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BOTSWANA HEALTH SERVICES DEVELOPMENT
PROJECT

DISCUSSION PAPER

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PREFACE

The following informal working paper has been prepared as a result of discussions which were held in November, 1978 in Botswana between a visiting Pacific Consultants' mission, representatives of the Government of Botswana (GOB) and personnel from the U.S. Agency for International Development (AID).

The paper is an unsolicited and very preliminary proposal which attempts to outline some tentative conclusions reached by the Pacific team with respect to the central concerns of the Botswana Government in the health field. The paper also raises questions about the Health Services Development Project (Number 633-0078) which was explored in some depth during the team's visit and suggests some approaches and considerations upon which Pacific Consultants would place priority in the event the firm should receive a contract to implement the project.

It is anticipated that the ideas and analysis set forth below will permit Botswana government officials and AID personnel to have a more complete understanding of the capabilities and experience of the firm which, in turn, should facilitate the decisionmaking which is required to transform the project proposal in question into a reality.

I. BACKGROUND

Upon return from Botswana in November, 1978 the Pacific team together with other relevant AFPLAN personnel ^{1/}conducted a review of the basic literature available to the firm which assesses health conditions in Botswana. From our own assessment of the 1976-1981 National Development Plan (NDP), the health sector review conducted by AID as part of its overall Southern African Development Analysis Project (SADAP) and other relevant documentation, it is clear that the AID supported Government of Botswana's Health Services Development Project addresses several critical problems which have constrained the effective delivery of health services, particularly in the rural areas.

The NDP stresses the importance of integrating curative and preventive aspects of health services and targeting them particularly at the community or village level. It gives highest priority to strengthening primary health services which should be equitably distributed and recognizes that, to accomplish this, the expansion and diversification of training facilities and opportunities for medical and para-medical personnel must be achieved.

^{1/} AFPLAN is Pacific Consultants' full-time team of development specialists who have focused their energies on the resolution of problems, in particular, in the sub-Saharan Africa region. See the attached brochure for more details, Annex V.

The "health post" is understood to be the most basic type of health facility in which nurses, or minimally, Family Welfare Educators (FWEs) provide initial care and referrals as required for their local community. The goal of the GOB is to locate health posts so that no citizen will find it necessary to travel more than 15km in the case of settled Batswana or 30km in the case of any Batswana.

To achieve this objective and, consequently, reduce the illness and mortality rates Government has engaged in an ambitious health development program through the expenditure of its own funds and with the support of numerous donors. The Norwegian development agency (NORAD) has expended over five million dollars for the construction of rural health facilities, the African Development Fund has provided a soft loan to permit expanded facilities for health training and several donors have provided professional medical personnel to staff some of the facilities and conduct some training.

The basic thrust of the NDP is reinforced by the January, 1979 AID draft health sector appraisal produced for SADAP which concludes that the four key constraints to improved health care in Botswana are:

- (a) the limited numbers of adequately trained staff;
- (b) less than adequate supervision and technical support for the FWEs who are defined as the

most important and permanent members of the health team at the most peripheral level of the delivery system;

- (c) limited knowledge of proper health practices by citizens and apparent underutilization of some health facilities; and
- (d) a limited health and demographic planning capacity.

From the above conclusions and the profile of the rural population presented in the Rural Income Distribution Survey, it is apparent that the Government project for Health Services Development has focused upon the key constraint in the sector. The components of the project - as understood from discussions with Ministry of Health and AID officials - will be examined in Part II, below, however, a few more general observations regarding impediments to the effective implementation of health delivery systems, based upon the prior experience of Pacific, are presented here.

Recurring impediments to effective health system delivery in developing countries may include:

- (a) unforeseen fiscal constraints caused by budgetary difficulties or altered priorities (in Botswana, for example, the necessary establishment of the Botswana Defence Force required the diversion of development resources);
- (b) inadequate or inappropriate management systems and planning within and among government ministries;

- (c) an inadequate pool of trained or educated manpower at lower levels can restrict the rates at which specialized training occurs at more technical levels, particularly in the health field where a strong science background is important;
- (d) insufficient coordination among donors and between donors and the host government can cause inefficiencies or inequities in the delivery of health care on the national level;
- (e) inadequate transport and communication can result in supply deficiencies for essential health equipment and medicines. A system for the regular supply of goods and maintenance of equipment is often needed to ensure that the more remote health posts in particular are able to function continuously;
- (f) the incomplete integration of family planning services with the overall health service program and particularly the Maternal and Child Health (MCH) component can have adverse consequences for the objectives of both;
- (g) inappropriate technology can be costly and counterproductive and overly sophisticated medical equipment in particular can absorb a highly disproportionate percentage of health resources while being able to assist only a very limited percentage of a country's population;
- (h) unequal access to health facilities can sometimes be a problem not only because of the adverse medical consequences for those so affected but because it can breed mistrust of the system itself;
- (i) the role of traditional healers has sometimes been ignored or minimized while a significant percentage of a population consults them with direct consequences for modern health services. Given the limited training of FWEs in modern medical practices and the knowledge of traditional healers through experience, consideration could usefully be given to the possibility of training some traditional healers to be FWEs.

