

PD-ABE-830
79594

Project Grant Agreement Amendment Number 5
AID Project Number: 645-0220

AMENDMENT NUMBER 5

to the

PROJECT GRANT AGREEMENT

between

THE KINGDOM OF SWAZILAND

and the

UNITED STATES OF AMERICA

for the

SWAZILAND PRIMARY HEALTH CARE PROJECT

Date: 16 MAY 1989

PROJECT GRANT AGREEMENT AMENDMENT

1. THIS AMENDMENT Number 5 to the Project Grant Agreement for the Primary Health Care Project, 645-0220, adds an increment of A.I.D. funding in the amount of \$800,000, increases the total anticipated A.I.D. funding over the life of the Project by \$588,000 to \$6,288,000, extends the Project Assistance Completion Date by six months to June 30, 1991, and makes other necessary changes as more fully set forth below.

2. The Project Grant Agreement dated August 23, 1985, which was amended on April 22, 1986, July 28, 1986, December 8, 1986, and June 29, 1988, is hereby further amended as follows:

(A) SECTION 2.1, Definition of Project, is deleted in its entirety, and is replaced by the following new SECTION 2.1:

"Definition of Project. The Project, which is further described in Annex 1, consists of assistance to the Grantee to improve the health status of Swazi children under five years of age and of women of child-bearing age. The Project will improve maternal and child health/child spacing (MCH/CS) services. The Project will finance long- and short-term technical assistance; participant training to be conducted within and outside of Swaziland; commodities in support of all areas of project emphasis; research, monitoring and evaluation; and other related costs."

(B) Subsection (b) of SECTION 2.2, Incremental Nature of Project, is deleted in its entirety, and is replaced by the following new subsection 2.2 (b):

"Within the overall Project Assistance Completion Date stated in this Agreement, A.I.D., based upon consultation with the Grantee, may specify in Project Implementation Letters appropriate time periods for the utilization of funds granted by A.I.D. under an individual increment of assistance. It is anticipated that, subject to the provisions of this paragraph, A.I.D.'s total contribution to this Project will be U.S. \$6,288,000."

(C) SECTION 3.1, The Grant, is deleted in its entirety, and is replaced by the following new SECTION 3.1:

"To assist the Grantee to meet the costs of carrying out the Project, A.I.D., pursuant to the Foreign Assistance Act of 1961, as amended, agrees to grant the Grantee under the terms of this Agreement not to exceed Five Million, Seven Hundred Thousand United States Dollars (\$5,700,000) ("Grant"). The Grant may be used to finance foreign exchange costs, as defined in Section 6.1, and local currency costs, as defined in Section 6.2, of goods and services required for the Project."

(D) Subsection (b) of SECTION 3.2, Grantee Resources for the Project, is deleted in its entirety, and is replaced by the following new subsection 3.2 (b):

"The resources provided by the Grantee for the Project will be not less than the equivalent of U.S. \$3,010,000, including costs borne on an 'in-kind' basis."

(E) Subsection (a) of SECTION 3.3, Project Assistance Completion Date, is deleted in its entirety, and is replaced by the following new subsection 3.3 (a):

"The 'Project Assistance Completion Date' (PACD), which is June 30, 1991, or such other date as the Parties may agree to in writing, is the date by which the Parties estimate that all services financed under the Grant will have been furnished for the Project as contemplated in this Agreement."

(F) SECTION 4.4, Notification, and SECTION 4.5, Terminal Dates for Conditions Precedent, are renumbered as SECTION 4.5 and SECTION 4.6 respectively, and the following new SECTION 4.4, Additional Disbursement: Commodities, is inserted:

"SECTION 4.4. Additional Disbursement: Commodities. Prior to disbursement of additional Project funds for commodities, the Grantee will provide A.I.D. with a detailed procurement plan, by 30 June, 1989, identifying items to be funded, and obtain A.I.D. approval for such plan."

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(G) Subsection (c) of SECTION 5.2, Additional Covenants, is deleted in its entirety, and is replaced by the following new subsection 5.2 (c):

"it will investigate and experiment with various forms of finance for health services in addition to normal Grantee budgetary resources with a view to increasing the amount of extra-budgetary funds spent by the Ministry of Health on health services."

