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INTERNATIONAL MEDICAL CORPS
INSTITUTIONAL SUPPORT GRANT
PDC-0801-A-00-1081

FINAL REPORT

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WASHINGTON, DC

INSTITUTIONAL SUPPORT GRANT
Grant No. PDC-0801-A-00-1081-00

FINAL REPORT

I. PROGRAM DESCRIPTION

a) On or about August 27, 1991, the International Medical Corps (IMC) was awarded an Institutional Support Grant (ISG), Cooperative Agreement No. PDC-0801-A-00-1081, in the total amount of \$89,944. The initial grant period was twelve months. The grant period was initially extended to March 31, 1993 and subsequently extended to December 31, 1993.

The goal of the grant was to ascertain the potential for IMC to become a Title II Cooperating Sponsor in Africa. The purpose of the grant was to provide funding to enable IMC to undertake review and analysis that would provide the basis for decisions and for taking initial steps toward integrating Title II into IMC's programs. Grant objectives included the following:

- Reviews and field visits to Mozambique and Liberia
- Determination of IMC's ability to become a Cooperating Sponsor in either or both of the above countries
- Development of IMC headquarters staff capability to become a Cooperating Sponsor
- Produce documents for new health programs in Liberia and Mozambique to incorporate food aid, if deemed feasible and appropriate

Due to continuing internal strife in Mozambique, it was later replaced by Angola as one of the countries for an assessment visit. Sierra Leone was added to the Liberia field visit due to internal disruption, including an influx of refugees, caused by the conflict on its eastern border with Liberia.

b) Prior to receiving the ISG, IMC was not involved in Title II program efforts in any of its projects, except in Angola. There IMC provided commodities to another non-governmental organization (NGO) under a Title II grant with the approval of the Bureau for Food for Peace and Voluntary Assistance. IMC's only other experience with food has been nutritional components focused upon therapeutic feeding of acutely malnourished children as an adjunct to preventive and curative health care. As mentioned under a) above, the objectives of the ISG were to determine what would be

the appropriateness and feasibility of IMC incorporating Title II into new program initiatives in Liberia, Sierra Leone, and Angola. The field visits supported by the ISG provided IMC with an opportunity to not only assess Title II possibilities, but as an integrated activity, to assess the needs and opportunities for development and implementation of new health programming initiatives. The latter would be an initial requirement prior to any IMC involvement in Title II activities in a country since IMC is first and foremost a medical relief and health training organization.

A further objective of the ISG was, assuming Title II programming was deemed appropriate and feasible for IMC to undertake as part of its health interventions, to build and develop the capacity of IMC headquarters to manage PL-480 commodities. The necessary investment of time, energy and resources required to develop a PL-480 capable staff at headquarters would have a major impact on organization goals and management direction.

II. ACTIVITY ACCOMPLISHMENTS

Liberia and Sierra Leone

Proposed activities included deployment of an assessment team to Liberia, and if deemed appropriate based on the results of the field visit, design of an operational program.

During the period February 13 through March 1, 1992, IMC fielded a two-person team to Liberia and Sierra Leone to better understand the dimensions of the civil war in Liberia and the impact of the war on the country and the effects on its neighbors. The team assessed needs in both countries for the types of health services IMC has delivered in other countries or for other services. The team also reviewed the situation of displaced persons, refugees, and others at risk in both countries to determine if there was a need for IMC to combine a PL-480 food component with new health initiatives. In Liberia the team met with representatives of: Interim Government of National Unity (IGNU) and National Patriotic Reconstruction Assembly Government (NPRAG), Ministry of Health (both factions), UN and international organizations, U.S. Mission, foreign NGOs and indigenous NGOs. In Sierra Leone, discussions were held with representatives of: UN and international organizations, U.S. Mission, Ministry of Health, and foreign NGOs.

For the most part, all activities relating to the investigation of Liberia, with the addition of assessment of the situation of Sierra Leone, were accomplished. The recommendations resulting from the field visit did not warrant IMC pursuing further

development of either a health or PL 480 food component for Liberia or Sierra Leone at this time.

Attached as Appendix A is the trip report which resulted from the Liberia and Sierra Leone field visit.

Angola (previously to be Mozambique)

As mentioned earlier, IMC originally planned to send a field assessment team to Mozambique. However, political turmoil in Mozambique substantially delayed sending this team to the field. In February, 1993, IMC requested a nine-month no-cost extension of the ISG and requested that Angola be substituted for Mozambique as the second African country targeted for an assessment visit. IMC was already working in Angola, and the human tragedy resulting from renewed civil strife following the September 1992 elections led IMC to believe Angola would be the best choice for a second assessment visit at the time. The no-cost extension was approved on or about April 16, 1993. Substitution of Angola was approved on or about August 27, 1993.

Proposed activities included conducting a field visit to assess Angola's need for food assistance and IMC's ability to develop appropriate child survival strategies around that need.

During the period October 10 through November 26, 1993, IMC sent a consultant to the field with the specific purpose of reviewing the need for additional food aid in Angola. The activities accomplished included a review of the food situation to determine if there was a problem and if a problem was identified, investigating if additional food aid would be the answer. The consultant met with NGOs operational in Angola, as well as UN organizations and donors. In addition, the consultant visited a number of municipalities, including Luanda, Lubango, Menongue, Muxima, Porto Amboim, and Sumbe.

As with the Liberia assessment, all activities were completed during the field visit to Angola, although specific recommendations were geographically limited to a site where IMC was implementing an immunization project at the time of the visit.

Attached as Appendix B is the trip report which resulted from the Angola field visit.

Develop and Institutionalize IMC Headquarters Staff Capability

Proposed activities were to identify a consultant to assist IMC headquarters to establish a food aid library and to conduct training programs to familiarize staff with statutory, administrative, and regulatory aspects of PL 480 legislation and current USAID thought and trends.

The first week of February, 1993, was devoted to participation in food aid management activities for two IMC headquarters staff. These two individuals traveled to San Diego, California, to attend a Food Aid Management Briefing at the headquarters of Project Concern International on the 1st and 2nd of February. Attached as Appendix C is a copy of the agenda for the briefing.

An expert in food aid management and PL 480 programming developed and conducted a two-day intensive discussion and training on food aid management on the 3rd and 4th of February at the IMC Los Angeles Headquarters Office. Training content included an in-depth overview of the Food Aid Briefing Resource Book which includes the various documents governing PL 480 food programming and the requirements of becoming a Cooperating Sponsor.

Lastly, with the assistance of the above-mentioned expert, steps were taken to initiate establishment of a food aid library. A number of manuals, publications, and documents were obtained over the coming months.

III. MONITORING/EVALUATION

The primary activities covered by this grant included field assessments. Monitoring involved ongoing surveillance of the countries proposed for field assessments to assure they were the most appropriate, as well as accessible for the purposes of conducting the required assessments. In the case of Mozambique, continuing civil strife delayed the assessment visit to the point where it was no longer feasible under the grant period. In addition, once the situation stabilized somewhat, numerous NGOs rushed to provide assistance in Mozambique, whereas in Angola, IMC was already positioned and fewer NGOs were providing assistance in the country. Thus, monitoring the in-country situations proved to be helpful in determining location of field assessments.

Monitoring of field visits was also conducted. The IMC Headquarters office remained in contact with the field teams deployed to conduct the country reviews. Progress was monitored through a series of communications while the teams were in the field. In the case of Angola, the IMC Country Director and Medical Coordinator monitored the progress of the consultant, who was in communication with them through his visit.

No formal evaluation of the grant was conducted. However, the grant itself was designed to evaluate both country situations, as well as the feasibility and appropriateness of IMC to undertake PL 480 Title II food programming. Results indicated that in Liberia and Sierra Leone, given continued levels of assistance provided by other organizations, the in-country capability and remaining

stability, for IMC to intervene with either a health program or a food assistance program is not necessary at this time. Both were being sufficiently covered by the work of existing NGOs, both expatriate and indigenous. Thus, IMC did not take action to design a proposal to start a project in Liberia or Sierra Leone but continues to monitor the situation in the event it deteriorates.

In Angola, the consultant identified a food supplementation intervention which could be linked to IMC's on-going immunization program. However, at the present time IMC opted to expand its health programs to other needy areas in Angola, rather than expand its activities and utilize scarce resources in an area that was easily accessible from the capital and was not as acutely affected as most of the other regions of Angola. IMC has chosen for now to utilize its expertise in health programming and expand those activities to other needy areas rather than start a new intervention and work in coordination with other agencies already involved with food assistance. Since IMC is active in a number of locations in Angola, monitoring of the situation is ongoing. In the event of deterioration in nutritional status in Sumbe or events indicate another agency to provide food aid is necessary, IMC will revisit its current decision.

An informal internal evaluation of the capability of IMC headquarters to become a Cooperating Sponsor was carried out. Given IMC's ongoing and new commitments in health care and training programs in countries devastated by war or other circumstances, IMC does not now have the human resources required to institutionalize and become PL 480 capable. An important outcome resulting from the ISG was that it helped to identify the necessary requirements and to clarify the organizational prerequisites for becoming a Cooperating Sponsor and implementing PL 480 activities.

IV. IMPACT

Liberia and Sierra Leone

Consultants were deployed to conduct field visits and assess feasibility for IMC to implement health interventions with food components. Areas of need were determined, activities of other operational organizations were identified, and a report produced.

The essence of the conclusions and recommendations of the field team included in their report are as follows:

In Sierra Leone there was no need for additional food distribution, vulnerable group feeding, or therapeutic feeding

programs. In addition, a full complement of multinationals and NGOs were meeting the health needs of the indigenous population, as well as the 75,000 Liberian refugees residing in Sierra Leone. In addition, international organizations and NGOs were providing the required health care for the 290,000 internally displaced Sierra Leoneans. Any proposed activities of IMC would be contingent upon future deterioration of the situation.

With respect to Liberia, the team concluded that the food delivery systems were functioning relatively well, and no agency contacted suggested there would be a need for another food distributing NGO. While the team's report highlighted several opportunities for IMC to play a meaningful role in Liberian health care, none of the opportunities mentioned suggested there would be a compelling need to supplement the activity with a food component. Since there was no demonstrable need for IMC to prepare a Cooperating Sponsor PL 480 Title II food program request, an investigation of the logistical requirements for conducting this type of program was not pursued.

The primary impact of the ISG in the case of the Liberia/Sierra Leone field assessment was to highlight for IMC the current situation with respect to food aid. At the time of the visit, indications were that no additional food aid was required in either Sierra Leone or Liberia. This outcome guided IMC to decide not to develop a new project for either country, but to continue to its monitoring efforts in the event the situation deteriorated.

Angola

The purpose of the field visit to Angola was to determine if there was a food problem in the country and if so, was additional food aid the answer to the problem. The activities of other organizations, both ongoing and planned, were to be ascertained and described. Lastly, IMC's potential for involvement in food program and the structure of such an intervention was to be described.

The activities of the consultant focused on locations where IMC was already operational. In one site, namely Menongue, IMC determined that sufficient agencies were involved in food aid, and initiation of a food program would not be appropriate. IMC has since, however, expanded its health programs to complement the activities of other organizations' food-related activities. As an example, IMC immunization activities were carried out in coordination with food distributions to assure that a large number of women and children were reached.

The review of Kwanza Sul, an area accessible by road from Luanda, indicated that although World Food Programme (WFP) commodities were readily transported to the province, distribution of food aid was not necessarily reaching the general population. Thus, IMC concluded that a further commodities distribution program

was not an appropriate response. The consultant recommended a targeted supplementary feeding program in conjunction with IMC's ongoing immunization activities. He specifically outlined an intervention using WFP commodities and recommended IMC not to become involved with PL 480 Title II as IMC did not have the human resource capacity to satisfy the requirements of being a Cooperating Sponsor.

Further analysis of the situation by IMC staff indicated that the best course of action for IMC at this time was to build upon its health expertise to expand health activities in Angola. IMC concluded that its resources would best be utilized in the health sector rather than taking the time to learn about food programming. Thus, the impact of the Angola field assessment was to guide IMC to expand its health interventions and attempt to link them with organizations already providing food assistance to the most vulnerable groups in Angola.

An important output and result of the Angola field visit is that IMC now has at its disposal a working document and plan of action for a nutrition supplementation component specifically designed for its Sumbe program but which could be easily modified for other locations. Should IMC's ongoing monitoring of the situation in Angola reveal that future IMC involvement in food aid is warranted, IMC would have a head start on development of such an intervention.

Develop and Institutionalize IMC Headquarters Capacity

Two of IMC's headquarters staff benefited from participation in a two-day food aid briefing sponsored by Project Concern International, as well as the two-day intensive discussion and training on PL 480 requirements that followed. In addition, IMC collected a number of resources on food aid management to begin formation of a library.

The ultimate impact, however, of this component of the ISG was to highlight the fact that IMC, as a small NGO with expertise in training and development of emergency medical and health programs, currently has insufficient human resource capacity to become a Cooperating Sponsor.

This conclusion may be an unplanned benefit for IMC. The ISG had the result of making it clear to IMC that it does not currently have sufficient institutional capacity to properly implement PL 480 Title II food interventions. If in the future IMC decides to become a Cooperating Sponsor, IMC headquarters will need to hire additional staff specifically for this purpose. The near-term benefit for the organization is confirmation that it should continue to focus its resources, both human and material, in the areas where IMC has clearly developed its reputation and expertise, namely, emergency medical programs and health training. IMC should

be prepared to make a significant human resource investment if, in the future, it decides to expand into food aid.

V> ISG PROGRAM

IMC found that locating a well-qualified PL 480 food programming expert with a broad range of related skills needed to assist an NGO in establishing and meeting the requirements for implementing such a complex activity was not easy. One area where the ISG could enhance the ability of NGOs to carry out Title II food assisted programs could be to have available resources for locating technical teams of experts on PL 480 food programming. Such teams, which would visit both the headquarters office and the proposed field site, could realistically assess an NGO's capacity to become a Cooperating Sponsor. The team could also provide guidance in understanding and interpreting USAID policies, regulations, and circulars governing food aid, as well as the nuts and bolts of actual implementation of PL 480 commodities.

