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FINAL REPORT
ON
PLANNING AND EVALUATING
COMMUNITY FINANCING
IN
KOLAHUN DISTRICT
LIBERIA
BY
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PRINCIPAL INVESTIGATOR

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PLANNING AND EVALUATING COMMUNITY
FINANCING IN KOLAHUN DISTRICT
FINAL REPORT

Executive Summary

This project was an operations research with the objective of finding the most efficacious scheme(s) by which the community can generate funds to pay for part of or all of the costs for it's PHC services. The need for the study originated from the realization that the health problems of the district in particular and of Liberia in general remain acute inspite of the tremendous amounts of resources devoted to such interventions as immunization, health education, maternal and child health, etc. from both government and external sources. The author discovered that these projects have lacked sustainability because after the external supports have been withdrawn the projects usually collapse. Therefore the need for a different approach was a real one.

This was an 18-month project undertaken in order to find solutions to this problem.

The project was divided into three (3) phases. The first phase involved analysis of the problem. During the second phase solution development exercises were carried out and the third phase involved field testing of the chosen schemes.

Three villages were chosen as study villages.

<u>Villages</u>	<u>Population</u>
1. Fanghalahun	539
2. Taninahun	261
3. Kondubengu	280

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The results of the project revealed that, although problems are inevitable when any new concepts are being introduced, the people have the ability and willingness to finance a substantial share of their health care costs. And the fact that the project started with three villages and by the end of the 18-month period has expanded to ten villages is evidence that the system is not only sustainable but expandable.

Back Ground Information

Liberia is a West African country with a population of 1.8 million. About 20% of the population are under five years of age. It is estimated that 80% of the people live on subsistence farming. The per capital income is about 280 US \$ per year. Religious groups are mainly Christain, Muslims and Animist. English and about 28 different ethnic languages are spoken in the country. Liberia has a military government which endorses the Alma Ata Declaration as a means of providing health for all by the year 2000.

Health problems in Liberia as a whole and in the Kolahun District are not unlike health problems in the developing world. The traditional life style of the people promotes poverty, ignorance and disease. Malnutrition, poor sanitation and the lack of basic knowledge about their health problems contribute to the high rate of mortality. In particular, the infant mortality rate is high mainly due to such preventable diseases as measles and nutritionally related diseases.

The following specific health problems are of great concern to the national leaders:

- a. Education: Although the level of education is increasing, it has not solved the problem of illiteracy which is estimated to be 80% for the nation as a whole and 85% in the rural areas.

- 3'
- b. Sanitation: Overcrowding and poorly constructed housing, unsafe drinking water, inadequate means of waste disposal, all have great impact on the health status of the population.
 - c. Malnutrition: A poor concept of nutrition and a scarcity of animal protein continue to produce high morbidity and mortality.
 - d. High Infant and Childhood Mortality: Infant mortality in the country as a whole is estimated to be 153 per thousand live births. It is much higher in rural areas. Although 20% of the population are under five years of age yet, 50% of all deaths occur in this age group. Life expectancy at birth is 45-48 years.

Primary cause of death in the underfive age groups are:

1. Diarrhea & Dehydration
2. Bronchopneumonia
3. Measles
4. Malnutrition
5. Neonatal Tetanus
6. Malaria
7. Tuberculosis
8. Meningitis

These health problems are also found to be the important ones in the Kolahun District. The target population for this study is children under five years of age, pregnant women and lactating mothers.

Existing Health System in the District

The Kolahun District has three health centers each with a minimum staff of two (2) Physician Assistants, one (1) Certified Midwife and one (1) Practical Nurse.

There are fourteen health posts, each with a minimum staff of one (1) Physician Assistant and one (1) Certified midwife. The District has a population of 72,000 distributed in approximately thirty isolated villages (see map).

There is a number of farmer's cooperative which have been encouraged by the government in recent years. The World Bank is financing an agricultural development project. Therefore cocoa, coffee and swamp rice production has begun to provide some cash income to the few families who participate in the project.

METHODOLOGY

Phase I Problem Analysis

We used the model in the PRICOR monogram on Community Financing (see appendix 1) to analyze the different components to the problem. We specifically addressed ourselves to the following:

1. What Services Will Be Provided? In order for the community to pay for its primary health care services, such services must be made available. It was agreed at series of community meetings that the following services will be provided.
 - a. Treatment of common illnesses with appropriate referrals when necessary. It was then necessary to make drugs available.
 - b. Coordination of immunization campaign. This will include mobilizing the mothers to bring children for immunization and locating those children who have not been fully immunized.
 - c. Health promotion activities such as health talks etc. (see VHW training syllabus).
 - d. Registration of births and deaths in the villages (see appendice 2 & 3).

2. Who Will Provide The Services? Due to the shortage of professional health care workers, it was agreed at series of community meetings that VHW/TBA will provide the village-level health care.
3. Who Will Participate? It was agreed that services will be open to all in the community.
4. Price Of Services And Benefit To Be Derived? It was agreed that services will not be free. There will be cost-recovery eg. drugs will be sold at 25% mark-up prices.
5. Income Level Of The People? A health care utilization survey was carried out which revealed the following description of the community. (see figures 1-4).
 - a. Average size of household - 6 persons.
 - b. Heads of households are usually older males. About two thirds of them are 55 years and over.
 - c. 72% of the people have no formal education.
 - d. 76% are farmers.
 - e. Household income was low: 70% reported annual income if less than \$200.00 and 41% reported annual income of less than \$100.00.
6. Willingness Of The People To Participate was to be addressed during the field testing.

After the problem and its different components were fully understood, the community leaders were ready to enter the next phase of the project, ie. the development of suitable solutions(s).

Phase II: Solution Development

During the second quarter of the project, at least four meetings were held with the community leaders of each of the three villages. At first eight possible financing schemes, which have been tried in other parts of the world, were introduced and explained. These schemes were:

- | | |
|--------------------------------|-----------------------------------|
| 1. Fee-for-service | 5. Community labor |
| 2. Drug Sales | 6. Individual labor |
| 3. Personal prepayment | 7. Donation and ad-hoc assessment |
| 4. Production-Based Prepayment | 8. Festivals, raffles, etc. |

The community leaders were told that the objective was to find the most effective scheme(s) by which they can pay a substantial share of their primary health care (PHC) cost. The following objectives were discussed:

1. The cost of the scheme(s) chosen will be equal to or less than the income generated from these schemes.
2. That a high proportion of the target population (underfives, pregnant women and lactating mothers) will utilize the essential services provided.
3. That a high percentage of households will participate
4. That the villages themselves will be able to sustain the scheme(s).

