried out to determine ways to strengthen the existing drug procurement and distribution system of the MH&SW, and to provide recommendations for drug pricing. The outcome of this study will be linked closely with the work of the TA team's Logistics Specialist. The study will identify specific management areas for strengthening, and the long-term technician, together with specialized short-term assistance, will work with MH&SW staff to strengthen the overall system. In anticipation of the need for trained managerial-level personnel in the future, two MH&SW staff members will attend long-term participant training programs in health services management and logistics; on their return they will assume management positions within the drug procurement and distribution system. These efforts will improve the effectiveness of the national system and help insure its capability to meet the long-term needs of the PHC Program.

## (2) County level

The establishment of strong county health departments in Grand Gedeh and Sinoe Counties will require a level and breadth of managerial skill which does not now exist at the county-level. In addition to the county health officer who will be responsible for all county-level operations of the MH&SW, two new positions will be established: administrative officer and logistics officer. Based on the guidelines for decentralization to be developed by

## INCOUNTRY TRAINING

As discussed in the detailed project description in section II.B., in-country training is one of the major emphases of the PHC Project. The development and strengthening of curricula for both village-level and mid-level workers is an important early step. For mid-level health workers this will be followed by the introduction of the revised curricula, and the improvement and expansion of mid-level training capabilities. In addition, there will be a carefully planned and implemented incountry training plan focused primarily on preservice and inservice training of health workers at all levels in the target counties.

Because of the importance of the mid-level training institutions in providing PHC-oriented training to mid-level health workers, the first part of this annex describes the institutions themselves, as well as related project needs and inputs.

The second part of this annex provides a description of each of the incountry training courses -- both preservice and inservice -- that constitute the elements of the project training plan.

### A. Mid-level Training Institutions

#### 1. Background

Expansion of the National Primary Health Care Program requires accelerated manpower development of mid-level health workers, particularly physician assistants (PAs) and certified midwives (CMs). PAs are trained for three years, while CMs are trained for two years. During the course of this project, these mid-level workers will be trained at four institutions:

#### Midwifery Training Center, Zwedru, Grand Gedeh County.

This center trains certified midwives, and first opened in 1983. Enrollment is drawn exclusively from the southeastern counties (Grand Gedeh, Sinoe, and Maryland) and 8 to 10 students are expected to graduate per year.

#### Tubman National Institute of Medical Arts (TNIMA), Monrovia.

TNIMA is part of the JFK Medical Center in Monrovia, and currently trains all three categories of mid-level workers -- PAs, CMs, and HIs. Approximately 30 PAs and 20 HIs are expected to graduate per year. It is hoped that 15 CMs will graduate annually, but the 1983 enrollment is 11 first-year students and only 7 second-year students.

#### Rural Health Training Center (RHTC), Suacoco, Bong County.

RHTC is a major new mid-level training institution located next to Phebe Hospital. It is expected to begin operations in 1984. Phebe Hospital School of Nursing currently graduates 10 to 15 CMs per year. When RHTC opens, the CM program will be incorporated into that institution, and annual output is expected to jump to 45. It also is planned that the PA and HI programs will be transferred to RHTC from TNIMA. Annual output of these health

workers is expected to increase at RHTC to 40 PAs and 27 HIs.

Curran Hospital School of Nursing, Zorzor, Lofa County

Curran Hospital is a missionary institution, and the School of Nursing is an integral part of its operation. On the average, Curran graduates 8 certified midwives per year.

2. Project Needs

As shown in the table below, there are currently insufficient numbers of mid-level workers in the target counties, and CMs are in critically short supply in the health posts and health centers.

NEED FOR CMs AND PAs\* IN THE PHC PROJECT AREA

COUNTY/CATEGORY	AVAILABLE	NUMBER OF HEALTH WORKERS**	
		NEEDED***	DEFICIT
<u>Grand Gedeh</u>			
PA	7	30	23
CM	2	32	30
<u>Sinoe</u>			
PA	9	35	26
CM	0	35	35
<u>Total</u>			
PA	16	65	49
CM	2	67	65

\* A registered nurse may serve in a position designated for a PA

\*\* Excludes hospital-based staff

\*\*\* Total needed by the beginning of project year 5

The shortage of CMs (which is also observed in other counties) is compounded by the tradition of not posting them to the rural health posts and health centers. The vast majority are posted to hospital maternity wards and 60 per cent of all CMs (of approximately 200 total) are deployed in Montserrado County (which contains Monrovia). Priority will be given to deploying CMs to rural health posts and health centers, particularly in the project area. To prepare CMs for this role, training focus will shift from hospital-based to clinic and community-based, and practical experience appropriate to this focus must be provided. More curriculum emphasis should be placed on primary health care, especially MCH, including family planning and maternity education, growth monitoring and oral rehydration. CMs must be trained not only to work with TBAs, but to supervise them and to train them. Moreover, the curricula of the four different CM training

schools need to be standardized. Recruitment of qualified students from the project area must be intensified. The training institutions must be supported so that their projected enrollment goals are attained.

Although PAs are trained mainly in JFK Hospital, they generally are assigned to rural health posts and health centers. Therefore, even at the current output, with the priority the MH&SW accords to the PHC Project, the expected numerical need for PAs in the project area should be met. Applicants from the project area should be recruited preferentially. However, all students need more practical, field-based community health experience and more curricular emphasis on PHC activities (oral rehydration, growth monitoring, family planning, community organization, etc.), and especially on working with supervising and training the village health team.

### 3. Project inputs

The long-term TA curriculum/training specialist will work closely with all mid-level institutions in standardizing and revising curricula in order to provide appropriate training for the tasks emphasized in the National PHC Program. The technician will conduct a review of existing materials, to be used as a basis for a curriculum development workshop involving faculty and experienced mid-level staff, to be held at RHTC in Project year 2. The purpose of this workshop is to revise, rationalize, and standardize curricula for the PA and CM programs, as well as for VHWs and TBAs. A follow-up workshop in year 3 will produce further modifications based on the experience with implementation of the new curricula. The technician will also work with the schools to improve teaching methodology. An additional six person-months of short-term consultancies in curriculum development will address other specific needs of the various training programs at all levels. To facilitate the needed field experience component of the training, TNIMA, RHTC and the Zwedru Midwifery Training Center will each be provided a small bus, along with limited operating expenses.

Audiovisual and training materials also will be provided. Working with faculty and staff of the Bureaus of Preventive and Curative Services, a short-term consultant will be engaged to upgrade and complete "The Handbook For Health Personnel in Rural Liberia". The clinical section needs revision and a comprehensive PHC/community health section should be incorporated. Existing materials (such as the Medex Series or the Rural Health Series) can be used as a basis for this work. The completed handbook would be helpful for the mid-level training programs, and especially for the health workers as a reference guide in the field.

To increase the number of CMs trained especially for the project, and to upgrade the caliber of training, several measures are planned. Five Peace Corps Volunteers (PCVs) are to be recruited to augment training faculty. These volunteers with nursing/midwifery backgrounds would be posted to the CM programs, one each at Zwedru, Curran and RHTC. One PCV with basic science training would teach in the PA program, and a PCV with background in training/curriculum development would be assigned to RHTC. The Curran School also will be supported during the project to increase the enrollment of CM students from the project area. A total of 24 scholarships are budgeted.

The project also provides for considerable, long-term faculty development. Since trained, field-experienced PAs would constitute the optimum PA faculty, support is provided to upgrade four experienced PAs to the B.A. level (through a special one-year tutorial program); and then for the PAs to obtain MPH training with varying emphases (i.e., health education, MCH, environmental sanitation, epidemiology). For long-term CM faculty development, five B.Sc. nurses would receive master's-level training with concentration on midwifery and teaching skills. Two would be posted to Zwedru and three to RHTC. Three prospective teachers will receive master's degrees, one each in MCH/family planning, nutrition and training/curriculum, and the three individuals will be posted to RHTC.

Contingent upon availability of funds and the specifics of each annual PL-480 Agreement between the GOI and AID, PL-480 counterpart funds also will be used to upgrade training institutions by construction or renovation of needed classrooms, laboratories and/or dormitories.