LIBERIA TRIP REPORT

February 13 - March 1, 1992

**Prepared for:
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GLOSSARY OF ABBREVIATIONS

| | |
|-------------|-----------------------------------------------------------------|
| ADRA | Adventist Development and Relief Association |
| AFL | Armed Forces of Liberia |
| AICF | Action International Contre le Faim |
| AID (USAID) | United States Agency for International Development |
| AID / FHA | Bureau for Food and Humanitarian Assistance |
| AID / OFDA | Office of U. S. Foreign Disaster Assistance |
| AID / FVA | Bureau for Food and for Peace and Voluntary Assistance |
| AIDS | Autoimmune Deficiency Syndrome |
| BCG | Bacillus Calmette-Guerain vaccine |
| CHAL | Christian Health Association of Liberia |
| CRS | Catholic Relief Services |
| CRWRC | Christian Reformed World Relief Committee (Liberia) |
| DTP | Diphtheria-Tetanus-Pertussis vaccine |
| EC | European Community |
| ECOWAS | Economic Community of West African States |
| ECOMOG | Economic Community Monitoring Group |
| ELWA | Evangelical Love World Africa |
| EPI | Extended Programme for Immunisation |
| HIV | Human Immunodeficiency Virus |
| ICRC | International Committee of the Red Cross |
| IGNU | Interim Government of National Unity |
| IMC | International Medical Corps |
| INPFL | Independent National Patriotic Front of Liberia |
| LJFMH | Liberian Japanese Friendship Maternity Hospital |
| LAC | Liberian American Company |
| LAMCO | Liberian-American-Swedish Mining Company |
| LUSH | Liberia United to Save Humanity |
| LWS | Lutheran World Service |
| MCH | Maternal Child Health |
| MedAir | Medical Environmental Development with Air Assistance |
| MERCI | Medical Emergency and Relief Cooperative International |
| MOH | Ministry of Health |
| MMR | Measles-Mumps-Rubella vaccine |
| MSF | Medecins sans Frontières (-B, Belgium; -F, France; -H, Holland) |
| NDS | National Drug Service |
| NGO | Nongovernmental Organization |
| NPFL | National Patriotic Front for Liberia |
| NPRA(G) | National Patriotic Reconstruction Assembly (Government) |
| OPV | Oral Polio Virus vaccine |
| SELF | Special Emergency Life Food |
| SDA | Seventh Day Adventists |
| UN | United Nations |
| UNDP | United Nations Development Program |
| UNDRO | United Nations Disaster Relief Office |
| UNHCR | United Nations High Commissioner for Refugees |
| UNICEF | United Nations Children's Fund |
| UNSCOL | United Nations Special Coordinator for Liberia |
| WFP | United Nations World Food Programme |
| W/H | Weight for Height |
| WHO | World Health Organization |

EXECUTIVE SUMMARY

From the middle of February through the beginning of March 1992, Hunter Farnham and R. J. Halbert travelled in Sierra Leone and Liberia for the International Medical Corps (IMC). The purpose of their trip, which received major funding from the Agency for International Development, was to better understand the dimensions of the civil war in Liberia, and its effects on its neighbors. They were further charged with assessing the needs in both Sierra Leone and Liberia for the types of medical services IMC has delivered to other countries in the past, or different services, and to assess the current situation of displaced people, refugees and others at risk in Sierra Leone and Liberia to determine if IMC should combine at this time a PL 480 food component with a medical program. It was anticipated that the synergy of mixing the two types of assistance would improve the effectiveness of both the food and medical components of any IMC program in the two countries. Their assessment resulted in the following recommendations:

Sierra Leone. It was determined that the current situation of Liberian refugees and displaced Sierra Leoneans was being handled effectively by the local government, international organizations, non-governmental organizations and bilateral donors present in the country at this time. However, given the instability of the political situation and the consequent changing conditions, the team recommended that IMC monitor the situation, and that the organization consider the idea of developing either a PL 480 food aid program or a medical relief program in Sierra Leone should the situation warrant.

Liberia. The situation in Liberia is considerably different. There has been much more suffering of the civilian population because of the war, and much more physical destruction of infrastructure. As a result, the emergency and relief needs in Liberia are greater. A number of non-governmental organizations have been working for the past several years with representatives of international organizations, the several interim governments, indigenous NGO's and bilateral donors to help the Liberians survive. Their efforts have been successful: Liberia is beginning to stabilize.

The IMC team found that the nutritional situation in Liberia had been bad during the latter part of 1990, but by the middle of 1991 concerted efforts by the donor community had resulted in a substantial reduction in the malnourished rate amongst all people in the country. This improvement appears to have been sustained and improved upon, so that the team does not believe IMC should consider a PL 480 program for Liberia under present conditions. However, the general instability in the area could change the situation in the very near future.

Provision of medical assistance is, however, a different story. During its investigations and discussions, the team found a number of different areas where IMC could play a useful role:

- In Monrovia, for example, there is an increasing need for general surgery and dental surgery.
- In Grand Bassa and River Cess counties there is no medical doctor working at the Buchanan hospital, nor advising rural clinics.
- In Grand Cape Mount and Bomi counties the security situation makes it impossible for NGO's to work at the present time. However, once the security situation improves, there will be an urgent need for medical teams to help bring health services to the population.
- There is also always a need for additional rehabilitation of health structures throughout the country, as well as a need to resupply and retrain Liberian medical personnel.

Given the current pace towards a country-wide election, it is likely that Liberia will endure several more years of uncertainty before forming a unified government. This means the health sector,

among others, will be hard-pressed to find revenues. For the foreseeable future, NGO's and international organizations will be required to provide the major funding, personnel and supplies for medical efforts in Liberia. Only after the new, country-wide government is formed is it likely that there will be a sufficient flow of resources to permit the suitable rehabilitation of the health sector.

1 OVERVIEW

1.1 A.I.D. COOPERATIVE AGREEMENT AND PURPOSE OF TRIP

In January 1991, The International Medical Corps (IMC) applied to the Agency for International Development's Bureau for Food and for Peace and Voluntary Assistance (A.I.D./FVA - the name of the Bureau has since changed to the Bureau for Food and Humanitarian Assistance, FHA) for a Planning Assistance Grant. The purpose of the grant request was to allow The IMC to undertake country assessments in Liberia and Mozambique to determine the feasibility of integrating U.S. Government food assistance with IMC health and training programs, and to develop a familiarity at IMC headquarters with U.S. Government food aid programs provided under the Agricultural Trade, Development, and Assistance Act of 1954, as amended (Public Law 480).

1.2 GOALS AND OBJECTIVES OF THE TRIP

Subsequent to revision of the grant request, IMC signed a Cooperative Agreement with A.I.D. to carry out the activities described above. In late November 1991, IMC submitted a scope of work to A.I.D./FHA for a proposed trip to Sierra Leone and Liberia. The scope of work, which was accepted, had four objectives:

- 1) to acquaint IMC with the current and possible future dimensions of the Sierra Leone and Liberian situation, and a better understanding of the human needs involved;
- 2) to introduce IMC to governmental, non-governmental, international organizations and other entities active in Sierra Leone and Liberia. IMC hoped to learn if there is a useful, productive and complementary role that an organization with IMC's skills could play in addressing the needs of the people-at-risk in Liberia, and amongst the refugees and displaced people in Sierra Leone, Guinea and the Côte d'Ivoire;
- 3) to examine the feasibility of integrating U.S. Government PL 480 commodity assistance with the particular type of health-related programs IMC can provide. The objective of integrating the two types of assistance would be to improve the impact of both; and
- 4) to prepare a written report covering the assessment trip, with recommendations.

From February 13th - March 1st, 1992, Hunter Farnham and R. J. Halbert, MD, MPH, travelled for IMC to Sierra Leone and Liberia. They were charged with assessing the situation in light of the goals and objectives described above, and writing an appropriate report.

1.3 COUNTRY OVERVIEW

1.3.1 The Region

The topography is characterized by relatively flat to rolling coastal plains rising to rolling plateau and low mountains. In many places there are long expanses of sand beaches interspersed with rocky promontories and mangrove swamps as rivers and streams empty into the Atlantic Ocean. Most of the country lies in the heaviest rainfall zone in West Africa. The rainy season usually lasts from May through October. The annual temperature

variation along the coast is minimal but the level of humidity is generally high. The arrival of the *harmattan* during the dry season clouds the sky with dust, obscures the sun and lowers humidity and temperature. Up country there is a wider temperature range and generally lower humidity.

While Sierra Leone is still forested, in recent times much of the forest has been felled to allow cultivation. Savanna woodland and grassland are increasingly common, particularly where the soil is too thin or the slopes too steep for tree growth. Swamps are plentiful in the coastal areas and mangrove swamps thrive in the saline, tidal estuaries along the coast.

Liberia contains west Africa's largest tropical rainforest but the entire country is subject now to deforestation because of the uncontrolled cutting of timber. As a result of the annual burning of the coastal region's parkland savanna, cattle raising has become more common in that area. Nevertheless, no more than six percent of the total land area in the Tennessee-sized country is arable and used for permanent cropping, or is meadows and pasture.

Natural resources are abundant in the region, with plenty of rainfall and springs feeding numerous rivers and streams. There is an enormous amount of forestland, plus precious minerals (gold, diamonds, platinum) and iron ore, bauxite, and rutile among others. Coupled with the temperate climate and generally abundant rainfall, crops grow well in the region and a large variety of food and cash crops -- including bananas, cocoa, coffee, rice, oil palm, rubber, peanuts and cereal grains such as millet -- are grown for local consumption or export. Given the natural resources and the history of reliable, adequate rainfall in the region there is every reason to expect that both Sierra Leone and Liberia should be at least food self-reliant.

1.3.2 Liberia

Liberia is Africa's oldest republic and covers an area of approximately 43,000 square miles. It has been a sovereign state since 1847.

Early settlements were established by French merchants in the late 14th and early 15th centuries, and by the Portuguese in the 15th century. The British arrived in the 17th century but their outposts were destroyed by the Dutch a year later. The outside world seems then to have generally ignored that portion of west Africa for the next 150 years.

Interest in the area revived in the early 19th century as the tide began to turn in favor of the abolition of slavery. In 1816 two agents of the U.S. Government and two members of the American Colonization Society, an abolitionist group, visited the area. After several failed attempts to establish settlements for freed slaves, in 1821 the American Colonization Society reached agreement with local African chiefs and was granted possession of Cape Mesurado. The first freed American slaves, including a number of African slaves liberated from slave ships in the Congo river, landed in 1822 on Providence Island in the mouth of the Mesurado river. Thus began Liberia, whose name means "place of freedom."

The freed slaves, called Americo-Liberians, established themselves under the leadership of Jehudi Ashmun, a white American. By 1828, when Ashmun left, the freed slaves had named their territory Liberia and their town Monrovia. The territory had a government, laws for the settlers, and the beginnings of a profitable foreign trade. More settlements had been started to the east of Monrovia, along the coast and inland along the St. John river.

President James Buchanan's cousin, Thomas Buchanan, was sent out by the American Colonization Society as Governor of Liberia in 1836. By 1838 Buchanan had united the

settlers under one banner and formed The Commonwealth of Liberia. Upon his death in 1841, he was succeeded by Joseph Jenkins Roberts, a freed slave born in Virginia in 1809. When, in 1847, the American Colonization Society decided its mission in Liberia was completed, Roberts proclaimed the independent Republic of Liberia, Africa's first republic.

The Americo-Liberians, and their True Whig Party, ruled the Republic of Liberia for the remainder of the 19th century, and up until the coup of 1980 that brought 28-year old Master Sergeant Samuel Kanyon Doe to power. Although never accounting for more than five percent of the population, the Americo-Liberians controlled the government, the economy and society, dominating the members of the many indigenous African tribes in the country, principally the Kranh, Mano, Gio, Bassa, and Gbandi.

The True Whigs recognized they could not govern without at least the silent acquiescence of the indigenous tribes, and in the early 20th century began a policy of direct cooperation with the tribes. Liberia then began to show a pattern of governance that has remained present since: a lack of consistent and persistent commitment by the leadership of the country to the development of the country; an emphasis on personal enrichment at the expense of the greater public good; and an inability of the mechanism of government to function effectively without significant foreign involvement.

The first major indications of the problem of governance came in the early 20th century when President Theodore Roosevelt appointed a commission to investigate political and economic conditions in Liberia. The commission recommended financial reorganization of the country. As a result, a western-run customs service was set up and administered by British, German and French government appointees, with a U.S. receiver-general. Later, U.S. army officers organized a frontier police force. These efforts, which began to help turn the economy and government around, foundered as the supporting foreign powers' attention was drawn off by World War I.

Though the Firestone Rubber Company began its rubber plantations in the 1920s (the world's largest rubber plantation is in Liberia), the governance problem continued as the Government of Liberia soon arranged a five million dollar loan from the (private) Finance Corporation of America to consolidate its debts and put the country's finances on a more stable basis. New governance problems soon arose. Members of the Government of Liberia, including President King and Vice-President Yancy, resigned in 1931 after a League of Nations investigation uncovered forced labor and slavery in Liberia. Shortly afterwards, new President Barclay appealed for further international financial assistance, this time to the League of Nations. Although his appeal was unsuccessful, several years later Liberia did arrange similar assistance from Firestone. As a result, administration of the customs service was placed in the hands of a U.S. adviser, assisted by five fiscal experts. This team had some power over the Liberian budget and expenditures.

Ties to the U.S. became increasingly close during World War II. First, Liberia's rubber plantations were the only non-Asian source of natural latex available to the Allies, and therefore important from a materiel standpoint. Second, the U.S. and Liberia signed a defense agreement which led to road building, the construction of the international airport at Roberts Field, and establishment of a deepwater port in Monrovia. U.S. money was declared legal tender in 1943, and shortly thereafter Liberia declared war against Germany and Japan, and joined the United Nations. Ties to the United States became increasingly close in the post-World War II period. Additional defense agreements were negotiated, training for the military was undertaken, and the U.S. foreign aid program began.

However, the same basic problems of governance remained: an inability to integrate and discharge effectively the responsibilities and requirements of enlightened government for the

benefit of the citizens of the country. In addition, the problem of underdevelopment or how to make the most effective use of the many natural resources of Liberia for the benefit of its citizens also remained.

These problems, which had been evident enough during the the 1960s and 1970s, intensified during the presidency of MSgt. Doe. Several new patterns of governance that had not previously been present in a significant way in Liberia also emerged under Doe's leadership: widespread human rights abuses and suppression of various ethnic groups because of their tribal affiliation. Coming to power in a 1980 coup, Doe and sixteen noncommissioned officers formed the People's Redemption Council. While most Liberians rejoiced when Doe, the first true African head of the country, came to power, his government's blend of corruption, repression and favoritism to his Krahn tribe soon began to polarize people along tribal lines.

In the early 1980's, Doe's government prospered, and over \$500 million of U.S. aid poured into the country between 1980 and 1987. Defense agreements were formed between the governments of the U.S. and Liberia. The Doe government supported the U.S. in the United Nations, broke diplomatic relations and expelled Libya from the country and suspended diplomatic relations with the Soviet Union.

Doe won the Presidential election of 1985 which was widely regarded as Liberia's first free presidential election. But post-election seizure of the ballot boxes and subsequent counting by the incumbent Government revealed a fraudulent election. The U.S. Congress terminated almost all types of foreign assistance to Liberia. Shortly thereafter a failed coup attempt gave President Doe an opportunity to crack down further against Gio tribesmen in Nimba county, again reinforcing the ascendancy of his Krahn tribesmen at the expense of other tribes and the country began to unravel.

The U.S. Government, always the most important foreign power in Liberia, adopted a cautious approach in dealing with President Doe and his increasingly repressive government. The U.S. kept up the pressure for Doe to reform, and be less repressive. By this time, too, Liberia had fallen afoul of the Brooke amendment to the U.S. Foreign Assistance Act, which forbids new development assistance when the recipient country is in default on loans from the United States. As a result, no further development assistance was possible: only emergency and humanitarian assistance, and food aid, could go to Liberia.

By the latter part of 1989, foreign exchange earnings were plummeting as world demand for iron ore and rubber dropped. Doe's blend of political repression, economic mismanagement (the U.S. Government had withdrawn its team of financial advisers earlier because they found Doe would not cooperate and was not serious about financial reform) and poor diplomacy brought Liberia once again to the brink of the nationwide collapse it had experienced on several occasions in the past.

