

AGENCY FOR INTERNATIONAL DEVELOPMENT
PROJECT IDENTIFICATION DOCUMENT
FACESHEET (PID)

1. TRANSACTION CODE
 A = Add
 C = Change
 D = Delete
 Revision No. _____
 DOCUMENT CODE 1

2. COUNTRY/ENTITY
 LIBERIA

3. PROJECT NUMBER
 669-0219

4. BUREAU/OFFICE
 AFRICA
 A. Symbol _____ B. Code 6

5. PROJECT TITLE (maximum 40 characters)
 Primary Health Care Phase II

6. ESTIMATED FY OF AUTHORIZATION/OBLIGATION/COMPLETION
 A. Initial FY 9/0
 B. Final FY 9/15
 C. PACD 9/15

7. ESTIMATED COSTS (\$000 OR EQUIVALENT, \$1 =)

FUNDING SOURCE		LIFE OF PROJECT
A. AID		\$10,000
B. Other U.S.	1.	
	2.	
C. Host Country		7,600
D. Other Donor(s)		
TOTAL		\$17,600

8. PROPOSED BUDGET AID FUNDS (\$000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE		D. 1ST FY		E. LIFE OF PROJECT	
		1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan
(1) DFA	533	510		5,000		10,000	
(2)							
(3)							
(4)							
TOTALS							

9. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each)

10. SECONDARY PURPOSE CODE

11. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)
 A. Code BWW
 B. Amount

12. PROJECT PURPOSE (maximum 430 characters)

To increase the proportion of the target population (women and children under 5) with access to an appropriate balance of preventive, promotive and curative services and to improve the quality of health care in the project counties.

13. RESOURCES REQUIRED FOR PROJECT DEVELOPMENT
 Staff: USAID/Liberia
 PDO, health officer, economist, controller
 REDSO/WCA - health officer
 CONSULTANTS - public health specialist and health economist
 Funds \$100,000

14. ORIGINATING OFFICE CLEARANCE
 Signature: John F. Hicks *John F. Hicks*
 Title: Mission Director
 Date Signed: MM DD YY 10 09 89

15. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION
 MM DD YY

16. PROJECT DOCUMENT APPROVAL
 S = Suspended
 A = Approved
 D = Disapproved
 CA = Conditionally Approved
 CD = Decision Deferred

17. COMMENTS

18. ACTION APPROVED
 Signature _____

19. ACTION REFERENCE

20. ACTION DATE
 MM DD YY

ACRONYMS

AIDS - Acquired Immune Deficiency Syndrome
BPRD - Bureau of Planning, Research & Development
CCCD - Combatting Childhood Communicable Diseases
CHAL - Christian Health Association of Liberia
EEC - European Economic Community
FFS - Fee for Service
GOL - Government of Liberia
HPN - Health, Population & Nutrition
IEC - Information, Education & Communication
IEE - Initial Environmental Examination
JHU/PCS - Johns Hopkins University/Population Communication
Services Project
LAMCO - Liberian American Mining Company
LRCN - Liberia Rural Communication Network
MH&SW - Ministry of Health & Social Welfare
NDS - National Drug Service
PACD - Project Assistance Completion Date
PVO - Private Voluntary Organization
PCVs - Peace Corps Volunteers
PHC - Primary Health Care
RDF - Revolving Drug Funds
REDSO/WCA - Regional Economic Development Support Office/West
& Central Africa
SER/PHC - South Eastern Region/Primary Health Care Project
TA - Technical Assistance
TBAs - Traditional Birth Attendants
UNICEF - United Nations Children's Fund
VDC - Village Development Councils
VDCs - Village Development Committees
VHWS - Village Health Workers
WHO - World Health Organization

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Background

A. Health Situation in Liberia

Liberia's principal public health problems are typical of third world countries. There is wide prevalence of communicable diseases such as measles, malaria, intestinal parasites, respiratory infections and tetanus. The infant mortality rate is high. While the Government of Liberia recognizes these problems, its resources to address the health needs of the population are inadequate and badly distributed. Although the estimated health care coverage is 40%, many of those people have access to only rudimentary health services with rural areas being badly underserved. Because of the foreign exchange problem, drug shortages exist throughout the country and most facilities are in desperate need of supplies.

On the other hand, there are several positive developments in health care. Unlike many other third world countries, Liberia has been in the forefront of health sector policy development. For example, not only has Liberia adopted a primary health care strategy of making health care accessible to 90% of the population by the year 2000, but it has official policies on population, immunization, oral rehydration, AIDS, and malaria. In addition, the MH&SW promotes decentralization of health services to the local level as well as cost recovery through fee-for-services and revolving drug funds. Substantial amounts of revenues have been collected from rural users willing to pay for health services that are available to them.

The impact of these positive developments has not been strong enough because the delivery of health services is not being carried out in any coordinated fashion. Attempts at a coordinated primary health care program have only been tried in Grand Gedeh and Sinoe counties, under the USAID/GOL supported PHC I Project (669-0165). Based on the success of Primary Health Care (PHC) I and realizing the need to accelerate the delivery of health services to rural Liberia where the majority of the population reside, the MH&SW has requested assistance in implementing a PHC Phase II project to expand health services to four more southeastern counties.

B. Primary Health Care Phase I

Utilizing low cost outreach strategies, PHC I expanded the delivery of primary health care and provided about 80% of the population with access to health services in two remote southeastern counties: Grand Gedeh and Sinoe. Fifty clinics in these counties that had been abandoned by the GOL were rehabilitated and are now functioning, providing needed health services. Adequate staff were trained to run the clinics and essential drugs and medical supplies were provided. The project also set out to strengthen the institutional capacity

of the MH&SW to develop national policies for county level decentralization and management improvement, and to fund certain basic project recurrent costs through cost recovery schemes such as fee-for-service (FFS), revolving drug funds (RDFs) and the motorcycle purchase fund. This was accomplished. Eight management systems for finance; drugs and medical supplies; personnel; transportation; communication; health information; facilities repair and maintenance; and general supplies are operational in both counties, though more time will be needed to fully institutionalize these systems. A national policy to retain funds collected for services and drugs at the county level was also implemented.