Then the constraints of each scheme were examined. Also the advantages and disadvantages of each scheme were discussed. Lastly a preference matrix was used to compare the eight schemes and the community leaders of each village selected a combination of the same four schemes. (See appendix 4) The schemes selected are:

1. Drug Sales
2. Community labor
3. Production based prepayment
4. Ad-hoc assessment

Drugs Sales

The villagers buy minimum essential drugs from the Kolahun District Drug Project (Annex 1) and sell them at about 25% mark-up (see appendix 5). This was the beginning of village-level revolving drug fund in each of the three villages. The initial amounts to purchase the drugs were raised by assessment. This was made possible because of a district-wide revolving drug fund established with a "seed-money" of ten thousand dollars (\$10,000.00) provided by the Gbandi Farmers' Cooperative based in the District. Adequate drugs are being ordered through the Christian Health Association of Liberia (CHAL) at discount prices.

Production - based prepayment

In the three villages, the people grow limited amount of cash-crops (mainly coffee & cocoa) in addition to growing rice (the staple). These cash-crops are harvested once a year. It was agreed in each village that participating households will contribute part of these harvests to the FHC funds.

Community Labor

Every year, it is a common practice in each village to make a communal rice farm. Now they have agreed to use part of the proceeds for FHC. However there is no agreement on just what percentage will be used for health. Also they agreed that at least part of the compensation for the village health worker will be in the form of community labor for him/her.

Phase III - Field Testing

In order to implement phase three it was necessary for each village to have: 1. Village Health Committee (VHC), 2. A trained Village Health Worker (VHW) therefore VHC'S were formed in the villages. Each VHC chose a VHW to be trained.

Each village already had a trained traditional birth attendant (TBA). Therefore a village health worker training program was undertaken and the first class of five (5) was trained and deployed in time for the commencement of the field testing phase of the project. (See annex 2). Now there are ten (10) villages with trained VHW'S and the number of villages participating in this project has grown to seven (7).

During the 12-month period of field testing supervisory visits were made at least once a month by the Principal Investigator (PI) and/or Research Assistant (RA). The following checklist was devised to assist in the supervisory process:

Check list

1. Village Health Committee
 - a. Is it formed?
 - b. Is it functional?
 - c. Original number of people on the committee?
 - d. Number of people still active?

2. Village Health Worker:
 - a. Is he on the job?
 - b. Does he have supplies?
 - c. What is the cost of the supplies?
 - d. His record reviewed?

3. Financing Schemes being used:
 - a. Any problems?
 - b. How successful?

4. How many households participating?
5. How much revenue collected so far?
6. Who manages the revenue collected?

In addition to following the checklist, disputes and conflicts, between the VHW'S and the VHC'S were addressed. In one village the town's people wanted to use the proceeds of the drug sales as their contribution to the funeral of a prominent chief. The VHW refused and the conflict was settled by the RA. It was then agreed the decision on the use of surplus money will be made by the VHC and approved by the town council. Another village intends to use surplus money from drug sales for a latrine project.

Record & Inventory:

The village health workers use a simple ledger to record patients seen, their problems, drugs dispensed, and the amount of money collected. (See appendix 6). Also ledgers are used to record births, and deaths although this was recently started.

MANAGEMENT PROCESS

Management Of Funds:

In all villages except Balahun, a member of the village health committee serves as treasurer. In Balahun VHW serves as Treasurer.

Commual Farm:

The question of what percentage of the proceeds from the commual farm will be used for health was addressed at a recent meeting of VHW'S and some members of VHC'S. No figure was agreed upon but the feeling was unanimous that health should be included in the present uses of the proceeds of the commual farm. Present uses include the following:

1. Entertaining guests of the town
2. Selling for cash to be used in ways agreed on by the village leaders.
3. Feasts on special occasions
4. Road building (Fanghalahun)
5. To assist with funerals.

Level Of Satisfaction:

This is difficult to quantify. However comments received from the people during supervisory visits indicate high degree of satisfaction. One dramatic evidence of this is when one of the VHW threatened to quit, he was approached by a few mothers who told him that his services have been very valuable. Now they do not have to go to the Health Center every time the children have fever. This shows that at least the mothers are satisfied.

Results:

The following tables give summaries of the revenues and drug expenditures (tables 1-4) also the number of cases treated (tables 5-8) in each village by quarter.

Table I
Revenues and Drug Expenditures.
July - Sept. 1984

Community	REVENUE				Total Cash On Hand [†]	Drugs/ Supplies Purchased	Balance [#]	No. Cases	Sales Revenue Per Case
	Donation Assessment	% Of House Hold Con- tribution	Drug Sales	Other					
1. Fanghahun	190.00	90%	53.00	1. Commual farm 2. 6 man- days for VHW	243.00	103.00	140.00	81	0.65
2. Taninahun	300.00*	-	95.20	1. Commual farm 2. 102.00 for farm con- tract	497.00	300.00	197.20	112	0.85
3. Kondubengu	-	-	-	1. Commual farm	-	-	-	-	-
4. Mbaghahun	150.00	85%	48.00	1. Commual farm	198.00	118.00	80.00	120	0.40
5. Balahun	59.00	75%	54.80	1. Commual farm	123.80	59.00	64.80	162	0.40

*\$300.00 Donated by a missionary couple.

† This includes balance from preceeding quarter.

This does not include value of drug in stock.

Table 2
Revenues and Drug Expenditures
Oct. - Dec. 1984

Community	REVENUE				Total Cash On Hand	Drugs/ Supplies Purchased	Balance	No. Cases	Sales. Revenue Per Case
	Donation/ Assessment	% of House Hold Contri- bution	Drug Sales	Other					
1. Fanghahun	-	-	39.00	1. Commual farm 2. 6 man- days for VHW	179.00	140.00	39.00	130	0.30
2. Taninahun	-	-	105.00	1. Commual farm 2. 360.00 from contracts	572.00	300.00	272.00	110	0.95
3. Kondubengu	-	-	-	1. Commual farm	-	-	-	-	-
4. Mbaghahun	-	-	52.80	1. Commual farm	132.00	125.00	7.80	132	0.40
5. Balahun	-	-	55.80	1. Commual farm	120.60	86.00	34.60	155	0.36

