

PD-ABM-481
-003-000-5

Midterm Evaluation

**Primary Health Care
Support Project, Mozambique**
(Project No. 656-0226)

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December 1995

The Midterm Evaluation of
the Primary Health Care Support Project, Mozambique
was conducted under the auspices of the Office for General Development,
United States Agency for International Development, Mozambique.
The Evaluation was conducted by the Health Technical Services Project
(Project No. 936-5974.10) of TvT Associates and The Pragma Corporation,
through a buy-in to Contract No. HRN-5974-Q-00-3002-00, Delivery Order No. 5.
The opinions expressed herein are those of the authors and do not necessarily reflect
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Acknowledgments

The Evaluation Team wishes to salute the Government of the Republic of Mozambique (GRM) and its employees for their efforts to improve the quality of life for its population, shown through its willing and conscientious participation in projects such as the Primary Health Care Support Project.

The Team wishes to express its sincere appreciation for the wholehearted cooperation and support it received from the GRM, the Ministry of Health, and the Provincial Health Directorates of Gaza, Niassa, and Zambezia. It also extends its appreciation for the collaboration and assistance received from the U.S. Agency for International Development in Maputo, especially from General Development Officer Mrs. Laura L. Slobey, and Project Officer Mr. Armand Utshudi Lumbu.

The Team also acknowledges the full cooperation and assistance received from the staff of the University Research Corporation, and in particular the Chief of Party, Mrs. Mary Ann Abeyta-Behnke, the Administrator Mr. George Silva, the IEC Advisor Mr. José Romero, and the Provincial Advisors Dr. Pierre Destexhe, Mr. Federico Rocuts, and Mr. Bjorn Holmgren.

In closing, we wish continued success to those mentioned above in their efforts to fulfill the goals and objectives of the Primary Health Care Support Project.

Acronyms and Abbreviations

AIDS	Acquired ImmunoDeficiency Syndrome
AMODEFA	“Associação Moçambicana para o Desenvolvimento da Família” = Mozambican Association for Family Development
APES	“Agentes Polivalentes Elementares de Saúde” = Elementary Multipurpose Health Agents
ARI	Acute Respiratory Infections
CDD	Control of Diarrheal Diseases
CMR	Child Mortality Rate
CR	“Centro de Reciclagem” = Retraining Center (Continuing Education Center)
CRDS	“Centro Regional de Desenvolvimento de Saúde” = Regional Health Development Center
DA	Decentralization Advisor
DANIDA	Danish International Development Agency
DDH	District Directorate of Health
DDS	“Direcção Distrital de Saúde” = District Health Directorate
DHS	Demographic and Health Survey
DPS	“Direcção Provincial de Saúde” = Provincial Health Directorate
EDP	Essential Drugs Program
EPI	Expanded Program of Immunizations
EOPS	End of Project Status
FE	Fundação Esperança
FP	Family Planning
GMD	Growth Monitoring and Development
GNP	Gross National Product
GOM	Government of Mozambique
GRM	Government of the Republic of Mozambique
HFS	Health Financing and Sustainability Project
HIS	Health Information System
IEC	Information, Education and Communication
IMR	Infant Mortality Rate
IPPF	International Planned Parenthood Federation
ICSQ	“Instituto de Ciências de Saúde, Quelimane” = Quelimane Institute of Health Sciences
ISC	Institute for Social Communication
IUD	Intrauterine Device
KAP	Knowledge, Attitudes and Practices

LOP	Life of Project
MCH	Maternal and Child Health
MCH/FP	Maternal and Child Health/Family Planning
MIS	Management Information System
MMR	Maternal Mortality Ratio
MOH	Ministry of Health
MSF	Médecines sans Frontiers
MSH	Management Sciences for Health
NEP	“Núcleo de Estatística e Planificação” = Planning and Statistics Nucleus
NGO	Non Governmental Organization
NHS	National Health Service
OJT	On-the-Job-Training
ORS	Oral Rehydration Salts
ORT	Oral Rehydration Therapy
PA	Provincial Advisor
PACD	Project Activity Completion Date
PAV	“Programa Alargado de Vaccinas” = Expanded Program for Immunizations
PDH	Provincial Directorate of Health
PHC	Primary Health Care
PHCSP	Primary Health Care Support Project
PIL	Project Implementation Letter
PM	Project Manager
PNC	Prenatal Care
PO	Program Outcome
PP	Project Paper
PVO	Private Voluntary Organization
RES	“Repartição da Educação da Saúde” = Health Education Office
RPM	Rational Pharmaceutical Management Project
RRH	“Repartição da Recursos Humanos” = Office of Human Resources
RSC	“Repartição de Saúde Comunitaria” = Office of Community Health
SCF/UK	Save the Children Foundation/United Kingdom
SCF/US	Save the Children Foundation/United States
SMI	“Saúde Materno-Infantil” = Maternal and Child Health
SO	Strategic Objective
SPO	Subprogram Outcome
STD	Sexually Transmitted Disease
TA	Technical Assistance
TB	Tuberculosis
TBA	Traditional Birth Attendant
UNDP	United Nations Development Program

UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations International Children's Education Fund
URC	University Research Corporation
USAID	United States Agency for International Development
USAID/M	United States Agency for International Development/Mozambique
USAID/W	United States Agency for International Development/Washington
WHO	World Health Organization
WVZ	World Vision of Zambezia

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Executive Summary

A. THE SITUATION IN MOZAMBIQUE

Mozambique is an independent republic on the southeastern coast of Africa. It has a population of approximately 16-18,000,000 persons. Most of the population is rural, with around 32 percent urban. Mozambique is a former Portuguese colony which gained independence in 1975. During the 1980's, it suffered a violent civil war which devastated the economy, caused massive population displacement, and resulted in the virtual disappearance of government services in many areas. The health sector suffered extensively from the instability, war, and lack of resources.

