

PD-NBA-136

NOV 1 1989

Memorandum

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To: See distribution

From: AFR/PD/CCWAP, Robert Hellyer *RH*

Subject: Liberia Primary Health Care(669-0165)-Phase I;
Transmittal of the Executive Summary
of the final evaluation, August, 1989.

In order to assist you in preparing for the Issues(Nov. 6) and ECPR(Nov. 13) meetings for the Liberia Primary Health Care(669-0219) Phase II project, please find attached a copy of the Executive Summary of the recent final evaluation of the phase I project. Complete copies may be obtained from AFR/PD/CCWAP-room 2443.

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Executive Summary

The broad objectives of the Liberia Primary Health Care Project as set forth in the original Project Paper and the Project Paper Amendment (669-0165) were achieved. The proportion of the target population with access to an appropriate balance of primary health care services was increased, and the institutional infrastructure was strengthened, both centrally and in the target areas. However, the management systems, developed and introduced as a major element of the effort to achieve the above objectives, are still fragile. Important elements of decentralization from the central to the county level have not been implemented, and the continued availability of low-cost drugs is threatened by the lack of sufficient foreign exchange.

Even so, the progress made by the project in making primary health care available in rural areas is impressive. There are close to 100 VHWS providing health services to their communities in the two project counties. Supervision is routine at the county level and down through the clinics to the VHWS. Although the eight management support systems are not institutionalized, they are operational to the extent required to prove their functional effectiveness. We strongly urge that the effort be continued in the project counties and expanded into additional counties.

The findings of the Evaluation Team follow the outline laid out in the Scope of Work (See Annex B). A summary of these findings follows below.

1. PHC Service Delivery, Coverage and Basic Health Status

A. Village Development Committees (VDCs)

The multisectoral concept of the VDC never materialized, as other sectors are only rarely included in the committees. Therefore, only "health" councils have been formed. Some of these are called Health Advisory Committees (HACs) and others Community Health Councils (CHCs). Of the proposed 114 committees, 99 were formed. Each of these supports a VHW and is actively involved in managing its community-based PHC system.

Some of the factors which promoted the success of the program included the mobilization carried out by the Physician Assistants (PAs) and Certified Midwives (CMs), the involvement of the communities from the very start, and the very attractiveness of the program with drugs becoming available. The communities claim ownership of the project because they feel they have control over the drugs and over their health worker.

B. Village Health Teams

Of the proposed 114 VHWs, 99 have been trained. Once deployed, they are supposed to work as a health team with the existing local Traditional Birth Attendant (TBA). These TBAs first received additional training, which has only recently been completed. Indications are that the VHW and the TBA will cooperate with each other. Basically, the two individuals are a team in the complementary sense, each providing a different health service.

Many of the VHWs were not receiving the promised farming help from their communities. Therefore, a decision was made by the project staff to allow the VHWs to charge a fee-for-service and keep it. Since the VHW is an employee of the community, his remuneration should, in the future, be left entirely in CHC/HAC hands. Fee-for-service should be a community option.

The VHWs are proving to be able to manage common illnesses at the community level. It is estimated that 28 percent of the community populations where the VHWs are located actually use their services. The system is effective.

C. Supervision

The supervisory model used in the counties is as follows: On a monthly basis, the county level Clinic Supervisors supervise the Health Center/Health Post (HC/HP) PAs, who in turn supervise the VHWs. The Clinic Supervisors visit the VHWs on a quarterly basis. When fully implemented, this schedule results in more frequent supervision of the VHW than the project felt necessary and certainly overloads the Clinic Supervisors. We recommend the Clinic Supervisors leave supervision of the VHWs in the hands of the HC/HP PAs.

The supervisors are making effective use of the motorcycles, but the spare parts scheme needs modification. Also, the mileage reimbursement plan needs to be revised to give the supervisors more incentive.

The supervisors have been quite effective in resolving problems at the community level, as evidenced by the low attrition rate for VHWs in the two counties.

D. Community/Village Mobilization

The proposed District Mobilization/Training teams never materialized because the project decided to use existing manpower rather than involving new personnel. Clinic Supervisors trained HC/HP PAs and CMs as mobilizers and supervisors for the community level. The effort was successful, as indicated by the number of communities organized and VHWs in place.