Table 3.
Revenues and Drug Expenditures
Jan. - March 1985

Community	REVENUE				Total Cash On Hand	Drugs/ Supplies Purchased	Balance	No. Cases	Sales Revenue Per Case
	Donation Assessment	%Of House Hold Con- tribution	Drug Sales	Other					
1. Fanghahun	19.60	-	30.00	1. Commual farm	88.60	42.40	46.20	124	0.24
2. Taninahun	-	-	90.00	1. Commual farm	326.00	200.00	162.00	105	0.86
3. Kondubengu	-	-	-	1. Commual farm	-	-	-	-	-
4. Mbaghahun	-	-	25.00	1. Commual farm	32.80	25.00	8.80	65	0.39
5. Balahun	-	-	51.00	1. Commual farm	85.60	66.00	19.60	151	0.34

Table 5

Number Of Cases Treated By Problem
July-Sept. 1984

	Fanghahun	Taninahun	Kondubengu	Mbaghahun	Balahun	Total Cases	%
Malaria	21	25	-	40	65	151	32.14
Worms	8	20	-	25	15	68	14.6
Headaches	15	20	-	20	30	85	18.2
Body pain	10	15	-	10	30	65	14.0
Sores (ulcer)	6	15	-	15	7	43	9.2
Bellyache	6	5	-	-	10	21	4.5
Boil	6	6	-	4	5	21	4.5
Scabies	0	4	-	6	-	10	2.1
Pneumonia	0	2	-	-	-	2	0.4
Others	0	-	-	-	-	2	0
TOTAL	72	112	-	120	162	466	100.0

Table 6

Number Cases Treated, By Problem. October-December 1984
Liberia--Community Financing System

	Fanghahun	Taninahun	Kondubengu	Mbaghahun	Balahun	Total Cases	%
Malaria	43	30	-	49	63	185	35.1
Worms:	27	25	-	26	20	98	18.6
Headaches	11	15	-	20	35	81	15.4
Body pain	12	10	-	11	29	62	11.8
Sores (ulcer)	16	15	-	16	0	47	8.9
Bellyache	11	0	-	0	8	19	3.6
Boil	8	5	-	4	0	17	3.2
Scabies	2	5	-	6	0	13	2.5
Pneumonia	0	5	-	0	0	5	0.9
Other	-	-	-	-	-	-	-
TOTAL	130	110	-	132	155	527	100.0

Table 7

Number Of Cases Treated By Problem
Jan.-March 1985

	Fanghahun	Taninahun	Kondubengu	Mbaghahun	Balahun	Total Cases	%
Malaria	50	36	-	22	44	152	34.2
Worms	-	20	-	12	15	47	10.6
Headaches	44	16	-	10	47	117	26.3
Body pain	8	13	-	8	24	53	11.9
Sores (ulcer)	4	10	-	6	3	23	5.2
Bellyache	12	4	-	3	15	34	7.6
Boil	4	3	-	2	2	11	2.5
Scabies	2	3	-	2	1	8	1.8
Pneumonia	-	-	-	-	-	-	-
Others	-	-	-	-	-	-	-
TOTAL	124	105	-	65	151	445	100.0

Table 8

Number Of Cases Treated By Problem
April-June 1985

	Fanghahun	Taninahun	Mbaghahun	Balahun	Ndambu	Yendohun *	Total Cases	%
Malaria	50	44	24	44	103	-	265	31.9
Worms	-	23	12	17	17	-	69	8.3
Headaches	46	19	10	52	84	-	211	25.4
Body pain	8	15	8	25	-	-	56	6.7
Sores (ulcer)	4	11	6	4	78	-	103	12.4
Bellyache	14	5	3	23	18	-	63	7.6
Boil	3	4	2	3	43	-	55	6.6
Scabies	3	3	2	2	-	-	10	1.2
Pneumonia	-	-	-	-	-	-	-	-
Others	-	-	-	-	-	-	-	-
TOTAL	128	124	67	170	343	-	832	100

*Data not in time for inculsion.

Table 9
Liberia--Community Financing System.
Composition of the Health Committees by Age and Sex

Community	Village Health Committees						VHW (Member of Committee)		
	Sex			Median Age			Median Age		
	Men	Women	Both	Men	Women	All	Men	Women	All
Fanghahum	8	3	11	55	30	40	35	-	35
Taninahum	9	3	12	50	45	50	30	-	30
Kondubengu	15	0	15	50	-	50	35	-	35
Mbaghahum	3	2	5	35	57	54	30	-	30
Balahum	<u>7</u>	<u>8</u>	<u>15</u>	<u>62</u>	<u>43</u>	<u>45</u>	<u>-</u>	<u>37?</u>	<u>37</u>
Total	42	16	58						
Median Age				50	45	50	33	37?	35

Discussion:

This project introduced the concept of community involvement in financing its health care services to the Kolahun District for the first time. The response of the people has been enthusiastic although there have been problems as will be seen later.

Phase I was an interesting exercise because ~~as~~ the problems and their different components were discussed, the people could see their importance. Phase II was even more interesting as we developed possible solution(s) together. However, some problems became apparent during the field testing phase.

The solution objectives were met. The costs of implementing the different schemes did not exceed the income generated. To assess the degree of utilization by the target population, one has to look at the health care utilization pattern of one of the Health Centers (Kolahun Health Center). The catchment area of this health center contains about 18,000 people (25% of population of the District). There are about 16,000 out patient visits per year representing about one visit per person per year.

The total number of visits to all the VHW'S was 2,285. Total population of the participating villages equals 2,680*.

We have to assume however that utilization at the village level is much higher since health care is readily available. Therefore, if one assumes two visits per person per year, utilization was better than 50%.

The percentage of households participating was assessed from the initial contribution to the "seed money" for the revolving drug fund which in each village was by ad-hoc assessment. Percentages ranged from 75% to 90%.

* Includes population of 3 other villages for which data are available.

It is evident that this project, in addition to having the potential for sustainability, also has the potential for expandability. From the original three (3) study villages, we have expanded to six (6) functioning villages. There are ten (10) with trained village health workers. Four (4) of them however, do not have functioning community financing system. It must be pointed out that the processes of phases I & II were not repeated in each additional village.

We found that Drug Sales were the number one source of revenue. This was followed by community labor. When there was a need for ad-hoc assessment, the response was good. Production-based prepayment did not play a role.

We also found that mainly curative health services were offered but preventive and promotive services are beginning.

PROBLEM:

The major problem encountered was the compensation of village health workers. In each village it was agreed that VHW'S will be compensated by villagers working for him on his farm through community labor. Although a total of 63 man-days of work was done for VHW'S there is general dissatisfaction among VHW'S. This has led to a second problem: attrition of VHW'S. A total of 3 trained VHW'S have left the job in search of better opportunity.