The project, nevertheless, has suffered some setbacks and implementation problems. After six years of effort, decentralization is still in varying stages of implementation, with central level support still weak. A key design error of PHC I was the underestimation of the role the various bureaus within the MH&SW play in the delivery of health services and the assistance they need to enable them to support county level operations. As a result, it has taken longer than expected to fully decentralize health services. The project also suffered from a range of other problems including poor personnel practices, lack of incentives for health workers, irregular supervision, mismanagement of some revolving drug funds and high staff turnover, thereby requiring the need for frequent training and continuing education. These problems, plus the inability of the GOL to provide adequate foreign exchange to the National Drug Service to procure essential drugs and medical supplies and equipment have hurt the project. Despite these problems, the recently completed final project evaluation has indicated that the project has achieved its major objective of delivering PHC services to 80% of the population in the two Project counties.

PHC I has also provided many valuable and useful lessons learned. Probably the most surprising outcome of Phase I was the recognition of the importance of hospitals as referral centers, at the apex of the primary health care network. We learned that without the ability to treat cases beyond the scope of the health worker at the clinics and health centers, patient trust in the preventive component of health care breaks down as does the health care delivery system as a whole. The final evaluation report noted that the hospital is the major supplier of outpatient primary health care for simple illnesses, is the backstop for life threatening situations which inevitably develop whether or not there is a PHC system and that the hospital is the financial backbone of the PHC system. As a result, it is clear that hospitals must be upgraded and made functional to serve as an important link to the delivery of PHC services.

Environmental health and sanitation did not receive emphasis during Phase I, but will be a major component of the Phase II. Project experience indicates that to have a complete and comprehensive PHC network, environmental health and sanitation must be provided along with the other PHC elements. This is to ensure that gains made by PHC are not lost through traditional unsanitary personal hygiene practices.

II. Relationship to the Mission Strategy

The design of the PHC II builds on USAID/Liberia's PHC I Project and 15 years experience in health and family planning assistance in Liberia. The overall goal of U.S. strategy for assistance in the health sector is to improve health status in A.I.D.-assisted countries, as reflected in increased life expectancy. This means reducing infant and early childhood mortality and morbidity, lowering maternal mortality and morbidity, using child survival interventions as the basis for building a more comprehensive health care system over time, ensuring that gains made in improving child survival and health are sustained, and developing new basic, effective technologies and improved systems for the delivery of child survival services.

USAID/Liberia's strategy for health and population and this project are fully in line with A.I.D.'s Health Policy Paper of December 1986. USAID/Liberia's overall strategy objectives are intended to assist the Government of Liberia support institutional and policy reforms, promote and strengthen MH&SW planning, budgeting and expenditure, improve resource management and deliver services. This specific project promotes the improved delivery of primary health services through expanded coverage of child survival services, reduction of constraints to increase preventive and promotive health services and development of sustainable fee for service systems and revolving drug fund schemes at all levels of the system. These elements of USAID/Liberia's overall health strategy as well as this particular project are all major components of A.I.D.'s worldwide health policy and strategy.

It has long been A.I.D.'s policy to focus its health programs on the most vulnerable members of the developing world's population - that is, on infants and children under five, along with pregnant and lactating women. This also supports one tenet of the Mission's strategy which is to continue to focus on basic human needs and the activities in the health sector help to promote human productivity and improve income levels. Liberia falls so short of its own targets in this sector, that one must first address the need for improvement in basic health and education to achieve these goals.

III. Project Description

A. Rationale for Project

Through a 1988 Health Sector Assessment USAID and the GOL have identified four major problems which have prevented the GOL from delivering quality health services to a majority of the Liberian people. They are: 1) the inability of the government to provide adequate resources and implement appropriate programs to reduce incidence of common diseases which are largely preventable; 2) lack of health infrastructure; 3) budgetary limitations and the misallocation of financial resources and 4) a highly centralized MH&SW that provides little support for county level health services.

PHC I has made meaningful progress in addressing these problems. However, its coverage has been limited to two counties. Without broader coverage of PHC services, progress made in PHC I could be eroded as other underserved counties in the region begin to place additional demands on the existing PHC systems developed in the two Phase I counties. Without this project, the health status of the population in the proposed new counties can be expected to deteriorate as GOL health resources continue to decline. Furthermore, the investment of PHC I in institutional strengthening and decentralization of health services nationwide may not be sustained if PHC II is not undertaken. Additional assistance is needed to improve the Central Ministry capability to support delivery of health services at the county and village levels. The final project evaluation conducted in August confirms this analysis. The report noted that because of the general success of PHC I, support should be given to expand PHC services to other parts of Liberia by replicating the PHC model and systems developed under PHC I. The report also emphasized that consolidation of PHC I activities in Grand Gedeh and Sinoe counties must be an integral part of the PHC II project. PHC II will provide the assistance required to consolidate project activities begun under Phase I and will introduce the necessary elements to expand and sustain PHC services in southeastern Liberia.

1. Health Problems

Progress in addressing problems in the health sector has been slow for a number of reasons, including lack of financial resources, commitment to PHC programs, and poor health infrastructure, including clinics, health centers and hospitals. Mortality levels have been declining too slowly. Estimates from the 1984 census indicate that in over 15 years, the infant mortality rate has declined to 127 per thousand births. Other sources indicate higher estimates ranging from

192 to 200 per thousand births. Although the data varies widely, it does indicate that levels for infant mortality are very high in comparison to other African countries. UNICEF and the US Census Bureau rank Liberia as 32nd among 49 listed Sub-Saharan African countries with acceptable health indicators. Data from the Liberia Demographic and Health Survey conducted in 1985 indicates high prevalence of certain diseases among children under five. It is shown that: 40% of children had diarrhea in the four weeks before the survey, 50% had fever and 37% had respiratory difficulties. Almost 20% of children under five have had measles. Indicators show that in Liberia there is an estimated under five mortality rate of 220 per 1000 live births and over half of these can be attributed to diseases preventable by immunization, (UNICEF Liberia 1988-1990). Liberia's immunization coverage of 22 percent is thought to be among the lowest in Africa. See table below of incidence of common childhood diseases in Liberia which are largely preventable and the percentage of childhood mortality that they represent.