The above issues must be addressed if primary health care as envisaged in Botswana's NDP is to be realized and if the constraints identified above by the SADAP paper are to be overcome. Each issue need not be completely resolved before a specific initiative such as the Health Services Development Project commences implementation, however, the nature and degree of the problem in Botswana in each case should be examined in relation to the proposed project in order to ensure that the executing agency or contractor is aware of likely constraints upon project implementation which are broader in scope than the project elements themselves.

A broad-based primary health care delivery program of the type being evolved in Botswana must also include a major thrust toward health education of the public in order that the consumers of health services will become more fully aware of and practice the health maintenance knowledge they obtain from health workers who, in many instances, are their own leaders. Such leaders may be found, for example, among village chiefs, elders, district council members, community development organizations and traditional organizations such as burial societies. Local leaders, while potentially the most effective conveyors of improved health knowledge, will not articulate sound health practices unless they are instructed in and encouraged to support the

concept of combining curative and preventive services at each level of the health service infrastructure. This is generally the case because traditional health care in rural Africa strongly emphasized the curative aspects without fully understanding the causes of illnesses and measures which could be taken to avoid them.

The objectives of Botswana's health care system could also be advanced by ensuring that the curriculum used in each training institution includes instruction in the management of and planning for a health post or clinic as well as in the substantive information related to the prevention and cure of disease. Those who train the instructors who will staff Botswana's health training institutions will need to impart to their students an understanding of the supervisory functions of health professionals and para-professionals so that the institutions of which they will become a part are able to carry out the functions entrusted to them. In addition to enhancing the effectiveness of the health post or clinic, attention to this aspect of training will also increase the feedback which the government will obtain from FWEs and others in the form of reports, statistics and an understanding of the extent to which the system is functioning as planned.

Once rural health personnel have been trained in management functions, motivational techniques, basic

financial operations, inventory control and other administrative necessities in addition to their instruction in health per se, it becomes important to ensure their participation in planning for generalized rural health services. Middle and village-level decisionmakers inclusion in the planning process often improves motivation among such health workers and community leaders; increasing the chances for the successful implementation of health delivery system plans. Local level participation helps to ensure continuing support for the program and, by making local workers full partners in the development of the system, greater efforts may be expected in related areas such as the provision of improved water supplies and the controlled disposal of human waste.

Being aware of its training deficiencies, the Botswana Government in 1973 requested technical cooperation from AID to initiate a program to train registered and enrolled nurses in the delivery of rural integrated MCH and family planning (FP) services and to develop a health education program. The training was designed to be short-term (eight weeks) and in-country for the most part but also included long-term participant training in the U.S. for Ministry of Health nurses and other personnel who were expected to serve at the higher level administrative and teaching positions.

The project was implemented through a grant to the Meharry Medical College and was scheduled to be completed in June, 1978. While the mid-1978 project evaluation revealed many project strengths, certain areas may require further assistance, particularly health education and the integration of the short-term training curricula into the National Health Institute's curricula for enrolled and registered nurses.

In order to build upon the accomplishments of the Meharry project and to develop more inclusive approaches to health care delivery, the GOB in 1976 requested AID to assist in the design of a follow-up country-wide Health Services Development project.

II. THE HEALTH SERVICES DEVELOPMENT PROJECT

From discussions in Gaborone, it is understood that the new project has five components: (1) nursing education to provide personnel for Botswana training institutions which will be combined with curriculum reform for the enrolled nurses program to ensure that course content is more directly targeted to prepare nurses for rural areas; (2) training of health administrators at the Institute for Development Management in Botswana; (3) training of health educators in an in-country training program to prepare them for service with regional health teams; (4) construction of a building in Gaborone to house the Health Education Unit will be undertaken and (5) research in nutrition will be undertaken in order to develop a National Nutrition Program jointly with project personnel and counterparts. The Nutrition Unit of the Ministry of Health would eventually be staffed by persons trained on the project and the Unit could be housed together with the Health Education Unit in the building to be constructed under the terms of the project.

While emphasizing again our incomplete knowledge of the project requirements in the absence of a formal Request for Proposal (RFP) from AID and stressing the tentative nature of our observations, the following comments may nonetheless provide an indication of some of our pre-

liminary concerns which arise from elements of the project design which were apparently part of the project as of our discussions last November.