We now realize that the wrong assumption was made when it was assumed that VHW'S will be considered in the same capacity as the traditional healers. Thus since these traditional healers are amply compensated for their services, it was assumed that the VHW'S will also be adequately compensated. This has not been the case in our study for reasons unknown.

Follow-up plan:

We plan to expand to other villages. Village health worker training program will continue on a yearly basis.

There is plan for a symposium for all PRICOR investigators in Liberia to present, share and disseminate our results.

CONCLUSION:

In our opinion the most important achievement from this project is the creation of community awareness that they have the power and the ability to finance part of their own health care services. In addition this project has shown the value of operations research by demonstrating that active community participation means involving the community in the problem solving process from the very start. If this is the case, the community is more apt to sustain whatever system is developed.

We found that although much has been learnt from experiences of other countries in community financing, it was essential to carry out the exercise on the spot.

Finally we feel that despite the problems mentioned above, the people of the Kolahun District will continue to carry out community activities that will help to finance part of their Primary Health Care services. However we realize that supervision is the key and the district health establishment will continue to offer the necessary supervision.

Staffing

<u>Position</u>	<u>Name</u>	<u>Responsibilities</u>
1. Principal Investigator	Andrew K. Cole, MD	1. Overall supervision of the project activities 2. preparation of all reports 3. Training of non-professional staff. 4. Analysis of data in conjunction with statistician.
2. Research Assistant	Augustine K. Samuka, PA	1. Assists PI in activities 2. Supervision of all field activities
3. Statistician	John Prell	Consults on all statistician problem
4. Consultant	Nancy Pielermier, Ph.D	Offered technical assistance during the project
5. Secretary	Victoria R. Cole	1. Typed all project documents 2. Purchased all local materials 3. Filed all records.

Management

The project was administered by Christian Health Association of Liberia (CHAL) through Mr. Paul Ippel, Executive Secretary.

Time Table:

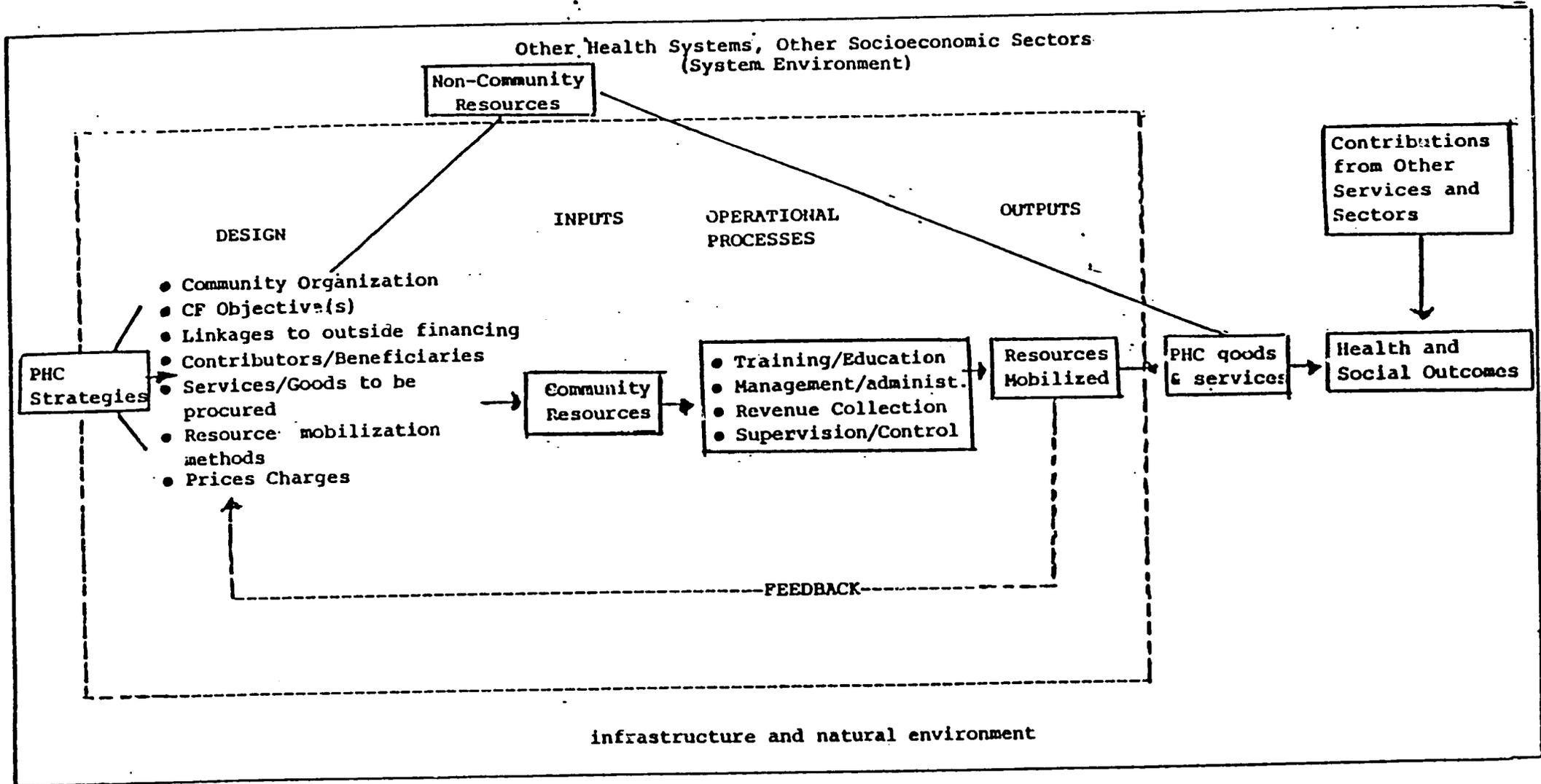
1. Recruit and Train interviewers	1 month
2. Type and print survey instrument	1 month
3. Introductory meetings with community leaders	1 month
4. Health care utilization survey	1 month
5. Analysis of survey Data	1 month
6. First progress Report	end of 3rd month
7. Systems Analysis (phases I & II)	2 months
8. Second progress report	End of 6th month
9. Field Testing	Months 7th - 18th
10. Third & Fourth Progress Report	End of 12th month
11. Fifth Progress Report	End of 18th month
12. Final Report	4 months after project

References

1. World Health Organization. Primary Health Care: Report of the International Conference on Primary Health Care. Alma-Ata, USSR, 6-12 September 1978. Jointly sponsored by WHO and UNICEF Geneva:
2. Russel, Sharn S., Reynolds, Jack Operations Research Method: Community Financing PRICOR Monogram 1984.
3. Zschock, D. Health Care. Financing in Developing Countries. Washington D.C., APHA, International Health Programs Monograph Series, No. 1, 1979.
4. Stinson, W., Community Financing, Washington, D.C.: The American Public Health Association, 1982, p. 13.
5. Werner, David: Where There is no Doctor, MacMillan Publishers, 1979.