#### 4. Related inputs

Through the regionally funded Strengthening Health Delivery Systems (SHDS) Project (698-0398), AID has supported the development of a regional post-basic nursing program at Cuttington University College in Suacoco, Bong County. This program trains registered nurses for an additional two and one-half to three years, leading to a B.Sc. degree with emphasis on primary health care and specialization in either community health nursing or midwifery. During Phase 3 of the SHDS Project, graduates of the post-basic nursing program are expected to take leadership roles in the PHC Program, for example, as teachers at training institutions, trainers of TBAs, supervisors, health center staff, etc.

The professional-level support of the project, JHPIEGO will continue to provide short-term training for high-level officials in reproductive health and program management. JHPIEGO consultants also are expected to assist in development of curricula for physicians and professional nurses in reproductive health and MCH/FP program management. This will facilitate the support and participation of these professionals in primary health care.

#### B. Incountry Training Plan

As indicated in the detailed project description, the incountry training plan is critical to the success of the project, since it will provide health workers and others in the project area with the information and skills they need to carry out their functions.

The incountry training program is summarized in Figure J-1. The training courses for VDCs, VHWs, and TBAs have been described in the detailed project description; the remaining courses shown in the figure are described in the following paragraphs.

The timing and sequencing of these courses is important, and is indicated at least generally in the description of each. However, the specific scheduling of each course will be addressed in the annual work plans for the project, in order to accommodate expected minor adjustments.

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### 1. PHC Orientation for County Officials

The purpose of this training is to explain the objectives and activities of the PHC Project and to enlist the support of the participants. Trainees will include the county superintendent, district commissioners, county representatives of the Ministries of Internal Affairs, Agriculture, Rural Development, Education, etc., and of the major concessions and missions. The trainers will be senior MH&SW officials including the Minister and PHC Project Director. One session in each county is planned during year 2. The duration of each seminar will be two days.

### 2. Curriculum Development Workshops

As described, the purpose is to revise and standardize curricula for PAs, CMs, HIs, VHWs, and TBAs so that each category of worker will be prepared to fulfill his/her expected role in the project and the national PHC program. Participants will include faculty of the training institutions, senior health workers with relevant PHC experience in other counties, selected mid-level workers, and the project area county health officers. Facilitators will be the curriculum/training specialist and counterpart. A two-week session at RHTC in year 2 is planned. A follow-up workshop, to be based on experience with the new curricula, is planned for late in year 3 in Zwedru, and will include mid-level trainers and supervisors.

### 3. PHC Orientation for Mid-level Workers

To train the mid-level staff for their new functions in PHC, three 28-day workshops are scheduled in each Project county. Each worker will attend one workshop. PAs, CMs, and HIs will be oriented to their new managerial, supervisory, and technical roles. The organization and functions of the VDC and VHT will be explained. The mid-level workers will be trained to help organize and to work with the VDCs. The importance of teamwork in the delivery of PHC will be stressed. To support the village health team, the mid-level workers will be taught supervisory skills and advised on the content of supervisory contact as well as on scheduling of visits. For technical proficiency, review and upgrading of skills in family planning, health education, growth monitoring and nutrition education, oral rehydration, malaria control, immunizations and prenatal care will be emphasized. These workers will be oriented to the new drug supply system and their responsibilities in it. Appropriate reporting forms will be reviewed. The motorcycle riding and maintenance will be taught.

The County Health Officer will be responsible for conducting these courses, with the assistance of training institution faculty and staff of the Bureau of Preventive Services. If needed to assist the county mechanic, an experienced mechanic from EPI will be recruited to do the motorcycle training.

Based on performance in the first two PHC orientation courses in each county, as well as on motivation, experience, and recommendations of previous supervisors, the CHO will select the workers to be trained and deployed as trainers and supervisors.

INCOUNTRY TRAINING PROGRAM SUMMARY

TOTAL TRAINEES	NO. OF SESSIONS	TRAINEES PER SESSION	TRAINEE CATEGORY	COURSE CONTENT	COURSE DURATION	FREQUENCY PER TRAINEE
1,450	290	5	Village Development Council	Orientation to PHC	5 days (not continuous)	once
290	17	15-20	Village Health Workers	Preservice Training	35 days	once
391	23	15-20	VHWs	Inservice training	5 days	annually
750	38	15-20	Traditional Birth Attendants	Preservice training	21 days	once
710	36	15-20	TBAs	Inservice training	3 days	annually
30	2	15	Influential County Officials	Orientation to PHC	2 days	once
20	1	20	Mid-level faculty, experienced senior health workers	Curriculum development	14 days	once
30	1	30	Mid-level faculty, experienced senior health workers, selected PAs*, CMs, HIs	Follow-up Curriculum development	7 days	once
154	6	18-28	PAs*, CMs, HIs	PHC orientation	28 days	once
73	4	9-25	PAs*	Basic use and care of microscope	5 days	once
10	2	5	PAs*, CMs, HIs	Supervisory training	21 days	once

\* or RNs

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TOTAL TRAINEES	NO. OF SESSIONS	TRAINEES PER SESSION	TRAINEE CATEGORY	COURSE CONTENT	COURSE DURATION	FREQUENCY PER TRAINEE
14	2	7	PAs*, CMs, HIs	Training of trainers	21 days	once
10	2	5	CHO, Hospital Medical Director, Admin. Officers, Logistics Officer	Decentralization Workshop	7 days	once
26	2	13	Community health dept. and hospital officials, PAs*, CMs, HIs	Decentralization management	14 days	once
26	2	13	Community health dept. and hospital officials, PAs*, CMs, HIs	Follow-up decentralization and management	7 days	once
492	7	50-82	PAs*, CMs, HIs	Inservice training	2 days	one to four
134	4	34-37	PAs*, CMs, HIs	Inservice training of trainers	14 days	once

\* or RNs

#### 4. Basic Use and Care of Microscope

This training is intended to review basic maintenance and use of the microscope for PAs. Emphasis will be on examination of stool samples and appropriate diagnosis and treatment. The PAs will be trained to keep the microscopes in good working condition in order to increase their own capabilities and to better support the village health team through appropriate care of referrals. Each session will last five days; two are scheduled in each county. An instructor from the Ministry's Public Health Laboratory, with assistance from the Peace Corps Volunteer laboratory technician, will teach the course under the supervision of the CHO.

#### 5. Supervisory Training

The purpose of this course is to enable qualified PAs, CMs, and HIs (selected following mid-level worker PHC orientation) to assume roles as supervisors of PAs, CMs, and HIs. Training will enhance supervisory skills and focus on the supervisory support needed at this level. Procedures for correctly filling out supervisory records, as well as drug supply and other forms and reports, will be explained and carried out. Community development skills and technical skills important for PHC activities will be strengthened. The County Health Officer will conduct these courses, with assistance from one RHTC faculty member and one officer from the MH&SW Preventive Services Bureau. The participants will be the designated PA, CM, and HI supervisors. The duration of training will be 21 days. The Grand Gedeh session is scheduled for month 22, the Sinoe session for month 28.

#### 6. Training of Trainers

The 3 PAs and 3 CMs selected as trainers of the VHTs in each target county are critical to the success of the Project. It is planned that the CMs train the TBAs, and the PAs train the VHWs. One PA and one CM from each county will have been selected prior to the PHC orientation to enable them to have participated in the 10-week Training of Trainers Course at the WHO Regional Training Center in Lagos. These individuals would serve as course facilitators, to assist in training the remaining trainers. This course will be conducted by the curriculum/training specialist and his/her counterpart, the CHO, and two staff members of the Preventive Services Bureau. Furthermore, assistance may be requested through AID centrally-funded projects, particularly for training TBA trainers. The course will cover training methodology with stress on practical skills, community organization and dynamics, and PHC technical skills. Twenty-eight day sessions are scheduled for Grand Gedeh in month 20 and for Sinoe in month 26.

#### 7. Senior-level Decentralization Workshop

This one-week workshop is intended to train senior county health officials about important fiscal and management procedures and policies related to county-level decentralization. Instructions and practice will be given on budget cycles, work plans with pro forma budgets, and work plans. These workshops will take place in Monrovia and will be conducted by an official from the Bureau of the Budget and two staff members from the MH&SW (Administration/Finance). The Chief of Party and Logistics technician and their counterparts will assist. Trainees will include both county health department personnel

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(county health officer, administrative officer, logistics officer) and county hospital staff (hospital medical director and hospital administrator). Grand Gedeh staff will be trained in month 26, and Sinoe staff in month 31.