Mozambique is one of the world's poorest nations. The GNP per person of \$80.00 in 1990 is the world's lowest. Only 20-33 percent of adults are literate, and primary school enrollment is low at 58 percent, among the worst educational indicators in the world. Health indicators are also among the worst in the world. Life expectancy at birth is approximately 47 years. Infant and child mortality rates and maternal mortality rates are very high. The health system suffers from poor access, lack of resources, and a lack of adequately trained personnel.

B. DESCRIPTION OF THE PROJECT

The Primary Health Care Support Project (PHCSP) was designed to improve overall health in Mozambique, especially among women and children. The purpose of the project is to enable the Government of the Republic of Mozambique (GRM) to more efficiently and productively utilize health resources, especially for decentralized, preventive, primary health care services.

The PHCSP has six principal components:

1. Essential drug program (EDP) and contraceptives
2. Policy studies
3. Decentralization
4. Provincial management
5. Training
6. Information, education and communication (IEC).

C. PURPOSE OF THE EVALUATION

This evaluation is a midterm review of three components of the PHCSP:

1. Essential drugs and contraceptives
2. Institutional strengthening, decentralization and management/planning support to Provincial Health Directorates (DPS)
3. Policy studies for preventive, primary health care.

The purpose of the evaluation is to review the appropriateness of project inputs, appraise outputs and progress to date, assess progress towards End of Project Status (EOPS), and make recommendations for the next phase. The evaluation methodology consists of document review, interviews and meetings with key persons, and site visits.

D. INPUTS AND OUTPUTS

The primary inputs of the PHCSP consist of financing, training, and technical assistance. USAID has contributed a total of \$29,500,000 to the project. USAID/M supervised the policy studies. UNICEF has procured and distributed the EDP kits, and provided initial logistics training. The University Research Corporation (URC) has established six long-term technical advisors to provide continuous management training and TA to three DPS (Niassa, Zambezia, and Gaza); training and education TA, and IEC training and TA to the three DPS and the MOH; and, decentralization TA to the MOH in Maputo. The Project has provided on-the-job training and has organized seminars, courses, and other training activities on subject areas related to management, IEC, training (e.g., training-of-trainers), and decentralization.

In general, the inputs are suitable and appropriate for the outputs. The time programmed initially for the project is considered too short. The level of inputs may not suffice to accomplish the outputs by the Project Assistance Completion Date (PACD). It is recommended that the PACD be extended at least two years, and the financial and TA inputs be supplemented as necessary to facilitate effective achievement of the EOPS.

E. CAPACITY OF GRM TO ACHIEVE PROJECT OUTPUTS AND EOPS BY PACD

The MOH of the GRM is attempting to improve the health of the Mozambican population by increasing the efficiency and effectiveness of its primary health care services. The PHCSP is precisely what the MOH needs to accomplish a significant part of this goal: improving the productivity of health services through better management. The strategy of the PHCSP is to develop the capacity of the MOH to perform at a level commensurate with EOPS through training and TA. Training takes time. The project, originally projected for three years will have

difficulty reaching the EOPS by the PACD. With a two-year extension it should be feasible to assist the MOH to achieve EOPS by the PACD.

F. PROJECT STATUS: PROGRESS TO DATE

The EDP has responded to a significant need by distributing essential medicines to primary care centers. It is functioning with varying degrees of success in different provinces and districts. Staff training in logistics management, including supervision, has begun but needs strengthening at all levels. The logistics management and information systems are weak. The kit distribution system is somewhat inflexible, and is not responsive to health facilities that have increased client load. The procedures for getting additional kits to meet growing demand is not well known to staff at health centers and posts. There are still shortages and stockouts of EDP kits in some places. Only one of three EDP supervisors has been hired.

There is demand for family planning, but the health system is not prepared to respond. Contraceptive prevalence is extremely low, with higher rates in urban areas and lower rates in rural areas. Where health center and health post staff have received some family planning training, contraceptive prevalence is higher. Little IEC or staff training has been done to date.

Two policy studies have been completed by short-term TA and MOH personnel. One deals with the delivery of PHC services through the private sector, and the other with MOH budget allocations for prevention and PHC. The studies have provoked discussion and debate within the MOH which have led to policy decisions. A third study will be conducted in the near future and will focus on family planning, contraceptive, and reproductive health policies.

There have been significant gains in strengthening a decentralized institutional capacity within the MOH. The planning and management capacities have noticeably improved in the DPS of Niassa and Gaza. Both of the Provincial Advisors have provided TA to DPS staff, including the DPS Director and the head of the Statistics and Planning Centers (NEP). They have also provided on-the-job training and TA to other staff members. The Advisor in Zambezia has experienced severe difficulties for several reasons, and hence has not been able to advance much.

An introductory management workshop has been given in Gaza, Zambezia and Niassa. A second workshop, on supervision, has been given in the first two provinces, and is planned for Niassa in the near future. A ten-month intensive health systems management course is being partially financed by the PHCSP in Maputo. There are 22 participants, including three each from Gaza and Zambezia. A number of other training activities have been supported by the technical advisors.

Systematic IEC activities have begun. Several staff members of the MOH Health Education Office (RES) have received initial training, though there is not yet a consistent counterpart for

the IEC Long-Term Advisor. The Advisor helped plan and supervise the collection of data for a KAP study of factors related to STDs/AIDS in the three project provinces. The data is currently being processed and analyzed.

An initial assessment on decentralization was performed by short-term TA. The assessment report was discussed at a meeting of MOH officials. A second meeting was organized to discuss ramifications of the assessment, and to define concepts and parameters. Further meetings are planned to help develop guidelines for decentralization. One hindrance has been frequent postponements required by the MOH due to conflicts with other obligations. A leadership workshop for MOH and DPS directors is being organized for the near future.