(a) The project's administrative officer is provided only for a two year period after which a trained counterpart is expected to replace him/her. The experience of our firm with other projects, some less complex than this one, in countries with severe manpower constraints such as Botswana would indicate that there may be difficulty in meeting this time schedule. Results have generally been best where the administrative element has been strong and consistent throughout the life of the project. In the event a counterpart should be trained in the limited period envisaged, the counterpart could only benefit from additional experience with the administration of the project which he/she would gain from a longer period of collaboration with that administrative officer.

(b) Although participant training is provided for a health planner for two years, it appears that only limited short-term training is planned for other members of the Health Planning Unit (chiefly statisticians). The nature and extent of training for the health planner will depend in part on the availability

and training of other Unit members. This will need to be determined by the contractor to ensure that the nature of the course and the qualifications of the trainee are suitable for the task at hand.

(c) It is our impression that the only secretarial assistance to be provided under the terms of the project will be one clerk/secretary to be paid from project funds. We are not aware of any government counterpart contribution for secretarial support services in addition to that provided in the project. If this is the case, it may well be that support services are inadequate to permit the project team to carry out its responsibilities in a timely and efficient manner.

(d) In order to mount an effective nationwide program in health education a graphic artist will be required and we understand that it has been suggested that a Peace Corps Volunteer might be made available for this purpose. It would be useful to know how successful the Peace Corps has been in the past in recruiting persons with these skills in order to know whether this is realistic or whether someone with the talents of a graphic artist would generally expect to be paid at the prevailing rates in the U.S. for such skills.

(e) With regard to the establishment of a Nutrition Program, it would be useful to know whether provision has been made for the establishment of a National Nutrition Advisory Board or a Nutrition Secretariat in the Ministry of Health. It has been our experience that Nutrition Units function more effectively with a small secretariat for support. The presence of an Advisory Board can provide an excellent source of promotional ideas and program suggestions and add weight to the recommendations of the Unit.

(f) It is our understanding that four vehicles will be provided for the project plus a driver/mechanic. We are uncertain whether provision has been made for spare parts but presume that an allocation equal to the value of about 25% of the vehicles would be considered normal for this purpose. It would be useful to know whether it is anticipated that normal commercial maintenance facilities in Botswana would be used to service the vehicles or whether they would be serviced by government maintenance facilities. The adequacy and availability of these facilities would be a point of interest to us since their absence can have serious adverse consequences for a project in a country of the size and terrain of Botswana.

(g) Also regarding transport facilities, it would be important to know whether light planes are available for rental in emergencies. In the event of illness or accident to project staff or a project related crisis in a remote area, this information would be available on a contingency basis.

(h) In a review of equipment which would be provided for the project, items like gas lanterns were mentioned. This would lead one to the conclusion that many areas of Botswana are not electrified. As a consequence the use of slides and slide projectors may not be appropriate and a sunlight projector might be substituted. Equipment needs and items to be procured would be reviewed by the contractor prior to the project team's arrival to ensure that appropriate items arrive in time for their use on the project.

(i) It appears that the project envisages the use of nurses as "physician extenders" in some rural health posts. The extent to which nurses can function in this capacity without the regular supervision of a medical doctor is limited and the term can be misleading for both the nurses and the patients. It has been our experience in other projects that nurses with this responsibility are often left to function mostly on their own and that the nurses curriculum should

take this into consideration.

(j) In the area of health education, the question of potable water is of central importance. For communities of less than two hundred people instruction in how to obtain pure water will be critically important and will be linked to questions of sanitation generally. Regional Health Educators will need information on this question, particularly since it appears that efforts to develop safe water supplies are, at present, being directed toward communities with slightly larger populations.

(k) To our knowledge it has not been specifically stated that health education should be distributed widely throughout the health care system with all health workers receiving some instruction in health education methodology. Our experience has been that this is of central importance to diffuse the knowledge of sound health practices as widely as possible.

(l) Substantive evaluation of both the impact of the project and its evolution as part of a national effort in the health care field will permit feedback to the project team and the GOB to ensure that project objectives remain relevant and are achieved in a timely fashion. It is presumed that this issue has been

addressed in the project design, however, it should be stressed that early evaluation in a project of this duration is important to provide base-line data for subsequent evaluations of project progress.

Additional issues of a more general nature which are nevertheless important include the fact that any contractor must be sensitive to the fact that this project is only part of a nationwide effort to deliver primary health care, that the Ministry of Health and possibly other designated government entities are responsible for the coordination of a large number of schemes and that, consequently, whatever is initiated under the Terms of Reference must be linked to the overall effort. Thus, for example, curriculum reform and training of nurses must be geared to the specific requirements of various health care levels and geographic areas of the country. Initiatives must be tailored to reduce the dependency on expatriate assistance while not reducing the quality of training available in the health sector. To achieve this, emphasis must be placed upon planning as a process and for its outcome.