Disease	# Cases 1985	% of Childhood Mortality	# Cases 1986	% of Childhood Mortality	# Cases 1987	% of Childhood Mortality
Malaria	4,759	40.9	5,180	35.6	6,456	39.4
Gastroenteritis	2,371	20.4	2,754	18.9	2,251	13.7
Upper Respira- tory Infection	1,423	12.2	1,717	11.8	2,511	15.3
Anemia	1,193	10.3	1,871	12.9	791	4.8
Helminthiasis	849	7.3	1,853	12.7	2,652	16.2
Malnutrition	537	4.6	626	4.3	629	3.8
Measles	298	2.6	242	1.6	886	5.4
Tetanus	196	1.7	314	2.2	210	1.3

Although Liberia's population appears small in relation to the country's land mass, the growth rate of 3.3 to 3.4% is alarming as is the number of women of reproductive age. That group increased from 377,000 in 1974 to 497,000 in 1984. The crude birth rate is estimated to be 46 per 1000 population per year and the total fertility rate is 6.9 children. In addition, women of childbearing age, (15-49) have an estimated maternal mortality of 4.9 per thousand, with an even higher rate among teenage mothers.

2. Health System Infrastructure

The Liberian health care system includes 32 hospitals, 23 health centers, and 330 clinics. Facilities are concentrated, as expected, in populated centers such as Monrovia, with rural areas virtually neglected. Health facilities are of 3 types: government, private (industrial) and church-related. Even in urban settings, the health facilities are only partially developed, staffed and equipped. The situation in rural Liberia is far worse.

According to international classification for developing countries, Liberia is in the category where primary health care coverage is only 40% of the total population when defined as within 0-10 miles or within one hour travel distance walking to a health facility. With the exception of Montserrado, Bong, Grand Gedeh and Sinoe counties, only one county averages more than seven visits per day per health worker. The MH&SW does not have sufficient and/or adequate structures that can serve as clinics, especially in southeastern Liberia, except for the PHC I counties, and parts of central and northwestern Liberia.

3. Budgetary Limitations and Misallocation of Available Financial Resources

Over the last ten years, the health sector budget has declined as a percentage of the total government recurrent budget from 11.4% in 1979/80, to 8.4% in 1988/89. The total GOL budget for 1988/89 is \$18 million, with 55% spent in Monrovia, 34% of which is allocated for the J.F.K. Medical Center, a purely curative hospital. The rest of the budget is spent for salaries and other central level operations. For 75% of the population living outside Monrovia, the budget allocation is currently only 45% (mainly for salaries). Limited GOL funds and the structure of health problems make the current practice of allocating more health resources to curative instead of preventive even more critical. To make matters worse, institutions rarely receive all of the money allocated to them by the budget. The majority of health problems are largely preventable in Liberia; however, the MH&SW still allocates more resources to curative services. Under this Project, USAID will work with the MH&SW to encourage it to reallocate funding to preventive health care.

4. Overly centralized and inefficient MH&SW.

An inefficient and highly centralized MH&SW compounds all of the problems listed above. The Ministry is structured into bureaus and divisions which support the delivery of both curative and preventive services. The key bureaus include Planning Research and Development (BPRD), Central Administration, Preventive Services, and Vital and Health Statistics. The Bureau of Planning, Research and Development is responsible for identifying health problems and formulating and monitoring programs and projects that would benefit the Liberian people. It coordinates all the bilateral programs and resources within the MH&SW. The Bureau of Central Administration is responsible for ensuring the availability and proper management of personnel, infrastructure, finances and logistics. The Bureau of Preventive Services' objectives are, among others, to control and prevent the spread of communicable diseases, promote the health status of mothers and children and

motivate and educate the public on the importance of good health and personal hygiene. Finally, the Bureau of Vital Statistics collects data from all the health facilities in Liberia. Each of these four bureaus is vital in supporting the delivery of health services at the county and village level. They have failed, however, to provide the level of assistance expected. Though the BPRD has shown the commitment to decentralization, it lacks the resources (trained staff, logistics) to plan, analyze, monitor and evaluate the various rural health programs.

On the other hand, Central Administration has been identified as the bureau most resistant to decentralization and health reforms. It also lacks adequate and trained staff, equipment and other logistics to support county level operations. The Bureau of Vital and Health Statistics, considered the most vital link between the central Ministry and the counties, was in disarray until PHC I provided assistance in setting up a data processing unit and conducting staff training. The bureau is currently being reorganized to ensure increased efficiency.

The one bright spot is the Bureau of Preventive Services which comprises the Information, Education and Communications; Maternal and Child Health; Environmental Health and Sanitation; and Communicable Diseases Control Divisions. It has made the most progress in the last five years in support of PHC activities and in supporting the Ministry's decentralization policies. However, much more needs to be done by Preventive Services to ensure that basic health services are available. For example, the Bureau must coordinate the activities of the divisions to focus on county level service delivery. Maternal and Child Health and Communicable Disease Control Divisions will have to devise simple cost-effective strategies to improve immunization coverage, nutrition practices and family planning.

B. Goal

The goal of the project is to reduce infant, childhood and maternal mortality and morbidity by making basic health care available and accessible to 90% of the population of Liberia by the year 2000.

C. Purpose

The purpose of this project is twofold: To increase the proportion of the target population (women and children under 5) in the project counties with access to an appropriate balance of preventive, promotive and curative services and to improve the quality of health care in the project counties.

D. Implementation Strategy

In order to improve the MH&SW's ability to allocate and manage resources and reduce preventable health problems mentioned above, the project will: 1) strengthen the MH&SW as an institution at the central and county levels and 2) deliver services to the villages.

1. Institutional Strengthening

(a) Central-level Support and Policy Reforms

PHC I's emphasis was on developing key management systems needed for decentralization. It succeeded in establishing the systems in the two project counties but failed to provide the necessary support within the Central Ministry to sustain these systems or to achieve decentralization of responsibility for several key systems, particularly personnel and finance. At the MH&SW, the project will accelerate the integration of the systems developed under Phase I. As yet, many central Ministry staff have not fully grasped the nature of the decentralization and management systems developed during Phase I. Despite approved decentralization policies and guidelines, some central Ministry staff continue to exercise authority that should be given to the counties as granted to them by the decentralization guidelines. To address this problem, the Ministry is developing a five-year health plan which will contain specific directives and strategies to implement the decentralization guidelines and policies and management systems.

To support the implementation of the five-year health plan, the project will provide technical assistance, training and commodities to strengthen key bureaus within the Ministry. Under the Project, support will include staff training, logistics and equipment for the Bureau of Central Administration. This is expected to improve its capability in financial planning and in correcting imbalances between curative and preventive services through monitoring of personnel assignment and resource allocation.