(H) Annex 1, AMPLIFIED PROJECT DESCRIPTION, including Tables 1, is deleted in its entirety, and is replaced by the REVISED AMPLIFIED PROJECT DESCRIPTION and Tables 1 attached hereto.

3. All other terms and conditions of the Project Grant Agreement, as amended, remain in full force and effect.

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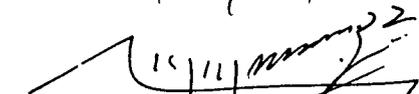
The Government of the Kingdom of Swaziland and the United States of America, each acting through its respective duly authorized representatives, have caused this Amendment to be signed in their names and delivered as of the date first above written.

THE GOVERNMENT OF THE
KINGDOM OF SWAZILAND



By: Elliot Bhembe
Title: A/Principal Secretary
Department of Economic
Planning and Statistics

Date: 16/05/89



By: C. Mkhonta
Title: Principal Secretary
Ministry of Health

Date: 16th May 1989

THE UNITED STATES
OF AMERICA



By: Mary A. Ryan
Title: Ambassador

Date: May 16, 1989



By: Roger D. Carlson
Title: Director,
USAID/Swaziland

Date: 5/16/89

TABLE 1

INCREMENTS TO DATE
 ILLUSTRATIVE BUDGET (DOLS)
 PRIMARY HEALTH CARE

645-0220

(\$000s)

Inputs	Authorized		Obligated thru 6/29/88		Amendment Number 5		Total Obligations	
	AID	GRANTEE	AID	GRANTEE	AID	GRANTEE	AID	GRANTEE
Technical Assistance	4515	-	2758	-	1169	-	3927	-
Training	850	-	1042	-	(192)		850	-
Commodities	529	-	600	-	(71)		529	-
Research, Monitoring and Evaluation	394		500	-	(106)		394	-
Recurrent Expenditure & local cost contri- bution	-	3010	-	1600	-	500	-	2100
	<u>6288</u>	<u>3010</u>	<u>4900</u>	<u>1600</u>	<u>800</u>	<u>500</u>	<u>5700</u>	<u>2100</u>

PROJECT GRANT AGREEMENT
SWAZILAND PRIMARY HEALTH CARE PROJECT

AMPLIFIED PROJECT DESCRIPTION

The goal of the Project is to improve the health status of Swazi children under five years and women of child-bearing age. Improvements in maternal and child health (MCH) and child spacing services can make a significant difference in maternal and child mortality and morbidity, and in overall health status. Therefore, the purpose of the project is to improve and expand the primary health care system.

I. OVERVIEW

The PHC Project is designed to assist the Ministry of Health (MOH) in its efforts to decentralize primary health care services and increase the productivity of primary health care workers, with particular emphasis on improving maternal and child health/family planning (MCH/FP) services. The Project provides technical assistance to the MOH in the areas of maternal and child health, nursing, administration and management, health education, laboratory services and manpower planning.

The Project is also providing formal long-term and short-term training in health education, administration, and information systems. In-country training includes workshops to improve skills of clinic staff, rural health motivators, community leaders and regional health management teams (RHMTs). The Project is also supplying a limited number of vehicles, microcomputers, and commodities essential for clinic operation.

II. EVALUATION AND PRELIMINARY AUDIT RECOMMENDATIONS

Mid-project evaluation. The mid-project evaluation of the PHC Project in September/October 1988 determined that the scope of Project activities was too broad and that objectives should be prioritized and the workplan streamlined. While the evaluators found good progress was made in the areas of growth monitoring, Oral Rehydration Therapy, high-risk clinic screening and in-service training of clinic staff, inadequate progress towards the remaining End of Project Status indicators was reported. The evaluation recommended re-focusing the project's workplan to emphasize the components relating to clinic-based service and outreach services, decentralization, planning and budgeting, and Health Information System. This revised amplified project description adopts same components as priority areas.