E. The Referral System and Child Survival.

At the start of the project there were 20 midlevel health workers (MLHWs) and at present there are 77.

VHWS are sending referrals to the HC/HPs, but it is difficult to determine the numbers from the available records. It was also difficult to ascertain if there are now fewer clients coming to the clinic level with common illnesses from communities where there is a VHW. However, the subjective feeling of the PAs is that there are, in fact, fewer such clients coming to them.

It was clear from Expanded Program on Immunization surveys from 1986 and 1988 that immunization coverage has increased. However, progress in other activities such as use of ORT, family planning, promotion of good nutrition, malaria treatment, etc. cannot be assessed without a survey.

The county hospital has been accepted by the project since the midterm project evaluation as being a critical part of the PHC system. In addition to being the major supplier of outpatient primary health care, it is the referral center for the entire county. And it is the financial backbone of the system. A concerted effort should be made to make it an attractive, credible institution.

2. Institutional Strengthening with Emphasis on County-Level Decentralization

A. Decentralization and the Eight Management Systems

As outlined in the findings, there is considerable evidence of Ministry support for decentralization. However, the most important step remains to be taken--that of decentralization of finance and personnel.

The project developed decentralization guidelines in 1986 to assist the Ministry in establishing management systems at all levels. Management system manuals were prepared based on these guidelines for finance and the RDF, drugs and medical supplies, personnel, transportation, communication, health information, general supplies, and maintenance. None of these management systems is yet institutionalized in the two project counties, but all are operational to varying degrees. Each has been tested sufficiently to have confidence in its replicability to other counties, given the required personnel and specialized training. At the central level, the National Drug Service (NDS) can be considered not only operational but institutionalized.

B. Cost Recovery

Of 36 Revolving Drug Funds (RDFs) established at HC/HPs, 34 are

currently operational. Of 86 established at the community level, 79 are operational. Each of the HC/HPs began their RDFs with a capitalization of \$300. Capital values of these RDFs ranged from \$500 to \$2,500 in Grand Gedeh in March, 1989, and from \$350 to \$1,600 in Sinoe at the end of June. The factors that appear to be the major determinants of RDF success are supervision and community involvement.

Fee-for-service income in Grand Gedeh county more than covered non-salary operating expenses in 1988. In Sinoe county, the FFS income only covered about 70 percent of non-salary operating costs.

C. Construction and Renovation of Health Facilities

Construction of the NDS warehouses and office space is complete and the facilities are adequate and in use. Additional facilities would be needed only if preparation and manufacture of selected drugs is undertaken.

New office space and a new storeroom for drugs and supplies has been completed at the county hospital in Grand Gedeh. The offices are occupied and the storeroom will be in use by mid-August. Renovation to provide space at the Sinoe county hospital is also complete.

Scheduled construction of HC/HPs and of staff housing has suffered repeated delays and is not yet complete. Work, however, is continuing. Communities did not have a clear understanding of the process, effects of the rainy seasons were not considered, materials did not arrive on time and building plans were changed.

D. Participant Training

The participant training program was generally suitable for the needs of the project and well managed. However, timing of the training was sometimes detrimental, allowing a counterpart for a technical advisor to be away for as much as a year of the time he could have been working closely with the TA. Twenty participants were interviewed. Although there were very few negative comments on the training itself, one common complaint was that too much information was given too fast. Comments on the MEDEX backstopping were universally positive.

A standard curriculum has been developed with project assistance for each form of medical training in Liberia. However, there has been no serious attempt to gear the output of these institutions to future manpower needs.

Local training by workshop and other methods has been effective. Supervisors trained locally are getting out to the villages and

their reports are coming in. VHWs are confident that they know what they are doing.

E. Technical Assistance

The long- and short-term technical advisors provided under the project have been generally effective. There were failures, e.g., an unacceptable management manual. But interviews with counterparts and individuals involved with training and management, a review of the management manuals, and the evident project successes, all point to a generally successful advisory team. There were some delays, some personality conflicts, but no more than should have been expected. The number of TAs, and the range of expertise required, dictated the use of an institutional contractor. USAID personnel would not have been able to field and support the technical assistance required.