On Christmas Eve 1989, Charles MacArthur Taylor, an Americo-Liberian who had been head of the Doe government's General Services Agency until fleeing the country when charged with embezzlement, led a band of fewer than 100 guerrillas across the border from Côte d'Ivoire. Calling his group the National Patriotic Front of Liberia (NPFL), and with backing from Presidents Campaore (Burkina Faso) and Boigny (Côte d'Ivoire), and Col. Qaddafi of Libya, Taylor had enough outside support to challenge the repressive and unpopular Doe government.

What began as a limited rebellion against the Doe government, with no explicit ethnic overtones, quickly degenerated into a series of vicious reprisals, primarily by the Armed

Forces of Liberia (AFL). As the rebels fought their way towards Monrovia, gaining recruits, the civilian population up country began to suffer more and more from indiscriminate killings, torchings, destruction and looting. The number of displaced persons and refugees grew quickly. At times it has been estimated that half the population of the country (or approximately 1.2 million people) was displaced, or seeking refuge in the neighboring countries of Côte d'Ivoire, Guinea or Sierra Leone.

Destruction was widespread everywhere. There was widespread looting including schools, clinics, hospitals, office buildings, and shops. In February 1992 the main road up country from Monrovia, to Kakata and Gbarnga, is still littered with the carcasses of burned out, overturned automobiles. Many of the items looted by the combatants and others were sold abroad.

Shortly after Taylor's NPFL rebels entered Liberia, Prince Yormic Johnson (not a member of royalty), one of Taylor's lieutenants, split away from Taylor and formed the Independent National Patriotic Front of Liberia (INPFL). Within six months of their original entry into Liberia, the two rebel groups had taken control of all but the area surrounding Monrovia, and were closing on the capital. By June of 1990, the rebels were close to Monrovia, and in control of most of the rest of the country. More than 5,000 people had been killed, and more than 100 times that uprooted, in what was being termed the bloodiest west African war since the Nigerian civil war 20 years earlier.

U.N. Secretary-General Perez de Cuellar issued urgent appeals to halt the slaughter, but to no avail. The battle for Monrovia began in earnest, with the troops of the AFL and Doe in the government center, and the troops of the NPFL and the INPFL controlling other sectors. The John F. Kennedy hospital, a U.S.-financed high-quality medical institution in Monrovia, became known as the "Just For Killing" hospital, and then was shelled, fought over and looted, becoming useless and inoperable, and perhaps structurally damaged. Non-combatant civilians bore the brunt of the fighting.

By August of 1990, with the battle for Monrovia raging day-by-day, the Economic Community of West African States (ECOWAS), a 16-member regional grouping of states from Nigeria to Mauritania, called an emergency summit meeting to discuss the situation. Although only seven members came, ECOWAS, under the leadership of Nigeria, took the unprecedented step of establishing a military force of its own to enforce a cease fire in Liberia. The Economic Community Monitoring Group (ECOMOG) began with 2,700 troops from the armies of Nigeria, Ghana, Guinea, Sierra Leone and The Gambia in Monrovia. Since that time, troops from Senegal and Guinea-Bissau have also become involved in this regional effort to halt the fighting, an unmatched achievement in regional group history in the world. The cease fire continues to hold.

Shortly after the arrival of ECOMOG troops in Monrovia, President Doe was captured in September 1990 by Prince Johnson's INPFL troops. He died the next day from wounds and shock. Since that time, and as a direct result of the ceasefire negotiated in Bamako, Mali, in November 1990, the fighting has stopped in Monrovia and in most of Liberia (there are still several areas of fighting, principally in Grand Cape Mount and Bomi counties near Sierra Leone, and in Grand Gedeh county in the northeast near the Côte d'Ivoire). The visible presence of ECOMOG troops in Monrovia and the surrounding areas has defused tensions a great deal.

As a result of pressure from ECOWAS, the Interim Government of National Unity (IGNU) was created in Monrovia, under the leadership of Amos Sawyer (who drafted the 1985 constitution and had been teaching at Indiana University). Charles Taylor created his own interim government, the National Patriotic Reconstruction Assembly Government

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(NPRAG), in Gbarnga, Bong county. Both governments are designed to create some structure to allow organization of civil authority and operation of facilities in their respective areas of control. Neither has much power, nor more important much money.

Some functions exist without regard to IGNU of NPRAG lines including the National Police force and the customs and immigration services. Stamps and actions by both are accepted in the other territories, but there is a decided preference for people to have documentation issued in both jurisdictions.

ECOWAS brokered a second set of agreements in Yamoussokro, Côte d'Ivoire, signed at the end of October 1991. As a result, the three major parties at war in Liberia (the NPFL, the INFPL and the AFL) agreed to: 1) enter camps, and 2) disarm soldiers as a condition leading to free and fair elections.

All this is to be accomplished within six months of November 1, 1991, so there will be time for electioneering and a proper open and free election can be held. But before the elections can be held, ECOMOG must be in control of all 13 counties of Liberia.

Charles Taylor, head of the NPFL, is resisting the requirement that he cede control over territory to ECOMOG. As of late February 1992, ECOMOG is in control only in the city of Monrovia, a little bit of Montserrado county (where it shares roadblocks with the NPFL), and has a small detachment of Ghanaian soldiers in the port of Buchanan, Grand Bassa county. The ECOMOG detachment in Buchanan is essentially confined to the port.

As a result, it is difficult to determine when ECOMOG will have enough control throughout the country to permit the beginning of the nationwide election campaign.

1.3.3 Liberia's Future

At this point in time, it is difficult to envision a rapid, steady and peaceful transition to a functioning government of a unified Liberia discharging its responsibilities in a capable fashion. Liberia's history suggests that whatever government eventually gains power will have a difficult time achieving such a goal.

Even if that were to come about, the economic rehabilitation facing the new government is vast. The economy and much of the infrastructure of the country has been destroyed by the war and subsequent looting and dismantling of the physical and social structures of society. Agricultural production has plummeted. Schools and clinics have been destroyed. Much of this will have to be repaired and rebuilt before life can begin to function in a normal fashion. The water system of Monrovia, for example, is not functioning because the pumping station and filtration plant no longer work. Liberia faces a mammoth task in coming back from the war.

As Rick Wells stated in "Africa Report" a year ago, "whatever settlement may emerge in Monrovia...it's going to be years before the wounds heal and normality returns. In which case, the short-term emergency relief that is currently being applied will, sooner or later, have to turn into long-term assistance."

2 NUTRITION

2.1 SIERRA LEONE

2.1.1 Prewar Status

Food needs in Sierra Leone have been more or less met each year by local production from the subsistence agriculture sector. Living in a country that benefits from sufficient annual rainfall to ensure harvest of any number of cereal grains and other foodstuffs, most people in rural areas have been able to grow adequate amounts of food for their own needs, or to arrange through barter or purchase what they cannot grow themselves. Although Sierra Leone has been a recipient of U.S. Government commodities (mostly rice) under the concessional sales program in the past, the commodities have generally been distributed and sold in the urban markets to feed the urban populations.

2.1.2 Impact of the Conflict in Sierra Leone

The impact of fighting in eastern and central-eastern Sierra Leone in 1990 and 1991, had an adverse impact on life for non-combatant populations in the rural areas of the region. Some villages and farms were burned, crops were destroyed and life was thoroughly disrupted. A number of people suffered from food shortages during this time, and the general level of nutrition amongst the people in the region was lower than usual.

2.1.3 Aid Groups Working in Sierra Leone

As a result of the disruption and the influx of refugees, a number of emergency feeding programs were begun, principally by the World Food Program (WFP uses food from the U.S. and European Community for the most part) and the United States. There were also minimal vulnerable group feeding programs, but overall the food was for general distribution.

The number of refugees registered and encamped by the United Nations High Commissioner for Refugees (UNHCR) Office in Sierra Leone as of February 1992 was approximately 5,000. The refugee camp is at Waterloo, several miles outside Freetown. At this point the refugees are receiving a monthly ration distribution from the WFP of 400 gms. per day of rice, 50 gms. per day of beans and 25 gms. per day of oil. The Sierra Leone Red Cross is WFP's cooperating agency for the distribution of the food.

The number of displaced Sierra Leoneans is estimated (February 1992) to be 290,000. The current monthly take home ration distributed to registered displaced persons is 300 gms. of rice per day, 50 gms. of beans and 25 gms. of oil. As the result of a multi-UN agency inspection and assessment last fall, the rice portion of the ration was reduced recently by 50 gms. per day. The non-governmental agencies cooperating with the WFP in the generalized food distribution program are Catholic Relief Services (also a cooperating sponsor for the U.S. Government), the Sierra Leone Red Cross, Cause Canada, and Action International Contre le Faim (AICF).

2.1.4 Assessment by Region in Sierra Leone

After a survey of 25,000 children in the Kenema region last year discovered that almost 20% were below the 80% of weight-for-height-for-age, AICF began a twice daily intensive feeding program for affected children. The feedings included Corn Soy Blend, milk, oil and sugar, and provided 985 kilo calories per feeding. As soon as children attained an

85% rating on the weight for height for age scale they "graduated" from the program. Recent follow ups on children in the Kenema region indicate that the current level of children below 80% has dropped dramatically, and is statistically insignificant.

AICF also created two therapeutic centers for treatment of children who tested at less than 65% on the weight-for-height-for-age threshold. In the past six months 200 children have been through the six-meal-a-day program and it appears the intensive program has been successful. There are few new candidates being found for entry into the program.

There is mixed opinions on the need for additional feeding programs. It was the unanimous opinion of all non-governmental and international organizations surveyed that there is no current need for additional food in generalized food distribution, vulnerable group feeding or intensive therapeutic feeding programs in Sierra Leone. However, some indigenous groups, such as the representatives of students at Fourah Bay College, feel differently. This student group's representatives appealed for food from donor groups at a recent emergency meeting for displaced persons.

All donor agencies, however, were careful to couch their recommendations, suggesting that if the situation worsens in some way, there might be a need for additional food assistance, and for more agencies to distribute food. Part of the problem of food distribution in Sierra Leone, according to several of the food distributing agencies, is security difficulties in the port of Freetown, and long delays and additional security problems moving food assistance over tortuous roads.

There are several key issues related to food assistance. One is the possible encouragement for refugees and displaced persons to remain in Sierra Leone in order to receive food. Another issue is how the government will deal with the 150,000 Sierra Leone refugees in Guinea and Liberia when they return in the areas of supplies and services.

2.1.5 Perceptions of IMC Role in Nutrition in Sierra Leone

How the government of Sierra Leone and donor agencies currently present in Sierra Leone deal with the issues above will indicate if it is appropriate for IMC to consider adding a food aid dimension to a possible program in Sierra Leone. At this time and in this situation, IMC needs to determine first if it believes there is an appropriate role to play in a medical sense. If so, and if a program is developed and approved, IMC should then be prepared from a conceptual and contingency standpoint to consider the design and implementation of a food aid component appropriate to the need that arises.

2.2 LIBERIA

2.2.1 Prewar Status

As stated earlier, Liberia existed in a mostly subsistence agriculture state in the period prior to the civil war. There were always significant rice imports from the United States, under the PL 480 concessional sales program (as in Sierra Leone, but more so), with the proceeds from the sale of the rice used to carry out development and self-help projects jointly agreed by the governments of Liberia and the United States. As the excesses of the Doe government came to be more widely known, and U.S. criticism of Liberia mounted, the amount of food available under PL 480 was cut back. Liberian firms and traders also imported additional food items, which were sold in marketplaces around the country. Chronic, persistent malnutrition and famine did not appear to be significant problems in

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Liberia. However, the role of malnutrition and protein calorie deficiency in regard to the susceptibility of Liberians to disease has never been thoroughly investigated.

In 1984, the Liberian Ministry of Health and Social Welfare claimed the second most important cause of mortality was malnutrition/anemia. This was contradicted a year later by the same ministry's national figure for weight/height malnutrition in under-fives of less than 1.6 %, representing a county by county survey with a range of 0.8% to 2.2%. The picture, as a result, was somewhat confused even before the war.

The health services in the early 1980's focused on curative rather than preventive medicine, with health care reaching about one-third of the population in and near urban areas. The government planned to extend health services to rural areas.

2.2.2 Impact of the Conflict in Liberia

Much of the human suffering that has existed in Liberia since that time has been caused by the fighting that began with the outbreak of civil war in 1989. A short list of the effects of war on the general populations' ability to survive would include: wanton destruction of life and property; inability to plant, weed and harvest crops; destruction of social services delivery mechanisms, including health clinics and schools, and looting of the locations; theft and pillaging of crops; and widespread dislocation caused by the impact of the war. As a result of the fighting, subsistence agricultural production plummeted in numerous locations and a significant food crisis arose.

The MSF-Belgium "Report on Nutrition Activities Carried Out During Emergency Operation in Liberia, September 1990 - October 1991" (Appendix III. A.) indicates that malnutrition among under-fives was higher than the Government's estimates in 1985. The MSF-B report indicates that the nutritional status of under-fives in Nimba, Margibi and Grand Gedeh counties were the worst, at around 10% malnourished on W/H. The 1985 Government figures for the same locations, where available, were 1.3% to 2.1%. This information is summarized in the table below.

Table 2.1. Comparison of 1985 and 1990/91 Estimates for the Prevalence of Malnutrition* in Different Counties in Liberia

| County | Survey Date | Agency | Survey Result | MOH: 1985 |
|------------------|-------------|---------------------|---------------|------------|
| Monrovia | Sep '90 | MSF-B | 31.0% | 1.4% |
| Monrovia | Dec '91 | JOINT | 5.1% | N/A |
| Nimba | Mar '91 | JOINT | 2.7% | 1.4% |
| Margibi | Mar '91 | MSF-B/H | 10.7% | 1.4 - 2.0% |
| Bomi | Apr '91 | MSF-B/H | 12.7% | 1.4% |
| Maryland | Jun '91 | MSF-B | 4.2% | 2.1% |
| Grand Cape Mount | Jul '91 | UNICEF/Concern/GOAL | 5.6% | 1.3% |
| Montserrado | Sep '91 | AICF | 4.6% | 1.4% |
| Grand Gedeh | Nov '91 | UNICEF/AICF | 10.6% | N/A |

Ref: Appendix III. A. MSF-B Report on Nutrition Activities Carried Out During Emergency Operation in Liberia, September 1990 - October 1991.

* Figures represent percentages of children below 80% weight-for-height except for Nimba and Margibi where they reflect the percentage more than 2 standard deviations below the mean W/H.

The impact of the fighting in Monrovia in the fall of 1990, essentially a city under siege for many months almost totally cut off from relief supplies, led to W/H malnutrition figures of 31.0% for under-fives surveyed in the city in 1990. This compares to 1.4% in the Government's 1985 report. The war had an obvious impact on the quality of life and availability of food. More importantly perhaps, the figures from Monrovia clearly indicated a human, life-threatening emergency of the highest order, and the western donor nations responded with significant amounts of emergency assistance.