#### 8. Mid-level Decentralization and Management Training

This training is designed for the county health department and hospital administrators, county health department logistics officer, hospital pharmacist, central warehouse logistics clerks, the PA, CM, and HI supervisors, and selected health center staff. The purpose of this workshop is to review procedures at the county level relating to formulating budgets and workplans, and various other administrative matters. This training will also cover the participants' functions in the new drug supply system. Reporting and accounting forms for health and management information. Scheduling of supervisory visits will be discussed.

This training will be conducted by the county health officer, assisted by two central MH&SW staff (Administration/Finance) as well as the Chief of Party and logistics technician and their counterparts. A 14-day session is scheduled for Grand Gedeh in month 27 and for Sinoe in month 32. A follow-up one-week session for both counties to review and update procedures will be conducted in month 42 in Sinoe County.

#### 9. Semiannual Inservice Training for Mid-level Staff

The purpose of this training is to convene all the mid-level staff in each county to review and upgrade their skills, as well as to provide an opportunity to discuss common problems. Two-day sessions are planned semiannually beginning in month 36 in Grand Gedeh and beginning in month 42 in Sinoe. At each workshop, one or two specific topics that are important to the PHC Program would be reviewed: for example, family planning, nutrition surveillance, oral rehydration, management of logistics, prenatal care, EPI and cold chain management, malaria, etc. Sessions would be conducted by the CHO with assistance from training institution faculty or MH&SW central staff as required.

#### 10. Inservice Training of Mid-level Staff as Trainers

Special trainers conduct all the preservice training sessions of VHWs and TBAs, as well as their inservice training, with the assistance and participation of local staff. Towards the end of the project, the local health post/health center staff will be trained to conduct the VHT inservice sessions themselves (5 days annually for VHWs, 3 days annually for TBAs), with the assistance of the PA and CM supervisors. For this purpose, in lieu of the semiannual training in Grand Gedeh in month 48 and in Sinoe in month 54, special two-week sessions will be conducted for mid-level staff and supervisors to enable them to conduct training sessions. The emphasis will be on training methodology and review of basic tasks of the VHW and TBA. The PAs will concentrate on training VHWs, and the CMs will concentrate on TBA training. These courses will be conducted by the CHO with assistance of the curriculum/training specialist and counterpart; the county trainers will serve as course facilitators.

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ENGINEERING DOCUMENTATION: CONSTRUCTION COST ESTIMATESCounty Administrative Building

Current construction costs in Sinoe and Grand Gedeh counties average \$55 per square foot for office-type buildings, \$50 per square foot for open-type buildings such as the warehouse, and \$35 per square foot for paved and roofed work areas.

Estimated costs per administrative building are:

Office Building	2400 SF @ 55/SF	\$132,000
Vehicle Maintenance Area	1200 SF @ 35/SF	42,000
Warehouse	750 SF @ 50/SF	37,500
	TOTAL	<u>\$211,500</u>

Central Warehouse - Monrovia

Current costs for warehouse-type buildings in Monrovia average \$40 per square foot. Estimated costs for the central warehouse are:

Warehouse building	10,000 SF @ 40/SF	\$400,000
Cold room, Refridgeration Equipment and Standby Generator		75,000
Moveable Shelving		30,000
	TOTAL	<u>\$505,000</u>

Estimated Budget Figures

Grand Gedeh County Administrative Building	\$211,500
Sinoe County Administrative Building	211,500
Central Warehouse	505,000
	<u>TOTAL</u>
	<u>\$928,000</u>

INITIAL ENVIRONMENTAL EXAMINATION (IEE)

PROJECT LOCATION: Liberia

PROJECT TITLE: Primary Health Care  
(669-0165)

FUNDING: \$15,000,000

LIFE OF PROJECT: 5 years

IEE PREPARED BY: Robert Braden, PE  
USAID/Liberia Engineer

ENVIRONMENTAL ACTION RECOMMENDED: Negative Determination  
(see attached)

MISSION DIRECTOR'S CONCURRENCE:   
Lois Richards, Director

Date: August 29, 1983

ASSISTANT ADMINISTRATOR/AFR DECISION:

RECOMMENDATION APPROVED: \_\_\_\_\_

RECOMMENDATION DISAPPROVED: \_\_\_\_\_

DATE: \_\_\_\_\_

## Examination of Nature, Scope and Magnitude of Environmental Impacts

### A. Project Description

The purpose of this project is to assist the GOL in the development and implementation of its long-term national primary health care program. The project aims to deliver full public health care services to the two most under-served counties in Liberia, Grand Gedeh and Sinoe. At the national level, the project will strengthen the MII&SW logistical system, especially drug procurement and distribution. Existing mid-level health worker training institutions will be strengthened and expanded.

Under 22 CFR 216.2(C) (2)viii, programs involving nutrition, health care or population and family planning services, except to the extent designed to include activities directly affecting the environment (such as construction of facilities, water supply systems, waste water treatment, etc.), are not subject to requirements for an Initial Environmental Examination.

The project includes construction of a central warehouse in Monrovia, and county office buildings for public health administration and training in Zwedru, Grand Gedeh County and in Greenville, Sinoe County. It is the construction component of the project which is of concern in this Initial Environmental Examination.

### B. Identification and Evaluation of Environmental Impacts

The environmental impacts resulting from proposed project activities will be negligible.

Obviously, construction of any type has an effect on the environment. However, the construction component of this project, a warehouse and two administration buildings, will have only the minimal, short-term, localized effects which accompanies any building construction.

Sites for the three buildings will be selected within developed areas of the respective cities of Monrovia, Zwedru and Greenville; and therefore no ecosystems will be affected. Criteria for site selection will include accessibility, available transportation, population concentration and requirements for future expansion. These criteria will provide for buildings which fit into the communities, and thus minimize any negative impacts.

Site selection will be subject to the approval of the USAID Engineer to insure that the criteria are met, and that negative environmental impacts are negligible.

IMPACT IDENTIFICATION AND EVALUATION FORM

A. Areas and Sub-areas Impact, Ident. and Eval.\*

- |  |       |
|--|-------|
| 1. Changing the character of the land through: |       |
| a. Increasing the population -----             | N     |
| b. Extracting natural resources-----           | N     |
| c. Land clearing -----                         | L     |
| d. Changing soil character -----               | N     |
| 2. Altering natural defenses -----             | N     |
| 3. Foreclosing important uses -----            | N     |
| 4. Jeopardizing man or his works -----         | N     |
| 5. Other factors:                              |       |
| _____  | _____ |
| _____  | _____ |

B. Water Quality

- |   |       |
|---|-------|
| 1. Physical state of water -----        | N     |
| 2. Chemical and biological states ----- | N     |
| 3. Ecological balance -----             | N     |
| 4. Other factors:                       |       |
| _____                                   | _____ |
| _____                                   | _____ |

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\* Use the following symbols: N - No environmental impact  
 L - Little environmental impact  
 M - Moderate environmental impact  
 H - High environmental impact  
 U - Unknown environmental impact

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IMPACT IDENTIFICATION AND EVALUATION FORM

C. Atmospheric

- |                          |       |
|--------------------------|-------|
| 1. Air addition -----    | N     |
| 2. Air pollution -----   | N     |
| 3. Noise pollution ----- | N     |
| 4. Other factors:        |       |
| _____                    | _____ |
| _____                    | _____ |

D. Natural Resources

- |  |       |
|--|-------|
| 1. Diversion, altered use of water -----       | N     |
| 2. Irreversible, inefficient commitments ----- | N     |
| 3. Other factors:                              |       |
| _____  | _____ |
| _____  | _____ |

E. Cultural

- |  |       |
|--|-------|
| 1. Altering physical symbols -----       | N     |
| 2. Dilution of cultural traditions ----- | N     |
| 3. Other factors:                        |       |
| _____                                    | _____ |
| _____                                    | _____ |

IMPACT IDENTIFICATION AND EVALUATION FORM

F. Socioeconomic

- 1. Changes in economic/employment patterns ---- N
- 2. Changes in population ----- N
- 3. Changes in cultural patterns ----- N
- 4. Other factors:  
\_\_\_\_\_  
\_\_\_\_\_