Appendix I

DIAGRAM OF A COMMUNITY FINANCING SYSTEM



Appendix 2

No. 1

Birth Record

Father's Name: Manuadea Dukala

Mother's Name: Ulendor Kpehe

Address Ndambu Tolon Lofa Co.

Place of birth Ndambu

Date birth June 9-1985

Birth Attended by Grambo Nekai
(T B A)

Birth Record by Mohammed Z. Jallah

Date of first seen June 9-1985

Time 4-50 P.M.

No. 2

Father's Name Bassania Ngongole

Mother's Name Molly Bassania

Address Ndambu Tolon Lofa Co.

Place of birth Kolahun health
Center.

Date of birth June 6-1985

Date first seen June 6-1985

Birth Attended by _____

Time _____

Death Record

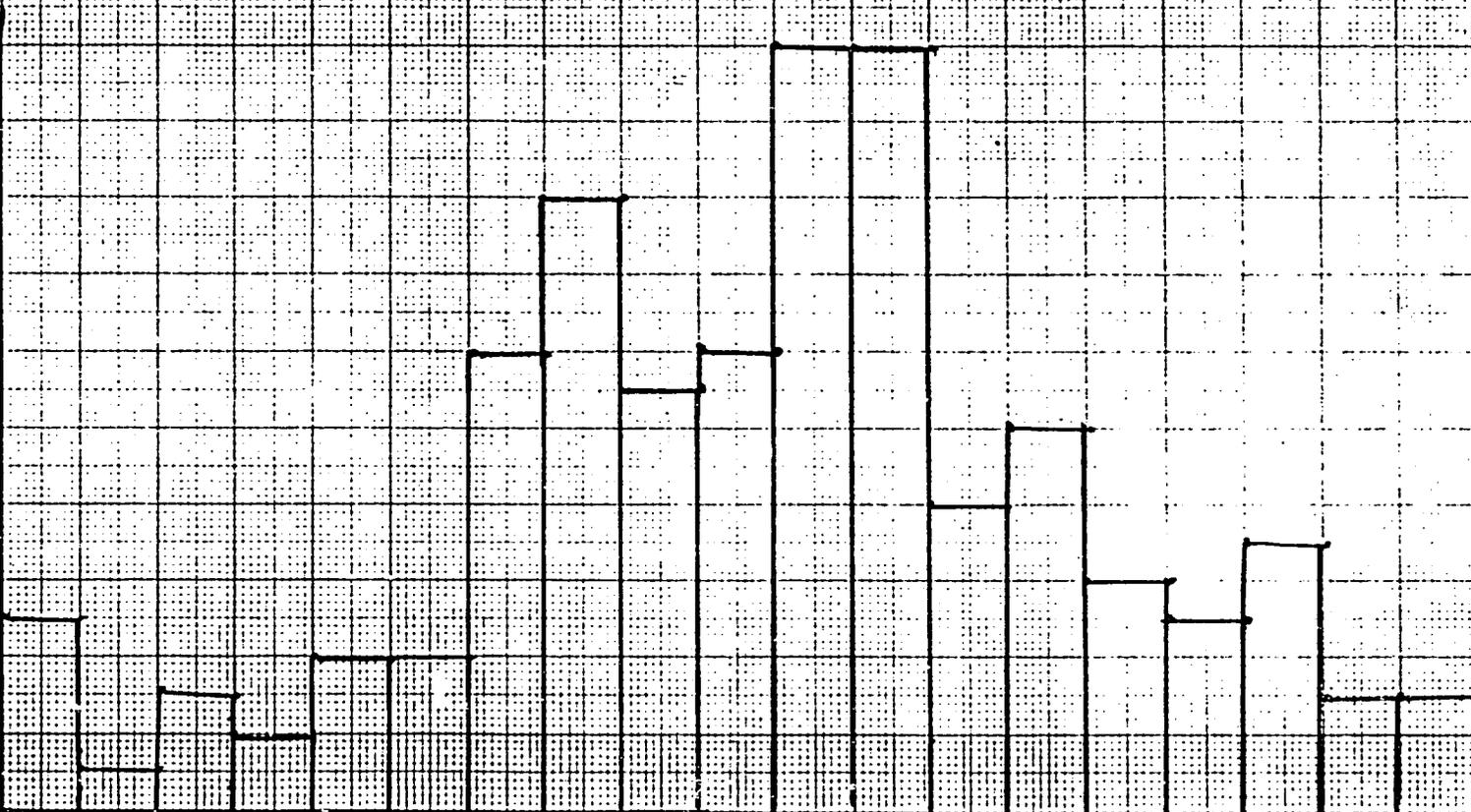
1. Sando Momo die April 6-1985
She die by Kalashor disease.
at the hour of 4-15 P.M. at
Kolahun health center.
2. Mboloklovik Korsmasah die June 2
1985 she die with hard fever. She
die to Ndambu Town Lofa Co.
at the hour of 8-15 P.M.
3. Old lady Koupo Ndebeh die July
14-1985, she die with Old age
she die at Ndambu Town Lofa Co
at the hour of 6-30 A.M.
4. Oldman Ngamah die July 27-
1985 she die to Ndambu Town
Lofa Co. He die with hard fever
with Old age too.
at the hour of 4-15 A.M.
5. Wlemor Malay die August 20-1985
at the hour of 7-18 A.M.
She die with bunch lung trouble.