2.2.3 Aid Groups Working in Nutrition Programs in Monrovia

In the Fall of 1990 the World Food Program approved a \$30 million dollar, 50,000 MT, six month emergency program for Liberian refugees and displaced persons. Catholic Relief Services (CRS) also became a cooperating sponsor with the U.S. Government for emergency PL 480 Title II food aid. As the food designated for Monrovia started to arrive, the Liberian NGO Special Emergency Life Food (SELF) was established. SELF set up a system for determining where and how much to give in a large scale general food distribution, breaking the city down into neighborhoods. Each neighborhood then elected a team of residents, and the team surveyed the houses in the neighborhood, recording the number of occupants in each. Each house was then given a ticket with the number of occupants inscribed thereon. At distribution time, the resident presented the ticket for his house and received the appropriate ration at the neighborhood's distribution point. There are some problems with this method relating primarily to over-counting residents or non-existent houses, but SELF is leading efforts to ensure the count is as accurate as reasonably possible.

According to all people talked with during the trip, SELF has worked out surprisingly well, considering its lack of prior food distribution experience. The IMC team met with the SELF leaders on several occasions, visited the Port of Monrovia in their company to watch and observe a ship off-loading, storage and accounting procedures and loading of trucks for generalized distribution, and talked about the future of the generalized food distribution system.

In the Monrovia area, SELF's generalized food distribution system works. It has been particularly effective in providing a safety net at times when other food commodities were not available (primarily in the latter part of 1990 and early 1991). The impact and integrity of the program is proof that there are concerned Liberians willing to accept responsibility for the destiny of their city and citizens. The SELF employees work long and hard, and appear to discharge their responsibilities in a fair, even-handed way and with a great deal of integrity.

The institutionalization of generalized food distribution in Monrovia and its environs, where perhaps 600,000 people are receiving assistance, has done much to improve the quality of life for the recently beleaguered population.

With the SELF generalized food distribution program apparently reaching all people in the Monrovia area, various other NGO's stepped in at the same time to provide additional, more highly-targeted feeding programs. The Joint nutritional survey done at the end of 1990 identified 21,000 under-fives as being malnourished (31%), and a population of 400,000. In addition to the under-fives, it was decided to target also older children, pregnant and lactating women and malnourished adults, since all of these groups were also showing signs of malnutrition. During the late summer of 1990, Monrovia was a true famine city: cut off from all relief supplies, heavy fighting going on, and people forced to

eat pets, lizards, and palm cabbage (part of the palm tree and a traditional famine food), amongst other things, to survive. Supplementary feeding programs begun at the end of 1990 included non-traditional target populations, such as the above.

In addition to the supplementary feeding programs, intensive therapeutic feeding programs, directed at children showing less than 70% W/H, were begun at day care centers. Parameters for entering and exiting the programs were agreed: children below 70% W/H were welcome in the Day Care Center programs and could stay until they weighed two consecutive weeks at greater than 70% and showed no signs of edema; people were welcome in the supplementary feeding center programs if they were between 70% and 80% W/H, and could participate until they weighed two consecutive weeks at greater than 85% and showed no signs of edema.

The first supplementary feeding center began in November 1990, run independently by George de Rosen, and the first day care center opened in December 1990. Soon there were numerous agencies active in both types of centers, principally AICF and MSF-B in supplementary feeding, and MSF-F and UNICEF in day care centers.

Both programs were noticeably successful, and by the late spring of 1991, when the next nutritional survey of Monrovia was done by MSF-B, the malnourished rate of under-fives had dropped dramatically to 5.1%. A similar improvement was noted in the other types of people treated, and new adult admissions decreased dramatically too. Although groups carrying out the feeding programs were reluctant to stop them entirely at this point, they began to make plans to shift over to take-home ration, a less intensive method of feeding. This took the form of an emergency school feeding programme (hot meal at school), or an MCH dry ration distribution. By October 1991, AICF was the only group with supplementary feeding centers still in business. The crisis had been met and dealt with successfully.

Post-experience evaluation of the supplementary feeding centers and adult malnutrition programs stressed some valuable lessons. There was no doubt the programs had succeeded in improving the nutritional level of the target groups, and in a spectacular fashion. This was due at least in part to the fact that the criteria for selection, admission and termination in the program were rather loosely enforced. The program, therefore, was probably more costly than it should have been, and went on longer than was necessary. All the same, the desired results were obtained. One should remember the lessons learned for the future, in order to ensure most effective use is made of the available (and increasingly scarce) resources.

Rounding out the food picture in Monrovia is the Vulnerable Group Feeding Programme, coordinated by CRS and WFP. Under that program, MSF-B has a 13-clinic MCH program that distributes a dry, take-home ration. In addition, food is supplied to orphanages, the elderly, disabled, the destitute and the displaced. Like the other food programs in Monrovia, demand and delivery peaked in the early part of 1991. As the security and food availability situation improved in Monrovia, the need for the Vulnerable Group program has declined.

As donor food aid has flowed into Monrovia, the price of food on the open market has declined. By late February 1992, all markets visited displayed large quantities of cereal grains, and tinned, preserved and imported goods. The prices were, to someone schooled on inland African prices, inexpensive. Certainly few people in current Liberia are earning much. Many civil servants, for example, have not been paid in a good long while, if at all. Money, however, does seem to be in circulation, and private commerce and trade appear to be thriving.

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It is also quite clear that outside donors are supplying whatever capital is being generated, whatever goods are being imported and most of the vitality in the current economy. The Interim Government of Dr. Amos Sawyer has very little revenue generating capacity, only revenues from foreign-flag owners for ship registration, and therefore the government-fed economy in Monrovia is all but non-existent. As a result, revenues generated from foreign organizations, through employment, provision of goods and services, and in other ways, is more important than ever before. The donors find themselves in a curious situation, where the donors are the "life support" system by which the country maintains some minor momentum as it attempts to sort out its priorities and move ahead.

2.2.4 Aid Groups Working Upcountry and Nutritional Assessment by Region

There is no doubt it is easier to quantify the need and provide nutritional assistance to people in and around greater Monrovia, the area of the IGNU, than in the area of the NPFL, "Taylor country." People in the Monrovia area are more accessible and the services and facilities to reach and serve them are better. While the destruction up country is not so all pervasive, there are areas where significant damage has been done and the need is great. People up country are much more widely dispersed, which makes them harder to reach – not only for the purposes of measurement, but also to provide them with emergency relief. In addition, the people up country are more mobile, and there is continual movement as displaced people circulate looking for the opportunity to alight, or return to their prior location. There are also refugees up country, primarily in northern Lofa country, from Sierra Leone. These people are fleeing from the fighting in eastern and northeastern Sierra Leone, fighting which could be NPFL-rebel based, or an internal Sierra Leonean conflict which has spilled over into neighboring countries.

Summarizing the nutritional situation in NPFL territory after reading the various nutrition reports contained in Appendix III., the similarity of the message is evident. While reports are not available for all counties, those available state that the nutritional situation has improved for the better as the result of generalized food distributions, that the percentage of under-fives who are at an 80% threshold W/H, or below, has decreased, and that continual nutrition monitoring is recommended. None of the reports recommend additional supplementary and intensive feeding programs, but most do indicate that some generalized food distribution is still needed – at least until the harvest of 1991. A post-harvest assessment is also needed, but there was no talk during the IMC team mission in Liberia that such a report was contemplated, or that anyone had made such an assessment at all.

A breakdown of reports, by county, reveals the following information:

Grand Cape Mount. As measured in June - July 1991, 5.6% of the measured population was malnourished. This figure represented 2.2% at less than 70% W/H, and 3.4% at 70-80% W/H. This represents a considerable improvement from earlier, and was attributed to the success of the seven feeding centers established and run by Irish Concern and the recent general food distribution. While the UNICEF/Concern/GOAL mission decided there was no need for additional supplemental or intensive feeding programs, they did recommend that Whey-Soy-Blend or Corn-Soy-Milk be included in future generalized food distributions.

Unfortunately, in February 1992 GOAL, Lutheran World Service, and all other NGO's working in Cape Mount and Bomi counties, withdrew because of the tense security situation. There was still a large presence of Sierra Leonean refugees, as well as displaced persons from other regions of Liberia in the county at the time.

As in all counties in Liberia, it was recommended that a regular nutrition analysis and sampling be done in Grand Cape Mount.

Bomi. MSF-F had established an extensive supplementary feeding program in Bomi county, with 12 supplementary feeding centers and two referral centers. As of November 1991, latest figures available, they were processing about 5,000 new admissions a quarter, of whom more than three in five (60%) were still receiving assistance into the next quarter. About one in five recovered and was discharged, slightly fewer dropped out of the program, and one in 40 died.

Upper Montserrado. AICF performed a nutritional survey in September 1991. They discovered a malnourished rate of 4.6%, of which only 0.9% represented people below 70% W/H, and 3.7% were below 80% W/H. AICF attributed the improvement to a recent general food distribution (June 1991) and the effective manner in which the ICRC and AICF implemented their supplementary feeding program. At the end of 1991, the program encompassed 10 supplementary feeding centers, six wet-feeding and four dry-feeding centers. Some of these were slated to be closed in the near future, as the total number of beneficiaries was only 500 and still going down.

Grand Bassa/Rivercess. UNICEF/GOAL carried out a nutritional survey in November 1991. They were surprised to discover the measured malnutrition rate was less than 5% below 80% W/H. They attributed the low figure to recent generalized food distributions and some highly targeted supplementary feeding programs carried out by Catholic Relief Services.

Margibi. The eight supplementary feeding centers begun by MSF-B were taken over by MSF-H in March 1991. By August the program had expanded to 13 centers and one intensive feeding center at the Rennie hospital, with 1300 beneficiaries. There was no current information on the state of malnutrition in Margibi county.

Bong. Five feeding centers were set up by MSF-B in November 1990. Within three months, four of them were closed because of the improvement in the situation. The only remaining center was at the Bong Mines hospital.

Sinoe. After the joint UNICEF/MSF-B/CRS assessment mission, MSF-B began three dry-ration centers in July 1991. The period July - August 1991 saw over 350 new admissions, 250 of whom were severely malnourished (with edema, or less than 70% W/H). Because MSF-B had no representative in Sinoe, CRS agreed to take over the program. There was no recent information available about the situation in Sinoe, but neither CRS nor MSF-B indicated the problem was severe.

Grand Gedeh. There were two missions to Grand Gedeh in 1991: a UNICEF mission in September, and a joint UNICEF/AICF one in November 1991. The difference in the malnutrition rates recorded, and the drop between the visits is quite significant.

The earlier visit surveyed 202 children, of whom 51% were below 80% W/H. Of the 51%, 24% were severely malnourished (below 70% W/H), and 27% were moderately malnourished (between 70 and 80% W/H).

Just three months later, the joint mission surveyed 338 children in the same towns and others, and found only 10.6% malnourished, of whom 11, (3.3%) were below 70% W/H, and 25 (7.3%) were between 70 and 80% W/H. While this improvement is impressive, it should be considered in the light of anecdotal information (not recorded) that told the team

that there had been a very high mortality rate for under-fives in the preceding three months.

There is still a great deal of information that remains to be collected and known about the nutritional situation in NPFL territory. In addition, there needs to be some contingency planning by all organizations for the possible return of some of the hundreds of thousands of refugees who remain outside their country of origin. Clearly, the impact of the returnees will stretch the skeletal systems to the utmost.

Nevertheless, at this point – with an increasingly, non-warring countryside and the slow revival of the internal logistics infrastructure – it is fair to say that on balance NPFL territory appears to be receiving adequate food for its needs.

2.2.5 Perceptions of IMC Role in Nutrition in Liberia

The situation here is much the same as in Sierra Leone. At present the food delivery system seems to be functioning relatively well. There are always shortfalls but given the many constraints, one of the major reasons for the rapid improvement in the condition of people in Liberia has been the ability to move food to people at risk on a timely basis.

No agency contacted suggested there was a need for another food distributing NGO in the field at this time. And, between WFP and CRS, it appears that there are an adequate number of cooperating sponsors.

A food component to an IMC program would be suitable make sense, but only in the context of an add-on to a larger program. For example, were IMC asked to undertake a medical program in a remote area of Liberia and nutritional analyses showed a significant nutritional problem, it would be appropriate to apply to either of the cooperating sponsors of A.I.D. for a sub-grant of food assistance.

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3 HEALTH CARE SYSTEM

3.1 PREWAR STATUS

3.1.1 Liberia

Prior to the conflict, Liberia had an estimated population of 2,447,000 (WHO). The crude birth rate was 49.2 per 1000 population and the crude death rate was 18 per 1000, giving a growth rate of 3.26% per year (1980 data). Average life expectancy was 48 years. Thirty-five percent of the population lived in urban areas (1980 data).

It is difficult to assess the overall quality of the prewar health care system other than through the general indicators below. Several informants indicated that MOH doctors and nurses prefer to work at private clinics. This seems to be related to the relatively low government pay scales. Most of those interviewed seemed to feel that primary health care at the village level was relatively good in most populated areas. More remote, inaccessible areas were apparently less well covered. Medical problems included malaria, respiratory infections, diarrheal diseases, and tuberculosis. Of note, cholera was endemic before the war, although apparently at a low level.

In 1986, the Liberia Demographic and Health Survey was conducted by the Ministry of Planning and Economic Affairs and the Westinghouse Institute for Resource Development. The following data is from that survey. The total fertility rate was 6.5. Infant mortality was estimated at 144 per 1000 live births, with an urban/rural distribution of 140/161, high for West Africa. Among children under five years of age, 34.3% had a health card recording vaccinations: among these children, 80.9% were immunized with BCG, 23.6% had received DTP-3, 21.7% had received OPV-3, and 53.6% had been immunized for measles. An estimated 90.9% of all births were attended by a doctor, trained nurse/midwife, or traditional birth attendant.

In comparison to the general chaos of the political system, the impact of exogenous medical groups – missionaries, NGO's and A.I.D.-funded projects – helped ensure that the Liberian health delivery system was relatively advanced for a developing country. There was a well developed network of hospitals, regional health clinics and health posts at the community level, most of which were adequately staffed with doctors, nurses and health auxiliaries (physician assistants, nurses aides, technicians of various types, village health workers, and traditional birth attendants). The small size of the country, its relative accessibility, and the quality of its infrastructure all contributed to the success of the medical system. Efforts made by American firms working in the area improved the situation, as did alliances with the U.S. Government, particularly in the period between World War II and the late 1980's.

3.1.2 Sierra Leone

Health care in rural Sierra Leone has been virtually nonexistent aside from mission hospitals. The Ministry of Health provided very scant resources for use outside the capital, Freetown. Medical problems were similar to those found in Liberia.

3.2 IMPACT OF THE CONFLICT

3.2.1 Liberia

Since the beginning of civil war in December of 1989, virtually all parts of the country have been affected by military activity of some kind. Current population estimates vary from 2.27 to 2.55 million persons within Liberia itself, with from 10,000 to 50,000 killed and about 500,000 refugees in the neighboring countries of Guinea, Côte d'Ivoire, Sierra Leone, Ghana, Nigeria, and Mali. An estimated 500,000 persons are displaced within Liberia. Although official (IGNU) estimates indicate that up to one half of the population (1.2 million) are now living in the ECOMOG zone around Monrovia, most aid groups (notably WHO and MSF-B) feel the number of people residing in and around Monrovia is closer to 600,000.