The Bureau of Vital and Health Statistics will be reorganized to include two divisions; one for Vital Statistics and the other for Health Statistics. Each will be assigned a Director. This will increase the effectiveness of this bureau in its collection, analyses and utilization of health information. The Bureau of Planning, Research and Development will also be reorganized to include a Deputy Minister's position to deal with PHC policy matters and related health sector policy issues. Through redeployment and project funded training, adequate and trained staff will be provided to improve the Bureau's planning, analytical, monitoring,

evaluation and research abilities. This Bureau will have major responsibility for the implementation, monitoring and evaluation of health projects and programs planned in the five-year health plan. Other Bureaus that will be strengthened will include Preventive Services (IEC Division and Environmental Health and Sanitation).

The Project will continue to assist the National Drug Service (NDS), a semi-autonomous agency of the MH&SW, because, without an adequate supply of drugs, the primary health care system can not work. To augment GOL resources to the NDS, PHC II will provide drugs, medical supplies and equipment to establish county depots and a fixed centralized cold chain system. Adequate equipment to strengthen NDS operations will be procured and installed. Short term technical assistance in financial management, logistics, inventory control and procurement will be provided. A full-time pharmacist will be trained to work at the NDS and long and short-term training for NDS finance, logistics and procurement staff, both centrally and at the county level, will be provided. The GOL will be required to provide at least \$50,000 per month in foreign exchange to the NDS as a precondition to USAID disbursement of project funds for drugs and medical supplies.

Technical assistance and training will be provided to help strengthen the institutional capacity of the Ministry to implement the project. There will be two long-term advisors assigned to the project in Monrovia: a management/training specialist and a logistics specialist. The management/training advisor will be assigned to MH&SW central headquarters and be primarily responsible for coordinating training activities and integrating the management support systems developed under Phase I in the field with the practices of the central level. The logistics specialist will work with the NDS to establish drug depots in each project county, to ensure that all health facilities are adequately equipped, to assist with the procurement of drugs, medical supplies and other project commodities and to ensure that the counties receive adequate logistical support from the central Ministry.

Short-term technical assistance will be provided to the appropriate bureaus within the Ministry. Local and outside consultants will be provided to the Bureau of Planning, Research and Development in implementing the five year health plan, conducting research and analytic work and in conducting monitoring and evaluation activities. Short-term TA will also be provide to the Bureaus of Preventive Services (IEC, MCH and Environmental Health Divisions), and Vital and Health Statistics.

Most of the mid and senior-level training will be done locally, drawing heavily upon the health officials already trained by Phase I. Some short-term outside consultants, however, may be required. Both short and long-term training will also be provided for staff from the Bureau of Planning, Research and Development, Project Management Office, Preventive Services (IEC) and also for appropriate county health services staff. Study tours to gather experience of similar projects and third-country training for some of the central and county health staff may be done in other African countries such as Ghana, Nigeria, Kenya, Sierra Leone, Malawi, Swaziland and Lesotho.

Through the central MH&SW, coordinated by the Bureau of Planning, several operations research studies will be conducted to identify implementation problems, develop innovative ways to accelerate project implementation and to help sharpen the focus of project elements. One potential research program is to collaborate with the University of Liberia in strengthening the curriculum of the Department of Community Medicine at the Medical School to focus on practical community-based PHC training. The objective is to increase orientation to primary health care and community-based health programs so that medical students who may not pursue a career in public health will still have an appreciation of PHC and the need for greater collaboration between clinical and public health physicians in delivering health services.

(b) County level support

On the county level, the project will continue the work begun under Phase I in Sinoe and Grand Gedeh to ensure that all eight management systems are fully implemented in these counties, to strengthen supervision through the provision of replacement vehicles and spare parts, and to provide training and continuing education as appropriate. Working through the NDS, drugs, medical supplies and equipment for the hospitals will be provided to set up local county drug depots. The final evaluation recommends that technical assistance be continued to the counties to help consolidate activities. In addition to continued support to Grand Gedeh and Sinoe counties, the Project will expand into four new counties -- Grand Bassa, Rivercess, Maryland and Grand Kru, though not simultaneously. These counties were chosen for several reasons: Rivercess and Grand Kru are relatively new counties, created only in 1984 and few health services are available. In Maryland, though, the services are fairly adequate but the management structure needs improvement. With the possible closure of the LAMCO (a mining company) hospital in Grand Bassa, the demand on government health service will increase. To meet this additional demand in Grand Bassa county, the county hospital and several health

facilities will be strengthened through renovation of existing facilities and the provision of drugs, medical supplies and equipment. However, if a plan now under consideration for the Ministry to take over the management of the LAMCO Hospital as the county hospital is approved, resources will not be used to upgrade the new county hospital. It will instead be upgraded to serve as the major health center in the county.

Maryland and Grand Bassa were selected as the initial project counties because of the level of development of health infrastructure; accessibility; and PHC (Maryland) and CCCD (Bassa) activities already taking place. Maryland County is the more developed of the two, with better trained staff, a newly renovated hospital, a functioning Community Health Department, some well run clinics and highly motivated and mobilized Village Development Councils (VDC).

Starting in these counties and using a phased approach, the Project will implement the eight management systems, establish cost recovery systems and undertake renovation/construction.

1) Management Systems

The Project will implement the eight management systems (personnel; finance; communication; drugs and medical supply; general supply; transportation; health information; and facilities and equipment). The systems that are now working well in Grand Gedeh and Sinoe will be replicated first. In years 1 and 2 of the project, the finance, logistics, transportation and personnel systems will be implemented. Efforts will be made to clearly establish procedures at county headquarters, with appropriate depot facilities and training of the county finance officer and county logistics officer. Movement down the distribution and service network to the health centers, health posts and communities will follow systematically. As the counties gain confidence and experience through adequate training and supervision, the rest of the systems will be replicated in years 3 and 4. The evaluation found this approach to be valid and recommended we proceed with implementation in this way.