Figure I
 DISTRIBUTION OF HOUSEHOLD HEADS
 BY AGE GROUP

NUMBER OF HOUSEHOLD HEADS

0 4 8 12 16 20

5-15
 15-19
 20-24
 25-29
 30-34
 35-39
 40-44
 45-49
 50-54
 55-59
 60-64
 65-69
 70-74
 75-79
 80-84
 85-89
 90-94
 95-99
 100+

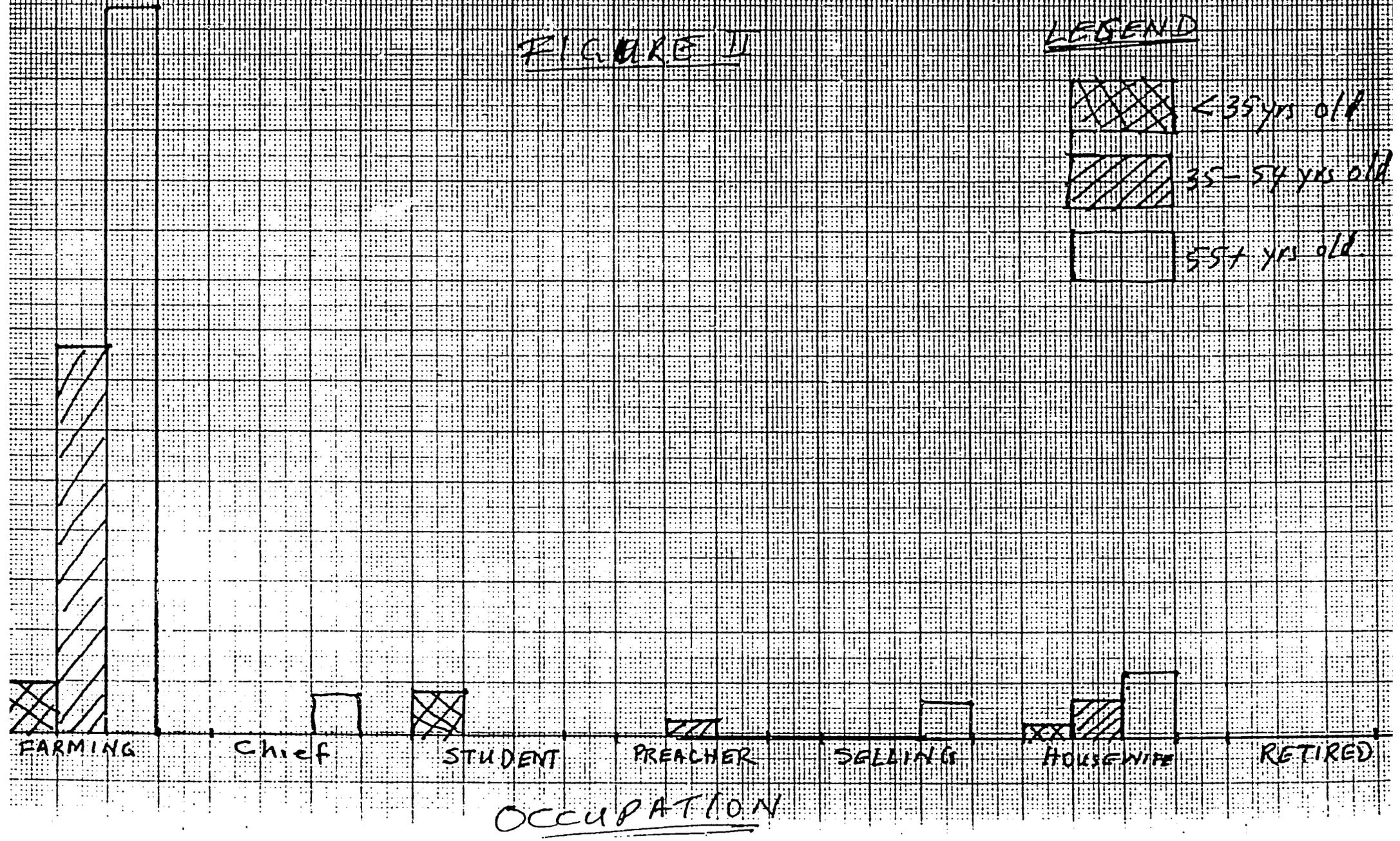


OCCUPATION OF HOUSEHOLD HEADS BY AGE GROUP