G. CONTRIBUTION TO THE USAID STRATEGIC PLAN

The PHCSP has contributed significantly to virtually all aspects of the health strategic objective (SO) of the USAID/M Country Strategic Plan. The overall goal of the Strategic Plan is to enhance human productivity in Mozambique. A sub-goal, improved health for women and children, was established as an important contributor to the goal. SO 3.0, the increased use of essential MCH/FP services, has three program and six subprogram outcomes (PO and SPO, respectively). The six components of the PHCSP are contributing to the fulfillment of all three of the POs, and the six SPOs. The specific contributions are summarized in Table i.

Table i. Summary of the Specific Contributions of the Components of the Primary Health Care Support Project (PHCSP) to the Fulfillment of the Health Strategic Objective (SO 3), and the Related Program and Subprogram Outcomes, of the USAID/M Country Strategic Plan.

Strategic Objective (SO) 3: Increased use of essential maternal and child health/family planning services.			
Program Outcomes (PO)	PHCSP Component	Subprogram Outcomes (SPO)	PHCSP Component
PO 3.1. Increased supply of quality MCH/FP services.	Policy Studies.	SPO 3.1.1. Increased outreach to communities and improved referral at all levels.	Provincial Management, and Training.
		SPO 3.1.2. More health facilities equipped to provide essential services.	EDP and contraceptives.
		SPO 3.1.3. More health facilities with trained staff.	EDP and contraceptives, Provincial Management, and Training.

PO 3.2. Improved family health knowledge and changed behavior.	Information, education and communication.		
PO 3.3. Strengthened provincial management of MCH/FP service delivery.	Decentralization.	SPO 3.3.1. Improved planning and budgeting systems.	Provincial Management, and Training.
		SPO 3.3.2. Improved MCH/FP data and information system.	Provincial Management, and Training.
		SPO 3.3.3. Improved supervisory systems.	Provincial Management, and Training.

More specifically, through explicit and strategic technical assistance and training at central (national) and provincial levels, and the provision of some critical supplies and infrastructure development, the PHCSP directly increases access to, and use of, essential maternal and child health and family planning services.

The policy studies enhance the extension of prevention and primary health care (PHC), thereby assisting in the completion of PO 3.1. The provincial management and training components both contribute to increasing outreach to communities and improving referral at all levels, which assist in completing SPO 3.1.1. The EDP and contraceptive component, with associated personnel training, contribute to equipping health facilities to be able to provide essential services and training staff at health facilities (which are SPO 3.1.2 and SPO 3.1.3). All three of these SPOs contribute to the fulfillment of PO 3.1, increasing the supply of quality MCH/FP services.

The IEC component develops programs, provides TA, and trains staff to increase family health knowledge and change behavior, contributing to the fulfillment of PO 3.2.

The decentralization component works at the central level to facilitate and strengthen provincial management of MCH/FP service delivery, and thereby contributes to fulfilling PO 3.3. The provincial management and training components both work at the provincial levels to develop and strengthen the provincial management of MCH/FP service delivery, thereby contributing to fulfilling the three SPOs (3.3.1, 3.3.2, and 3.3.3), which assist in completing PO 3.3.

H. CONCLUSIONS AND RECOMMENDATIONS (Listed in order of priority, and explained in more detail in the text.)

1. The PHCSP is fulfilling its purpose and is successfully providing critical training and TA to the MOH. The Project is also addressing and achieving objectives and outcomes of the

USAID Country Strategic Plan. To continue the successful initiation of the PHCSP, and to take fuller advantage of the investment expended in establishing the technical advisors, the URC institutional contract should be extended at least two years.

2. USAID/M should be prepared to supplement funds from other donors to assure an adequate supply of EDP kits and/or medicines, and should continue to supply contraceptives, technical assistance, and training in family planning. Funding should continue for more training and TA in logistics management and information systems, rational drug use, and assistance in the development of suitable policies and strategies. UNICEF and the MOH should be urged to hire and put into place the remaining two EDP monitor/supervisors without further delay.
3. USAID/M should assist the MOH in developing four policies and implementation strategies. The first is a population and family planning policy. The second policy topic in which the MOH has indicated interest is cost recovery. This is important for the MOH to achieve a greater degree of financial stability and sustainability. The third regards completion of an IEC policy and development of a national strategy. The fourth is a national training policy.
4. Decentralization guidelines should be developed for both the MOH and the DPS, and a general strategic plan would greatly facilitate the process of decentralization. The TA provided by the provincial advisors to the three DPS is very important for their continued development and to prepare them for decentralization. It should continue in Niassa and Gaza, and a new provincial advisor should be named for Zambezia. More workshops and seminars should be planned for the provinces to complement the TA of the provincial advisors.
5. The Training Advisor should focus on assisting the MOH to develop a national training policy and strategic plan, improving the effectiveness of the MOH training institutions in Zambezia, and providing training TA to the provincial advisors and their corresponding DPS. NGOs could be subcontracted to conduct health management workshops for the three provinces. A long-term management training course should be conducted in the three provinces. Management training should become institutionalized in the MOH training centers.
6. The IEC Advisor should concentrate on training a cadre of core personnel at the central level in the MOH (in Maputo), and in the DPS of each of the three provinces. IEC training should also be institutionalized within the human resource development structure of the MOH. The IEC training should be practical and focus on producing materials for priority child survival and maternal health programs.