2) Cost Recovery Systems

Fee-for-service and revolving drug fund schemes will be established at all health facilities in these counties. Monies collected under the RDF from the sale of drugs will be used to continually replenish drug stocks to ensure a constant supply. Major control activities of the RDF, of pricing and profit/overhead will be established at the county headquarters level in year one. The evaluation stressed that RDF profits must be made available to cover recurrent costs of supervision

and transport in the counties. Fees from services rendered by clinic staff under FFS will go toward meeting certain basic recurrent costs to operate the health facilities, while funds generated under the motorcycle purchase plan from the sale to health workers of motorcycles purchased by the project will be used to procure spare parts and to maintain the motorcycles. Other cost recovery mechanisms will include direct remuneration by the villagers themselves to the village health worker and traditional midwives for services rendered. Additionally, the GOL will redeploy excess staff already on its payroll to the project areas instead of hiring new staff. Each of these mechanisms will help reduce the recurrent cost burden on the GOL as the PHC system develops in the project counties.

3) Construction/Renovation

The Maryland County Community Health Department building is in excellent condition, but the Grand Bassa County Community Health Department building will need major renovation and extension. Grand Kru and Rivercess counties will require new Community Health Department buildings. There is a wide disparity within the four counties in the physical condition of health facilities, including health centers and clinics. Many of these facilities need renovation and upgrading, while construction of additional facilities in those areas grossly underserved will be undertaken. Staff houses will be constructed in all four counties as incentives for health workers to accept assignments in the project counties. Funding for construction/renovation of hospitals, health facilities and staff houses will be provided by the GOL.

The bulk of the work in Grand Kru and Rivercess will not begin until the Project completes its assistance to Sinoe and Grand Gedeh, an evaluation of activities in Maryland and Bassa counties is completed and the European Economic Community (EEC) has done substantial work in upgrading the road network in these counties. In the meantime, mobilization of communities and the establishment of village development committees (VDCs) will take place.

Two public health management specialists, assigned to Maryland and Bassa counties, will be primarily responsible to provide technical directions in the delivery of health services at the county level. They will also provide assistance to improve management at the village level. Peace Corps participation will be secured to assist in project implementation. PCVs will be assigned to the project counties in areas of management, health education, training and supervision, community mobilization and logistics support. The two GOL counterparts to the long-term TA public health management specialists will undergo long-term training (MPH degrees) in public health.

2. Village level service delivery

Village level services are the foundation of any primary health care delivery system. More than 85 percent of the population in the project counties live in remote areas, mainly in villages of less than 500 people. They lack modern health services and, even when there is access to a health facility, it is usually inadequate. This Project will provide the resources to increase access to health services to about 90 percent of the population in Grand Gedeh and Sinoe counties, and 80 percent in the four new counties. To achieve this, village health teams will be trained in each county (upgraded in the case of Grand Gedeh and Sinoe). Each team will consist of a village health worker (VHW) and one or more traditional birth attendants (TBAs). Health facilities will be upgraded to acceptable standards through renovation, adequate staffing and provision of essential drugs, medical supplies and equipment. The delivery of health services will focus on the following interventions:

(A) Child Survival: Immunization, ORT, malaria treatment, child spacing, growth monitoring and nutrition will be promoted through strengthened outreach, immunization clinics, and other techniques. These include promotion of home fluids and ORS packets, correct treatment of malaria through administering the correct dosage of malaria medications, establishment of nutrition demonstration and training units, and effective health education.

Because in its initial stages this Project will concentrate on institutional strengthening, another USAID project, Combatting Childhood Communicable Diseases (CCCD), will coordinate activities and resources provided by the project to support service delivery. CCCD emphasis is on immunization, diarrheal disease control, malaria treatment and community activities in health education. CCCD technicians, with some support from already trained PHC I staff, will do the actual service delivery while the PHC II Project will pick up logistic support costs for training, supervision and cold chain operation and maintenance. Activities in environmental health and sanitation; and health education/IEC and family planning will primarily be the responsibility of the PHC Project. Some of the services will be coordinated with the other donor projects (see Section G.) to carry out construction/renovation; establish FFSS and RDFs; and mobilize and supervise communities. Close collaboration with CHAL will continue in an attempt to standardize as many of the health service activities as possible, particularly those involving the RDF.

(B) Population and Family Planning: In addition to the provision of commodity support (basic contraceptives, posters, training materials), a massive information, education and communications (IEC) campaign will be launched to promote population/family planning activities using the Liberia Rural Communication Network (LRCN) and technical assistance to be procured from the Johns Hopkins University/Population Communication Services (JHU/PCS) centrally-funded project and other available centrally-funded family planning/population services. Population activities will be coordinated with the planned USAID bilateral population and family planning project currently being designed.

E. End of Project Status

By the end of this Project, all six counties comprising the Southeastern Region will have greater access to PHC services. The MH&SW, working with other donors and the private health sector, will continue to implement the decentralized management systems until all the 13 counties of Liberia have been included under a comprehensive PHC program and a uniformed primary health care system exists throughout the nation.

By the PACD, this Project will have established a PHC delivery system that provides basic preventive, promotive, and curative health services to approximately 500,000 rural Liberians in Grand Gedeh, Sinoe, Rivercess, Maryland, Grand Bassa and Grand Kru counties. Specific indicators include the following:

1. Access to a village health team (within one hour walking time) will increase from 80% to 90% in Grand Gedeh and Sinoe Counties and from an estimated 35% to 80% in Rivercess, Grand Bassa, Maryland and Grand Kru counties by 1995.
2. Increase of at least 45% utilization of the PHC delivery system in Grand Gedeh and Sinoe counties and an increase of 35% utilization in the rest of the counties by 1995.
3. Decrease of at least 30% in infant and maternal mortality in Grand Gedeh and Sinoe counties and a decrease of 25% in the four new project counties by 1995.
4. Eight project management support systems in place in the six counties and operating by 1995.
5. Health staff trained and providing maternal support and child survival services.
6. GOL standard protocol followed for preventive and curative services.

F. Project Outputs

1. A functioning Health Planning Council that will coordinate health activities with other ministries and donors.
2. Six referral systems established from community level to county hospital.
3. Self-sustaining community revolving drug funds operating in all project counties.
4. Fee-for-service systems operating in all project counties.