FIGURE II

LEGEND

-  < 35 yrs old
-  35 - 54 yrs old
-  55+ yrs old



OCCUPATION

FIGURE III

EDUCATION OF HOUSEHOLD HEADS By AGE GROUP

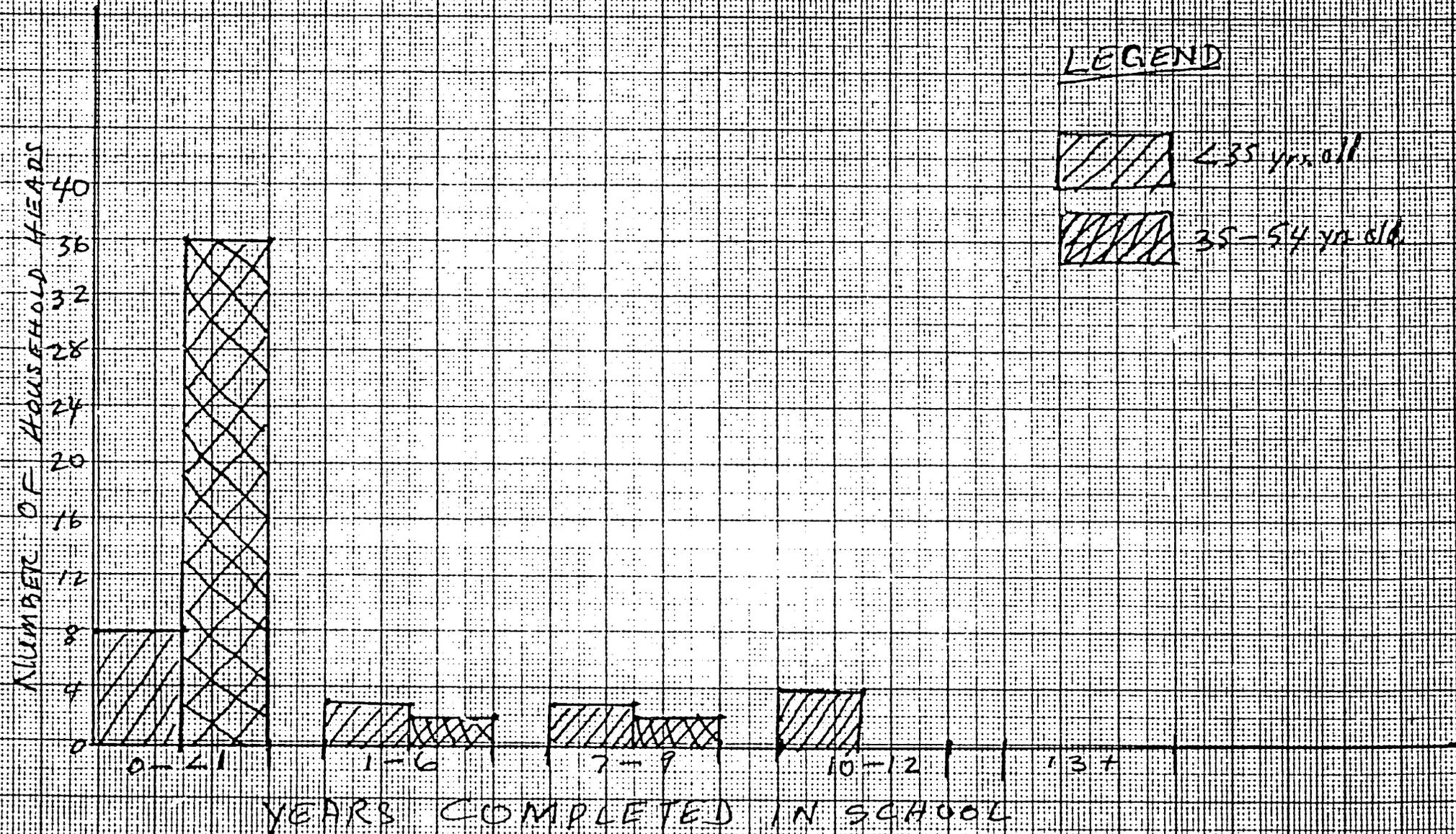


FIGURE IV A

DISTRIBUTION OF HOUSEHOLD
BY SIZE

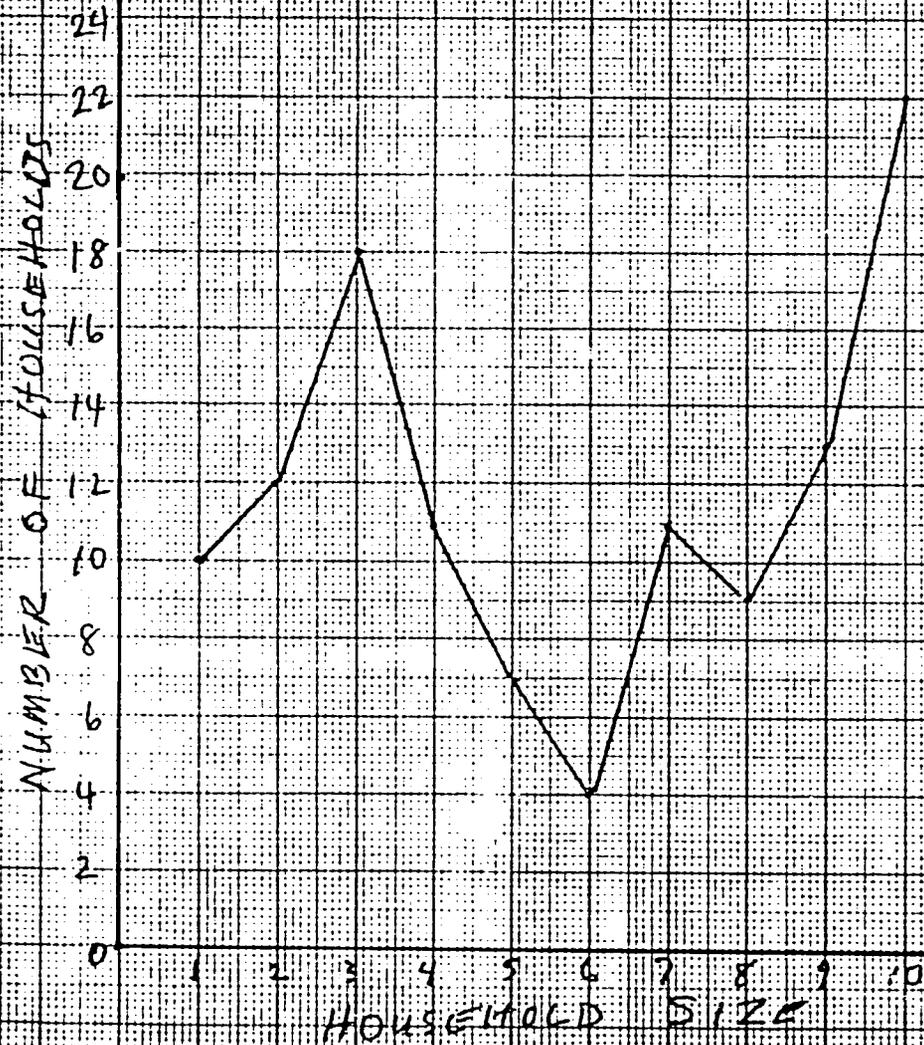
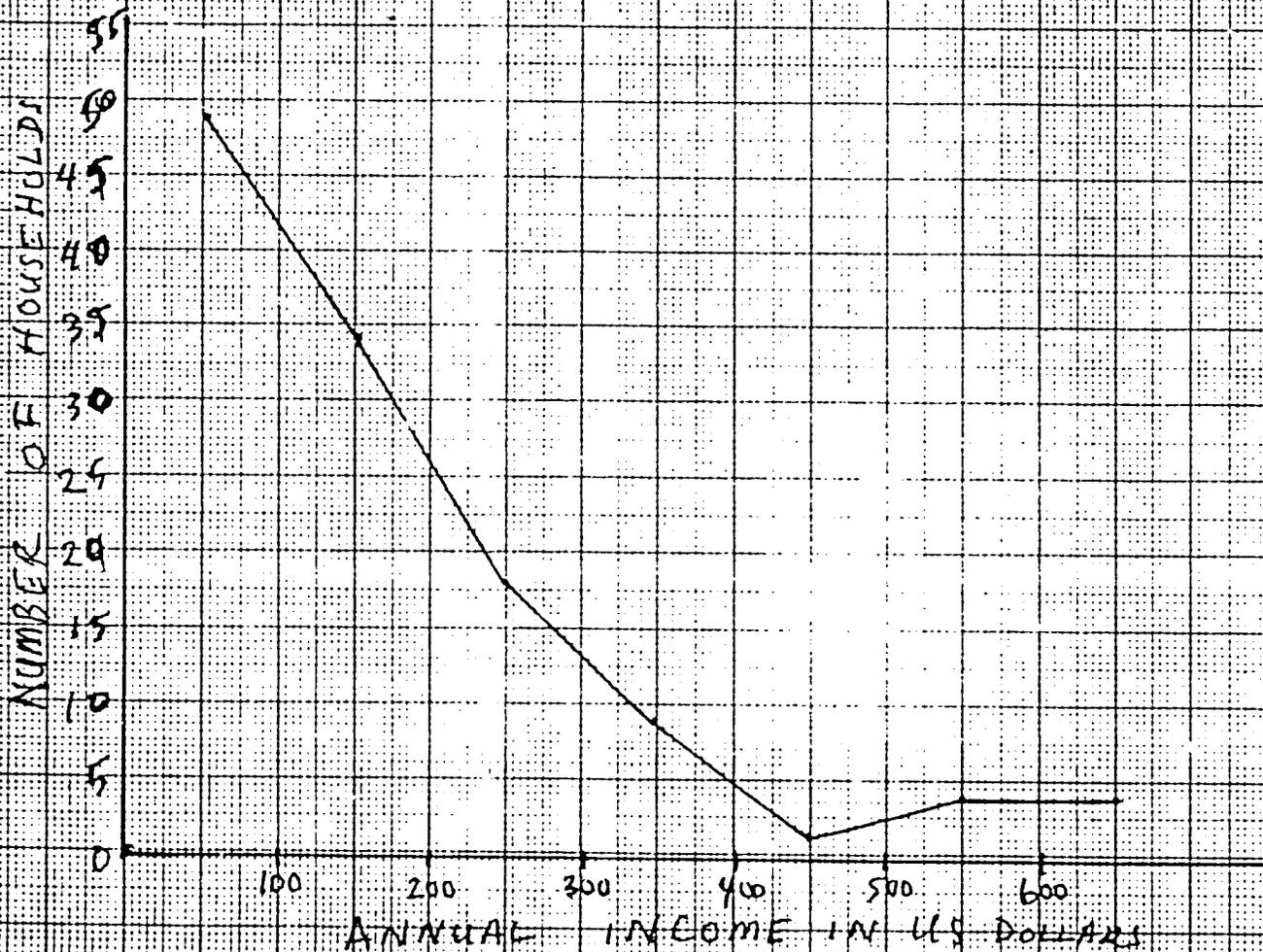