Program results audit. In January 1989, a Regional Inspector General/Africa Nairobi team carried out a program results audit of the PHC Project concluded that the Project would have difficulty achieving its purpose due both to unrealistic expectations in the project design and a variety of implementation problems. The use of GOS national health targets as EOPS indicators was considered to be an inappropriate measure of Project performance. In addition, the auditors contended that GOS was not making its required 25% contribution to Project costs. Following the audit, information provided by GOS clearly demonstrated that not only was GOS meeting its 25% commitment, but it was exceeding it. The GOS contribution to total Project costs is estimated at 32% (See Section VII.B.)

III. MODIFICATION OF PHC PROJECT

A. Rationale for Project Modification

Following the recommendations of both the mid-project evaluation and audit, USAID/Swaziland, in consultation with the GOS, redesigned the PHC Project, narrowing the focus in order to ensure that Project resources would be used effectively and would have lasting impact on the quality of primary health care in Swaziland. The original design called for assistance to all levels of the health care system and initiatives in a variety of areas affecting child health including Expanded Programme of Immunizations (EPI), control of diarrheal diseases (CDD), and Acute Respiratory Infections. In this modification, project resources will be channeled to the priority areas of clinic-based and outreach services, decentralization, planning/budgeting/financial management/health care financing, and HIS, all of which will strengthen MOH capability to provide services. Implementing the decentralization strategy and institutionalizing regional health management functions will improve the efficiency of service delivery by making it more directly responsive to specific health care needs in each region.

The rationale for reducing or eliminating PHC Project activities in several areas is that the activities to be reduced or eliminated are presently covered by other donors or other AID-supported projects. For example, all EPI, CDD, and ARI assistance which has been reduced in the PHC Project will be picked up under the CCCD Project.

Institutional strengthening at the regional and clinic levels requires additional technical assistance (TA) beyond what was planned for in the original design. The primary additional input required is long-term technical assistance. The Clinic Management Advisor and Decentralization/Administration Advisor

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will be extended for 12 months each, and the Planning and Budgeting Advisor will be extended for a period of 14 months. The evaluation noted that the levels of long-term TA in the original PP were unrealistically low. This is particularly true of the Planning/Budgeting Advisor, who also has responsibilities as Chief-of-Party. It should be noted that the original project design provided for the possibility of extending these positions depending on the situation at the time of the mid-project evaluation.

In addition to re-focusing project activities, the EOPS indicators have been changed so that they are meaningful measures of project progress and achievement. The EOPS indicators adopted in the original Project Paper were MOH targets for 1990 health status and are inappropriate for evaluating Project achievement since many other factors beyond the Project's control influence attainment of these targets.

Four of the five original project outputs remain basically the same, but one has been dropped from the logical framework. The objectively verifiable indicators have been revised so they are more precise. In addition, assumptions at all levels of the logical framework have been clarified and made more explicit.

The PACD has been extended by six months through June 30, 1991. It had been expected that all three long-term participants would finish Bachelor's degrees in three years, but only one will be able to do so. The extension will allow the remaining two participants to complete their degree programs and return to Swaziland before the end of the project.

IV. PRIORITY PROJECT ACTIVITIES

As described in Section II, Project revisions resulting from the evaluation and audit recommendations are intended to focus on four priority areas: (1) clinic-based and outreach services, (2) decentralization, (3) the related components of planning/budgeting, financial management, and health care financing, and (4) health information system. Each of these areas is discussed in the subsections which follow.

A. Clinic-based and Outreach Services

The clinic represents the front line of preventive, promotive, and curative health services in Swaziland, and is the principal focus of the Ministry's emphasis on primary health care. It is also the base from which community-level activities are launched. These include working with chiefs and other community leaders, directing and supervising the work of Regional Health Management Team, making home visits, and providing community health education.