For this reason, further consideration might be given to increasing assistance to the Health Planning Unit beyond that envisaged in the health administrator training to be provided at the Institute for Development Management.

Examples of additional assistance which would be considered include:

(a) the provision of more long-term training opportunities for additional Health Planning Unit personnel (e.g., a hospital secretary trained in the planning process and communication, a health information system, an epidemiologist trained in operational research related to evaluation of health programs, and a public health nurse trained in group dynamics, supervisory techniques and their application in rural health delivery systems.

(b) additional training in modern management concepts. Contract assistance might be considered for short-term consultant services to the Institute for Development Management to permit five to six week management development seminars to be held for health workers. Similar seminars have been held over the past three years at the Ghana Institute of Management and Public Administration (GIMPA) with the assistance of the West African Health Secretariat and the British Overseas Development Ministry (ODM). The UNDP/ILO has also conducted such management seminars at the Management Development Training Center in Zambia.

(c) training for non-governmental personnel involved

in the health field to improve management, planning and budgeting at religious mission clinics and hospitals.

(d) short-term third country in-service or observational training for selected members of the GOB Health Planning Unit may also be useful. The Government of Ghana Health Planning Unit has been operational for over three years and has recently produced a document titled, "A Primary Health Care Strategy for Ghana." Batswana health personnel may find the comparative exposure to an HPU in another African country to be stimulating and this would also provide an opportunity for Technical Cooperation among Developing Countries (TCDC) of the sort encouraged during the 1978 TCDC Conference in Buenos Aires.

To summarize, the Health Services Development Project is designed to augment existing health cadres through training which will produce personnel both for rural health posts and for the training institutions. The project will help to lessen the key constraint in the health field - a shortage of trained manpower - while also containing an important institution building component for the Ministry of Health (Nutrition Unit and Health Planning Unit) and for health training institutions. The major expenditure is likely to be in nurse education followed by nutrition.

III. PACIFIC CONSULTANTS AND PROJECT MANAGEMENT

In the event that Pacific Consultants is given responsibility for the implementation of the project in question, the role of the firm, obviously, would be to carry out the activities in the Terms of Reference while providing feedback to the GOB and AID regarding progress made and difficulties encountered. Since project implementation is a dynamic process which operates in a changing environment, it is assumed that there would be scope for modification in the Terms of Reference in the event that there was tripartite (GOB, AID, Pacific) agreement to this effect and that such a project revision could be demonstrated to be necessary to facilitate the achievement of project objectives.

It would be premature at this stage to propose a detailed Plan of Operations since this should be formulated in close consultation with GOB and AID officials. It is, however, possible to provide some idea here of the components of project management which Pacific Consultants would stress and to accompany them with project specific illustrations.

Pacific Consultants considers good management to be the key to successful project implementation. This is defined in terms of the process as well as the outcome of management. The following elements are fundamental to Pacific's approach and are common to projects which

are or have been the responsibility of the firm.

A. The Process of Management

1. Development projects are understood to be government projects which receive a portion of their financial resources from external donors and may be implemented through any of several types of executing entities, e.g., universities, specialized agencies of the United Nations, private consulting firms, etc. Consequently, the primary responsibility for operational management and decisionmaking rests with the host government. The role of Pacific as the implementor, using a collaborative approach, is to assist and facilitate government efforts to achieve project and sector objectives. As such, Pacific personnel function in a framework of technical cooperation which is supportive of principal operational personnel who, frequently, are government civil servants.
2. A well designed project will create conditions for local management to function within the project and within the local counterpart department or ministry. To ensure that local management is able to carry out its tasks, Pacific builds into its operations ample provision for as many field visits as necessary for headquarters management staff to provide administrative backstopping, technical support and other necessary management functions.
3. Local management is also normally institutionalized within a Project Management Unit consisting of relevant project and government personnel working jointly to achieve project objectives in an orderly, coordinated and comprehensive manner. This is reinforced by the fact that Pacific is capable of providing personnel on a long-term basis both at headquarters and in the field. The absence of frequent management changes will thereby ensure project continuity. See Annex II, Proposed Project Management Organizational Chart.