There is little disagreement that the conflict has disrupted virtually all of the Liberian health care system. During the period of active fighting, most health facilities in Monrovia, Nimba and Grand Gedeh sustained extensive physical damage. Outside these areas, however, health facilities suffered only mild to moderate damage. In all counties, medical equipment and supplies were destroyed or looted. Many health care professionals either fled the country or became displaced. Many of those remaining are concentrated in Monrovia, but few are working in any part of the country. Most professionals are working in the private sector in for-profit clinics. Dr. Bartee of MERCI estimates that there are between 50 and 60 physicians and 300 to 400 nurses left in Liberia, with 25 doctors in the NPRAG area.

Neither the IGNU nor the NPRA has the resources to support any significant portion of the health care system. Furthermore, there is the question of whether these groups are willing to allot resources to the health sector. We saw no indication that either of the interim governments holds health as a high priority. The issues of government funding and priorities have heavily influenced the course of public sector health care, which has been largely taken over by NGO's and multinational groups.

Due to the fact that most of the NGO's in Liberia are primarily relief groups, health care under the NGO's has focused primarily on curative care, with the majority of attention given to Monrovia. Rehabilitation of hospitals and clinics has predominated, including coordination and supervision, provision of drugs and supplies, and staffing with Liberian or expatriate health professionals. It is customary to charge \$5.00 Liberian for each adult outpatient visit and \$2.50 for children at most health facilities in the public sector, including those run by the MOH and NGO's. (At the time of this trip, the exchange rate fluctuated between \$7.00 and \$8.00 Liberian per \$1.00 U.S.)

Since the interim governments are able to pay only minimal salaries to health workers – and irregularly, at that – most NGO's have adopted the practice of paying "incentives" to indigenous health workers. These are roughly equivalent to one-half of prewar salary levels, but are not taxed. There is considerable concern among NGO's about the sustainability of health programs if the interim governments are not willing or able to continue payment of health workers upon the removal of NGO support.

Aside from malnutrition, principal medical problems remain similar to those before the war. Malaria is the primary health problem: there is only limited chloroquine resistance. Upper respiratory infections are common. Disruption of water supplies have increased the incidence of diarrheal diseases, and there have been sporadic outbreaks of cholera. Tuberculosis appears to be increasing. MSF-B unofficially estimates the incidence at about

four cases per 1000 population per year. Scabies and other parasites are common, as are sexually transmitted diseases. Some primary health measures have been instituted in limited areas, including rehabilitation of water supplies and EPI programs. These have been limited to the larger urban areas for the most part, and have involved multinational groups such as ICRC and UNICEF.

The following table is compiled from the June, 1991 WHO "Health Sector Needs Analysis" (Appendix IV. D.), updated to include more current information. Please compare with Appendix IV. B.

Table 3.1. Estimates of Liberian Population, Health Facilities, and Health Care Personnel, by County, June 1991

| County | Estimated Population | Hospitals | Health Centers | Health Posts | Physicians | PA's & Nurses |
|--------------|----------------------|-----------|----------------|--------------|------------|---------------|
| Bassa | 220,000 | 2 | — | 11 | 3 | 26 |
| Bomi | 90,000 | 2 | — | 9 | 6 | 24 |
| Bong | 280,000 | 2 | 2 | 17 | 7 | 75 |
| Cape Mount | 90,000 | 2 | — | 11 | 1 | 25 |
| Grand Gedeh | 30,000 | — | 2 | — | — | 5 |
| Grand Kru | 40,000 | — | — | — | — | 10 |
| Lofa | 175,000 | 3 | 2 | 18 | 4 | 110 |
| Margibi | 180,000 | 2 | 2 | 4 | 2 | 21 |
| Maryland | 100,000 | 2 | — | 4 | 2 | 22 |
| Monserado* | 650,000 | 9 | 27† | 17 | 30† | 100† |
| Nimba | 320,000 | 2 | — | 28 | 4 | 60 |
| River Cess | 40,000 | — | 1 | 3 | 1 | 1 |
| Since | 50,000 | 1 | 1 | — | 1 | 27 |
| Total | 2,265,000 | 27‡ | 49 | 122 | 61 | 506 |
| Prewar Total | 2,447,000 | 36 | 26 | 257 | N/A | N/A |

Ref: Appendix IV. D. WHO Health Sector Needs Analysis, June, 1991

* Includes Monrovia.

† These numbers are based on MERCI estimates.

‡ Running water is available at only two hospitals outside Monrovia, and power at only six.

3.2.2 Sierra Leone

About 75,000 Liberian refugees are currently living in Sierra Leone. Approximately 5,000 registered refugees are encamped at Waterloo, several miles outside Freetown, while the rest are spontaneously settled throughout the central and eastern region of the country. The health needs of the refugees are "mostly taken care of" by NGO's and multinationals working in the country.

The issue of Sierra Leoneans internally displaced by the conflict is more problematic. Up to 290,000 are displaced within Sierra Leone, and another 97,000 became refugees in Guinea. NGO's bear primary responsibility for internally displaced Leoneans. The current feeling is that malnutrition is minimal (see section 2.1.3), as are war-related injuries. The majority of medical problems in this group are similar to pre-war patterns: malaria, infectious diseases, difficult obstetrical problems, etc.

There is real debate on the future status of displaced persons in Sierra Leone. Although "common wisdom" indicates that the situation will improve, some of those interviewed felt that there may well be a worsening of the health situation as NGO's begin to withdraw and refugees from Guinea return to Sierra Leone. These problems will be concentrated in the eastern portion of the country, along the border with Liberia and Guinea.

3.3 GROUPS INVOLVED IN HEALTH CARE

3.3.1 Multinationals

United Nations Organizations. Among the UN groups, WHO and UNICEF play the greatest role in health care, with limited involvement from UNDP and UNDR0. UNICEF is primarily concerned with EPI programs, and is currently working in Monrovia and parts of Nimba and Lofa counties. They have also produced nutritional surveys for many counties (see Appendix III).

WHO is serving primarily in an oversight capacity, and is oriented toward longer-term problems. Dr. Tshabalala, the WHO Representative for Liberia, emphasized the impending HIV/AIDS problem along the Côte d'Ivoire border, the reconstruction of the health information system (routine reporting and sentinel surveillance), EPI and MCH programs, and the need for mental health services. She stressed the current imbalance between food and nonfood aid, specifically mentioning the urgent need for medical supplies and equipment, including laboratory supplies. WHO produced a country-wide assessment of the health needs in June of 1991 (Appendix IV. D).

International Committee of the Red Cross (ICRC). ICRC is primarily concerned with prisoner exchange, reuniting families, and other nonmedical interests. Although they were previously supplying clinics in Grand Bassa County, after two ICRC workers were detained by the NPLF these activities were terminated. ICRC has also been involved with rehabilitating the water supply in Monrovia and selected sites upcountry. These activities have largely been completed.

European Community (EC). We met with a representative of the German Government's technical assistance organization (GTZ), which is beginning a project to rehabilitate Monrovia's water purification plant under a grant from the EC.

3.3.2 Exogenous Nongovernmental Organizations

Action International Contre le Faim (AICF). AICF is gradually transferring its activity from feeding programs to medical and rehabilitation programs such as sanitation and seed and tool projects. The group runs two clinics in Monrovia and eight in Monserrado county. Its program includes logistical support, supplies, training, and payment of incentives to Liberian staff (primarily nurses).

Adventist Development and Relief Association (ADRA). The main activity of this group is distributing food to schools. In Monrovia, ADRA operates the SwedRelief hospital under a contract from UNICEF, but is planning to transfer this activity to the Seventh Day Adventist - Cooper Clinic as soon as that facility can be rehabilitated. ADRA also runs a small school clinic near Kakata.

Catholic Relief Services (CRS). Although primarily involved in food distribution, CRS also supplies some medicines to clinics run by Catholic groups, including Sister Carmen's

clinics in River Cess and Grand Bassa, and the St. Joseph's Hospital in Monrovia. These are merely sporadic commodity drops, however, and do not include any coordinated oversight.

GOAL Ireland. GOAL's primary area of interest is in Grand Cape Mount and Bomi counties, but the continuing disturbance in these areas has made them "unworkable." This is a small group (four expatriate nurses and one logistician) with limited resources. They are currently coordinating EPI activities in Monrovia with UNICEF/WHO funding and are considering a similar program in Grand Bassa. They also provide some support (supplies, equipment, and coordination) to clinics in Grand Bassa, including Sr. Carmen's clinics. GOAL is currently planning to leave by the end of July, 1992.

Lutheran World Service (LWS). In addition to their large feeding program, LWS supports private Lutheran hospitals in Suakoko (Phebe Hospital) and Zorzor, in NPRA areas. Like CRS, they also give limited support to some Lutheran clinics in Bong and northern Lofa counties.

Medecins sans Frontières - Belgium (MSF-B). MSF-B is the primary player in health care at the present time, and has been instrumental in the development of indigenous NGO's (SELF, MERCI, NDS). They are a major provider, through the National Drug Service, of drugs and medical supplies. MSF-B plays a large role in the coordination of NGO's working throughout Liberia. They are also involved in direct delivery of care, including MCH and tuberculosis control programs in Monrovia, and several clinics in the northern counties of Lofa, Bong and Nimba. They are planning to expand into the southeast counties of Maryland, Grand Kru, Grand Gedeh.

MSF - France (MSF-F). This group is currently running a pediatric hospital in Monrovia, and delivers some direct medical care in Margibi county. They are planning to leave in spring or early summer, 1992.

MSF - Holland (MSF-H). From June - October of 1991, MSF-H carried out a cholera control program in the area of Buchanan. This involved rehabilitation of the water supply and health education. Currently, they are working in Margibi county exclusively, having reopened several health centers and three hospitals. Two of these clinics and one hospital have now been taken over by the Firestone Company. MSF-H provides drugs and supplies, coordination, and rehabilitation of the remaining facilities, and are now running the county health office and county pharmacy. Although they are planning to pull out, they may set up a county health office and pharmacy in Grand Bassa prior to their departure.

3.3.3 Indigenous Nongovernmental Organizations

Christian Health Association of Liberia (CHAL). This is primarily a coordinating body for Christian churches throughout Liberia since 1975. All program ideas are generated by member organizations, and CHAL helps in coordination and procurement of funding. In general, they try to complement MOH activities. CHAL emphasizes primary preventive health care, AIDS and "family life" education. They also do some procurement of bulk drugs and medical supplies.

Liberia United to Save Humanity (LUSH). The Taylor country analogue of SELF. Presumably, it is less well organized and funded.

Medical Emergency and Relief Cooperative International (MERCIC). Founded October 1990, this group is composed of Liberian medical professionals: currently, there are 17

doctors and approximately 150 nurses affiliated in some way. The IGNU has given a mandate to MERCI to coordinate all NGO's involved in health care, but this is not yet a reality. MERCI personnel are working in 12 clinics in the Monrovia area: these are divided between MOH and NGO clinics. Two members of the NPRA-MOH (Dr. Macarthur Wolo, Chief Medical Officer, and Dr. Joseph Dhan, Assistant CMO) are in MERCI, and the group has an agreement with the Taylor government to begin working in those areas.

National Drug Service (NDS). This service was organized by MSF-B as a central drug and EPI warehouse. Supplies from member groups are brought to NDS for redistribution according to need. Currently, the NDS serves the Monrovia area primarily, with limited activity upcountry. Members include MSF-B, UNICEF, WHO, AICF, UNDP, MERCI, CHAL, the IGNU Ministries of Health and Planning, The National Bank of Liberia, and The Meridian Bank. USAID serves in an advisory capacity only.

Ronald Van Dijk, UNICEF Project Officer in Liberia, indicated that the NDS is revising its administrative structure, at the insistence of its members and under the push of UNICEF, to appoint Liberian Deputy Directors. This will simultaneously help "Liberianize" the organization and make the Liberians more accountable to the donor groups. The new structure under discussion will have a Director (Mrs. Duncan) at the top, with three Deputies. After the new structure is established, NDS intends to set up regional distribution points tied to clinics in each region.

Special Emergency Life Food (SELF). Primarily involved in food distribution, this group also distributes condoms with WHO at "Community Health Centers." Their excellent computerized tracking abilities and large warehouse at the free port could be used for medical commodities. They are interested in becoming active in environmental health (water supply, waste and sewage disposal). See section 2.2.3 for further information.

3.3.4 Ministry of Health

Interim Government of National Unity (IGNU-MOH). Since the MOH was not reconstituted until July - September, 1991, it has played a relatively small role in the evolution of postwar health systems in the IGNU area. The Chief of Health Services, Dr. Moses Galakpai, feels that the MOH is still largely ignored by NGO's in the decision making process. He also points out that many of these relief groups have come and gone without leaving any sustainable programs behind. He said that "assistance should be oriented toward reconstructing those systems that were there before the war." The IGNU-MOH has been involved in rehabilitating and staffing the Liberian Japanese Friendship Maternity Hospital and the Redemption Hospital. It also runs eight clinics in Monrovia.

Salaries for health workers employed by the MOH are low, as well as being somewhat irregular, and many professionals only work short hours at the MOH facility before leaving to work most of the day at a private office or clinic.

National Patriotic Reconstruction Assembly (NPRA-MOH). The NPRA has given very little political or financial support to its MOH, relying mostly on the good intentions of NGO's and the UN. The MOH obtains much of its operating budget from the clinics it operates. 40% of this income goes to the MOH.

Although the MOH continues to "run" several hospitals and a number of clinics in Taylor country, many of these units are understaffed and many of them receive logistical support and supplies from various NGO's. Many health professionals "donate" their services or receive minimal salaries.

3.3.5 Entrepreneurial

There are approximately seven privately run clinics in Monrovia, with a number of well-stocked pharmacies. At least three of these clinics offer some surgical capacity, with limited inpatient facilities. These operations are strictly for profit, appear quite expensive by local standards, and are patronized largely by expatriates and wealthy Liberians. There are also a few private clinics in the NPRA area, notably in Buchanan.

3.3.6 Sierra Leone

There is a full complement of UN groups and NGO's delivering health care in Sierra Leone. These include some indigenous groups, notably the Methodist Church of Sierra Leone. The bulk of health care among refugees is done by UNHCR and UNICEF. Principal groups working with displaced persons include ICRC (along the Liberian border), CRS (countrywide), and AICF.

3.4 HEALTH ASSESSMENT BY REGION

3.4.1 Monrovia

Hospitals. The following table is summarized from the MSF-B "Application for cofinancing for the rehabilitation of the Japanese Friendship Maternity Center in Monrovia, Liberia" (Appendix IV. C.), updated to include more current information.

MSF-B estimates a current capacity of 2205 persons per bed (272 beds for 600,000 persons), while official estimates would put it closer to 3677 per bed. Surgical services are available at only two hospitals, with elective surgery available only at the ADRA/Swed-Relief Hospital.

Clinics. Twelve clinics are run by MERCI, eight by the IGNU-MOH, and seven or eight private clinics are running. Three of the private clinics have some limited surgical capacity.

Primary Health Care. An EPI program is run by GOAL and UNICEF. MSF-B and the IGNU-MOH support tuberculosis control and MCH programs. The NDS coordinates all donated drugs and supplies for Monrovia.

3.4.2 Northern Counties: Lofa, Bong, and Nimba

MSF-B has an extensive operation in this area, including a large warehouse in Ganta. Supplies are brought by truck through Côte d'Ivoire from Abidjan.