FIGURE IV B

DISTRIBUTION OF HOUSEHOLD
By ANNUAL INCOME



Appendix 4

<i>Preferred to</i>	Fee for service	Drug Sales	Personal Prepayment	Production based payment	Community labor	Individual labor	Donation ad-hoc assessment	Festival raffles etc	Total
FEE-FOR SERVICE	-	0	0	0	0	0	0	0	0
DRUG SALES	X	-	X	X	X	X	X	X	7
PERSONAL PREPAYMENT	X	0	-	0	0	0	0	X	2
PRODUCTION BASED PREPAYMENT	X	0	X	-	0	X	X	X	5
COMMUNITY LABOR	X	0	X	X	-	X	X	X	6
INDIVIDUAL LABOR	X	0	X	0	0	-	0	X	3
DONATION AND AD-HOC ASSESSMENT	X	0	X	0	0	X	-	X	4
FESTIVALS, RAFFLES, ETC	X	0	0	0	0	0	0	-	1

X = Preferred

0 = Not preferred

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Appendix 5

BOLAHUN DISTRICT VHW DRUG LIST AND PRICES

<u>DRUG</u>	<u>HEALTH CENTER PRICE</u>	<u>VILLAGE PRICE</u>
Chloroquine Tabs	1000-\$20.00/1 for 2¢	2 for 5¢
Iron Tablets	1000-\$15.00/2 for 3 ¢	1 for 2¢
Aspirin Tabs	1000-\$ 7.00/3 for 2¢	1 for 1¢
Mebendazole	1000-\$20.00/1 for 2¢	2 for 5¢
Penicillin Tabs	1000-\$25.00/2 for 5¢	1 for 3¢
Mag. Trisilicate Tab	1000-\$ 7.00/3 for 2¢	1 for 1¢
Multivitamin Tabs	1000-\$ 4.00/2 for 1¢	1 for 1¢
Folic Acid Tabs	5000-\$ 6.70/3 for 2¢	1 for 1¢
Neomycin/Bacitracin Oint	100-\$30.00/1 for 30¢	1 for 35¢
Benzyl Benzoate	1 Liter -\$ 5.00/30cc for 15¢	30cc for 20¢

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	NAMES	MEDICINES	FOR	TREATMENT	Amount paid	APPROX AGE	DATE
1	old man Kormah	Aspirins	Headache	2 ASA	5¢	Adult	June 29, 84
2	Kimba Duwor	Aspirins	Headache	4 ASA	10¢	Adult	June 29, 84
3	Ndorbor Kpawor	Aspirins	headache	10 ASA	25¢	Adult	June 30, 84
4	sarmah sallay	ASA & penic	headache & body pain	4 ASA 2 p.e	20¢	Adult	June 30, 84
5	MAMA Bendu	chloroquine	Malaria	2 chl.	5¢	Adult	June 30, 84
6	Korpo Kpele	Aspirins	headache	2 ASA	5¢	Adult	June 30, 84
7	Sumo Osiye	ASA & chl.	headache & malaria	2 chl. & 2 ASA	25¢	Adult	June 30, 84
8	Molley Telleh	Aspirins	headache	2 ASA	5¢	Adult	June 30, 84
9	Sika Gamba	ASA & chlor.	headache & malaria	2 chl 2 ASA	10¢	Adult	June 30, 84
10	Kimba Duwor	penicillin	body pain	2 p.e	10¢	Adult	July 1, 84
11	Molley Kpele	chloroquine	malaria	2 chl	5¢	Baby Adult	July 1, 84
12	Joseph Ballah	chloroquine	Malaria	4 chl	10¢	Adult	July 1, 84
13	Korpo Kpele	chloroquine	Malaria	2 chl	5¢	Adult	July 1, 84
14	Kpambu Molay	chloroquine	Malaria	2 chl	5¢	Adult	July 1, 84
15	FARNEE	chloroquine	malaria	4 chl	10¢	Adult	July 1, 84
16	Wleemuce Hena	Magnesium	belly pain	2 mag	5¢	Adult	July 1, 84
17	Koleenjal	penicillin	body pain	2 p.e	10¢	Adult	July 1, 84
18	Vanyah Ngiamu	chloroquine	malaria body pain	10 chl	25¢	Adult	July 2, 84
19	yallah sika	chloroquine	malaria	2 chl	5¢	Adult	July 2, 84
20	Koilor Neele	chloroquine	malaria	4 chl	10¢	Adult	July 2, 84
21	selle Moinjama	chloroquine	Malaria	4 chl	10¢	Adult	July 2, 84
22	Kimba Duwor	chloroquine	malaria	2 chl	5¢	Adult	July 2, 84
23	Wleemuce Hena	Magnesium	belly pain & heart trouble	4 mag	10¢	Adult	July 3, 84
24	Sarmah sallay	Magnesium	belly pain	4 mag	10¢	Adult	July 3, 84
					\$ 2.45		