4. Management is a full-time responsibility and is not entrusted by Pacific to a technical person who, when his own technical job is completed, will only then turn to the "extra" responsibility of management. Numerous projects have collapsed as a consequence of this misguided attempt to cut costs on major projects. A key responsibility of government in this regard is to provide a counterpart to the project manager as early as possible in the life of the project.
5. More detail with respect to Pacific's management approach is provided in our Proposed Project Management Information System which appears as Annex I

B. The Outcome of Management

1. Sound management should accomplish more than the substantive objectives identified in the project documentation which are to be achieved during the life of the project. In addition, a project should ensure that management skills are transferred to local counterparts so that the activities of the project which are to be continued by host country personnel are successfully sustained.
2. The "institution building" component of a project such as the Health Services Development Project should be uppermost in the mind of management. Skilled local managers must be left with a system as well as the capacity to refine the system to meet changing needs after the departure of expatriate technical personnel.

The above points serve to underscore Pacific's commitment to active, creative and sustained management using modern management techniques while ensuring that these are firmly planted in the institution in which we are working. The following are some additional specific examples of how Pacific would organize to achieve these principals.

IV. GENERAL SUPERVISION AND MANAGEMENT

The overall management and supervision of this project would be the responsibility of Mr. Paul Soria,^{1/} Assistant Vice President for the International Division of Pacific Consultants. Mr. Soria is located in the Washington, D.C. office.

Staff supervision, the technical quality of all project deliverables, liaison with appropriate AID/Washington officials, and administration and management of logistical support would be provided by Dr. J.S. Prince.^{1/} Dr. Prince would be in close contact with the project team and the Chief of Party in Gaborone utilizing Pacific's ITT telex. Dr. Prince would travel to Botswana as necessary to meet and confer with the team, with USAID officials and appropriate officials of the Botswana government. He would be assisted by a full-time administrative assistant in Washington and supported by the AFPLAN team.

As Project Director (U.S.), Dr. Prince would report through Mr. Soria to Mr. Stephen J. Edelman, Vice President of Pacific Consultants' International Division and/or Mr. Otho J. Green, President of Pacific Consultants. Mr. Edelman and/or Mr. Green would be responsible for overall quality and for contractual matters, and would ensure that all of Pacific Consultants' corporate resources are available to the project team.

^{1/} For the professional background of Dr. Prince and Mr. Soria, please refer to the accompanying AFPLAN brochure and Annex I.

A. The Project Team

The Pacific Consultants' team that could implement the Health Services Development Project consists of technical specialists, each of whom has had recent experience which is relevant to the project. Detailed curricula vitae are provided in Annex I.

B. Short-Term Consultants

The technical cooperation team proposed by Pacific Consultants can be augmented by short-term consultants whose skills may be needed at particular junctures for limited periods. It is understood that financial provisions will be made in the project budget for such services. Pacific's full-time AFPLAN team can make available one or more of its members for specific short term assignments. In addition, the firm maintains a roster of consultants upon whom it can call for such short term assignments. The consultants have been used repeatedly and successfully in numerous other projects which have required highly specialized services for brief periods.

C. Scheduling of Project Inputs

It has been the firm's experience that the advance arrival of the project's administrative officer can greatly facilitate project implementation by resolving the numerous initial adjustment problems which would confront a new project team upon its arrival in Botswana (identification and allocation

of housing, provision of office space, hiring local secretaries, drivers, etc., procurement of supplies and equipment, establishing initial administrative liaison with government officials, etc.). This approach is also highly cost effective since it will make it possible for technicians to begin working on project implementation immediately on arrival in country and not have them all preoccupied with and spending undue time on personal and professional relocation problems.

Other inputs would be scheduled after consultation with GOB officials and AID personnel and the development of a detailed Plan of Operations. A week by week work plan in chart form represents an important project management tool in this regard.

D. Management Aspects of Substantive Project Elements

1. Participant Training - of Botswana counterparts in programs with the most relevant possible curricula, of proper duration in a setting conducive to the achievement of the educational objectives of each Motswana is of central importance to the success of the project. To ensure that this is accomplished, that participants return to Botswana on schedule in order to benefit from subsequent in-service training with the project team and have sufficient time during the project's life to assume the functions of expatriate personnel as their contracts expire, the firm's Washington

headquarters would provide detailed information to the GOB and the project team early in the life of the project and arrange for overseas training to commence as quickly as possible. Pacific Consultants' experience in arranging such training for other projects is further strengthened by the firm's Conference Management and Training Center which maintains contact with likely training centers and could assist in facilitating necessary arrangements.

While our Washington office provides information regarding preferred training courses and institutions and makes arrangements for training Botswana, the project team would work in close cooperation with the GOB to select qualified persons for the training. The establishment of a Selection Committee consisting of GOB officials and relevant project team members can help to identify candidates who have the proper educational background.