I. Introduction

A. PROJECT CONTEXT: SITUATION IN MOZAMBIQUE

Mozambique is an independent republic on the southeastern coast of Africa (see map, Annex 1). It has a population of approximately 16-18,000,000 persons. Most of the population is rural, with around 32 percent urban. Mozambique is a former Portuguese colony which gained independence in 1975. During the 1980's, it suffered a violent civil war which devastated the economy, caused massive population displacement, and resulted in the virtual disappearance of government services in many areas. The health sector suffered extensively from the instability, war, and lack of resources.

Mozambique is currently one of the world's poorest nations. About 85 percent of the population works in agriculture, much of which is for subsistence. Daily caloric intake is among the world's lowest, estimated by UNICEF to be only 77 percent of basic requirements in 1988-90.¹ The World Bank indicated that the GNP per person of \$80.00 in 1990, was the world's lowest by a margin of 20 percent (see Table 1).² Only about 33 percent of adults are literate, and primary school enrollment is low at 58 percent, which are among the worst educational indicators in the world.³

Health indicators are among the worst in the world (see Table 1). Life expectancy at birth is approximately 47 years (1992).⁴ Infant mortality rates (IMR) and child mortality rates (CMR) are very high: in 1992, they were reported to be 167 and 287 respectively, per 1,000 live births. This means that for every 1,000 babies that were born alive, 167 children under the age of one year died, and 287 children under the age of five years died. In the U.S., the IMR and CMR reported for 1992 were 9 and 10, respectively.⁵

¹ Center for International Health Information (CIHI): MOZAMBIQUE, Country Health Profile, 1995. Arlington, VA. Page 1.

² World Bank: World Development Report, 1993. New York, Oxford University Press, 1993.

³ UNICEF: State of the World's Children, 1994. New York, Oxford University Press, 1994.

⁴ United Nations Development Program (UNDP): Human Development Report. 1994.

⁵ UNICEF, op.cit.

Maternal mortality rates are also very high. The maternal mortality ratio refers to the number of women who die as a result of pregnancy or birth per 100,000 live births. In Mozambique, this ratio has been estimated to be between 300 and 1,000. As in many countries, it is lower in cities and higher in rural areas. The average seems to be around 800. The fertility rate is 6.5, which is also very high. This means that for every woman of fertile age (between the ages of 15 and 45 years) there are 6.5 births.⁶

Table 1. HOW MOZAMBIQUE COMPARES: COMPARISON OF SOCIAL AND HEALTH INDICATORS⁷

SOCIAL & HEALTH INDICATORS	MOZAMBIQUE	Sub-Saharan Africa	Low-Income Countries	Developing Countries
Gross National Product per Capita, 1991	\$ 80.00	\$ 400.00	\$ 360.00	\$ 1,150.00
Life Expectancy at Birth, 1992 (Years)	47	50	52	64
Infant Mortality Rate, 1993 (deaths of children under one year of age per 1,000 live births)	164	100	96	53
Child Mortality Rate, 1993 (deaths of children under 5 years of age per 1,000 live births)	280	163	158	67
Maternal Mortality Ratio, 1988 (maternal deaths per 100,000 live births)	800	700	700	230
Access to Potable Water	26%	50%	50%	71%

The most common causes of sickness and death in Mozambique are communicable or transmittable diseases. Most of these are associated with poor environmental conditions and malnutrition. Among children, the most common causes of sickness and death are diarrheal diseases (DD), acute respiratory infections (ARIs) [especially pneumonia and whooping cough], measles, malaria, parasitic infections, and nutritional deficiencies. Among adults, the most common causes of sickness and death are malaria, ARIs, diarrheal diseases including cholera, tuberculosis (TB), measles, sexually transmitted diseases (STDs), and birth complications.

⁶ Ibid.

⁷ CIHI, op.cit.

There is very limited access to safe, potable water and adequate sanitation in Mozambique. Potable water and sanitation are among the most important and effective public health measures. UNICEF⁸ indicated that in 1991, 22 percent of the population (44% in urban areas and 17% in rural areas) had access to potable water, and 20 percent (61% in urban and 11% in rural areas) had access to adequate sanitation.

The health system suffers from poor access, lack of resources, and a lack of adequately trained personnel. There is very poor access to health services (see Table 2): UNICEF estimates that only 39 percent of the population lives within one hour of travel to modern health services. The Ministry of Health (MOH) is extending the network of primary health care (PHC) facilities to increase per capita access, but it is hampered by lack of financial and human resources. The World Bank estimated that in 1990, there was one physician for every 50,000 persons.⁹ The MOH has trained a large number of nursing and paramedical personnel to compensate for the lack of physicians, but there is still a significant deficit of adequately trained personnel in the MOH health facilities.

Table 2. HOW MOZAMBIQUE COMPARES: COMPARISON OF HEALTH CARE SERVICES¹⁰

HEALTH CARE SERVICES INDICATORS	MOZAMBIQUE	Sub-Saharan Africa	Low-Income Countries	Developing Countries
Access to health care services	39%	60%	66%	83%
Prenatal care for pregnant women, 1988-1990	54%	70%	64%	70%
Births attended by health personnel, 1985-1990	25%	41%	40%	61%
Population per physician, 1990	50,000	21,230	19,240	9,980
Population per nurse, 1990	3,820	5,720	5,850	3,850

The national health services system (NHS) is administered and managed by the MOH. There are three principal administrative levels: 1) the national level, represented by the MOH; 2) the provincial level, represented by 11 provincial directorates of health (DPS = "Direcção Provincial

⁸ UNICEF, op.cit.

⁹ World Bank, op.cit.

¹⁰ CIHI, op.cit.

de Saúde”); and 3) the district level, represented by 128 district directorates of health (DDS = “Direcção Distrital de Saúde”).

The NHS is organized into four levels of service delivery. Level 1 provides primary health care at the community level through 934 health posts and 224 health centers. The services include preventive and basic curative care, and maternity services. Health posts are staffed by unskilled, semi-skilled, elementary, and basic level personnel. The health centers may have some beds, and are staffed by basic and mid-level personnel. The health centers supervise the health posts.