Peace Corps volunteers provided significant technical assistance throughout the project and should be considered a major resource for the future.

F. Strengthened National Drug Service (NDS)

The NDS is operational and its depot has been institutionalized as a supply point for the project counties. Given the necessary foreign exchange, the NDS could meet all current demands and adequately respond to the increased needs that would result from PHC expansion.

The NDS could be self-supporting with an easily achievable goal of \$1.4 million in annual sales. Given the vital role drugs and medical supplies play in the provision of health care, it is shocking that the Government of Liberia (GOL) has only provided \$100,000 in foreign exchange to the NDS in its first three years of operation.

G. Financial Viability of the PHC Program

A review of training and supervisory costs in the two project counties indicates that training, support and supply costs for one VHW have run about \$317 a year (\$217 for one-time training and \$100 recurrent supervisory). These costs would put a strain on county finances, depending of the number of VHWS involved, but there is a good likelihood that they could be met in an expansion program. Costs could be reduced by cutting some courses and organizing larger classes. The training and supervisory model should be considered replicable.

Firm evidence of commitment to PHC through analysis of the regular budget is impossible without the materials that were used to develop the budget. With certain assumptions, the GOL allocation of PL-480 funds to the project can be shown to

evidence support of PHC. The availability of counterpart funds has enabled the MH&SW to meet most of its commitment to the project.

As activities began to formalize in the two project counties, the GOL realized there was no way it could finance the salaries of the staff required for the planned county health system from recurrent budget funds. The salaries of the new staff were placed on the development budget as a special concession to permit the project to continue. This continuation gave time for significant development of the project activities, providing a sounder basis for a judgment to be made as to the effectiveness and replicability of the Grand Gedeh and Sinoe counties experiment in the provision of PHC. It is important to note that the development budget cannot be expected to pay salaries for expansion into new counties. Existing staff will have to be trained or underutilized personnel transferred from elsewhere to fill the required positions.

The cost per person of PHC activities at the community level is about \$1 per year, primarily for supervision and continuing education of the VHW. It is unlikely that the GOL will include even this small sum, which would be about \$12,000, in the recurrent budget. Fee-for-service and RDF profits will have to be budgeted to cover the most essential activities. This income is currently not enough to cover the entire amount, as other activities will have to draw on these sources. FFS income is expected to increase as confidence in the health services and accessibility increases.

3. General

- o Recommendations of previous evaluations were, with some exceptions, implemented. Implementation of recommendations from the Midterm Evaluation were instrumental in speeding up the action in getting CHC/HACs and VHWs in place.
- o The local radio station in Zwedru broadcasts health programs three times a week and indications are that the people listen to them. A survey could determine how effective these programs are.
- o Major lessons learned in the project encouraged the following advisories:
 - (a) Have expansion county staff in position at the beginning of project activities and keep them there.
 - (b) Know the infrastructure and community attitudes of the expansion county.
 - (c) Do a baseline health survey for each expansion county.

- (d) Do not ignore county hospital needs.
 - (e) Don't expect anything more from the Ministry recurrent budget than is now being received.
 - (f) Place strong emphasis on incentives to make personnel more willing to work in the less desirable counties.
 - (g) Urge redeployment of underutilized personnel.
 - (h) Allow the community to decide whether fee-for-service will be a means of remunerating the VHW.
 - (i) Emphasize a condition precedent requiring adequate foreign exchange.
 - (j) Emphasize a condition precedent calling for decentralization of finance and personnel.
- o Broad objectives of the project have been achieved and the management systems are sufficiently operational to judge their replicability. However, additional external assistance will be required to consolidate the progress made. The interim period between projects could be critical. Whatever action is possible should be taken to assure county personnel that USAID assistance has not ended. A strong effort is also needed to keep good personnel in place and to get incompetent personnel dismissed.

Recommendations

A number of recommendations are scattered through the evaluation report as it proceeds to answer the questions posed in the Scope of Work. These recommendations are summarized below more or less in the order they appeared for the convenience of the reader. Some of the recommendations are vital to the proposed Phase II activities. The section concludes with several pages of comments applicable to future activities in the establishment of primary health care in the counties.