Outreach services in Swaziland represent an important way to expand PHC services to areas not served by the rural clinics. They follow a specific pattern of development, to ensure community support. Initially, underserved rural areas are identified, and discussions held with community leaders. If the leaders agree to support an outreach site, they begin to construct a modest shelter, of simple design and built from local materials and resources. In turn, the Regional Public Health Unit initiates monthly visits to the site, providing preventive, promotive, and curative services. With the seven pilot outreach sites developed thus far under the project, modest, locally-made furnishings were provided with project funds (examining table, waiting area benches, desk and chairs, etc.). The project also purchased metal trunks that are used to carry equipment and supplies to and from the outreach sites; and if necessary, basic equipment. Thus, these outreach sites have the potential for expanding the availability of PHC services to a major segment of the rural population who otherwise are not likely to have access to such services in the foreseeable future.

The mid-project evaluation stressed the importance of strengthening and expanding services at both clinic and community level, in order to increase the availability and utilization of modern health services, and eventually to reduce morbidity and mortality from largely preventable diseases. Therefore, this has become a priority for the remainder of the project.

Clinic-based services. The emphasis of clinic-based services is to increase both the skill level and motivation of clinic nurses, so that they are more effective in delivering services and in promoting their use. Clinic-focused inputs from the project deal with improving the quality of priority PHC services, as well as with promoting their use. In-service training deals not only with the clinical areas (maternal health, family planning, growth monitoring, immunizations, diarrheal disease control, and acute respiratory illnesses), but also basic management skills, health education, supervision of Rural Health Motivators (RHMs), and skills for working with community leaders. Basic clinic equipment is provided, so that a standard range of PHC services is available at all clinics. The effectiveness of this strategy was acknowledged by the mid-project evaluation, and as a result it will be continued and expanded, with particular emphasis on the community-oriented skills.

Outreach services. As noted above, the expansion of outreach services is essential in order to reach many of the underserved rural Swazis. Thus during the remainder of the project the initial seven pilot outreach sites will be expanded to 49, providing from seven to ten sites in each of the six regions or sub-regions. Project resources will be used to purchase basic furnishings for the additional shelters.

Clinic-based and outreach services constitute the major focus for three long-term TA team members: the Clinic Management Advisor, the MCH Physician, and the Nurse/Midwife. These three team members will collaborate to ensure that inservice training (both workshops and on-the-job) in all of the requisite areas effectively meets the needs while minimizing the time clinic staff must be away from their facilities. In addition, clinic/outreach activities will incorporate important clinic-level elements of the decentralization, planning and budgeting, and health information system areas, as appropriate.

B. Decentralization

Decentralization provides the framework within which the regional health care system functions. Its purpose is to provide the ways and means for making the health care system more responsive to the needs of the people and to bring decision-making closer to the point of service delivery. It allows for greater input from the local level in the planning and implementation of services, and is designed to improve communication, referral, and supervision. Once fully operational, decentralization in the MOH should contribute to improved productivity, and could serve as a model for other Government ministries.

The strategy is to phase in decentralization over time. On the one hand, the institutional framework must be strengthened. This includes developing the organizational structure, roles and responsibilities, communication and team building; and strengthening the Regional Health Management Teams (RHMTs), community health committees, and Regional Health Advisory Councils. On the other hand, specific administrative functions must be regionalized one by one; these include personnel and training, health information system, planning, budgeting, financial management, transport management, and supplies management.

As the mid-project evaluation noted, decentralization efforts under the project involve a gradual process that cuts across nearly all major project activities. As decentralization becomes institutionalized, it should make support to peripheral clinics increasingly efficient, and should impact positively on health service delivery.

Priorities during the remainder of the project include (1) strengthening the institutional framework by improving the functioning of the RHMTs and Regional Health Advisory Councils, strengthening existing community health committees, and encouraging new ones where needed; (2) strengthening program management through the development, implementation, and monitoring of annual plans in each region; and (3) designing and implementing individual management systems (noted above) in each region.

Decentralization activities are principally the responsibility of the long-term Decentralization/Administration Advisor. However, there are a number of areas where there must be close collaboration with the Planning and Budgeting Advisor, who is also responsible for health information system development and implementation at both central and regional levels. Similarly, because of the cross-cutting nature of the decentralization process, the other advisors will coordinate closely in developing and implementing activities of mutual interest at the regional level.