2. Curriculum Revision - to be successful must be viewed as a process. A curriculum is not revised to "make it more relevant to the rural environment" or respond to some other cliché of the "development world"; rather it is viewed as a continuous exercise of adjusting what is taught to the changing conditions of a developing country. The need for substantive health care knowledge and knowledge of health care teaching methodologies will evolve as Botswana's health delivery system is improved and extended to all parts

of the country. Previously trained personnel will need refresher courses, others will need upgrading courses and new entrants five years from now may need a longer and more sophisticated curriculum than those entering this year. The objective of curriculum reform is, therefore, relatively open-ended and is developed to permit a fundamentally different concept from the classic curricula of colonial education and training which was often inherited by African countries in which a fixed body of truth was transmitted in a rather rigid format from one generation to the next.

Pacific Consultants' experience with curriculum reform has led us to emphasize the continuous nature of the exercise and we would suggest that a Curriculum Review Committee of project team members, Botswana instructors and GOB officials in the Ministry of Health should be established and meet periodically to review the revised curriculum which would be proposed by the project team and then to review what has been adopted on an annual basis to guarantee that the curriculum remains a vital and germane guide to instruction.

3. Construction - of a building to house the Health Education and the Nutrition Unit implies the need for suitable oversight of the construction process. Presumably this would be conducted by an appropriate

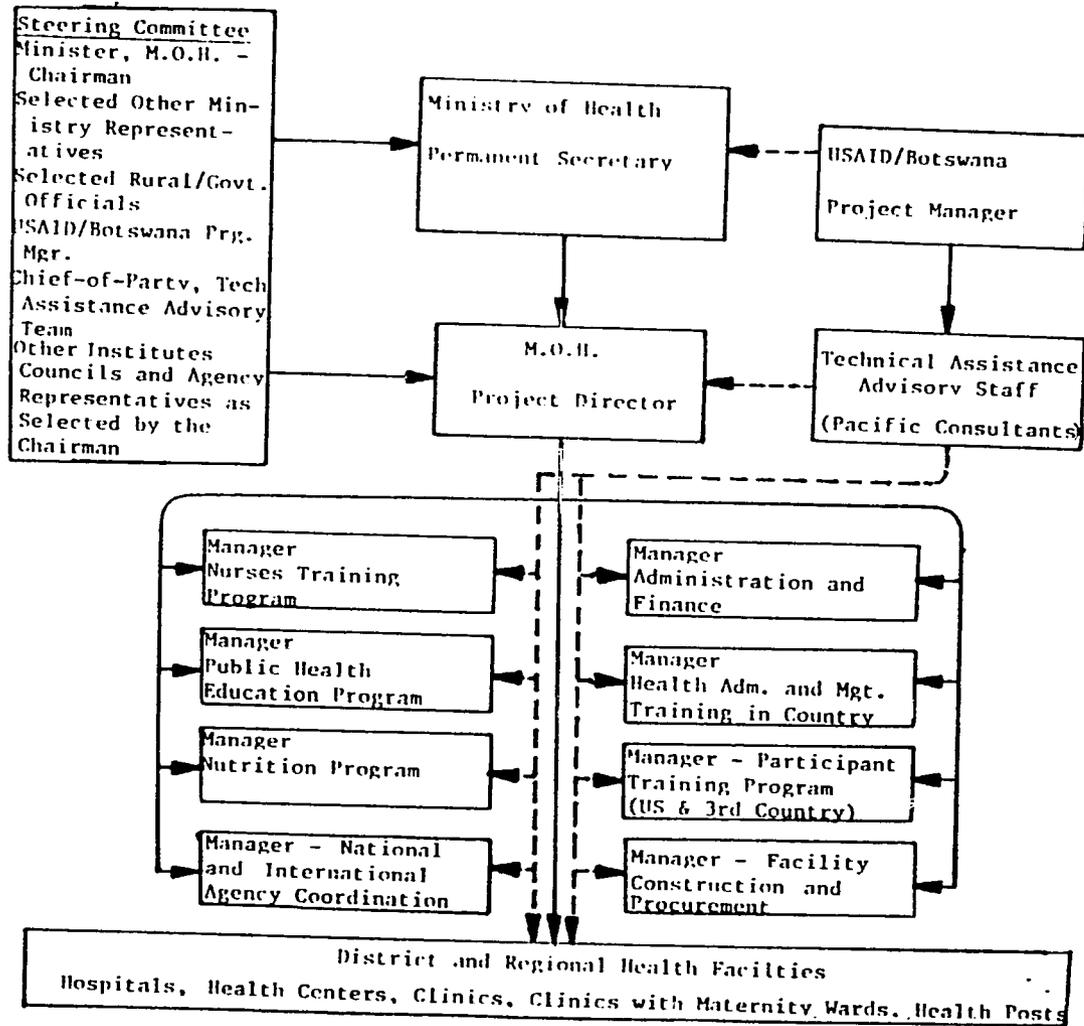
government architect. In the event such oversight has not been planned for in the project, Pacific would urge that proper technical supervision be delegated to a qualified person in government or, if this is not possible, that provision be made for this in the project. In the latter event, this would become a management function of the firm.