Lofa. Lofa has a significant population of displaced Liberians and Sierra Leonean refugees (approx. 80,000). MSF-B is present in the four northern districts of Voinjama, (one hospital, nine health clinics), Kolahun, Foya, and Vahun (one hospital, three clinics). CHAL operates in the three central districts of Zorzor (including Zorzor hospital), Salayea, and Belleh. There is a small MCH program at Zorzor. MSF-B and CHAL plan to continue in these areas.

Table 3.2. Overview of Hospitals in Monrovia, Liberia

| Hospital | Agency | Prewar Beds | Postwar Beds | Current Status |
|-------------------|------------------------|-------------|--------------|---------------------------------------------------------------------------------|
| JFK Memorial | Government | 300 | 0 | Outpatient dental services only. Considerable structural damage. |
| LJFMH | Government | 150 | 0 | Currently, maternity outpatient clinic only. Good potential for rehabilitation. |
| SDA-Cooper Clinic | Seventh-Day Adventists | 50 | 0 | Outpatients only, but planning to open soon. ADRA will shift to this facility. |
| Redemption | Government (MSF-B) | 35 | 35 | Open: limited services. |
| ELWA | ELWA Church | 35 | 0 | Outpatients only. |
| St. Joseph | Catholic | 150 | 121 | Open: medical and emergency surgical services available. |
| Island | Private | 50 | 0 | Outpatients only. |
| SwedRelief | ADRA, UNICEF | 0 | 69 | Full service hospital in a temporary facility. UNICEF contract expires 4/92. |
| Brumskine School | MSF-F | 0 | 47 | Pediatric hospital in temporary quarters (school). Due to close 3/92. |
| Total beds | | 770 | 272 | |

Ref: Appendix IV. C. MSF-B Application for cofinancing for the rehabilitation of the Japanese Friendship Maternity Center in Monrovia, Liberia.

Bong. The most stable county outside Monrovia. UN has an office in Gbargna. CHAL has their main office at Phebe Hospital in Suakoko. Phebe was considered the second best hospital in Liberia before the war. It has four or five Liberian physicians and is supported by CHAL and LWS. There is a small MCH program at Phebe. AICF runs some clinics in the south.

Nimba. Two hospitals (including the Methodist hospital at Ganta) and 30 health clinics are supported by MSF-B and a County Health Team. EPI program since June, 1990. MSF-B plans to continue supporting this county. The Liberian-American Mining Corporation (LAMCO) runs a hospital for its employees in northern Nimba. They are now requesting drugs and supplies.

3.4.3 Central Counties: Margibi and Monserrado

Margibi. Entry point to Monrovia at Kakata, with a high concentration of displaced persons. MSF-H and a County Health Team support two hospitals and 11 clinics. MSF-H is considering leaving in the late summer of 1992.

Monserrado. There is no major population concentration outside Monrovia. Medical activities (including eight clinics) are covered by AICF and the County Health Team from Margibi county.

3.4.4 Western Counties: Grand Cape Mount and Bomi

All activities in these counties has been disrupted by ongoing fighting between ULIMO and NPLF.

Grand Cape Mount. Previously, GOAL supported one hospital, 14 clinics, and one leprosarium. No NGO activity since August, 1991.

Bomi. Previously, MSF-F covered medical activities in Bomi. Bomi and Guthrie hospitals are reported to be operating, but without NGO support. Up to one-half of inpatients in these facilities are casualties. MSF-F is planning to leave Liberia shortly.

3.4.5 Eastern Counties: Grand Bassa, River Cess and Sinoe Counties

For a more complete discussion, please refer to the UNICEF/GOAL Nutritional and Health Assessment of Grand Bassa and River Cess Counties (Appendix IV. E.).

Grand Bassa. Buchanan is the second largest city in Liberia, with a good port facility. The government hospital in Buchanan is currently run by two medical students with little NGO support. This 36-bed facility has running water and electricity, and is generally structurally sound.

The County Medical Officer, Dr. Jarasuraya, runs his own private "Holy Family Clinic" in Buchanan. This facility serves up to 100 outpatients per day and does between one and four operations per day. There is an MSF-H feeding center at this clinic. It is a very popular clinic, and charges the standard government rate of \$5 Liberian per adult outpatient visit.

Two large companies working in the area run their own private hospitals, which occasionally take public patients. The LAMCO hospital has 50 beds, with water and electricity. Charges for non-LAMCO patients are \$15 Liberian for adults and \$7 for children. LAC runs a 40 bed hospital 30 miles north of Buchanan, with two doctors providing busy outpatient services as well as inpatient medical and surgical care.

Sister Carmen Nava of the Consolata Sisters supervises ten MOH clinics in Grand Bassa, along with the River Cess clinic. She has only one vehicle, however, and is somewhat overextended. She receives occasional support from GOAL and CRS. Another clinic is run by Gladys Ayree of Christian Extension Ministries. GOAL and UNICEF are currently planning an EPI program for this county, but it is not yet in place. MSF-H has some tentative plans to pick up after GOAL leaves.

River Cess. A small, sparsely populated area, which is linked to Grand Bassa for health management. It has one large health center, not currently supported by an NGO. There is no doctor available, and lack of drugs is a problem. MSF-H may begin some activity here.

Sinoe. Following an emergency drug distribution by MSF-B in July, 1991, one hospital and six health clinics were reopened. There is no NGO supervision. One doctor is still present.

3.4.6 Southeast Counties: Grand Gedeh, Grand Kru, and Maryland

Grand Gedeh. A large, sparsely populated county with sporadic ambushes in the east. Some people are still hiding in the bush. There was a single drug supply drop by MSF-B in July, 1991. AICF now supports one clinic and five aid posts (mostly supplementary feeding, just beginning health activities).

Grand Kru. A small, inaccessible county with no doctor. Five clinics reopened after a single drug supply drop by MSF-B in July, 1991. Completely dependent upon Maryland county for health management.

Maryland. With a high concentration of displaced persons, Maryland is the entry point from Côte d'Ivoire. MSF-B operates one hospital and six clinics with a well organized local health team. MSF-B plans to expand activities in Maryland and Grand Kru.

3.5 PERCEPTIONS OF IMC ROLE IN HEALTH CARE

Since there is very little support forthcoming from either of the interim governments, there is a very real perception on the part of both Ministries of Health that NGO's should continue to support the health sector at current or increased levels. Furthermore, there is a strong sense that the U.S. still has an obligation to Liberia: this is particularly noticeable in the NPRAG. Dr. Gbokolo, the NPRAG Minister of Health said "I'm expecting a lot from your organization." Clearly, these expectations will influence the reception of any IMC proposals.

As previously mentioned, there is general concern that the interim governments are not willing or able to continue payment of health workers upon the removal of NGO support. This affects the sustainability of any project begun by the IMC as well as its long-term impact unless, of course, the situation changes with an election to elect a government of all of Liberia.

Most of the NGO's contacted were very supportive of IMC involvement. Several groups suggested cooperative or coordinated efforts. It was repeatedly mentioned that several NGO's were considering leaving Liberia within the next four to six months, leaving several gaps in the health care system.

Specific suggestions for IMC involvement were solicited from various groups. These are listed below:

3.5.1 Ministry of Health

IGNU-MOH

- 1) Curative services delivered at the Liberian Japanese Hospital, with some support of the Redemption Hospital.
- 2) Specific request for surgical and dental services.

NPRA-MOH

- 1) Immediate provision of drugs and supplies.
- 2) Logistical support: vehicles, office supplies, MOH salaries.
- 3) Salaries for doctors and other health professionals.
- 4) Preventive services: EPI, education, environmental health.
- 5) Rehabilitation of damaged structures.

Dr. Gbokolo also listed the following regional priorities:

- 1) Grand Bassa county.
- 2) River Cess county.
- 3) Maryland and Grand Kru counties.

3.5.2 Nongovernmental Organizations

CHAL

- 1) Short term medical personnel of various types.
- 2) Laboratory equipment, training, and short term staffing.
- 3) Identified a special need in the southeast counties.

MERCI

- 1) Direct emergency care, possibly through SwedRelief hospital.
- 2) Training of mid-level health and managerial workers.
- 3) Physician retraining.
- 4) Urban and rural primary health care, through "Community Centers."

MSF-B

- 1) Equip and staff one 50 bed surgical unit in the Liberian Japanese Hospital. (MSF-F to run 50 pediatric beds, MSF-B to run 50 medical beds.)
- 2) Take over Grand Bassa and River Cess counties, either replacing or complementing the work of GOAL and MSF-H. There is particular need for support of the government hospital in Buchanan.
- 3) Assist with the support of Phebe Hospital in Bong county.
- 4) Take over Grand Cape Mount and Bomi counties after departure of GOAL. Presumably, this is contingent upon some decrease in military activity.

MSF-H

- 1) Training mid-level health workers in Bassa county.

WHO

- 1) Immediate supplies of drugs and equipment.
- 2) Recruiting of specialized health professionals: psychiatrist, internist, mental health nurses.

4 CONCLUSIONS AND RECOMMENDATIONS

4.1 SIERRA LEONE

4.1.1 Nutrition

There is no current need for additional food in generalized food distribution, vulnerable group feeding or intensive therapeutic feeding programs in Sierra Leone. If the situation worsens in some way, however, there could be a need for additional food assistance, and for more agencies to distribute food. Food needs may also be expected to increase when the estimated 150,000 Sierra Leonean refugees return from Guinea and Liberia.

How the government of Sierra Leone and donor agencies currently present in Sierra Leone deal with the above will indicate how appropriate it will be for IMC to consider adding a food aid dimension to a possible program in Sierra Leone.

At this time, we recommend that IMC first determine if it believes there is an appropriate role to play in a medical sense. If so, and if a program is developed and approved, IMC should then be prepared from a conceptual and contingency standpoint to consider the design and implementation of a food aid component as part of an integrated health program.

4.1.2 Health

At present, there is a full complement of multinationals and NGO's delivering health care in Sierra Leone. The health needs of the 75,000 Liberian refugees currently living in Sierra Leone, including 5,000 registered refugees, are well covered by present NGO's and the UN groups. For approximately 290,000 internally displaced Leoneans, ICRC, CRS, and AICF bear primary responsibility for health care.

The principal medical problems in this group are generally similar to those of other west African nations. Although "common wisdom" indicates that their situation will improve, there may well be a worsening of the health situation as NGO's begin to withdraw and refugees from Guinea return to Sierra Leone.

Given the current adequate coverage of refugees and displaced persons. We therefore recommend that any IMC medical activity in Sierra Leone be contingent upon future deterioration of the situation. We further recommend that planned activities in Sierra Leone be preceded by a detailed reassessment. Such activities must also take into account the virtual lack of health care prior to the current conflict. It may be assumed that when the country stabilizes the need for preventive medical programs, including EPI activities, should be a priority.

In light of the above, it is possible to suggest possible types of programs that could be conducted in Sierra Leone. These might include:

- 1) medical screening of returning refugees, with some curative care for the worst cases;
 - 2) short-term medical training for Government of Sierra Leone health workers whose clinics have been destroyed, possibly in conjunction with clinic rehabilitation;
 - 3) rehabilitation of health centers or hospitals in affected areas;
 - 4) a one-shot commodity drop; or,
 - 5) preventive health care program as part of rebuilding the health care system.
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4.2 LIBERIA

4.2.1 Nutrition

At present the Liberian food delivery system seems to be functioning relatively well. There are occasional shortfalls, but one of the major reasons for the rapid improvement in the condition of people in Liberia has been the efficient and timely movement of food to people at risk. No agency contacted suggested there was a need for another food distributing NGO in the field at this time. Between WFP and CRS, it also appears that there are an adequate number of cooperating sponsors.

A food component to an IMC program might be suitable in the context of an add-on to a larger program. For example, were IMC asked to undertake a medical program in a remote area of Liberia and nutritional analyses showed a significant nutritional problem, it would be appropriate to apply to either of the cooperating sponsors of A.I.D. for a sub-grant of food assistance.

At this time there no demonstrable need for IMC to prepare and submit a stand alone, cooperating sponsor PL 480 Title II food program request.

4.2.2 Health

The conflict has disrupted virtually all of the Liberian health care system. Most health facilities in Monrovia, Nimba and Grand Gedeh are extensively damaged, with mild to moderate damage in other areas. Medical equipment and supplies have been destroyed or looted countrywide. There appears to be an adequate supply of Liberian health professionals to meet current needs, but few are working.

Health care is almost entirely a donor-financed activity now, and will probably remain so in the future. Neither the IGNU nor the NPRA has the resources to support any significant portion of the health care system. There is also some question of whether these acting governments are willing to allot resources to the health sector. Thus, public sector health care has been largely taken over by NGO's and multinational groups, and has focused primarily on curative care, with the majority of attention given to Monrovia. Rehabilitation of hospitals and clinics has predominated, including coordination and supervision, provision of drugs and supplies, and staffing with Liberian or expatriate health professionals.

Principal medical problems remain similar to those before the war: malaria, upper respiratory infections, diarrheal diseases (including cholera), tuberculosis, scabies and other parasites, and sexually transmitted diseases.

There are several opportunities for IMC to play a meaningful role in Liberian health care. These include:

- 1) Establishment of a surgical unit in the Liberian Japanese Friendship Maternity Hospital in conjunction with MSF-B and MSF-F (possibly with some support of the Redemption Hospital). This would require providing equipment and staffing, as MSF-B is proposing to rehabilitate the physical structure. Most of the staffing could be done with Liberians (through MERCI), with as few as two or three full time expatriate staff, complemented by rotating physicians and nurses as needed.

Another possibility is the creation of a small dental unit in the LJFMH or in nearby JFK Hospital. There is an acute need for these services.

- 2) As an alternative to 1), the SwedRelief hospital could be run by IMC after ADRA leaves, filling an important gap during the four to six month period it will take for other hospitals to become functional, full service units. This should be considered a "second-best" option, as the temporary nature of the facility (an old warehouse with a leaky roof) means that IMC will be making no long-term contribution.
- 3) Assist in Grand Bassa and River Cess counties, either replacing or complementing the work of GOAL and MSF-H. This could involve supporting the government hospital in Buchanan, running the network of clinics in these areas, training of mid-level health workers, clinic rehabilitation, a commodity drop, or some combination of these.
- 4) IMC's experience with war injuries makes it an excellent candidate to coordinate emergency medical assistance in Grand Cape Mount and Bomi counties after the departure of GOAL. This would be contingent upon some stabilization of the military situation.
- 5) There is a great need for immediate supplies of drugs and equipment, including laboratory equipment, to the National Drug Service for distribution to various NGO's. This could be a simple "commodity drop" or something more comprehensive.
- 6) CHAL and WHO suggested providing equipment, training and short term staffing for laboratories at several health facilities.
- 7) Short-term provision of mental health services, as suggested by WHO and CHAL. This could involve a single psychiatrist and one or two mental health nurses, and could be set up as a brief training course.