C. Planning, Budgeting, Financial Management and Health Care Financing

The evaluation identified planning and budgeting as an important element of the project refocusing. On the other hand, the evaluation team felt that the project covenant dealing with generating extra-budgetary resources should be deleted, since in their view "the current political climate appears to preclude the consideration of such alternative financing schemes during the remaining life of the project." At the same time, the evaluation failed to recognize the close interrelationship among planning, budgeting, and financial management.

As a result of the discussions and negotiations with the MOH following the evaluation, there was agreement that planning and budgeting remains a priority area, but that both financial management and health care financing should also be included as key areas for involvement during the remainder of the project.

Planning and budgeting. Planning and budgeting are vital parts of the decentralization process. As described in the Project Paper, major emphasis is at the regional level. At the same time, in order that regional planning and budgeting are integrated into the overall Ministry processes, work at the central level is also important. With the new GOS three-year rolling development plan now in effect, project planning activities take on an additional dimension, and the opportunity exists to institutionalize meaningful regional planning and budgeting into the MOH systems.

In addition to the ongoing planning/budgeting functions at the regional level and linkages with the central level, the project will fund the development and printing of planning and budgeting manuals, assist in updating the manpower plan, and assist in producing a health planning and statistics guide.

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Financial management and health care financing. Three important studies are planned to support improved MOH financial management. All three have been planned with the full involvement of the MOH Financial Controller. Two of the studies, one in the area of user fees and the other concerning unit costs of health services, are closely linked with potential activities in health care financing. The third is actually an assessment of MOH financial management and the development of improved procedures. This assessment also provides an opportunity to link financial data with service data through the health information system, leading to ongoing quantification of the unit cost of health service utilization. These three studies should provide the basis for further activities in the area of health care financing, and may lead to the development of specific alternative financing proposals.

There are likely to be opportunities to develop specific pilot activities in community-based financing during the remainder of the project. For example, the project is providing basic laboratory equipment for clinics, so that critical tests can be performed in support of PHC services. The advantage to the patient is that results are available quickly, rather than to have to wait for the sample to be sent to a distant laboratory and the results returned after a long interval. In exchange for this service improvement people should be willing to pay a nominal charge for the lab test, which in turn allows the clinic to purchase new testing supplies and/or reagents, thus replenishing the system through locally-generated funds. This and other such mechanisms can be tried on a pilot basis to determine their feasibility for broader use, and could become the basis for a shift in GOS policy toward alternative financing and the retention of such fees by the MOH.

D. Health Information System

The evaluation concluded that assistance in developing and institutionalizing the Ministry's Health Information System (HIS) should be a high priority during the remainder of the project. During the project thus far, the MOH has identified the HIS as critical to support its national PHC program. The HIS being developed is comprised of two major components or sub-systems: one which tracks health service and health status indicators, and the other which tracks the flow of resources (including financial resources) to both service and support activities. The emphasis of the HIS being developed under the project is at the regional level, in support of decentralization. However, project support is also necessary to assist the MOH in strengthening its central Statistics Unit so that the unit becomes an integral part of the overall HIS.

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There are a number of key areas for assistance during the remainder of the project. First, it is critical to develop an understanding among MOH officials of the importance of data analysis and the power of microcomputers in doing so. This will be followed by training in computer use to ensure that key MOH officials have the skills to use the computer equipment effectively. This is true both at the Headquarters and regional levels, and in a wide range of MOH technical and managerial units. As noted above, assistance is also needed to strengthen the functioning of the Statistics Unit, to improve the documentation of existing data and make it more readily available. Major emphasis will be given to support the regionalization of the HIS. The HIS is currently being implemented in one region, and work is progressing well. Additional assistance will be given in the other three regions to develop and implement their HIS systems, in accordance with individual regional plans.

Other priorities include improving the inventory system for commodities channeled through the Public Health Unit, including family planning supplies; improving family planning data collection, analysis, and feedback; improving the inventory and distribution system for the central vaccine stores; developing a system for monitoring inservice training; and improving the utilization of the computerized personnel system.