Level 2 consists of 21 rural hospitals and four general urban hospitals. The hospitals offer curative, maternity, laboratory and radioscopic services. They have between 40-180 beds, and are staffed by basic and mid-level personnel, and a few physicians.

Level 3 is made up of seven provincial hospitals. These have 180-300 beds, and provide emergency, medical, surgical, pediatric, and obstetric services. They are staffed by support personnel, nurses and physicians. This level supervises lower-level facilities in the province. Level 4 consists of three central hospitals and two psychiatric hospitals. These have 400-1,500 beds, and are staffed by nurses and physicians, including specialists, and offer specialty services.¹¹

B. PROJECT DESCRIPTION, PURPOSE, GOALS AND OBJECTIVES

The Primary Health Care Support Project (PHCSP) for Mozambique (USAID Project No. 656-0226), was designed in 1991, and the Project Paper (PP) was signed in August of that year. The project seeks to improve the overall health status in Mozambique, especially among women and children. The purpose of the project is to enable the Government of the Republic of Mozambique to more efficiently and productively utilize health resources, especially for decentralized, preventive, primary health care services.

The project has four main components:

- 1) Ensuring the adequate supply of essential drugs and contraceptives.
- 2) Strengthening a decentralized institutional capacity within the MOH to more effectively plan, manage, and deliver health services in three Provinces: Gaza, Niassa, and Zambezia.

¹¹ CIHI, *op.cit.*, page 13. Gish, O. & Pavignani, E: Health Manpower Development Plan, 1992-2000. MOH GRM, 1991, pages 34-35. Patterson, et al: Recommended USAID Health and Family Planning Sectorial Strategy for Mozambique, 1995-2000. BASICS, 1994, page 18.

- 3) Exploring several policy issues which have the potential to increase the scope and availability of health services.
- 4) Providing basic water supply through the drilling of new wells and the rehabilitation the supply of hand pumps for existing wells (**this component is not included in this evaluation**).

Though the PHCSP was approved in 1991, activities did not begin until 1992, due to contracting difficulties, and general social unrest in Mozambique at the beginning of the contract period. Components 1, 3, and 4 were initiated in 1992, and Component 2 did not begin until 1994, due to delays in the contracting process, difficulties in establishing the contractor's team in country, and the lack of coordination and definition of project activities and relations in the Provincial Directorates.

Table 3 outlines the various contractors, components, dates and budgets, contained in the latest Project Implementation Letter (PIL), PIL 11, dated August 8, 1995. The total project budget is \$29,500,000, with a Project Assistance Completion Date (PACD) of August 31, 1997.

Other elements of the project include budget for project management, renovation for housing the institutional contractor, additional short-term TA for drought relief activities, water, and pharmaceutical areas, and project evaluation.

The inputs specified in the Project Paper (PP) are as follows:

1. Essential drugs and contraceptives:
 - a) Procurement and distribution of essential drugs through a contract with UNICEF. This includes training in rational drug management and the contracting of three regional Essential Drug Program (EDP) monitors.
 - b) Procurement of contraceptives directly through USAID/W.
2. Three policy studies that explore policy issues within the health sector. These are to include:
 - a) Expanding health services outside the public sector.
 - b) Determining the necessary proportion of MOH resources to be allocated to cost-effective, preventive, primary health care (PHC) services.
 - c) Increasing budgetary transparency for pharmaceuticals and exploring the potential involvement of private organizations in the pharmaceutical sector. (Note: Only the first two were completed as of this midterm evaluation. The third study will likely not be done. See Section B on policy studies.)

Table 3. PRIMARY HEALTH CARE SUPPORT PROJECT CONTRACTORS AND COMPONENTS SUMMARY OF PIL NO. 11

Institution	Responsibilities	Contract Dates	Amount
UNICEF	<ul style="list-style-type: none"> • Procurement and distribution of EDP kits • Training in rational EDP management (through MSH) • Contracting three regional EDP advisors 	04/10/92 to 12/31/96	\$ 12,027,479.00
University Research Corporation (URC), with subcontractors Development Associates & Austral	<ul style="list-style-type: none"> • Long-term and short-term technical assistance for decentralization and improved Provincial PHC management 	01/14/94 to 01/13/97	\$ 6,264,570.00
USAID/W	<ul style="list-style-type: none"> • Procurement of contraceptives 		\$ 1,832,510.00
UNICEF	<ul style="list-style-type: none"> • Wells and pumps 	1992	\$ 2,000,000.00
USAID Mission, Mozambique	<ul style="list-style-type: none"> • Policy studies (three proposed, two completed) 	1992	\$ 390,000.00

3. Inputs provided through the contract with University Research Corporation (URC), and subcontractors Development Associates and Austral:
- a) Achievement of project tasks as detailed in the annual work plan.
 - b) The production of annual work plans.
 - c) Short courses in HIS, personnel management, leadership, logistics management, and strengthening MCH/FP services at the district level. Short-term training, as necessary, to complement planning, management, decentralization, and services delivery.

- d) Supervision support in the form of support for transportation costs and per diems of supervisors. This included MOH/Maputo and AMODEFA travel and per diem from Maputo to the provinces for the purposes of designing, implementing, and monitoring project activities, and supervisory costs from the provincial to district levels in the three target provinces.
 - e) Production of IEC print and radio materials on PHC, including the cost of dissemination.
 - f) Costs for limited rehabilitation of health posts (but not health centers), including such items as screens, locks, roofing materials, basic equipment, etc.
 - g) A baseline health survey and studies on facility operations, impact of IEC materials, etc.
4. The drilling of deep and shallow wells, the rehabilitation of existing wells, and the purchase of hand pumps in drought-affected areas of central and southern provinces.