1. Fee-for Service

- A. The FFS was imposed on some Phase I communities as a means of remunerating the VHW after the community had failed to do promised field work. In the future, FFS should be presented to the community at the time of mobilization as one means of VHW remuneration. It would then be the community's own decision whether to pay for consultations with the VHW.

2. Supervision

- A. The supervisory visits to VHWs contribute to their improved performance and assist in resolving CHC/VHW disputes. An effort should always be made to meet with some members of the CHC/HAC. This may require overnight visits. Steps need to be taken to assure that these monthly visits actually take place, and are not just scheduled on paper. After the VHW is well established, the content and focus of the visit may become more important than the frequency.
- B. Some form of incentive should be worked out for supervisors, especially since a precedent was set during mobilization. Perhaps RDF profits might be drawn on for a small per diem.
- C. The county-level PA supervisors are at present visiting HP/HC PAs and CMs monthly and VHWs quarterly. Together with their other tasks, this supervisory load overburdens the county-level PAs. The supervision of the VHWs should be left in the hands of the HC/HP PAs.
- D. Currently, the clinic PA supervises the VHW and the clinic CM the TBA. Two clinic-level employees acting as supervisors may create confusion. We recommend that the PA supervise both the VHW and the TBA. If the TBA has technical problems, he or she can be referred to the CM, who can either make a supervisory visit or offer suggestions through the PA.
- E. Supervision of the finances at HC/HPs needs to be strengthened. The PA supervisors should make more careful

reviews of RDF and FFS collections. The County Finance Officer (CFO) should make a yearly visit to each HC/HP for such a review, and should also check the status of their RDFs with HACs and CHCs. The County Logistics Officer (CLO) should make a similar yearly visit to check on supplies.

3. Health Information

- A. Collection of data related to referrals, and referrals acted upon, should be effected in a more consistent, utilizable manner.
- B. A contraceptive use survey and a general baseline survey of health status should be conducted.
- C. Authority should be sought to issue official birth and death certificates at the county level.
- D. The 75 reporting forms in the HIS manual should be revised and shortened. Possible revisions might include combining some forms, replacing word answers with numerical answers where possible, and simplifying the language. There should also be more feedback to the reporters to make them realize the importance and usefulness of their work. Key county personnel should be given some training in the analysis of the data that comes to them from the communities, clinics and other divisions of the county hospital. This would facilitate use of this data in making management decisions.

4. County Hospital

- A. The county hospital is an integral part of primary health care, and the major source of income to support the recurrent costs at county level. Appearance is extremely important--lights should be operable, window panes in place, mosquitoes screened out, floors swept, and walls clean. Basic medical equipment should be available. The VHW and/or the clinic PA or CM should have a reasonable degree of confidence that the patient referred to the hospital will receive the required care. Suggestions regarding desirable equipment and staff are presented in Section 1.F.(5) of the Findings sections of this report.

5. Maintenance

- A. Assignment and control of vehicles should be firmly decentralized to the county health services. Unless there is a compelling mechanical reason, maintenance and repairs should always be arranged locally and monitored locally by the CLOs.

- B. A study should be made of all county health facilities and equipment, with notations as to amortization, condition and maintenance or repair needed.
6. Finance
- A. Regardless of PHC II expansion plans, it would appear useful to allow other counties to review the financial management manual and start planning for its implementation in a decentralized system.
7. Information Retrieval
- A. Systematized filing/storage and retrieval is not at all in place in the counties. Peace Corps volunteers could be of assistance in this area.
8. Motorcycle Fund
- A. The motorcycle recipients should probably be required to pay one-half of the local price of a motorcycle. A part of the might be recovered from an allocation of RDF profits.
9. Construction
- A. Although construction of rural clinics and staff housing has been under the direction of the MH&SW thus far, and probably will be in the future, it is suggested that the USAID engineer be included in the review of plans and scheduling on a regular basis. The engineer has indicated his willingness.
10. Health Care
- A. In Grand Gedeh none of the VHWS have ORS packets whereas in Sinoe some do. We consider the SSS therapy more practical for use by the VHWS, but a definite policy should be established as to whether the VHWS will be taught just SSS, or SSS and ORT.
- B. A stronger emphasis should be placed on the importance of preventive and promotive health services. At the village/community level, it is important that VHWS not think that time spent with patients who are mildly ill, and pay FFF, is more desirable than time spent promoting good water and sanitation or advising mothers on the care of babies.
11. Consolidation and Expansion
- A. We recommend that USAID provide whatever immediate assistance it can to consolidate the impressive progress made to date in the two SERPHC Phase I counties and proceed