V. PROJECT OUTPUTS :

The priority activities just described are designed to achieve the following four Project outputs. As summarized in the revised logical framework in the Project Paper Amendment, the objectively verifiable indicators have been revised so that they are more precise and should lead to a better assessment of achievement of the outputs.

- Improved service delivery and outreach approaches developed and implemented.
- Improved skills and motivation of health workers, brought about by improved conditions of service, improved transportation and communications, and improved supervision and management support.
- A decentralized system of planning, budgeting, personnel management, supervision, and financial management in place and operating effectively at MOH Headquarters and in the regions, in accordance with approved regional workplans.
- An increased proportion of GOS recurrent expenditures for health devoted to primary health care; and mechanisms developed for at least pilot efforts to provide extra-budgetary support for PHC programs.

VI. REVISED IMPLEMENTATION SCHEDULE

The Contractor and the MOH will jointly develop a revised workplan for the remainder of the project, including the six-month extension through June 1991. This revised workplan will indicate how the final 26 months of the project will be implemented, and how GOS and project resources are linked to project outputs. Given that long-term technical assistance will be completed by December 1990, the workplan should be designed to ensure that project outputs will be achieved by that time. The workplan will be reviewed and approved by the GOS and USAID/Swaziland not later than 30 June 1989.

The following schedule indicates major implementation actions that will take place during the remainder of the project:

<u>DATE</u>	<u>ACTION</u>	<u>ACTION AGENT(S)</u>
May 1989	Project Paper Amendment authorized and Grant Agreement Amendment signed	GOS, USAID
May 1989	Contract amendment executed	MSH, USAID
Jun 1989	Swazi returns from Bachelor's degree training in Health Education	GOS, MSH
Jun 1989	Revised LOP workplan approved	MOH, MSH, USAID
Jun 1989	Training needs assessment completed	MOH, MSH, CCCD, USAID
Jun 1989	Vehicles purchased	MOH, USAID
Jul 1989	Remaining laboratory and clinic equipment purchased and distributed	MOH, MSH
Jul 1989	Implement improved project monitoring system	MSH, Drew
Jul 1989	Begin implementation of Maternal Health/Family Planning 3-year plan	MOH, MSH
Aug 1989	Expansion of outreach sites initiated	MOH, MSH
Sep 1989	Communications and Transport Management studies completed	MOH, MSH, Consultants
Sep 1989	Critical lab tests being performed routinely in clinics and health centers	MOH, MSH
Oct 1989	User fees and unit cost studies completed	MOH, MSH, Consultant

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Nov 1989	Pilot cost recovery mechanism implemented for laboratory tests performed at clinics	MOH, MSH
Jan 1990	Final-year project workplan reviewed and modified as necessary	MOH, MSH, USAID
Jan 1990	Finalize annual workplans for regions, and begin implementation	MOH, MSH
Jan 1990	Initiate follow-up training program for RHMs and community leaders	MOH, MSH
Feb 1990	Establish regional health education units in two regions	MOH, MSH
Mar 1990	Inservice training in clinic management areas (nursing, management, and community-oriented skills) completed	MOH, MSH
Apr 1990	Health information Systems operating in two regions, MOH Financial Controller's Office, and Public Health Unit	MOH, MSH
Aug 1990	Decentralization/Administration Advisor departs	MSH, USAID
Aug 1990	49 outreach sites established and operating	MOH, MSH
Oct 1990	Final project evaluation	MOH, MSH, USAID
Nov 1990	Health Information Systems operating in final two regions	MOH, MSH
Dec 1990	Remaining four advisors depart	MSH, USAID
Jun 1991	Remaining two Swazis return from Bachelor's degree training (Health Education and Computer Science)	GOS, MSH
Jun 1991	Project close-out (PACD 6/30/91)	GOS, USAID

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VII. PROJECT INPUTS

A. AID

AID inputs to the Project include long- and short-term technical assistance; overseas and incountry training; a limited amount of funds for commodities; and funds for research, monitoring, and evaluation.