G. Relationship With Other Donors

1. UNICEF: In Grand Bassa, one of the counties PHC II will work in, UNICEF has initiated a pilot PHC program to establish RDFs at selected clinics, upgrade these clinics to acceptable standards, train clinic staff and to mobilize community support for the program. Therefore, under PHC II, USAID will only supplement UNICEF activities. In addition, UNICEF has already completed an inventory of some of the clinics in the other project counties. This information will prove useful when the project begins mobilization activities.
2. EEC: In three of the proposed PHC II counties, (Grand Kru, Rivercess and Grand Bassa), the EEC is planning a water supply and sanitation project. This project will be useful in supporting the environmental health and sanitation components by providing the basic hardware, including pumps, wells and latrines for PHC II communities. Additional support from the EEC includes a planned road project to rehabilitate access roads in southeastern Liberia beginning in 1990. Better roads will be helpful since it will permit travel to many clinics which are virtually inaccessible in the rainy season. Grand Kru will greatly benefit from road rehabilitation.
3. Government of the Netherlands: The Dutch Government supports the Maryland County Village Health Workers Project that installs wells, trains village health workers and traditional birth attendants, mobilizes communities and supports the community health department in Maryland County. Though this project is scheduled to end in October 1989, Phase II can build upon the foundation already developed by expanding upon the village health worker program and cost recovery mechanisms already in place.
4. World Health Organization (WHO): The 1989 workplan has not yet been approved; it can be assumed that WHO will continue its traditional assistance of providing consultants to the MH&SW for selected health activities.

IV. Factors Affecting Project Selection and Further Development

A. Social Considerations

The population of the four new counties is approximately 364,000. They belong mostly to the Kwa (or Kru) ethnic group. Although at one time this region had been prosperous, it is now on the decline. The southeastern region is difficult to reach and because housing and basic services are often unavailable, very few professionals are willing to work there. This part of the country has some of the poorest infrastructure with many areas being cut off from Monrovia and even from secondary cities in the area during the rainy season due to extremely bad roads; even in the dry season, vehicles are unable to reach several areas in the various counties. With the imminent closure of a major branch of a company located in the region, many services heretofore provided privately should now be provided by the government.

Though women and children will be the primary project beneficiaries, whole communities will be the indirect beneficiaries. The upgrading of the hospitals and the availability of drugs through revolving drug funds will benefit all those living in the project counties. Village health workers will be trained to take care of all types of simple diseases at the village level.

The Kru and Grebo people are already used to some form of administrative structure. In places where a village development council exists, the Project will work through that group, adding a health member to it. In other areas, village health councils will be established. As the Project will work with the county health officers and the village health councils, no problems are expected in introducing new health methods that may be considered taboo in this region. Moreover, the village health worker who will be trained will be a member of the village and will know the best approach to changing traditional beliefs. Acceptance of the primary health care concept can be expected because even in areas where no large scale activities are ongoing, usually some small scale PHC activities have occurred either through donors, missionaries or the MH&SW. In counties where villages may be slow in accepting new practices, the mobilization to be carried out by the Project will take place over a longer period of time.

B. Economic Considerations

The primary health care approach according to the Agency's Health Sector Strategy Paper, offers the most cost-effective way to decrease infant and child-mortality and maintain a healthy labor force in the short run. The Liberian health

delivery system is based upon delivering primary and preventive care and the MH&SW leadership accepts the approach as the desired option for reaching the majority of the population. Contrary to Ministry policy, however, the current MH&SW expenditure patterns represent a strategy which remains contrary to the PHC concept as it is currently conceived. According to the recent Health Sector Assessment, 80 percent of current MH&SW expenditures are absorbed by curative components, while only nine percent is invested in prevention. Further, this allocation has persisted for the past ten years.

During the PP design, a thorough cost effectiveness analysis will be undertaken in order to demonstrate that the Project's activities are the least costly approach to the health problems facing Liberia. In addition to certifying the economic soundness of the activity, a recurrent cost assessment will be done to determine any additional long-term costs associated with the expansion of PHC activities in the four counties.

After six years of implementing Phase I of this USAID activity, the inefficiencies and decreasing budgetary allocations to the Central Ministry persist and, if not addressed, will continue to plague attempts to fully implement this project, especially in terms of long-term institutionalization. The fee-for-service system and the revolving drug fund remain central to the project. However, additional work in the PP will determine the GOL's ability to facilitate sustainability of certain systems this project will put into place.

The economic soundness of this activity as it is currently conceived will be heavily determined by the design effort to identify an implementation strategy which will result in a real change in GOL emphasis, budget and policy. The final evaluation report emphasized that decentralization must fully take place, especially for the personnel and finance activities, for the project to be sustained administratively. The report also cautioned that not much change should be expected from the MH&SW recurrent budget except for payment of salaries of health workers. It noted that some project costs could be sustained through locally generated revenues from RDFs and FFS, but that the GOL contributions to the project will continue to be largely funded from the development budget, which is solely financed by the PL-480 program. The PP will also analyze the effect that the total absence of PL-480 counterpart funding would have on the implementation of Phase II.

C. Relevant Experience with Similar Projects

1. Lofa County Rural Health Project (1975-1980): Beginning in 1975, the Lofa Project was USAID's and the GOL's first attempt at primary health care. The project was designed to provide a well-functioning, countywide health network with 30 health

posts and 5 health centers supported by adequate supervision, supplies, transportation and trained personnel. This network was intended to be an outreach for John F. Kennedy Hospital. While the project achieved some of its goals, weaknesses were identified in supervision, logistical support and training. Outreach beyond the health center to the village level was not included in the design of this project. One key problem noted was that the project attempted to implement a facility-based system without proper monitoring which would have permitted modifications of the systems that were not working.

2. Maryland County PHC Program (1976-1989): Initiated in 1976, and supported by the MH&SW and the Netherlands Government, this project tested decentralization of health services to the county level, trained village health workers (VHWs) and midwives, installed handpumps for safe drinking water, and established cost recovery mechanisms in the project, including Revolving Drug Funds. The project broadened the degree of community participation in PHC activities, although the external support level was not sufficient to establish a comprehensive PHC system.

3. Health Management Planning Project (1976-1982): This institution building project, supported by USAID, was designed to provide the MH&SW with assistance to upgrade its planning and development capability for health service delivery and utilization, health facilities management, management systems development, health manpower development and health commodities/logistics improvement. Key lessons learned were that : (1) there were too many objectives to be accomplished in a short time; (2) there was insufficient political will and commitment from the MH&SW to the project; and (3) the technical assistance team was unable to effectively implement the project.