with the development of a Phase II project to expand into additional counties.

- B. Provide TA without delay for consolidation of progress in Grand Gedeh and Sinoe. This could be by PSC, picking up someone in Liberia, preferably comparable to the current management consultant based in Sinoe county. A second best means would be to use Peace Corps personnel. Consider the coming crop of PCVs and post those with seemingly proper attitudes, personalities and specialties to the weaker management areas in the two counties. A means to coordinate this action with the Peace Corps should be possible.
- C. Key personnel for the introduction of the new systems should be in place when the action starts and should stay in place. Long-term training, if it is to take place, should be out of the way before activities begin.

12. Technical Assistance

- A. We recommend public health management specialists, rather than public health physicians, as technical assistants for both for the management guidance needed in consolidating progress in the two project counties and for the introduction of the management systems into expansion counties (Further comments below).
- B. For the consolidation of SERPHC activities in the project counties, the technical assistant should be based in Sinoe but spend significant time in Grand Gedeh.

13. National Drug Service

- A. The JFK Memorial Hospital should be required to buy its drugs through the NDS, just as are all other government facilities.
- B. The NDS should review its inventory valuation method with a view of bringing it into line with generally accepted accounting methods. It should also assure that the maintaining of accounts and the reconciling of the bank book are in separate hands.
- C. The possibility of packaging some solid drugs, mixing and bottling liquid preparations, even tableting, should be considered as a means of reducing the price the poor must pay for drugs. The NDS should look for donor support for laboratory construction and provision of equipment.

14. Incentives

- A. Place more emphasis on incentives designed to make personnel willing to come to the less desirable counties and to stay there. These should include housing and a small per diem for supervisory travel. Hardship pay for serving in a less comfortable location should be considered. Home electricity by photo-voltaic cells is recommended for CHOs.

15. Surveys

- A. Social and behavioral studies as well as a survey of the infrastructure should be in hand prior to entering any new county with the SERPHC concept. A lack of such information created problems in Phase I.

16. Personnel

- A. Make a strong effort to keep good personnel in place. Publicize the intent to go ahead with a Phase II Project. Present a full 1990 development fund budget request for Phase I county needs. Continue efforts to dismiss incompetent personnel, thus keeping possession of their slots and salaries.
- B. Continue to press for redeployment of underutilized personnel. This means slot, body and salary.

17. Decentralization

- A. Transfer of responsibility for finance and personnel from the Ministry level to the County is vital, both for continuation of the program in the current counties and for expansion into additional counties. The CHO must have control of county personnel. This decision should be a condition precedent to USAID disbursement of funds for Phase II because it is critical to project success.

18. Foreign Exchange

- A. A covenant in the current project requiring that the NDS be given priority for foreign exchange for purchase of drugs and medical supplies was not met. Necessary foreign exchange must be obtained on a regular, assured basis. Without drugs, the health services program cannot be effective.

RECOMMENDATIONS RELATIVE TO PHC PHASE II

Because of the general success of PHC Phase I, we support development of a PHC Phase II Project that would extend the present SERPHC activities into additional counties. This support assumes that consolidation of the Phase I activities in Grand Gedeh and Sinoe counties would be a part of the Phase II Project.

Comments on consolidation of Phase I activities are a part of the evaluation findings and are not repeated here. However, we fear the hiatus between projects (Phases I and II) may be lengthy, and urge that a means be found to provide interim technical assistance to Sinoe and Grand Gedeh counties. This assistance would not just provide further guidance but would also provide some assurance to county personnel that USAID interest and support continues.