G. Health

- 1. Changing a natural environment ----- N
- 2. Eliminating an ecosystem element ----- N
- 3. Other factors:  
\_\_\_\_\_  
\_\_\_\_\_

H. General

- 1. International impacts ----- N
- 2. Controversial impacts ----- N
- 3. Larger program impacts ----- N
- 4. Other factors:  
\_\_\_\_\_  
\_\_\_\_\_

PROCUREMENT PLANA. Responsibilities and Methods

The GOL, represented by the Ministry of Health and Social Welfare, will be the implementing agency for this project. Procurement of commodities listed in Figure M-1 will be performed as follows:

1. The majority of the listed commodities will be procured through a Procurement Services Agency (PSA) who will act on behalf of the GOL. The PSA will be selected on the basis of experience, responsiveness and responsibility, and price charged for services on FAS exit port basis. Procurement practices will follow criteria of Chapter 3, AID Handbook 2.
2. All vehicles except motorcycles, as well as the furniture and appliances for the TA team, will be procured directly by USAID under the current system established within the Mission.
3. Local procurement will be in accordance with the shelf-item and local cost financing rules, as discussed in Section E below. (Also see AID Handbook 1, Supplement B, Chapter 18.)
4. Procurement of pharmaceuticals will be in accordance with the statutory and policy restrictions outlined in Chapter 4, AID Handbook 1, Supplement B. In case any medical equipment and pharmaceuticals are procured through UNICEF, PIO/Cs will be issued as worksheets for final issuance by AID/W, Office of Commodity Management.
5. The TA contractor will have technicians who will provide detailed descriptions and specifications for equipment and supplies to be ordered. The USAID Project Officer will coordinate all procurement with the TA contractor and the MH&SW. In all cases a Project Implementation Order/Commodities (PIO/C) will be issued to implement procurement.

B. List of Commodities

The commodities to be procured under this project are summarized in Figure M-1.

C. Commodity Eligibility

All commodities listed are eligible for AID financing, and will be procured from AID geographic Code 000 (US only) except for items designated for local procurement and for which a waiver has been granted as indicated in Section G below.

D. Source/Origin

Except as indicated elsewhere in this annex, all commodities are from AID Geographic Code 000 Source/Origin.

FIGURE M-1: PROCUREMENT EXPENDITURES BY PROJECT YEAR (\$)

<u>COMMODITY</u>	<u>QUANTITY</u>	<u>YEARS 1 AND 2</u>	<u>YEARS 2 AND 4</u>	<u>TOTAL</u>
<b>A. Vehicles</b>				
1. Motorcycles (30 yr. 1, 50 yr. 3) @ \$1,250 (incl. 25% spare parts)	130	100,000	62,500	162,500
2. Motorcycle helmets @ \$75	130	9,650	--	9,650
3. 4 WD Jeep-type vehicles @ \$12,000 (4 county level, 1 Family Health Div., 1 Nutrition Div., 4 TA teams)	10	96,000	24,000	120,000
4. Pick-up trucks, 2 WD, @ \$14,000 with tarp & benches (6 yr. 1, 4 yr. 3) (County level)	10	84,000	56,000	140,000
5. Trucks, 5-7 tons @ \$40,000	2	40,000	40,000	80,000
6. Busses, 12-18 Passenger, @ \$20,000	3	60,000	--	60,000
7. 15% spare parts for 25 vehicles (items 3-6)	N/A	42,000	18,000	60,000
			Subtotal	<u>632,150</u>
<b>B. Equipment and Supplies</b>				
1. Garage equipment - 2 counties	2 lots	21,000	--	21,000
2. Medical equipment & supplies (Health posts: 47 @ \$1,500 = \$70,500 + 40%) (Health centers: 9 @ \$3,000 = \$27,000 + 45%)	Varies	95,000	41,500	136,500
3. Drug Cabinets Health posts and health centers: 56 @ \$100	56	3,000	2,600	5,600 (L)
4. Examining table Health posts and health centers: 56 @ \$100	56	3,000	2,600	5,600 (L)
5. Salter scales @ \$35 + 40%	200	9,800	--	9,800
6. Weight charts and prenatal charts	Varies	21,000	--	21,000
7. Furniture + Furnishings for county health departments 2 @ 25,000 + 40%	2 lots	70,000	--	70,000

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	<u>QUANTITY</u>	<u>YEARS 1 AND 2</u>	<u>YEARS 3 AND 4</u>	<u>TOTAL</u>
8. Furniture & furnishings for county guest houses, 2 @ 15,000	2 lots	30,000	--	30,000 (LC)
9. Office supplies for target counties Health posts: 47 @ \$500 + 40% Health centers: 9 @ \$1,000 + 40% County health depts: 2x5,000 + 40% (U.S. source, \$30,000; LC source, \$29,500)	Varies	30,000	29,500	59,500 (LC)
10. Contraceptives		45,000	30,000	75,000
11. Training equipment and materials (U.S. source, \$175,000; LC source, \$45,000)		195,000	45,000	240,000 (LC)
12. Microcomputer and required software, plus Voltage regulator and accessories	1	10,000	--	10,000
13. Radios, 2-way (SSB), to provide reliable communication between Monrovia and the project counties	3	6,750	--	6,750
For TA team members based in Monrovia	8	20,000	--	20,000
			Subtotal	<u>710,750</u>
C. <u>Drugs</u> : For illustrative list, see Annex N Villages: 290 @ \$650 + 40% = \$263,000 Health Posts: 47 @ \$4,500 = \$211,500 Health Centers: 9 @ \$15,000 = \$135,000 Hospitals: 2 @ \$75,000 = \$150,000 <u>\$496,500</u> x 40% = \$695,100	Varies	575,000	383,100	958,100
D. <u>Commodities for Technical Assistance Team</u>				
1. Office Equipment: 5 offices	5 sets	20,000	--	20,000
2. Office machines	Varies	15,000	--	15,000
3. Office supplies @ \$1,000x16 person-years (U.S. source, \$8,000; LC source, \$8,000)	Varies	16,000	--	16,000
4. Vehicles, (included in A.3. above)				
5. Insurance for TA Team vehicles @ \$1,500x16 vehicle-years		24,000	--	24,000
6. Furniture @ \$20,000/set	5 sets	100,000	--	100,000
7. Appliances @ \$8,000 (A/C, stove, refrigerator/freezer)	5 lots	40,000	--	40,000
8. Generators @ \$15,000	2	30,000	--	30,000
			Subtotal	<u>245,000</u>

	<u>YEAR 1</u>	<u>YEAR 2</u>	<u>YEAR 3</u>	<u>YEAR 4</u>	<u>YEAR 5</u>	<u>TOTAL</u>
<b>E. <u>Other Costs</u></b>						
1. Vehicle operation and maintenance 20 vehicles @ \$7,000/yr.	140,000	140,000	140,000	140,000	140,000	700,000 (LC)
2. 100 Motorcycles @ \$200 (average 80 motorcycles/yr.)	16,000	16,000	16,000	16,000	16,000	80,000 (LC)
3. Generator system and maintenance	5,000	25,000	25,000	25,000	10,000	90,000
					Subtotal	870,000
					TOTAL FOR COMMODITIES	3,416,000
Estimated PSA fee (7%) (except for commodities passed directly by USAID)						259,000
Estimated shipping charges (40%) (except for commodities already marked "+ 40%" and those marked "LC")						507,000
					GRAND TOTAL	3,416,000

- Notes:
1. It is anticipated that items identified with "LC" on the commodity list will be procured in Liberia with currency set aside for that purpose. This includes vehicle operation and maintenance costs and other selected commodities. Construction commodities have not been included in these figures. "LCX" means only part of that figure is local cost.
  2. Procurement of the microcomputer will only take place after cable concurrence has been received from AID/W, M/SEC/DM, to purchase a specific model.
  3. The grand total for commodities shown in this figure differ from the amount shown in the Cost Estimates (Section 3, Figure III-1) because several items included here appear under other line items in the Projected Expenditure of AID Grant Funds.