4. Commodities. It is our suggestion that commodities procurement be considered as a contractor responsibility and that the function be made a firm requirement for a contract. Pacific is prepared to undertake all procurement and coordination of commodities according to internationally acceptable procurement practices and procedures and has the experience to do so.

5. Steering Committee. A Tripartite Steering Committee (GOB, AID and Pacific) representing the host government, funding agency and the contractor given the responsibility for project execution should be established and meet periodically to review project progress, discuss difficulties which may arise and provide feedback particularly to the project team about the Committee's assessment of their efforts. Members of the Committee would be determined through consultation with the GOB once project implementation is about to begin. Pacific would require a brief written report from its principal representative on the Committee regarding key substantive points raised and proposed follow-up actions.

This management tool would provide a record of progress made and constraints identified and overcome. It would also provide valuable data for later design and implementation of other similar projects by helping to anticipate likely problems before they occur.

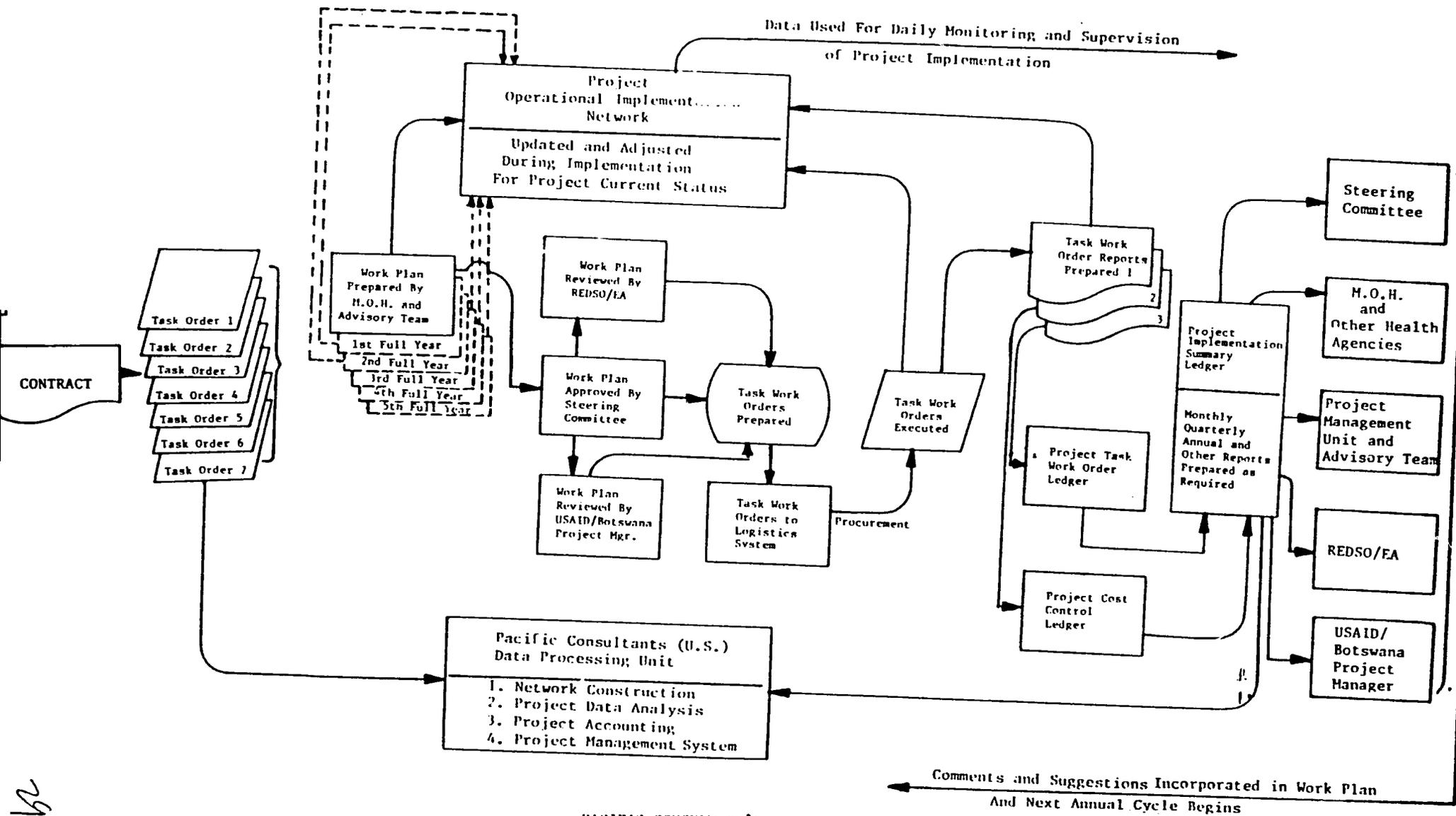
PROPOSED PROJECT MANAGEMENT ORGANIZATION CHART