(Note: This aspect of the project was completed more than a year ago, and was not included in this evaluation.)

Six outputs are specified in the Logical Framework (see Annex 2). These are:

1. Health facilities supplied with essential drugs and contraceptives on a steady and reliable basis.
2. More productive health providers and more effective management support to those providers in Zambezia, Gaza, and Niassa Provinces.
3. A decentralized system of planning, budgeting, financial management, supervision, and program management better defined and implemented at national and provincial levels.
4. IEC messages for MCH/FP are more regularly and effectively delivered to Mozambican families in Zambezia, Niassa, and Cabo Delgado Provinces¹².
5. Development of a better understanding of policy issues which support preventive, PHC.
6. Construction of water supplies to meet the needs of drought-affected populations.

¹² This output will be modified to replace Cabo Delgado Province with Gaza Province.

Midterm Evaluation: Primary Health Care Support Project, Mozambique

II. Evaluation Design

A. PURPOSE OF THE EVALUATION

The purpose of this evaluation is to complete a midterm review of *three components of the Primary Health Care Support Project (PHCSP)*. The components of the project are:

1. Essential Drugs and Contraceptives
2. Institutional Strengthening - Decentralization and Management/Planning Support to Provincial Health Directorates
3. Policy Studies for Preventive, Primary Health Care.

A fourth component of the project provided funds for emergency water supplies in response to a serious drought in the early 1990s; this component was completed in 1993-1994, and consequently is not included in the current evaluation. The evaluation team was requested to address the following (see Annex 3: Scope of Work):

- Review the appropriateness, timeliness and quality of project inputs; assess the validity of design assumptions, eligible activities and impact indicators; and provide a descriptive analysis of project status relative to the inputs provided.
- Review project outputs and evaluate progress made towards achieving outputs; provide a detailed explanation of those areas where project outputs have been exceeded or are not likely to be achieved over the life of the component.
- Review the project purpose and assess the extent to which project inputs and outputs are, or are not, leading to the achievement of the purpose by the project assistance completion date (PACD).
- Make recommendations for the next phase of project implementation.

In addition, the team was asked to address the following four specific questions and topics:

1. Have the quality and quantity and timeliness of USAID technical assistance and financial inputs been adequate to achieve project outputs at this time, and are sufficient resources available during the remaining life of project components?

2. Is the absorptive capacity of the GRM adequate to achieve project outputs and end-of-project status (EOPS) by PACD?
3. Are the activities described in the Project Paper being carried out? What has been the impact of these activities on project outputs and EOPS?
4. After approximately 18 months of operation and experience of the institutional contractor, does the team have recommendations for altering any of the tasks, realigning personnel skills with project tasks, etc.?

B. EVALUATION TEAM

The evaluation team consists of three persons. Peter Boddy, MD, MPH, Team Leader, is country director of Esperanza Bolivia, a health PVO, and is a specialist in information, education and communication (IEC), training and education, and primary health care management and delivery. Mr. Charles Johnson, MA, MPH, is a retired USAID health-population officer with extensive experience in project design, evaluation and management. Donald Whitson, MD, MPH, is a pediatrician and community health physician and is director of primary health care for Esperança Brazil. Together, team members have over 30 years of experience working in public health programs in developing countries.

C. EVALUATION METHODOLOGY

The principal methodologies used for this evaluation include: document review; interviews of individuals and groups; and site visits. Following two days of team planning and document review in Washington, D.C., the team spent three weeks during September 1995 in Mozambique reviewing pertinent documents (see Annex 4); interviewing and meeting with MOH officials and staff at the national, provincial, district, health center, and health post levels; meeting with USAID/ Mozambique staff; interviewing and meeting with the four present and two former members of the URC contract team; and interviewing and meeting with representatives of other donor and non-governmental organizations (see Annex 5).

The team traveled to the provinces of Gaza, Niassa, and Zambezia for site visits. The visits were made to ascertain how the essential drug program functions; better understand the problems facing the provincial and district health authorities in their efforts to provide primary health care services; and observe the field activities of the contract team. During the course of the three weeks the team met with over 100 persons (see Annex 5). After presentations to USAID, the MOH, and the URC team, Dr. Boddy remained in Mozambique for follow-up interviews and revision of the team's report.

III. Findings and Recommendations

A. ESSENTIAL DRUG AND CONTRACEPTIVE SUPPLIES

1. Inputs and Outputs

The Project Paper (PP) provided for a grant to UNICEF of \$9.0 million to support UNICEF's provision of essential drugs to the MOH and \$1.4 million for UNICEF's in-country administrative and program development costs. This program is called the Essential Drugs Program (EDP). The PP also provided for \$1.6 million for direct procurement by USAID/M of oral contraceptives and IUDs to meet national needs. PP Amendment #1, approved in September 1992, provided an additional \$332,234 for condoms, purchased through the USAID/W procurement system, to assist in the prevention of AIDS and sexually transmitted diseases (STDs). Some funds were permitted to be used for UNICEF/New York administrative support of the Mozambique program.

PP Amendment #1 also provides \$4.0 million for USAID/W procurement of pharmaceutical supplies in response to the drought-related emergency situation in certain provinces and the unusual demand on existing health services due to the rapid return of refugees. Activities of the emergency component of the PHCSP are not discussed in this evaluation.

With some subsequent budget adjustments, the project budget for essential drugs and contraceptives is currently \$14,865,327, of which the UNICEF grant is \$12,027,479. The remaining \$2,837,848 is for contraceptives and supplies. Separately, USAID/M has contracted with Management Sciences for Health through the Rational Pharmaceutical Management Project (RPM) to provide short-term technical assistance to the MOH in drug management and the rational use of drugs.