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APPENDIX I. LIST OF MEETINGS AND CONTACTS

Sierra Leone

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APPENDIX III. NUTRITION REPORTS

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- A. MSF/B. Report on nutrition activities carried out during emergency operations in Liberia, September 1990 - October 1991.
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ANGOLA ASSESSMENT
PLANNING ASSISTANCE GRANT
INTERNATIONAL MEDICAL CORPS/ANGOLA
PREPARED BY: RICHARD CARBONE
OCTOBER/NOVEMBER 1993

Executive Summary

This assessment outlines the feasibility of designing programs in Angola that integrate commodities available under Title II of Public Law (PL) 480 with the health care programs of International Medical Corps (IMC) and makes appropriate recommendations.

Before presenting the results of this assessment, it is important to convey the following baseline information:

- IMC/Angola currently conducts immunization programs in Sumbe and Menongue. It is understood the focal points of this assessment to be these areas of Angola where IMC is currently delivering health care, and not the country as a whole.
- IMC's Emergency Assessment Team (EAT) completed a clinico-epidemiological survey of 30 randomly-selected communities in Sumbe.
- The IMC/EAT survey results identify the need for a nutrition intervention targeted at an estimated 38,523 children <5 years of age and their families.
- There is no other private voluntary organization (PVO) on the ground in Sumbe which can design and administer a commodity assistance program addressing the identified nutritional needs of the community.
- This report focuses solely on the needs of Sumbe and Menongue and is not intended to incorporate any other mission of IMC or change its core purpose and functions.
- This report does not recommend an IMC nutrition intervention in Menongue as Care, Caritas, CICS and MSF/France, are providing commodity assistance through a cooperative relationship with WFP similar to that recommended for IMC in Sumbe.
- Host country government contacts were limited to avoid future misunderstandings if IMC decided not to program commodity assistance. Contacts centered on other PVOs, United Nations international agencies, US government representatives, and IMC personnel.

As indicated by IMC/EAT's survey and the observation and assessment of this writer, there is unaddressed nutritional need in the <5 years of age population in Sumbe.

Currently, the World Food Programme (WFP) transports food to Sumbe by road versus the air cargo links necessary throughout much of Angola. This means a dependable commodity supply can be expected. This transport is subsidized by outside donors, who have similarly assumed the transportation costs within Sumbe to the beneficiary. It is recommended that IMC seize this unique opportunity to address Sumbe's nutritional need by cooperating locally with WFP in implementing a commodity assistance program.

This recommendation is feasible because:

- IMC will be reimbursed for transportation costs and must concern itself logistically only within Sumbe to the beneficiary.
- An in-country agreement with WFP allows for IMC application of the commodity resource in Sumbe without liability concerns and detailed administrative requirements normally incumbent upon a PVO implementing a classic PL 480 Title II commodity program.
- WFP continues to earmark a significant tonnage of its limited commodity assistance budget to Sumbe but does not have the technical backstopping in Sumbe needed for this intervention.
- The IMC - trained community health promoters and center staff are the program's developmental entree into the community increasing participation in activities of human and economic development.
- This is a specific need with specific circumstances and thus IMC's involvement is controlled and contained; complimenting its core mission and not usurping it or changing it.

IMC will have full responsibility for this proposed nutrition intervention. It is recommended that IMC enter into this WFP agreement for one year. This will facilitate review of program activities formally at that time. With IMC/EAT survey results serving as a baseline, IMC is in a position to assess its nutrition intervention impact at that time. The nutrition intervention provides IMC a practical vehicle to assess the feasibility of integrating commodity programming with health care programs. Simultaneously, this intervention is structured to provide community health promoter training, health care delivery and community development; all of which complement on-going IMC immunization efforts. But most importantly, IMC is designing and administering a program to address the nutritional needs of the community's children <5 years of age affected by varying stages of malnutrition.

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Introduction

A window pane is not replaced when broken. Paint is not applied to a building's exterior. A raw sewage pipe not replaced flows freely in the street. Seed is not available to the farmer and the livestock extension agent does not have vaccine. A public health vaccinator's ministry salary is not paid for nine months. Of 299 mothers interviewed in Sumbe, 61% of them have had at least one child die. Young men are pressed into open-ended military service. Infrastructure is allowed to deteriorate without investment by the government.

Couple the obvious destruction with the insidious effects of a protracted, war-related economy, and the result is the present prescription for a human tragedy.

In the 1993 United Nations (UN) Consolidated Appeal for Angola, WFP forecasted total emergency commodity requirements of a staggering 350,141 metric tons for the period 1 May 1993 to 30 April 1994 for the target beneficiary population, which at the time of their forecast was estimated to be two million beneficiaries. Revised estimates by the UN in their report S/26644, dated 27 October 1993, now place the number of those affected at three million people, or one out of every four Angolans.

This ever-increasing need affects WFP's delivery capacity. Mined roads and destroyed bridges combine to render normal commerce and relief road transport impossible to many parts of the country. Consequently, costly air links must be forged for commodity movement. Appendix # 1 marks these air and road corridors. This logistical constraint translates into unavoidable shortfalls in tonnage delivered and a steady drain on donor cash resources. Air cargo costs are currently estimated at US\$300 per metric ton.

WFP's logistical constraints are symptomatic of Angola's present situation. Currency speculators manipulate the exchange rates daily. Consumer prices in the market must react accordingly. With the conspicuous exception of oil-production, all other socio-economic sectors have been wrecked by the war, which has extensively damaged or destroyed the physical infrastructure and severely disrupted health, social and communication services.

A review of Appendix # 2, which outlines the total funding requirements for the 1993 UN Appeal for Angola, will highlight the emphasis that the organization places on commodity assistance in the overall emergency relief effort. Similarly, the Centers for Disease Control (CDC) suggests that planning for emergencies be included as an integral part of routine health development programs in countries like Angola where sudden population displacements occur as a direct result of war's action.

CDC recommends that these programs include:

- health information systems.
- diarrheal disease control programs.
- expanded programs on immunizations (EPI).
- control programs for endemic communicable diseases.
- nutrition programs.
- continuing education programs for health workers.

IMC/Angola's current activities already include two public health elements of an appropriate emergency response program.

IMC/Sumbe and the recently re-established IMC/Menongue are both conducting EPI. It is hoped that the populations will remain stable for at least the next three months, especially in Menongue which has been isolated by the fighting for the past nine months. The operational capacity to administer vaccine is adequate. Both programs are administering a complete schedule of vaccines. Adequate immunization records are being kept and personal immunization cards are issued. Finally, the national EPI is thoroughly integrated into the IMC activities. Appendix # 3 includes graphic illustrations of IMC/Sumbe's EPI reporting on their recent campaigns.

The second IMC emergency response program element in Angola currently is the EAT and its survey activities in Sumbe. Given the importance of their survey's nutritional findings and analysis, their clinico-epidemiological study has been included in this assessment in its entirety for ease of reference as Appendix # 4.

The EAT survey results identify a need for a nutrition intervention targeted at an estimated 38,523 children <5 years of age in Sumbe. This report recommends a health and nutrition program to address that need. The proposed IMC Health and Nutrition Program as outlined is only suggested, however, for the Sumbe area. The need for similar nutrition programs in Menongue has been identified but other agencies are or will soon be addressing the need for immediate food distribution and targeted feeding programs for severely malnourished children. These are clearly the interventions of first priority. This report highlights the need in Sumbe because, unlike Menongue, there is no other PVO on the ground capable of designing and administering such programs.

Logistical Assessment - Overview

The need for PVO commodity management and PVO commodity programming in Angola is poignantly clear. But the decision for an organization like IMC to become involved is complex. Commodity management is the logistics of food delivery, while commodity programming takes the resource, food, and constructs goal-oriented activities designed to address needs and achieve results.

People are hungry, and the food needs to get to the people. WFP is overextended, and the organization is the first to admit it. Where people frequently prefer to work for food rather than local Kwanzas or even US Dollars because the local market has little to offer for purchase, the utility of commodity management is real. People are hungry, and this basic human need must be met before other interventions can be expected to have impact.

WFP is aggressively trying to solicit PVO interest at the regional level to enter into cooperating sponsor relationships hoping to insure more effective commodity management. This is needed. But it still begs the question of the quality of the effort. The introduction of commodity programming designed to do more than food delivery is the next step. PVO involvement in commodity programming is needed because the resource, which is food, is not used to its full potential at the final distribution point. General distribution in Angola is the PVO/WFP standard commodity tool, not the exception.

WFP fixes its focus on the logistical aspects of commodity management from ship through port, to warehouse, on a cargo plane, and finally to key provincial locations throughout the country. WFP is hard-pressed to address at this level the issue of commodity programming. Commodity resources are turned over to the host country government for general distribution and an opportunity is missed.

Logistical Assessment - Sumbe

WFP logistical capabilities, as previously discussed, provide an opportunity for an interested PVO to take advantage of donor logistical investments and introduce commodity programming to the emergency relief effort in Angola, without the operational responsibilities of a classic PL 480 Title II commodity assistance program. A PVO working with WFP has access to the commodity resource without the extensive and detailed logistical responsibilities for shipment by sea, port clearance, and inland transportation.

A graphic presentation of the documentation required, at the headquarters and field office levels, to implement a formal PL 480 Title II commodity assistance program is included as Appendix # 5 for review. It demonstrates what is NOT required of a PVO cooperating with WFP in Angola.

As mentioned previously, commodity management is the logistics of food delivery. These logistical requirements are no more technical than the delivery of vaccines, drugs, or other medical supplies which IMC in Angola practices daily. With WFP's logistical coverage, commodities are available to the cooperating sponsor at the regional level and the PVO is not responsible for the commodities until that regional point.

The other important commodity management issue noted in the assessment is the nature of the relationship between WFP and the cooperating sponsor accepting responsibility at the regional level. The WFP/cooperating sponsor contract is included as Appendix # 6 for review. WFP's boilerplate contract does not contain a liability clause. The PVO working with WFP is not bound by the normal PL 480 Title II regulations and requirements. Title II's detailed Handbook 9 is not applicable to the relationship between WFP and its cooperating sponsor.

WFP will continue to be responsible for the shipment, receipt, port clearances, ship surveys, internal transport, storage, air freight, and handling of the commodities. The PVO on the ground will be responsible for tertiary transportation, distribution, and monitoring at the provincial level. Please refer to Appendix # 7 for small scale maps of the Sumbe project area.

It is also important to note that the PVO's tertiary transport costs are reimbursed by WFP. Outside donors, most significantly the US Office of Foreign Disaster Assistance (OFDA), subsidize WFP's logistical network in Angola from ship to end-use point. WFP passes that coverage on to the cooperating sponsor. The PVO is asked to make its own transport and handling arrangements and periodically to submit invoices to WFP for reimbursement.

Furthermore, Sumbe is one of only four WFP regional distribution points supplied by truck convoy. The other three include Luanda, Lobito/Benguela, and Namibe/Lubango. All other regional distribution points must be supplied by WFP by air. Sumbe, on the other hand, enjoys road access with Luanda, one of the few usable roads left in the country.

Fortunately, Sumbe is a relatively stable area from a security standpoint with little of the military activities negatively impacting Menongue programming.

Most importantly, there is no other PVO on the ground in Sumbe which can design and administer a commodity assistance program addressing the identified nutritional needs of the community. Similarly, there is no local non-governmental organization with the capability to do the type of commodity management and programming that the IMC/EAT survey results indicate is necessary.

Nutritional Assessment - Overview

Since its foundation in 1984, IMC has concentrated its efforts on providing emergency and developmental health assistance in under-served regions of the developing world. IMC has worked in areas where few other agencies are able or willing to provide assistance, and where the needs are comprehensive and acute.

IMC's experience includes dealing with public health emergencies in Somalia, Angola, Cambodia, Afghanistan, and Bosnia. All of these situations have resulted in programming reaction to some degree of forced population migration, war, and civil strife. Inevitably, these public health emergencies have been associated with severe food shortages.

While undernourished persons - particularly children - are at higher risk of mortality, the immediate cause of death is usually a communicable disease. Malnutrition causes an increased case-fatality ratio in most common childhood communicable diseases. Those at highest risk of mortality during non-emergency times - namely, the poor, the elderly, women, and young children - are the same groups most at risk for the mortality and morbidity caused by emergency and war. In addition, the movement of populations into crowded and unsanitary urban areas, the violence associated with forced migrations, and the negative psychological effects of fear, uncertainty, and dependency contribute to the health problems experienced by those displaced.

An important goal of IMC is to provide health care in its broadest definition, encompassing preventative as well as curative service delivery. The health needs of the population, especially those of women and children, are profoundly affected by nutritional status. Addressing critical health needs while ignoring nutritional issues reduces the effectiveness of emergency and development programs.

IMC can bring a decidedly different focus to commodity assistance programming. As an emergency medical training organization, IMC is uniquely qualified to deliver commodity assistance in a goal-oriented manner intended to assist in the alleviation of immediate suffering while simultaneously helping the population-at-risk to become more self-reliant. IMC brings a proven capability to manage medical training and public health care delivery programs in the most difficult settings imaginable.

Nutritional Assessment - Sumbe

IMC's EAT has recently completed a clinico-epidemiological survey of 30 randomly-selected communities in the Sumbe area. Its results have a direct bearing on the question of IMC involvement in commodity programming and a nutritional intervention in Sumbe.

The nutritional status of displace populations is closely linked to their chances of survival. Initial assessment by IMC/EAT of the nutritional status in Sumbe serves to establish the degree of urgency in delivering commodity assistance, the need for intermediate supplementary feeding programs, and the presence of micronutrient deficiencies that require urgent attention.

IMC/EAT survey results indicate that 1% of the 299 families interviewed responded that their sole source of food was WFP commodities. An additional 3% stated that their source of food was WFP commodities supplemented by market purchases. A further 0.7% indicated that WFP commodities were augmented by produce from their fields. Another 0.3% of those interviewed combined WFP commodities with their fish catch and market purchases. Thus, 5% of the families interviewed acknowledged receiving WFP food in Sumbe.

IMC/EAT tasked itself to determine the nutritional status for underfives in the Sumbe area. The total group of children <5 years of age evaluated in the nutrition study was N=443. Of this total, only 35% of the sample population have a normal nutritional status in contrast to the remaining 65% who report various types of malnutrition. The moderate and severe acute stages of malnutrition account for 7.2% of the total population, while the moderate and severe chronic states of malnutrition represent 23.9% of the sample population.

Additionally, these percentages of chronic malnutrition can easily and quickly develop into acute stages of malnutrition given the paucity of adequate health care delivery systems in the area and the lack of established intervention strategies.

Immediate action is the most prudent form of addressing the nutrition concerns of Sumbe. The real number of children who are affected is an estimated 38,523 children <5 years of age in normal or malnourished conditions.

Proposed Intervention - IMC Sumbe Health and Nutrition Program

The proposed intervention as outlined is similar to other PVO efforts in commodity programming, but specific reference is made to a field trip report prepared by IMC Regional Director Stephen Tomlin in May, 1991 which is provided as Appendix # 8. The IMC Sumbe Health and Nutrition Program will aim at controlling up to 90% of the causes of child mortality and morbidity. This will be achieved by:

- making sure that all enrolled children are vaccinated.
- making provisions for oral rehydration therapy and treatment of respiratory infections.
- mass treatment of intestinal parasites.
- elimination of both severe and moderate grades of protein-calorie malnutrition.

The primary objectives of the program are those that are directly related to the transfer of commodities to the beneficiaries. They are:

- to mitigate poverty through the transfer of commodities.
- to increase food consumption, especially to the most vulnerable members of the household; children and mothers.
- to increase participation of the household in community activities of human and economic development.