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E. Shelf-item Procurement: Local Cost Financing

The Primary Health Care Project will utilize approximately \$1 million for local cost procurement of such items as spare parts, fuel/oil/lubricants, examining tables, drug cabinets, and some furniture. Procurement under the shelf-item rule will be in accordance with rules outlined below.

1. Local procurement of commodities can provide the following items:
  - a. Indigenous commodities: those mined, grown or produced in the cooperating country. Non-free world componentry is disallowed.
  - b. Shelf items: those items imported and stocked to meet a general public demand in the cooperating country. They are not goods imported solely to support an AID-financed project.
2. Both indigenous goods and shelf items must meet eligibility criteria, and are subject to the statutory and policy restrictions found in Handbook 1, Supplement B, Chapter 4.
3. Financing Support
  - a. Indigenous goods can be financed by AID project funds without limitation, other than the total local currency limitation of the project.
  - b. Imported shelf items from Code 000 (U.S.) sources can be financed in unlimited quantities. Imported shelf items from Code 941 sources (U.S. and less Developed Countries) can also be financed in unlimited quantities; the eligible source(s) must be identified in the Grant Agreement. Shelf items from Code 935 sources can be procured if the price per unit does not exceed \$5,000; the total amount of these project purchases cannot exceed \$25,000 or 10% of the total project local cost financing, whichever is higher, but in no case will they exceed \$250,000 without a source/origin procurement waiver.
  - c. Prices to be paid for locally procured commodities will be no more than the lowest available competitive prices, and purchases will be in accordance with good commercial practices. Commodities on the local market that are imported from non-Free World countries are not eligible for AID financing.
  - d. Vehicles are not eligible as "shelf items"; however, cement, sand, gravel, fuel/oil/lubricants, and construction materials are obtainable with local cost financing. Some locally-procured items may be ineligible as a result of being shipped abroad non-Free World vessels; high visibility commodities (tractors, farm equipment, fertilizers, etc.) may fall under this heading.

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- e. Invoices for payment should state the source and origin of locally purchased materials, if such a requirement is practical.

F. Waivers

The waivers required under this procurement plan are as follows:

1. Source/origin waiver for kerosene stoves and spare parts and salter scales.
2. Source/Origin waiver for trail motorbikes.

The waiver justifications are included as Annexes M-2 and M-3.

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## UNITED STATES AID MISSION TO LIBERIA

c/o American Embassy  
 Monrovia, Liberia



## ACTION MEMORANDUM FOR THE DIRECTOR, USAID/LIBERIA

FROM: Glenn L. Post, M.D., Health Officer *Glenn L. Post*

SUBJECT: Primary Health Care Project (669-0165)  
 Procurement Source/Origin Waiver

Problem: Your approval is requested for a procurement source/origin waiver from AID Geographic Code 000 (US only) to Code 935 (Selected Free World) to permit the procurement of approximately 56 kerosene stoves and spare parts and approximately 200 Salter scales.

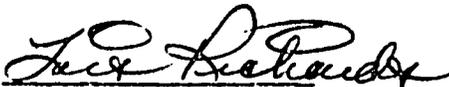
Cooperating Country:	Liberia
Authorizing Document:	Grant Agreement
Project:	Primary Health Care Project No. 669-0165
Nature of Funding:	Grant
Description of Goods:	Kerosene stoves and spare parts; Salter scales
Approximate Cost:	\$17,600
Probable Source:	Western Europe
Probable Source/Origin:	Code 935, Selected Free World, including Host Country.

Discussion: The Primary Health Care Project requires the use of kerosene stoves to be used for sterilizing instruments and equipment at remote health facilities and villages where there is no other satisfactory energy source available. Also, Salter-type scales are required to carry out nutrition surveillance activities at rural health facilities and in the villages. This type of scale has been found to be ideally suited for the existing conditions in remote areas, and is both low cost and maintenance free.

There are no known US manufacturers of either the required type of kerosene stove or the Salter-type scales. The only source of manufacture known is Western Europe. These commodities are not available from Code 941 countries. AID Handbook 1, Supplement B, Chapter 5B 4a (2) states that a source/origin waiver may be granted if the commodity is not available from the authorized source. This is the case for this procurement.

Recommendations: Based upon the above and the authorities granted to you by Delegation of Authority 140, Revised, it is recommended that you:

1. Approve a change from the authorized Geographic Code 000 (US only) to Geographic Code 935 (Selected Free World) to permit the procurement of kerosene stoves and spare parts and Salter-type scales for the approximate amount of \$17,600; and
2. Certify that exclusion of procurement from Free World countries other than the cooperating country and Code 941 countries would seriously impede attainment of U.S. foreign policy objectives and objectives of the foreign assistance program.

APPROVED: 

DISAPPROVED: \_\_\_\_\_

DATE: August 29, 1983

## ACTION MEMORANDUM FOR THE ACTING ASSISTANT ADMINISTRATOR FOR AFRICA

FROM: AFR/PD, Norman Cohen

SUBJECT: Source/Origin Waiver

Problem: Your approval is required for a source/origin waiver from Geographic Code 000 (U.S. only) to Geographic Code 935 (Special Free World) for the purchase of 130 trail motorbikes and spare parts valued at approximately \$192,800.

1. Cooperating Country: Liberia
2. Project: Primary Health Care (669-0165)
3. Nature of Funding: Grant
4. Description of Commodities: 130 trail motorbikes (100 to 125cc displacement) plus spare parts
5. Approximate Value: \$192,800
6. Probable Source: U.S. or Liberia
7. Probable Origin: Japan

Discussion: The Primary Health Care (PHC) project will assist the Ministry of Health and Social Welfare (MH&SW) to provide village-based PHC services in two counties in rural Liberia, as well as to institutionalize decentralized operations in these counties. Supervision is a critical and integral aspect of this system. Mid-level health workers in the rural areas currently have no means of transportation to provide much-needed supervisory and support services. Owing to the high cost of fuel and vehicle maintenance, the poor quality of the Liberian road network, and the remote location of the rural health facilities and villages to be served, trail motorbikes clearly offer the most efficient means of transportation for supervisory health workers. The motorbikes should have the capacity to support two persons so that transportation resources can be conserved as much as possible by carrying a co-worker when appropriate. Such motorbikes have been used successfully by health workers under the AID-assisted LOFA County Rural Health project, and by other GOL entities.



DRUG, EQUIPMENT AND SUPPLY LISTS FOR VILLAGE HEALTH TEAM AND RURAL HEALTH FACILITIES

This annex provides representative lists of drugs, equipment, and supplies for issuance to and use by the following elements of the county-level PHC delivery system: village health workers, traditional birth attendants, health posts, and health centers. The lists reflect agreement between the MH&SW and USAID as to what ought to be supplied and used at each level; however, the lists should be viewed as illustrative, and subject to change during final project development and implementation.

Of the items on the lists, it is expected that some will be purchased with project funds, while others may be funded by the MH&SW, and still others may be obtained through other donors. In general, the project will fund the initial supply of essential items listed for VHWs and TBAs. Particularly for the health post and health center items, procurement will be determined according to several factors: AID procurement regulations, urgency of need, unit cost, MH&SW preferences, and availability through other donor sources.

A. Drugs, Equipment and Supplies for VHWs

Aspirin (300 mg tablets)  
Benzyl benzoate lotion  
cash box  
Chloroquine (150 mg base tablets and 65 mg base syrup)  
Condoms  
Contraceptive suppositories and/or foam  
Cough mixture for children (expectorant - Guaifenesin)  
Ferrous sulfate syrup  
Gentian violet solution  
Health, family planning, and nutrition education materials  
Medicine box with padlock  
Oral contraceptive pills (refill only)  
Oral rehydration salts (sachets)  
Piperazine (syrup and 500 mg tablets)  
Tape, gauze, bandages, cotton wool, scissors  
Thermometer, oral (if VHW can read numbers)

B. Drugs, Equipment and Supplies for TBAs

Chloroquine (150 mg base tablets)  
Condoms  
Contraceptive suppositories and/or foam  
Health, family planning, and nutrition education materials

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Gentian violet

Multivitamins with iron/folate tablets

Oral contraceptives (refill only)

UNIPAC midwifery kit type 2 with aluminum case. (to be provided by UNICEF)

C. Health Post Drug List

Acetaminophen elixir 120 mg./5 ml, 2 lt/bt

Alcohol isopropyl 70%, gal.