1. Technical assistance

a. Long-term technical assistance

The evaluation concluded that the original Project Paper had significantly underestimated the magnitude of long-term technical assistance required to complete the project activities that would lead to achievement of the project purpose. The audit similarly concluded that the long-term TA workload level was unrealistic, even when recommended streamlining of the project was put into effect. This confirmed project implementation experience to date. As a result, three long-term advisor positions have been extended significantly beyond their levels of effort in the original Project Paper: the Planning/Budgeting Advisor by 26 person-months, the Clinic Management Advisor by 24 months, and the Decentralization/Administration Advisor by 12 months. These extensions are reflected in the person-month figures noted for each position in the following paragraphs.

MCH Physician (52 person-months). This advisor will provide overall coordination of the clinical and related aspects of the MCH/child spacing activities, directed toward clinic-level and outreach services. As agreed between the MOH and USAID, he will focus on maternal health services, but will also be the advisor responsible for child health/child survival activities under the Project.

Family Nurse Practitioner/Child Spacing Advisor (49 person-months). Together with the MCH Physician, this advisor will provide assistance with the coordination of clinical activities at the clinic level, focusing primarily on family planning/child spacing, pre-natal care, attended deliveries, and post-partum care.

Clinic Operations/Management Advisor (48 person-months).

Clinic Management is perhaps the central element of the priority area dealing with Clinic-based and Outreach Services. This advisor will be principally responsible for the non-clinical aspects of clinic-based services improvement -- management skills, health education, supervision of RHMs, and community development activities. In addition, she has responsibility for the expansion of the outreach component, including the development of 49 outreach sites during the remainder of the project.

Planning/Budgeting Advisor (50 person-months). This advisor, who also has major responsibilities as Chief of Party, will be responsible for two of the priority areas to be emphasized during the remainder of the project -- Planning/Budgeting, Financial Management, and Health Care Financing; and the Health Information System. The overall 26-month extension of his position means that he will continue through December 1990, the end point for long-term technical assistance.

Decentralization/Administration Advisor (48 person-months). This advisor is responsible principally for the Decentralization component, another of the priority areas identified in the evaluation. As described earlier, the decentralization process is key to the success of the project and the regionalization strategy of the MOH. This advisor will also collaborate with the Planning/Budgeting Advisor in developing and implementing the planning and budgeting components at the regional level. Given the nature of working in four different regions and the time required to implement the various regional program components, a one-year extension of the Decentralization/Administration Advisor, through May 1990, is critical to achieving the objectives of the Decentralization component.

b. Short-term technical assistance

The original Project Paper proposed the use of 80 person-months of short-term technical assistance. Based on project implementation thus far and plans for the remainder of the project, this amount will be in excess of project requirements. In addition, the evaluation recommended that short-term technical assistance be reduced except in support of priority areas. Some short-term TA will also be added to support the work of the long-term advisors. Although specific short-term TA needs won't be identified until the revised workplan is completed for the remainder of the project, it seems clear that the LOP use of short-term TA is likely to be reduced to approximately 60 person-months. This figure includes the use of both external consultants and short-term assignments by employees of both the Contractor and Sub-contractor.

2. Training

The evaluation recommended significant reductions in overseas short-term training, especially in the area of study tours and short courses in the U.S. Similarly, owing to the impact of the heavy schedule of incountry training on the availability of health workers' time to carry out their jobs, it was recommended that incountry training be reduced to a more manageable level. This will be monitored carefully as

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the revised workplan is prepared. The nature and quantity of incountry training will be guided by the outcome of the forthcoming training needs assessment (jointly funded by the PHC and CCCD Projects), and by the resulting mechanisms established to control and monitor inservice training in the Ministry.

In relation to long-term training, only 5 long-term third country participants will be trained, a reduction from the 12 originally proposed. On the other hand, two of the three long-term U.S. participants will need to spend four full academic years to complete their Bachelor's degrees, rather than three years each as envisioned in the Project Paper.

3. Commodities

The original PP budget allocation for laboratory equipment provided minimal equipment for only ten health centers. During early project implementation an assessment was carried out to consider laboratory equipment needs to support PHC services at all levels of the MOH system including clinics. Based on this assessment, the budget for laboratory equipment in the approved, revised workplan was increased. However, as a result of the recommendation of the mid-project evaluation, this budget was reconsidered, and funds for equipment for the central public health laboratory and regional laboratories have been reduced from the level proposed in the assessment.