UNICEF provides the essential drugs in three types of kits, prepackaged and shipped from Copenhagen, Denmark. Kit A is designed to serve 1,000 outpatients at a health center; Kit B 500 outpatients at a health post; and Kit C 250 outpatients at a village health post (see Annex 7 for a list of EDP kit contents). In an effort to assure that the kit contents provide the drugs needed to match the epidemiological profile of Mozambique, an expert committee has been formed with representatives from several units of the MOH and UNICEF. It meets annually in June to review the epidemiological status of the country and each province. The committee makes recommendations for modifications in the drug contents of the three types of kits for the following year.

Table 4 indicates the number of kits purchased and distributed each year since 1992. The figures for 1995 are the planned distribution, not actual.

Table 4. ESSENTIAL DRUG KITS PURCHASED AND DISTRIBUTED TO DATE BY YEAR. PRIMARY HEALTH CARE SUPPORT PROJECT, MIDTERM EVALUATION. MOZAMBIQUE, SEPTEMBER 1995.

Year	Kit A			Kit B			Kit C			Total USAID	Total Others
	USAID	Others	Total	USAID	Others	Total	USAID	Others	Total		
1992	0	3000	3000	1000	0	1000	1500	0	1500	2500	3000
1993	5465	0	5465	4357	0	4357	5011	0	5011	14833	0
1994	670	800	1470	1500	0	1500	2000	0	2000	4170	800
1995	5044	700	5744	4364	0	4364	4744	0	4744	14152	700
Total	11179	4500	15679	11221	0	11221	13255	0	13255	35655	4500

USAID/M has received or has on order, the following quantities of contraceptives to be procured and shipped through the USAID/W Office of Population:

Oral contraceptives	2,027,000 cycles
IUDs	142,738 units
Condoms	15,000,000 units
Depo-Provera	248,000 doses

The three outputs included in the PP and Amendment #1 are:

- a. adequate reserves of essential drugs and contraceptives maintained at all levels of the delivery system (national, provincial, district and health facility)
- b. distribution of contraceptives included in EDP kits
- c. reduced stockouts and reduced wastage of MCH/FP supplies for PHC.

2. Capacity of GRM to Achieve Project Outputs and End of Project Status by Project Assistance Completion Date

Based on visits by team members to three provinces to observe the EDP in operation at provincial and lower levels of the health system, as well as discussions with MOH, USAID,

UNICEF, and URC provincial advisors, it appears that the MOH capacity to manage the planning and distribution of essential drugs is improving. However, the team noted significant provincial variation in that capacity. Stockouts and shortages still occur. Over the past year, increasing numbers of MOH staff have received training in logistics and management, and in rational drug use to build the institutional capacity to manage a large drug distribution program. Some EDP manuals have been completed; when approved by the MOH, copies will be distributed to providers and training institutions throughout the country. Supervision to manage the EDP program remains weak, although the URC provincial advisors have begun to encourage and involve MOH counterparts in field site visits.

More specific information regarding the MOH capacity is provided in the following section describing progress to date.

3. Project Status: Progress to Date

The Essential Drug Program (EDP) received its initial support from UNICEF and the Italian Government. Beginning in the southern provinces and then extending north, the EDP covered all provinces by 1989. The Italian Government discontinued funding in 1991 and USAID/M assumed financial responsibility. UNICEF continues to seek other donor contributions. The European Community made a small contribution in 1995 and the Dutch Government has offered to provide \$4.0 million in 1996. In accord with UNICEF practice, the Dutch will issue international tenders for drug procurement.

To put the EDP in proper perspective, it currently accounts for \$6 million of the annual GRM drug expenditure of \$42 million. The EDP is one of eight drug procurement systems utilized by the MOH. In addition to the EDP, the *via classica* provides drugs for hospitals and health clinics; the MCH Department is responsible for contraceptives, and the Community Health Department is responsible for vaccines. Four verticle, single disease or disease group programs provide medicines: TB and leprosy, malaria, cholera and AIDS/STDs.

The *via classica* is the MOH's drug distribution system for hospitals and clinics. Under this system, each hospital or clinic orders supplies as its current stocks are drawn down, a "pull" system rather than the "push" system used by the EDP. Under the EDP "push" system, kits are sent automatically to each health facility based on an estimate of need. Because of donor funds, the EDP is better financed and supplies are more adequate. The *via classica* is funded by the MOH budget and suffers from shortages of funds to procure adequate quantities of drugs in a timely manner.

Some project outputs have been achieved. The most important is that the EDP has achieved national coverage, although to varying degrees of success. Stockouts and shortages still occur. Logistics management has improved with better leadership and supervision at the provincial and

district level. The team found significant differences among the three provinces visited. In Gaza, the Provincial Health Office prepared an EDP plan and kit request which was sent to Maputo for approval. Many of the numbers were changed, nearly doubling the number of A kits sent and cutting heavily the C kits. In Niassa, a detailed EDP plan was prepared identifying kit requirements down to the health post level; the Province got what it had requested. In Zambezia, provincial health staff indicated that they did not need to make a plan, relying on Maputo to send adequate numbers.

The EDP has had positive benefits for other project components, such as decentralization. It is one element of an early GRM attempt to decentralize services to the provincial and district levels. According to the EDP concept, supplies should be determined through a bottom-up system, dependent on the number of patients served and drugs distributed. The number of consultations should be reported monthly to the MOH staff, who then respond with the appropriate number of kits to treat the number of consultations reported.

If successful, the MOH decentralization could serve as a model for other ministries. The EDP combines MOH-donor-NGO resources in an effort to reduce duplication. A good system has been put in place to provide and distribute pharmaceuticals at all operational levels. While problems exist, provinces and districts now have a drug supply which arrives on a regular basis. A distribution and information system is in place at the pharmacy and health center levels which is to be checked against information generated by the national HIS.