Aluminum hydroxide suspension 5%, 2 lt/bt

Aminophyllin tablets 100 mg, 100 ml/bt

Ampicillin suspension 125 mg, 100 ml/bt

Anusol suppositories

Aspirin (acetylsalicylic acid) 300 mg, tablets, 1000's/bt

Benzoic + salicylic acid ointment 500 mg/jr

Benzyl benzoate lotion (25%) 2 lt/bc

Calamine lotion, 2 lt/bt

Cetrimide solution (conc. 40%) 2 lt/bt

Chloroquine inj. 320 mg/5 ml 100's/bx

Chloroquine syrup 65 mg base per 5 ml, 2 lt

Chloroquine tabs 250 mg 1000's/bt

Chlorpheniramine maleate tablets, 4 mg

Cimetidene, 300 mg

Contraceptives (condoms, foam, oral pills, suppositories)

Cough mixture syrup (adult) 2 lt/bt (expectorant - Guaifenesin)

Cough mixture syrup (children) 2 lt/bt (expectorant - Guaifenesin)

Diethylcarbamazine tablets 50 mg 1000's/bt

Ethyl chloride spray - 100 ml bt

Ferrous sulfate syrup, 200 mg/5 ml 2 lt/bt

Ferrous sulfate tablets, 300 mg 1000's/bt

Furadantin, 50 mg  
 Gentian violet solution 2%, 21t/bt  
 Hydrochlorothiazide tablets 25 mg 1000's/bt  
 Hydrogen peroxide 3% 500 ml/bt  
 Levamisole  
 Lidocaine inj. 2%, 50 ml, vial  
 Liquid paraffin (mineral oil) 2 lt  
 Magnesium trisilicate compound tablets, 1000's/bt  
 Methyl salicylate liniment, 2 lt/bt  
 Milk of magnesia suspension, 2 lt/bt  
 Multivitamin pediatric syrup, 2 lt/bt  
 Multivitamin tablets, 1000's/bt  
 Nystatin vaginal suppositories  
 Nitrofurazone soluble dressing 1 lb, ea  
 Oral rehydration salts, pk  
 Penicillin G. procaine inj. 3 mega units, 100's/bx  
 Penicillin (phenoxymethyl) tablets 250 mg, 1000/bt  
 Phenobarbital tablets 30 mg 1000/bt  
 Piperazine citrate tablets, 500 mg 1000's/bt  
 Pyrantel pamoate suspension 250 mg/5 ml, 60 ml/bt  
 Pyantel pamoate tablets 125 mg, 6's x 25/bx  
 Prenatal tablets (multivitamin, iron, folate, calcium)  
 Reserpine tablets, 0.25 mg 1000's/bt  
 Tetracycline capsules 250 mg 1000/bt  
 Tetracycline oint. ophthalmic  
 Thiabendazole suspension, 500 mg/ 5 ml, 120 ml/bt  
 Thiabendazole tablets, 500 mg, 100's  
 Trimethoprim/sulfamethoxazole  
 Water for injection 10 ml 100's/bx

D. Health Center Drug List

Acetaminophen elixir 120 mg./5 ml  
 Alcohol Isoprophyl 70%, gal.  
 Aluminum hydroxide suspension 5%, 2 lt/bt  
 Aminophyllin tablets 100 mg, 1000's/bt  
 Ampicillin capsules 250 mg, 1000's/bt  
 Ampicillin suspension 125 mg/5 ml, 100 ml/bt

Anusol suppositories  
Aspirin (Acetylsalicylic Acid) 300 mg, tablets, 1000's/bt  
Benzoic + Salicylic Acid ointment 500 gm/jr  
Benzyl benzoate lotion (25%) 2 lt/bt  
Calamine lotion 2 lt/bt  
Cetrimide solution (conc. 40%) 2 lt/bt  
Chloramphenicol capsules 250 mg  
Chloroquine inj. 320 mg/5 ml 100's/bx  
Chloroquine syrup 65 mg base per 15 ml 2 lt  
Chloroquine tablets, 250 mg 1000's/bt  
Chlorpheniramine maleate tablets, 4 mg  
Cimetidene, 300 mg  
Codeine phosphate 30 mg tablets  
Contraceptives (condoms, diaphragms, foam, IUD's, oral pills, suppositories)  
Cough mixture syrup (adult) 2 lt/bt (expectorant-Guaifenesin)  
Cough mixture syrup (children) 2 lt/bt (expectorant-Guaifenesin)  
Dextrose 5% in normal saline 500 ml, ea.  
Diethylcarbamazine tablets 50 mg 1000's/bt  
Epinephrine, 1:1000 for injection  
Ergonovine maleate injection 0.2 mg/ml, 100's/bx  
Ergonovine maleate tablets 0.2 mg 1000's/bt  
Ethyl chloride spray 100 ml/bt  
Ferrous sulfate syrup 200 mg/5 ml 2 lt/bt  
Ferrous sulfate tablets 300 mg 1000's/bt  
Furadantin, 50 mg  
Gentian violet solution 2% 2 lt/bt  
Hydrochlorothiazide tablets 25 mg 1000's/bt  
Hydrogen peroxide 3% 500 ml/bt  
Lactated ringers inj. 500 ml, ea.  
Levamisole  
Lidocaine inj. 2% 50 ml, vial  
Liquid paraffin (mineral oil) 2 lt  
Magnesium trisilicate compound tablets 1000's/bt  
Magnesium sulfate 50% inj. (5 g/10 ml.)  
Metronidazole tablets, 250 mg 500's/bt  
Milf of magnesia suspension, 2 lt/bt

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Multivitamin pediatric syrup 2 lt/bt  
 Multivitamin tablets, 1000's/bt  
 Nitrofurazone soluble dressing 1 lt, ea.  
 Oral rehydration salts, pk.  
 Penicillin G. procaine inj. 3 mega units 100's/bx  
 Penicillin (phenoxymethyl) tablets 250 mg 1000's/bt  
 Phenobarbital tablets 30 mg 1000's/bt  
 Piperazine citrate syrup, 500 mg/5 ml gal/bt  
 Piperazine citrate tablets, 500 mg 1000's/bt  
 Pyrantel parmoate suspension 250 mg/5 ml, 60 ml/bt  
 Pyrantel parmoate tablets, 175 mg, 6's x 25/bx  
 Prenatal tablets (multivitamin, iron, folate, calcium)  
 Prochlorperazine tablets 10 mg  
 Reserpine tablets, 0.25 mg 1000's/bt  
 Sodium chloride (normal saline) 0.9% 1000 ml/bt  
 Tetanus antitoxin inj. 1500 units  
 Tetracycline capsules 250 mg 1000's/bt  
 Tetracycline oint. ophthalmic  
 Theophylline elixir 80 mg/15 ml  
 Thiabendazole suspension, 500 mg/5 ml, 120 ml/bt  
 Thiabendazole tablets, 500 mg 1000's  
 Trimethoprim/sulfathoxazole  
 Vitamin B-complex tablets, 1000's/bt  
 Water for injection 10 ml 100's/bx

E. Health Post Equipment and Supply List

Acetic Acid  
 Adult Scale  
 Albustix  
 Applicator sticks, cotton tipped  
 Bandage scissors  
 Bandages  
 Benedict's Solution  
 Cards with plastic cover: weight ("Road to Health"), prenatal/general  
 Cashbox

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Centrifuge - hand type  
Centrifuge tubes  
Cotton wool (113 gauze)  
Cover slips  
Cup, feeding, with cover  
Cup, solution - stainless steel  
Cutlery set - 4 pc.  
Drug cabinet - secure (locally made)  
Dressing tray with cover  
Examining table (locally made)  
Flashlight with spare bulb and batteries  
Forceps, hemostat/mosquito  
Forceps, hemostat/straight  
Forceps, tissue  
Funnel, 75 mm. diameter  
Gauze  
Health, family planning and nutrition education materials  
Ice chest with cold dogs  
Infant scale (Salter) (3)  
Instrument forceps  
Instrument tray with cover  
Kidney basin (large)  
Kidney basin (small)  
Lamp - kerosene, (240 ml.)  
Measuring cup (1000 ml.)  
Lens paper  
Microscope  
Midwifery kit/type 3 (UNIPAC)  
Nasogastric tube  
Needle, straight with handle  
Needle, suture, 1/2 inch, pkg. of 6  
Needles, 21 gauge, 23 gauge, 26 gauge  
Otoscope with spare bulb and batteries  
Refrigerator - kerosene (in selected health posts - supplied by EPI).  
Saline  
Silk black

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**Slides**

Sphygmomanometer (aneroid)  
 Sterilizer (fuel type)  
 Stethoscope - adult (2)  
 Stethoscope - fetal  
 Stove/burner - kerosene  
 Suture nylon sterile  
 Syringes 5 ml. and 10 ml. luer glass  
 Tape, adhesive  
 Teaspoons 5 ml.  
 Test tubes  
 Test-tube holder  
 Thermometers, oral (6) and rectal (6)  
 Tissue (teeth) forceps (6)  
 Tongue-depressor (metal)  
 Vaginal specula  
 Vision testing chart  
 Wash basin (4 ltrs.)