Grand Bassa and Maryland counties apparently have a much stronger operating core of health services and should be given priority over Rivercess and Grand Kru. (We understand these are the four counties being considered for expansion assistance). A phased introduction of the management systems into Maryland or Grand Bassa could begin immediately after the project paper is approved and the ProAg signed, provided USAID has found a way to fund proper studies of the county and can enter with the assurance that the systems and services to be introduced will have the support of the population.

By "phased introduction" we mean that not all of the eight management systems need be introduced in parallel into the new counties. Emphasis should be placed on finance and RDF and the elements of the personnel and transportation systems required to get drug distribution underway. Efforts should clearly establish procedures at county headquarters, with appropriate depot facilities and training of the CFO and CLO. Movement down the distribution and service network to HC/HPs and communities should follow systematically. Major control activities of the RDF, of pricing and of profit/overhead, should be established at the county headquarters level as soon as possible. The other supporting management systems can be phased in as the situation allows. We estimate three years will be required for all systems to be operational.

The move into a second county should begin no later than the start of the project's second year.

We recommend three LTAs: One in Monrovia, one in the first county to be entered, and one who would initially assist in the consolidation of activities in Grand Gedeh and Sinoe. Assuming USAID had managed to provide PSC or other advisory services to the Phase I counties during the interim between projects, this

third LTA should be free to move to the second expansion county by the end of year one of the Phase II Project.

We have no specific recommendation regarding the number of short-term technical assistants that may be required, other than that their numbers should be considerably less than that necessary for Phase I and that some should be Liberians.

Phase I emphasized the design and development of the eight management systems, required a broad range of technical assistance, and probably benefitted from the use of a large, complex, institutional contractor with a vested interest in the systems. Phase II will emphasize maintenance, spread and growth of existing systems. It may be better served by a smaller organization whose vested interest is in the successful fielding of coordinated TA activities to further the implementation and effectiveness of existing systems. USAID should also maintain the option of picking up individuals present in Liberia and with known qualifications on PSCs.

The LTAs in the expansion counties should use the best of the established officers in Grand Gedeh and Sinoe in the training of their peers in the new county. For example, the newly designated CFO for the expansion county should work with the CFO in Grand Gedeh for several weeks, or as long as it takes for him to have a fair understanding of the financial management system, before assuming his new position. The Grand Gedeh CFO could later make several trips to the expansion county to complement the work of the LTA in assuring that the new CFO understands, and is properly performing, the functions of his office. The expansion county CHO, as well, should work with one of the CHOs of the Phase I counties for several weeks.

In the case of the CLO, NDS headquarters in Monrovia, will be able to provide a degree of the training required. This training can then be supplemented with a program similar to that described above for the CFO.

The PHC system is in a management implementation stage. Problems will relate to management. The system is operational but fragile. For these reasons, we believe that TA emphasis should be on public health management skills. Two of the evaluation team members have had unfortunate experiences with a series of public health physicians as technical advisors where management elements were important. Not just one experience each, but a total of six such experiences. We have to emphasize that the physician with a practical approach and management abilities is a rarity--and even the rare ones find it difficult to turn their backs on medical service needs in the absence of other physicians. We are saying that the chances are not good of getting what you need, if you accept an unknown public health physician to fill a LTA position in Phase II. Our team is not

entirely in accord on this point, however. Our physician feels that the advantages of a physician working with a physician as his counterpart are a very important aspect of the advisor relationship and may outweigh other considerations.

Maryland and Grand Bassa counties will probably require the same staff needed in Grand Gedeh and Sinoe to fully implement the eight management systems, though it might be possible to drop the CPO if the Community Health Services Administrator (CHSA) is capable. Grand Kru and Rivercess can do with less.

RDF profits must be available to cover recurrent costs of supervision and transport in the counties.

Close work with CHAL should continue in the attempt to standardize as many of the health service activities as possible, particularly those involving the RDF.

The red motorcycle and authority as a supervisor, plus going to the county headquarters from time to time, are incentives to be a PA. Add housing, and a small per diem for supervisory trips, and these employees may be willing to stay in the less desirable counties.