The secondary objectives of the program are those related to the logical integration of commodity programming with health care delivery within the framework of proposed child survival activities, including:

- training of community health promoters.
- growth monitoring.
- promotion of breast feeding.
- oral rehydration therapy.
- immunizations.
- control of intestinal parasites.
- treatment of respiratory infections.
- referral for medical conditions.
- community development/income generation.
- maternal education programs.

The above objectives are listed as secondary not because they are of lesser importance, but because their achievement is very much dependent upon the primary objectives of the program and the significance of its income transfer.

One of the three primary objectives of the program is to increase participation of the household in community activities of human and economic development. Community based development is unique in that the major factor of production (in economic development) and the major factor of effectiveness (in human development) is community participation. Other factors, such as capital and technology, are secondary to participation.

Paradoxically, although participation is the major factor in community based development, it is very often in short supply. In fact, the poorer the community, the lower the level of participation.

Community based development includes programs that deliver educational and preventive health (such as maternal child health and child survival programs) directed at lowering the excessive rates of death, disease, and malnutrition. These programs make available low cost health technologies that are highly effective in lowering mortality and morbidity, and can be handled by IMC - trained community health promoters with no professional qualifications.

However, what frustrates the effectiveness of these technologies is the low participation of the community, as manifested in the low attendance rates at the program sessions. Surveys show that less than 20% (average 7% - 10%) of the eligible population of parents and children of the developing areas effectively participate in programs of parental education and prevention of childhood diseases.

Participation in community development is increased with promotion. However, the impact of promotion on participation is limited. On the other hand, when promotion is complemented with an incentive, such as the income transfer of a commodity program, the increase in participation is impressive. Whether the community activity is a maternal child health program or a food for work project, participation may increase from a small percentage to almost one hundred percent of the eligible population.

Proposed Intervention - IMC Sumbe Training Program

IMC is primarily a medical training organization. Therefore, IMC in Angola is well-suited to deliver the type of training necessary to meet the goals and objectives of the nutrition intervention. Primary IMC - training focus is placed on the community health promoters and center personnel, who will be responsible for the introduction, application, and educational reinforcement of the growth monitoring technology with the parents participating on the nutrition program.

Commodity distribution within the nutrition program is accompanied by a growth monitoring technology that utilizes a grade system. None of the established systems (the Nabarro Board, the Weight for Age Graphic, the Weight for Height Chart) effectively fit into a maternal child health program; either because the system is suitable for screening but not suitable for follow-up, or is not intelligible to parents, or requires an additional measurement that increases the frequency of error. Thus, children are graded relative to the weight for age on a scale of 1 to 10 that is sensitive to minor changes in nutritional health; that is easily understood and retained by parents with little or no education; and that can be handled by personnel with no professional qualifications. Grades 5 and under are unsatisfactory, while grades 6 to 10 are satisfactory (Grade 10 = 100% Harvard Standard). Movement from lower to higher grades indicate progress, and the rate of progress is considered more important than the level of condition.

Extensive tests with this growth monitoring system in several developing countries have shown that 95% of the participating mothers, regardless of educational status, can tell the current grade of their child and recall the grades attained in the past several months. Moreover, mothers can give a plausible explanation of the progress made by their child between the periodic monitoring sessions. This is regarded as a clear demonstration of the high educational and promotional potential of the system. Because of these features, this growth monitoring grade system is considered a breakthrough in child health technology.

Mothers take an active role in the growth monitoring process, and, depending on the result of the procedure, mothers should be counseled individually as to the measures to be taken to effect the progress of the child. This takes place after a child has been graded and the current status can be compared to past grades. Mothers are each interviewed individually about the medical history of the child over the previous session, and each receive " counseling " which includes:

- the promotion of breast feeding.
- the promotion of oral rehydration therapy.
- the provision of immunization, directly or through referral.

- medical referral for diagnosis and treatment, where required.
- closer supervision of the most malnourished.
- referral of pregnant women for prenatal care.

Within a few months of a center's operation, all mothers should be able to give the correct answer to the following questions:

- What is the current grade of your child?
- What was the grade of your child at the last monitoring session?
- What is the explanation for the change that has/has not taken place in your child's nutritional health?

Just as children must have an immunization record card to qualify for the program benefits, expectant mothers must satisfy program personnel that they are receiving the required prenatal care from a qualified public health unit, if one exists within a reasonable proximity.

The availability of the commodity transfer guarantees at least 95% participation in the maternal child health program from the community. This figure contrasts dramatically with the 10% - 15% participation rate in institutional maternal child health programs where no commodity transfer is available and where, thus the opportunity cost of attendance is so high.

As well as the fundamental training in the use, application, and import of the growth monitoring techniques, further training by IMC of the community health promoters and other center personnel is required to successfully meet the secondary objectives that relate to:

- promotion of breast feeding.
- oral rehydration therapy.
- control of intestinal parasites.
- treatment of respiratory infections.
- participation of beneficiaries in community activities.
- referral for medical conditions.

With regard to the last above-mentioned objective, IMC - trained community health promoters and center personnel are ideally situated to inspect the child who has been undressed for weighing. With IMC training, they will be able to observe some of the most common abnormalities, such as:

- high temperature.

- abnormally distended abdomen.
- skin infections.
- inflammation of the eyes.
- discharge from the ears
- severe anemia (through inspection of the conjunctivae).
- signs of kwashiorkor and marasmus.
- signs of vitamin A deficiency (Bitot Spots).

Due to the low opportunity costs to mothers attending the IMC nutrition program centers and the consequent high participation rates as described above, there is a captive audience for maternal education programs. Furthermore, since the IMC program centers are run by the community, for the community, there is an excellent opportunity for a training organization, like IMC, to identify health leaders in the population to train as promoters for further maternal child health or child survival interventions. As a result, to IMC, the potential for sustainable training interventions over a prolonged period makes the proposed health and nutrition program an effective complement to its on-going immunization efforts in Sumbe.

It is noted that the program centers have no special requirements with respect to premises. Community halls, school buildings, health centers, dispensaries, parish halls, and private homes may all be utilized. Operating 20 days a month, 1200 enrolled children is the maximum number that any one center can effectively handle if the educational and promotional value of the program is to be maintained at optimum levels. The essential equipment, supplies, and furniture for conducting center operations consist of:

- tables and chairs for center personnel.
- personal weighing scale (Detecto scale, model 450).
- growth charts/records.
- ledgers and registers.
- teaching aids.
- posters.
- utensils for demonstrations on food preparation.

List of Organizations Contacted in Angola:

Private Voluntary Organizations:

1. ADRA
2. BSCF
3. CARE
4. Caritas International
5. CICS
6. Concern
7. Goal
8. IMC
9. MAF
10. MSF-Belgium
11. MSF-France
12. MSF-Holland
13. MSF-Spain
14. World Vision International

United Nations:

1. UCAH
2. UNICEF
3. FAO
4. WFP

Governmental Organizations/Donor Agencies:

1. FFP
2. OFDA

Areas Visited:

Luanda, Lubango, Menongue, Muxima, Porto Amboim, Sumbe

List of Appendices:

1. Air and Road Corridors in Use
2. Total Funding Requirements for the 1993 UN Consolidated Appeal for Angola
3. IMC/Sumbe EPI graphics
4. IMC Emergency Assessment Team Clinico-Epidemiological Study
5. Basic Steps in the Implementation of a PL 480 Title II Program
6. WFP/Cooperating Sponsor Sample Contract
7. Scale Maps of Sumbe Project Area
8. IMC Field Trip Report of May 1991 Regarding Health and Nutrition Program

FOOD AID MANAGEMENT'S FOOD AID BRIEFING
 Project Concern International Headquarters
 3550 Afton Road
 San Diego, California
 February 1 and 2, 1993

AGENDA

REGISTRATION

8:30 a.m. to 9:00 a.m.

WELCOME AND INTRODUCTIONS

9:00 a.m. to 9:30 a.m.

Thomas Zopf

INTRODUCTION TO FOOD AID

9:30 am to 10:30 a.m.

Legislative history, historical perspective, emerging purposes and experience, purposes reflected in programs (direct food distribution, monetization, development), the role of PVO managers in today's world, relevant rules and regulations, meeting needs, starting programs, administering programs, and assessing programs.

Dan Shaughnessy

Break 10:30 a.m. to 10:45 a.m.

FOOD AID FROM A FIELD PERSPECTIVE

10:45 a.m. to 12:00 p.m.

The stages of a food aid project beginning with design, the pipeline (selection of commodities, calls forward, U.S. port, ship), the port operations (foreign port, unloading, transit warehouse), logistics (transport, warehouse, transport, distribution point) and distribution (counterpart, beneficiary) and evaluation. At each stage the questions are asked: Why do we do it? How do we do it? Who does it? With what skills? Under what constraints? At what cost?

Larry Holzman

LUNCH

FOOD AID CYCLE COMPONENTS

1:00 p.m. to 4 p.m.

Design

Calls Forward, Procurement, Shipping

Port Activities

Joyce King

Rita Hudson

Larry Holzman

Break 3:15

Inland Transport, Storage, and Handling
 Issuance for Distribution and Consumption
 Evaluation and Design

Don Crosson

Joyce King

Joyce King

DONOR PERSPECTIVE

Rita Hudson

4 p.m. to 5 p.m.

FHA organization, MYOPs, institutional strengthening grants, Farm Bill grants, donor requirements, relationships with A.I.D., headquarters, and field missions.

RECEPTION-PROJECT CONCERN HEADQUARTERS

5 p.m.

DAY TWO

PROJECT GOALS AND ACTIVITIES

Joyce King

9 a.m. to 10:15 a.m.

Discussion of how the food aid cycle components are addressed in the design; the relationship and distinction between the distribution, activities, and goals.

Break 10:15 to 10:30 a.m.

COSTS

Steve Hansch

10:30 a.m. to 11:30 a.m.

Exploration of cost dimensions of food programming and potential funding sources.

MONETIZATION

Steve Hansch

11:30 a.m. to 12:00 p.m.

Discussion of some of the basic techniques and resource material. Description of terms and process.

LUNCH

ACCOUNTABILITY AND REPORTING

T. Zopf, D. Crosson

1:00 p.m. to 3:00 p.m.

Introduction to GACAP, requirements of OMB Circulars A-110 and A-133, Regulations 10 and 11, Handbook 9, Bellmon Amendment. Internal control procedures, performance audits, characteristics of a well-managed commodity program. Necessary documentation, management inventory system.

Break 3:00 p.m. to 3:15 p.m.

RESOURCES and FOLLOWUP DISCUSSION

S. Hansch, T. Zopf

3:15 p.m. to 4:30 p.m.

Resource material available, organizations' policies and standards; pros and cons of food aid, present situations, inventory of skills, question-and-answer session.

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FOOD AID MANAGEMENT'S FOOD AID BRIEFING
FEBRUARY 1 AND 2, 1993

Speakers and Presenters

DON CROSSON

Don Crosson is a Senior Manager at Catholic Relief Service with 27 years of experience in managing CRS programs. His expertise is in the field of Title II Food Aid and Grants/Contracts management. He has served 15 years in CRS overseas programs in India, the Philippines, and Tanzania from 1965-1980; 9 years 1983-1992 in various posts with the Office of Project Resources Management at Headquarters and on special assignments overseas assisting in emergency operations, oversight issues, and trouble-shooting activities. At present, he is serving as Compliance Officer at CRS/Headquarters. He is presently serving on Food Aid Management's Accountability Committee.

STEVEN HANSCH

Steve Hansch is Program Director at Food Aid Management where he is helping the PVOs to consolidate and document their field experiences. Prior to joining FAM, he conducted food aid and food security evaluations for PVOs, A.I.D. and FAO. In the 1980s he conducted food economics surveys in two dozen refugee camps in Central America, East Africa, and Asia to aid UNHCR and NGOs in improving relief food aid. His interest in understanding the impact and uses of emergency food aid rose out of his work with the International Rescue Committee, for whom he ran supplementary, therapeutic, and hospital feeding programs for Ethiopian refugees.

LARRY HOLZMAN

Larry Holzman has worked for CARE for twenty-seven years and is presently CARE Country Director in Belize. He has an extensive background in feeding programs, specifically in logistics and administration. His first contact with a food aid program was as a Peace Corps Volunteer in Liberia and he ran a CARE school feeding program for 75 students. Since then he has administered food programs in India, Sri Lanka, Turkey, Korea, Haiti, Bangladesh and the Dominican Republic. The largest food program was in India which reached 15 million people through 200,000 distribution points.

RITA HUDSON

Rita Hudson has been a Food for Peace Officer for the Agency for International Development for six years. She has worked for A.I.D. for 22 years. Ms. Hudson spent a year and a half in OFDA providing budget and financial support for the African Locust Task Force. She also spent eight years in the PVC office. During her 22 years of experience in A.I.D., she has served many roles including that of budget officer, registration officer, and project officer. Ms. Hudson is currently project officer for Food Aid Management.

JOYCE KING

Joyce King is an independent consultant with extensive experience in the areas of food and nutrition in design, evaluation, planning, and programming. Ms. King spend sixteen years abroad, working 10 years for A.I.D, including an assignment as a Food for Peace officer. She has a broad range of experience in working with PVOs on evaluations, project papers, and workshops. In 1992 she wrote a paper that was a synthesis of Latin American Title II activities and an analysis of the Food for Peace legislation with recommendations for PVO programming in the next decade.

DAN SHAUGHNESSY

Shaughnessy is presently the Executive Director of Project Concern International. His association with food aid began in 1963 when he joined A.I.D. He has been Director of Food Aid and Nutrition for A.I.D. in India. In Washington, Mr. Shaughnessy has served as the Director of worldwide Title II programs and as Deputy Coordinator for the Office of Food for Peace. He was Staff Assistant for food aid for Senator Hubert Humphrey and the Senate Agriculture Committee. In 1978 he was appointed Executive Director of the Presidential Commission on World Hunger in the White House. Following his work with the Presidential Commission, he was Assistant Administrator for PL 480 and CCC credit programs in the Foreign Agricultural Service. When he left government service, he represented firms and trade associations involved in the supply, handling, and shipment of food aid commodities before being appointed as Executive Director for International Programs for World SHARE in San Diego, California. Dan has served as Chairman of the Steering Committee for Food Aid Management for 1991 through 1992.

TOM ZOPF

Tom Zopf has been the Director of Food Aid Management, an association of U.S. private voluntary organizations dedicated to improving the effectiveness and efficiency of food aid, since its inception in 1989. He has twenty-one years of experience with CARE, sixteen of them overseas and has been closely involved in food aid throughout his career. He has worked with school feeding, food-for-work projects, maternal/child health programs in India, the Philippines, Tunisia, and Egypt. Mr. Zopf developed CARE's first food-for-work project, introduced double-entry bookkeeping to commodity accounting in India, and served on the committee that developed CARE's food-aid policy. From 1984 to 1989, Mr. Zopf was Director of Technical Assistance and Evaluation at CARE headquarters. Mr. Zopf has guided FAM in providing a forum for the discussion and exploration of food aid issues, providing monetization workshops, working with the PVOs in identifying common operational standards and procedures, documenting field experience, sharing information and technology, and developing field collaboration.

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