**NOTES:** Equipment and supplies at health centers will include all of the above in larger quantities. In addition, linen for inpatient care is required.

Each health post will be supplied with a monocular light microscope; each health center will be supplied with a binocular microscope powered by a 12-volt battery (along with a spare battery and bulb, and immersion oil). IUD-insertion kits will also be supplied to health centers.

Varying amounts of the equipment are already present at the health facilities. The MH&SW will conduct an inventory of existing equipment prior to disbursement of funds for medical equipment. This inventory, to be approved by A.I.D., will be the basis for determining the commodities that need to be ordered.

The sum of \$1500 per health post and \$3000 per health center (plus 40% shipping and PSA) is budgeted. An additional \$200 per facility is budgeted for the locally made examining table and secure drug cabinet.

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DRAFT SCOPE OF WORK FOR CERTIFIED PUBLIC ACCOUNTANT ( CPA ) FIRM

I. Purpose of Contract

The purpose of this contract is to assist the Government of Liberia in establishing an effective financial management system within the Ministry of Health and Social Welfare that will insure adequate financial information and control of funds provided under the AID-assisted Primary Health Care Project and to provide a periodic financial review of the receipt and expenditure of project funds.

II. Scope of Work

The contractor will provide sufficient professional and support services to accomplish the following specific tasks:

A. MH&SW Financial Management System

The contractor will assist MH&SW officials and the project's long-term technical assistance team in developing and implementing a financial management system within the MH&SW capable of the following:

1. The system will provide adequate internal control for cash receipts and disbursements, intragovernmental transfers, account balances, and inventories of expendable goods.

2. The system will accommodate the budgetary and financial management implications of the county-level decentralization envisioned in the project, while maintaining compatibility with central-level MH&SW financial systems. For example, in view of the expanded authority and responsibility at the county level, the present budgetary/accounting categories may be inadequate for proper financial management and control, and will need to be restructured/expanded. At the same time, the capability of recombining the categories in a format compatible with the central MH&SW accounting systems will need to be maintained.

3. The system will incorporate mechanisms sufficient to monitor the revenue-generating system within the county, including:

- a. County-level revolving drug fund (see B below), with charges retained within the county health department.
- b. Village-level revolving drug funds (see C below), with charges retained by the individual villages.
- c. Registration fee system currently in effect for routine outpatient visits and inpatient admissions to MH&SW health facilities, with fees returned to GOL general revenues via the Ministry of Finance.

To the extent that the MH&SW financial management system will interface with the annual project financial reviews (see D below), the contractor will coordinate the integration of the information collection and reporting

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systems. The financial management system will be developed as an outgrowth of the study of MH&SW managerial and financial systems (beginning in project month 15), and the implementation of the study's recommendations.

B. Revolving Drug Fund at the County Level

The contractor will assist in the development and implementation of simple but effective record-keeping systems so as to provide financial control of the county-level revolving drug fund, including cash disbursements and receipts, as well as the control of physical goods (procurement, inventory, and issue/transfer). The contractor's assistance will be coordinated with the development and implementation of the county-level drug distribution system (implementation in Grand Gedeh County in Project month 29, and in Sinoe County in month 34).

C. Revolving Drug Funds at the Village Level

The contractor will assist in the development and implementation of simple but effective record-keeping systems to insure the adequate accounting and control of funds, so that the village-level fund will effectively regenerate and sustain itself. The contractor's assistance will be coordinated with the development and implementation of the village-level drug system (implementation in Grand Gedeh County beginning in Project month 30, and in Sinoe County in month 38).

D. Annual Project Financial Reviews

1. The contractor will assist in the design and implementation of the necessary financial and record-keeping systems for the performance of annual project financial reviews. The design of these systems will begin in Project month 6.
2. Utilizing the system developed and implemented in 1. above, the contractor will carry out annual financial reviews, including a partial audit of project funds, based on GOL fiscal years (i.e., July through June). The first review will be completed by Project month 13, and subsequent annual reviews at 12-month intervals thereafter.

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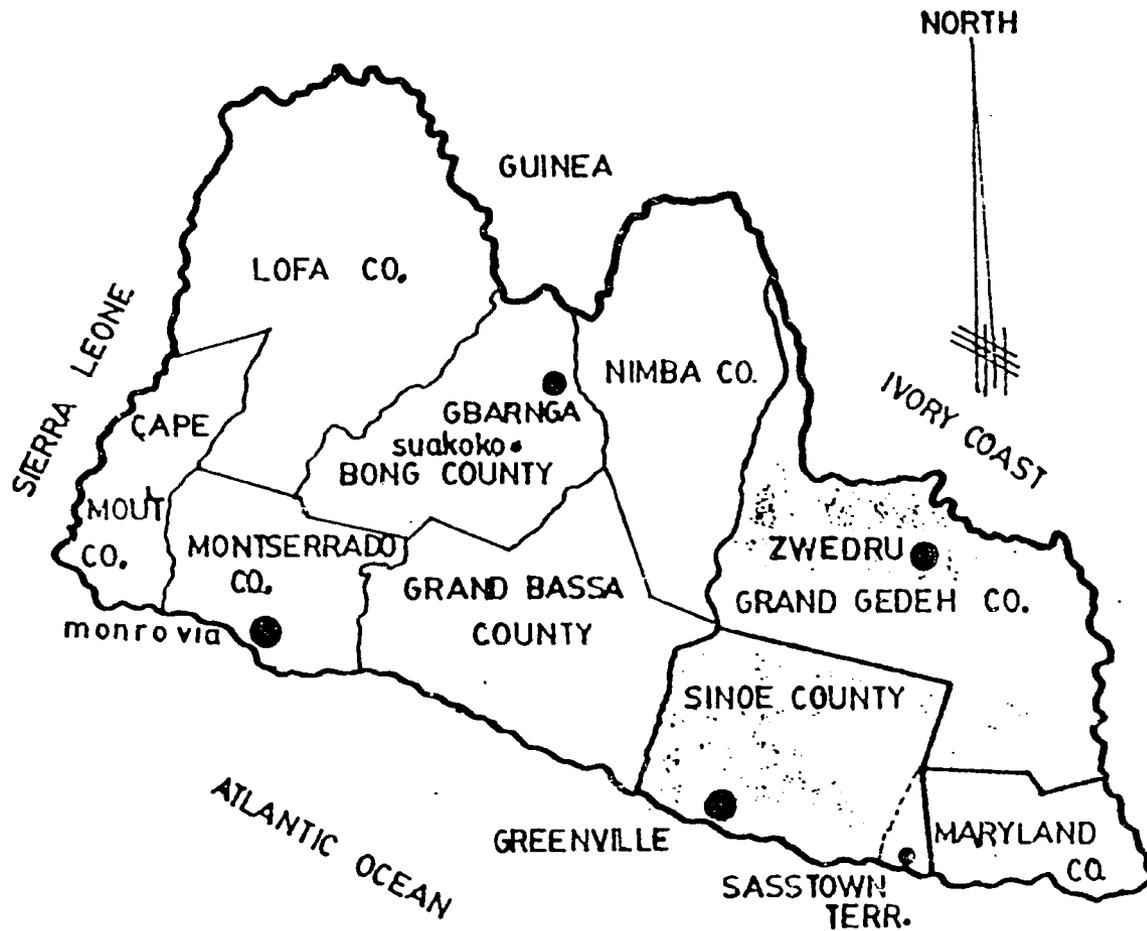