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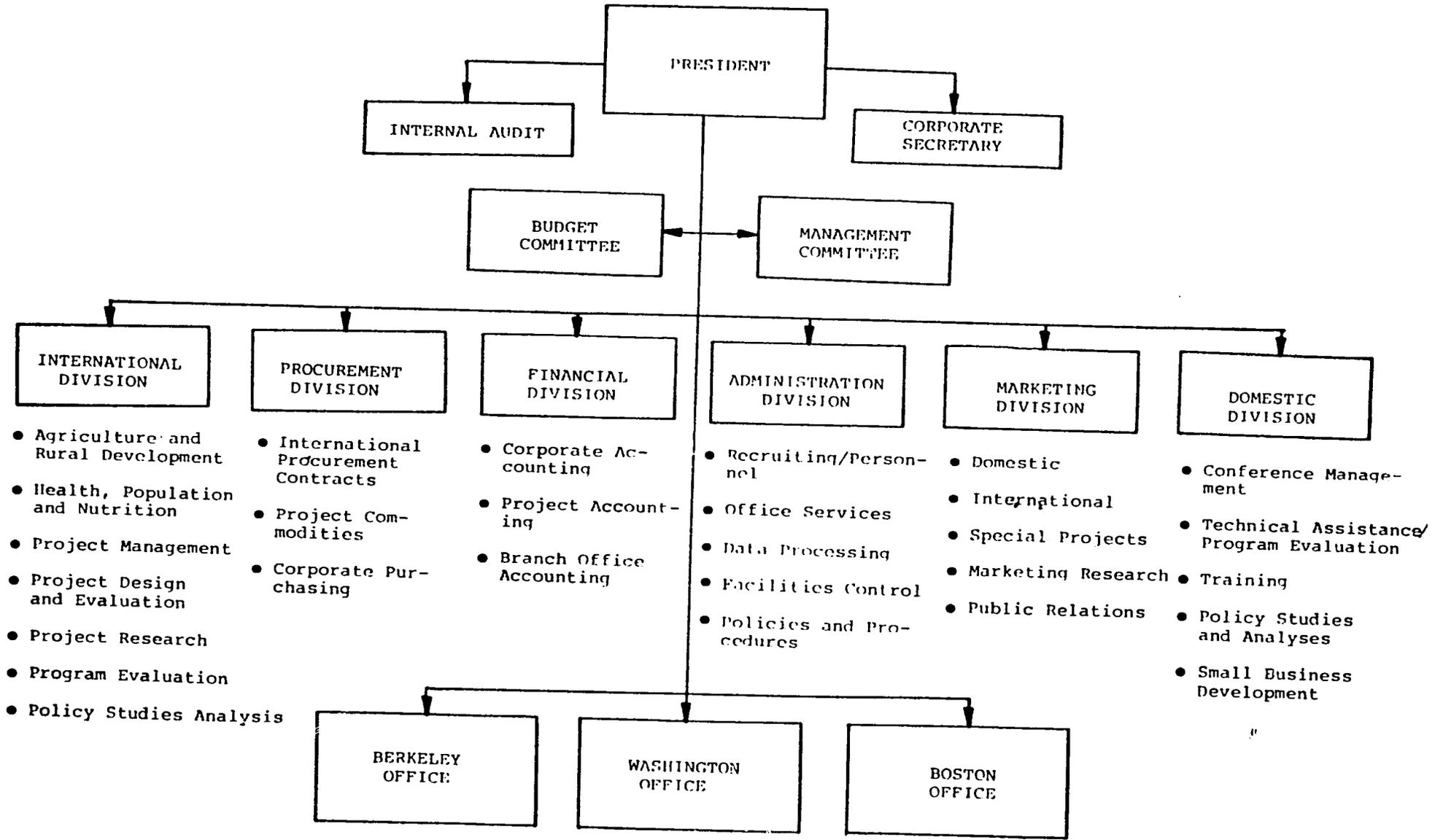
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PACIFIC CONSULTANT'S
PROPOSED PROJECT INFORMATION SYSTEM

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PACIFIC CONSULTANT'S ORGANIZATIONAL CHART

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