Four 4-wheel-drive vehicles will be procured to support the regional nursing supervisors. In addition, in order to assist in providing incentives for rural nurses, project funds will be allocated for the purchase of modest furnishings for the nurses' accommodation in the rural areas. The mechanism setting forth the type and allocation of these furnishings will be approved in advance by USAID/Swaziland. As also noted earlier, there will be a reduction in the funding for two-way communications radios. Finally, in relation to the reduction in Project support for selected programmatic areas (Section IV.F.1.), there are corresponding reductions in other commodities.

4. Research, Monitoring and Evaluation

The original Project Paper contained an extensive list of operations research and other studies to be conducted during the project. In actual practice during Project Implementation, it has been difficult to distinguish among many short-term TA assignments as to whether they were "studies" or "consultancies," and thus whether to attribute them to the Technical Assistance line item or the one for Research, Monitoring and Evaluation. Therefore, in the

PP Amendment the input called Research, Monitoring and Evaluation has been redefined to include only the cost of the Family Health Survey and the two Project evaluations. The TA costs of other less major studies have been included in the Technical Assistance line item, and contribute in part to the significant increase in that line item in the PP Amendment budget.

B. Swaziland Contributions to the Project

The major mechanism for the GOS to generate its contribution to this project is through an increase in the proportion of the MOH budget for primary health care. The original Project Paper contained a covenant to this effect, and the budgeted increase was to equal at least 5 percentage points over the five-year life of project (i.e., an increase from 15.3% to 20.3% of the overall MOH budget supporting PHC services). Based on the experience of the first four GOS budget years (1986/87 through 1989/90), the percentage has increased to 19.30%, the target for year four. In this fourth year of the Project, PHC expenditures comprise 19.3% of the total MOH budget. However, since the MOH received much higher than expected budgetary increases during the last three years -- averaging nearly 40 per cent per year -- the actual contribution of the 4% PHC increase will far exceed the intended financial target. Even if the MOH budget increase is only 6% per year in both 1990/91 and 1991/92, the financial contribution from the GOS from this source alone will be equivalent to approximately \$2,671,000 calculated to the PACD of 6/30/91.

In addition to this contribution, the GOS has been asked to contribute specific amounts to meet local costs in several areas (incountry training, international air fares for participants, commodities, and vehicle maintenance and repair). The estimated inputs from these contributions will total an additional \$339,000. Thus the GOS contribution to the project is expected to be the equivalent of \$3,010,000, or more than 32% of the total project cost of \$9,298,000.

C. Illustrative Financial Plan

Table 1 of this Annex, which follows, sets forth the planned contributions of AID and the Government of Swaziland. Changes may be made to this plan by written agreement of the representatives of the Parties identified in Section 8.2 of the Grant Agreement without formal amendment to the Agreement, provided such changes do not cause (1) AID's contribution to exceed the amount set forth under Section 3.1 or (2) the Government of Swaziland's contribution to be less than the amount set forth under Section 3.2.

TABLE 1

INCREMENTS TO DATE
ILLUSTRATIVE BUDGET (DOLS)
PRIMARY HEALTH CARE

645-0220

(\$000s)

Inputs	Authorized		Obligated thru 6/29/88		Amendment Number 5		Total Obligations	
	AID	GRANTEE	AID	GRANTEE	AID	GRANTEE	AID	GRANTEE
Technical Assistance	4515	-	2758	-	1169	-	3927	-
Training	850	-	1042	-	(192)		850	-
Commodities	529	-	600	-	(71)		529	-
Research, Monitoring and Evaluation	394		500	-	(106)		394	-
Recurrent Expenditure & local cost contri- bution	-	3010	-	1600	-	500	-	2100
	<u>6288</u>	<u>3010</u>	<u>4900</u>	<u>1600</u>	<u>800</u>	<u>500</u>	<u>5700</u>	<u>2100</u>

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