FIGURE P-1: MAP OF LIBERIA

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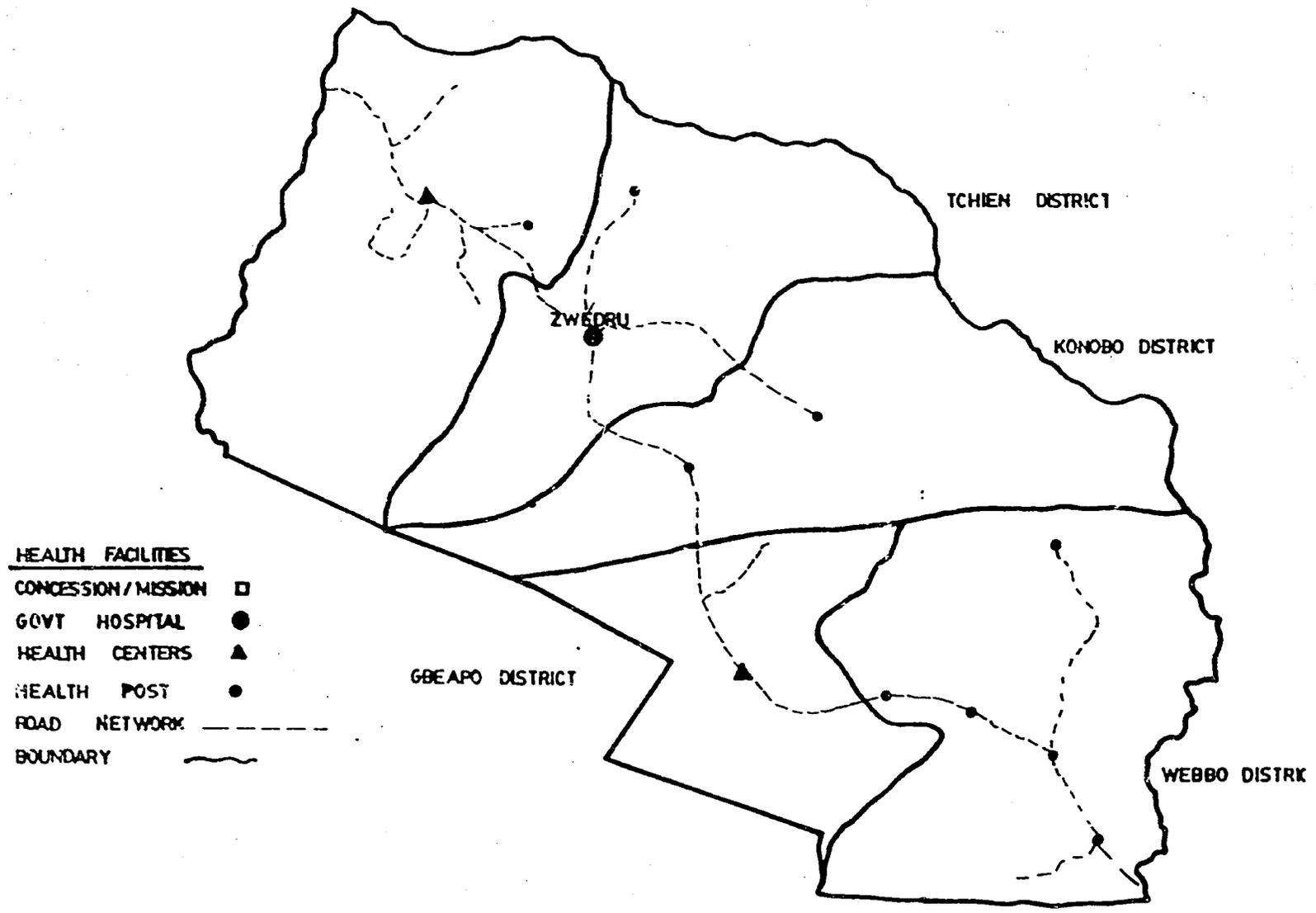


FIGURE P-2: MAP OF GRAND GEDEH COUNTY SHOWING HEALTH FACILITY LOCATIONS

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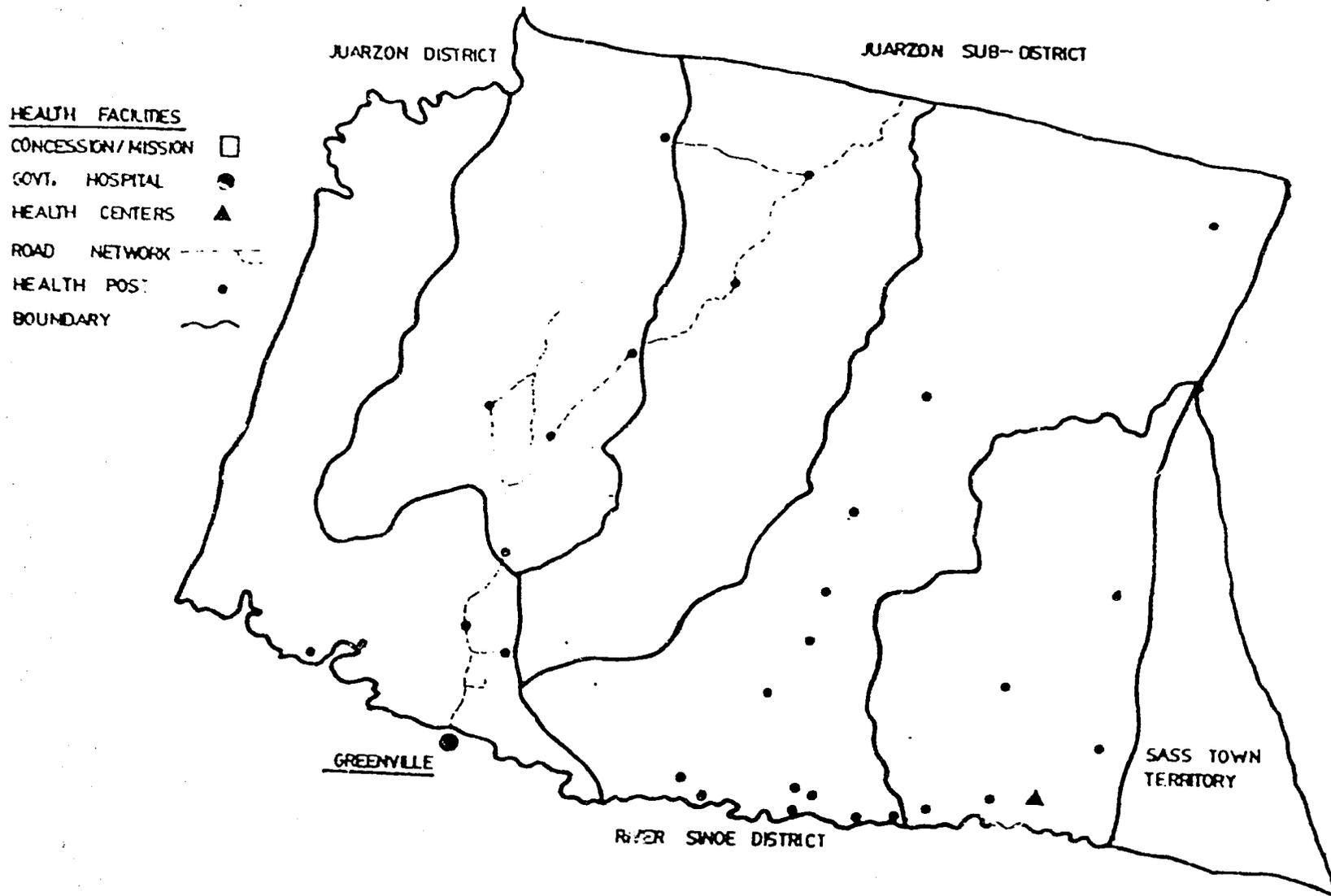


FIGURE P-3: MAP OF SINOE COUNTY SHOWING HEALTH FACILITY LOCATIONS

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