4. Combatting Childhood Communicable Diseases (1983-1991): The CCCD Project, which emphasizes service delivery of three basic child survival/PHC interventions (immunization, ORT and malaria treatment), is a regionally-funded project supported by USAID and the GOL. It also supports institutional strengthening, including health education, health information system, operations research and cost recovery, as a means to promote county-level decentralization of health services. The CCCD Project provides valuable experience in the promotion of low-cost child survival activities, improved service delivery techniques, supervision and training of health workers, cost recovery schemes and their ability to sustain health services.

5. Christian Health Association of Liberia (CHAL)(1986): CHAL was a key subcomponent of the PHC I Project. CHAL, the Christian Health Association of Liberia, is a local PVO which cooperates with the MH&SW and receives USAID assistance. CHAL supports PHC activities in most of central and northwestern Liberia.

CHAL incorporates PHC elements, including child survival interventions, nutrition, family planning and water and sanitation, into the activities of its membership of six hospitals and 46 clinics reaching 450 communities.

D. Proposed Grantee and Implementing Mechanism

Phase II will continue to be implemented through a grant agreement with the MH&SW. At the MH&SW, implementation of the Project will be carried out by a project management team consisting of a Project Manager, Assistant Manager, Administrative Assistant and clerical and support staff from the Ministry. They will receive technical advice and direction from a technical assistance team that will be contracted by USAID possibly through a contract with an 8(a) firm. The MH&SW Committees to be used are the Financial, Executive and the PHC subcommittee. The Financial Committee is responsible for Ministry requests for Project funding and expenditures, and serve as the financial oversight arm of the MH&SW. The Executive Committee will be responsible for decisions on project management administrative matters, and the PHC subcommittee provides technical direction on project implementation. USAID is a member of all these committees. In addition, the Health Planning Council and the Donors Coordinating Committee will also make sure PHC activities are being coordinated with other ministries and external donors. Finally at the county level, participants trained under Phase I have returned and will be able to train others in the new project counties.

The only training required to strengthen management of the Project is an MPH for the assistant project manager and short term training in finance for the project manager.

E. AID Support Requirements and Capability

The Mission has a direct hire health officer who will be responsible for this project. He will be assisted in project implementation by an FSN Health Program Specialist. REDSO/WCA will provide backstopping on an as needed basis.

F. Estimated Costs and Methods of Financing

1. Cost Estimate

Cost estimates at this stage are illustrative, though based primarily on recent USAID experience with PHC I and other projects in the Mission's portfolio. The total cost of the project is estimated at \$17.6 million. A.I.D. contribution is expected to be \$10 million while the GOL will provide \$7.6 million both in-kind and cash.

B. Financial Plan

(1) AID Contribution

Four long-term technical specialists, representing 17 person years of technical assistance, will be provided, as well as 24 person years of locally-hired assistance that includes an administrative assistant, financial officer and secretary. In addition, at least 60 person-months of short-term technical assistance are expected to be needed. The total cost of this input is expected to be \$4.5 million.

Long-term participant training is comprised of an estimated 32 person-years; short-term participant training about 80 person-months. In addition, in-country training and local scholarships will be provided. The total cost of the training component is estimated at \$1.5 million.

Twenty-five vehicles and about 200 motorcycles (including mid-project replacement) are planned to be procured. Other commodities will include drugs, medical supplies and equipment, furniture and appliances for TA team and locally-made furniture for health facilities. The estimated cost of commodities is \$2.0 million.

A.I.D. will fund other project activities which will include evaluations, audits, special studies, and operations research. Planned cost is \$500,000. A contingency factor of approximately 1.0 million is included as well.

(2) GOL Contribution

The GOL will pay the salaries of all project staff and related health workers participating in the project. Personnel costs are estimated at \$1.0 million. It will be expected to provide funds totalling \$3.6 million in foreign exchange during the life of the project for the procurement of drugs and medical supplies and equipment. Cost of construction/renovation of health facilities and staff housing is estimated at \$2 million. The GOL will spend approximately \$1.0 million on various other items, including building and equipment maintenance, vehicle operations, maintenance and repairs, international travel, per diem for health worker, and subsidies.

Summary Budget
(\$000)

	<u>USAID</u>	<u>GOL</u>	<u>TOTAL</u>
TECHNICAL ASSISTANCE	4,500	-	4,500
TRAINING	1,500	-	1,500
PERSONNEL	-	1,000	1,000
COMMODITIES	2,500	3,600	6,100
CONSTRUCTION	-	2,000	2,000
STUDIES	250		
EVALUATIONS/AUDITS	250		
CONTINGENCIES/OTHER COSTS	1,000	1,000	2,500
=====			
TOTAL	10,000	7,600	17,600

G. Design Strategy

The Mission completed the evaluation of Phase I in July and the PID will be forwarded to AID/W in October for review. The PP team will consist of three external consultants: a health planner/management specialist, a health economist, and a locally-hired public health specialist. Other USAID members of the design team will include the Mission Economist, Controller, Project Development Officer, Health, Population and Nutrition Officer, and if available, the REDSO/WCA HPN Officer. The participation PP team members from the GOL will include: the SER/PHC Project Manager/MH&SW, the Assistant Minister for Planning, Research and Development/MH&SW, the Deputy Chief Medical Officer/MH&SW and a Health Planning Officer from the Ministry of Planning and Economic Affairs.

The external consultants will stay in-country for six weeks and will visit Maryland, Grand Bassa, Sinoe and Grand Gedeh Counties. The cost of the PP design team is expected to be about \$100,000. Since AID/W is reviewing the PID, an evaluation of PHC I confirmed that the approach to be used in designing Phase II is sound, we request authority to approve the PP be approved in the field.

H. Recommended Environmental Threshold Decision

A negative environmental threshold decision is recommended. The Initial Environmental Examination (IEE) is contained as Annex II.

I. PP Design Issues

The following issues will be carefully examined during the PP design:

1. Improved GOL Resource Allocation

The MH&SW's official health policy states that priority will be placed on the establishment of a PHC program designed to reach the population in rural areas. At present, the imbalance in medical care--curative versus preventive and urban versus rural areas shows that, from 1977/78 to 1988 the personnel component of the budget increased from 61% to 74% and the total cost of personnel went from \$9.1 million to \$14.0 million. At the same time, the materials and consumables (supplies, drugs) and services (gasoline, maintenance, communication utilities) have decreased from 19% to 7% and 10% to 5%, respectively.

Such an allocation is not consistent with the GOL policy of extending PHC to all its citizens since basically funds were used mainly for curative services in urban areas. USAID will hold discussions with the GOL to address these imbalances. As a first step, MH&SW will be requested to prepare a report showing the allocation of the recurrent health budget for 1991 and 1992 by major line items (personnel, drugs, transportation and maintenance) and curative and preventive classifications, in order to have baseline data with which to assess the level of support given to the PHC program.

2. Recurrent Costs

As set forth in A.I.D.'s Policy Paper on recurrent costs, A.I.D.'s contribution will not fund recurrent costs except where a plan exists or will be developed to eventually shift the entire cost burden to the GOL. The GOL will be required to assume a greater share of recurrent expenses of the PHC program through a national cost recovery policy, including Fee for Service (FFS) and Revolving Drug Fund (RDF) schemes. During the implementation of PHC II, USAID will request the MH&SW to prepare a report which will detail the amount of fees collected at hospitals and provide a list of prices to be charged by MH&SW for drugs and the amount of revenue received from drug sales.

3. Private Sector Participation

In Liberia, private sector health services consist of church-sponsored medical missions, commercial concession medical facilities, and private for-profit medical practitioners (physicians, medical stores, private dispensers and traditional healers and midwives). Until the past few years, the emphasis of most of these services had been in providing services for the acutely ill. These organizations are now cooperating with the CHAL to offer health services in support of governmental programs which are preventive in

nature. Through support for CHAL under an operational program grant, USAID will encourage the GOL to continue to seek maximum cooperation and explore arrangements with the private sector to assume a larger role in the provision of health services through privatization of some GOL health facilities in urban areas.

4. Efficient Utilization of MH&SW Manpower

The Mission will encourage the Ministry to institute a hiring freeze for five years and utilize existing staff through retraining and redeployment. Where practical, the Ministry will be urged to retrench unnecessary and unproductive personnel.

5. Foreign Exchange Allocation

The continued survival of the cost recovery systems depends on the ability of the GOL to provide the foreign exchange to procure essential drugs and medical supplies/equipment on a regular basis. The failure of the GOL to allocate adequate foreign exchange under Phase I has been ostensibly resolved with the Ministry of Finance, although funds are not currently being made available on a timely basis. This will be closely monitored during Phase II.

J. Gray Amendment

The technical assistance contract to be awarded for the implementation of this project is being considered by USAID/Liberia as an 8(a) firm set aside. However, if a decision is made that the contract will be subject to open competition, it will require that the prime contractor (if not a minority firm) subcontract a portion of the contract to a minority entity. If an education institution is selected, the same requirement will apply.

K. WID Strategy

In order to ensure that gender issues are addressed in the project, the baseline survey to be designed will include a means to disaggregate the data by gender. Throughout the life of the project, data contained in the technical assistance team's quarterly reports will also be disaggregated by gender. Finally, the project will also identify any gender specific constraints and outline steps to be undertaken to overcome them.

Life of Project:
From FY 90 to FY 95
Total U.S. Funding \$10,000,000

Project Title & Number: Primary Health Care Phase II (669-0219)

<u>NARRATIVE SUMMARY</u>	<u>OBJECTIVELY VERIFIABLE INDICATORS</u>	<u>MEANS OF VERIFICATION</u>	<u>IMPORTANT ASSUMPTIONS</u>
Program or Sector Goal:	Measurements of Goal Achievement:		Assumptions for achieving goal targets:
To reduce infant, childhood maternal mortality and morbidity by making basic health care available and accessible to 90% of the population of Liberia by the year 2000	Cases of preventable diseases and malnutrition down	Mortality survey	Population growth rate remains constant
	Proportion of population with access to adequate health care increased by 50% in 1990; 70% in 1995 and 90% in 2000	GOL statistics UN statistics	General economic conditions do not further deteriorate PHC remains a GOL priority
Project Purpose:	End of Project Status:		
1) Increase the proportion of the target population (women and children under 5) with access to an appropriate balance of preventive, promotive and curative services in the Project counties	80% of target population within 1 hour walk to a health facility/ services	Site visits	Number of trained Ministry personnel adequate in project counties
	35% increase in utilization of health services by 1995	MH&SW records Project Baseline Study	
2) Improve the quality of health care in the project counties	8 project management systems in place and operating	Project evaluation	Community mobilization effective for target population
	25% decrease in infant and maternal mortality in project counties by 1995	Baseline survey	
	Health staff trained and providing child survival services; Full 8 person county health team in place	Site visits	Decentralized systems in place to support service delivery
	GOL standard protocol followed for preventive and curative services	MH&SW Records/ site visits	

Project Outputs: targets:	Magnitude of Outputs:		Assumptions for achieving goal
Functioning Health Planning Council	Interagency coordination established	Observation at quarterly meetings	Strong commitment from MOH and MPEA for establishment of council
	External donor coordination established		Other ministries, PVOs and health sector institutions will actively participate on Council
	MH&SW Five Year Plan developed		
Referral system established from community level to county hospital	5 hospitals, 100 health facilities, and 4 community health departments renovated, staffed and equipped to referral standards 50 staff houses constructed	Site visits	TBAs & CHWs adequately trained to know when referral is needed
	Community outreach programs and outpatient services functioning		Once hospitals are renovated, adequately staffed & equipped, they will be utilized by community
Self-sustaining community revolving drug funds operating in all project counties	External funds not needed to resupply drugs	MH&SW clinic, hospital records	Tight financial management and monitoring controls are in place GOL provides adequate foreign exchange for purchase of drugs
Fee-for-service systems operating in all project counties	10% of funding for recurrent costs (excluding personnel) generated at county level	Site visits/evaluation	People will pay more for improved services provided
Inputs:	Implementing Target (Type & Quality)		Assumptions to providing inputs:
Long term TA	2 public health specialists; 1 management training specialist and 1 logistics specialist	Site visits	Brooke sanctions are not in effect
Short term TA	60 months of short term TA in finance; community mobilization; training/supervision; health information systems		Funds are available on a timely basis
Training	Long, short and in-country		
Commodities	Vehicles, motorcycles, drugs and medical supplies/equipment		