Pharmaceutical departments and staff at the national and provincial levels have been strengthened by developing and putting into place the EDP logistics planning and management systems. MSH carried out a pharmaceutical sector assessment in 1993 through a buy-in to the Rational Pharmaceutical Management Project (RPM). After lengthy delays, the RPM prepared a work plan for June 1995-May 1996; USAID/M and USAID/W provided \$390,000 for training and technical assistance for logistics management and rational drug use. Additional training funds have been made available through UNICEF.

These combined resources are beginning to produce MOH staff trained in rational drug use and stock control. Three levels of staff have received training: 1) drug prescribers (both doctors and medical technicians); 2) pharmacists; and 3) health post pharmacy attendants (“agentes de medicina”). The initial training course took place in June, 1995 and included 40 persons for a one-week course in stock management, 30 persons for a three-week course in rational drug use, and ten persons in a one-week training of trainers course. Utilizing two MSH trainers and two Mozambican counterparts, three courses are planned: one for the Northern Provinces (which will include Niassa); one for the Central Provinces (including Zambezia); and one for the Southern Provinces (including Gaza).

Despite not having the regional supervisors in place, EDP UNICEF staff at the central level, along with MOH counterparts, have conducted supervisory activities. Field visits of the joint team visited Niassa, Nampula, Inhambane, Cabo Delgado, Sofala, Manica, and Zambezia Provinces. The principal areas covered by the field visits included drug reception and distribution, stock control, and the reporting system through the health information system.

In early 1995, drafts for three EDP manuals were produced, dealing with the following subjects: Essential Drugs, Therapeutic Guidelines, and Differential Diagnosis. They were submitted to key MOH officials for approval and suggestions. Initial reactions were positive, and after recommendations are incorporated in the texts, a large number of each manual will be printed and distributed nationally to providers and training institutions.

The URC provincial advisors have taken on an important role in provincial and district management of EDP kits, including training for stock control, monitoring and supervision, and provision of stock inventory and control cards.

Several outputs have not been attained.

- a. **Contraceptives:** Contraceptives were to be included in the three types of kits to simplify distribution. This has not happened. The PP assumed that by 1992 the essential drugs would be procured by UNICEF and shipped in bulk to Maputo for local packaging. Thus, contraceptives could be conveniently included in the kits. However, kits continue to be pre-packaged in Copenhagen, shipped to Mozambique where they are forwarded directly to provincial and district warehouses and distributed directly to the health facility. The main concern with bulk shipments is the potential for drug losses or diversions from MOH facilities (known locally as "inventory shrinkage") once shipments arrive in Mozambique. Contraceptives are controlled by the MCH division of the MOH. The contraceptives are often shipped along with the EDP kits to provincial and district warehouses where they are stored.

It is probably not recommended to include contraceptives in the EDP kits. The kit supply system is relatively inflexible and is not responsive to actual needs, and in practice, is unable to respond rapidly to increased demand, which is important for contraceptive supply and family planning programs.

- b. **Stockouts:** Stockouts and shortages of essential drugs have been problems for several reasons. In an analysis prepared for the team in Zambezia, for example, during 1994 there were stockouts or shortages in every district for some to most of the months of the year. Figures for early 1995 show the problem is continuing. One of the main reasons identified by UNICEF was financial constraints resulting

from delays in the disbursement of funds which impeded the procurement of the kits. Another reason appears to be the lack of an adequate logistics information system: deficits are not reported consistently, and suppliers do not followup on the utilization and local demand for pharmaceuticals.

- c. **Regional Supervisors:** UNICEF has not hired all of the three regional EDP supervisors called for in the USAID grant. The MOH is in agreement that the supervisors should be in place, and the EDP evaluation team reinforced this. One advisor was hired in 1994 and is based in Maputo to serve the southern provinces. The positions for EDP supervisors for the central and northern regions, to be located in Beira and Nampula, remain unfilled after several years. UNICEF advertised recently to fill the two positions and received twelve applications from retired pharmacists, pharmacy technicians, and physicians. The candidates were evaluated by a committee of representatives from the MOH, UNICEF, and USAID. The process has been delayed because all of the candidates belong to the National Health System, and are consequently ineligible according to MOH and USAID regulations.

The EDP is an important program. A number of factors stand out as important reasons for progress to date:

- a. Project ownership: MOH officials view the EDP as their program.
- b. Increasing commitment to decentralization by both national MOH officials (perhaps somewhat reluctantly) and provincial health officials who now feel that they are in control of planning and budgeting for their provinces.
- c. Capacity building at both the individual and institutional levels as managers become trained to take on responsibility and they have the assurance of a regular supply of commodities to plan for and supply to their health centers and posts.
- d. Centralized procurement of drug kits and standardization of kit contents.
- e. Increasing warehouse capacity from the national level to health post, although many facilities are simple and many in need of repair or renovation.

At the same time, the EDP is far from perfect. Some of the problems observed are the following:

- a. There is a shortage of adequately qualified personnel at all levels in the field to properly plan, manage, and account for a large volume of commodities.

- b. There are no incentives within the current personnel system to reward initiative and creativity, and few of the staff have observed well-functioning logistics systems in other countries.
- c. There is diversion or loss of drugs, equipment, books and supplies from the MOH system although no one has a clear picture of the extent.
- d. The existing HIS is in place nationally but is not widely used for planning and evaluation, in this case, of the drug supply and distribution.
- e. Stock control records are kept by some, but not all, health units and vary widely in quality and timeliness.
- f. Rational use of pharmaceuticals by prescribers and users is mixed, with consequent wastage of valuable resources.
- g. Staff training at all levels in drug management is still limited and inadequate.
- h. Health centers and posts suffer from periodic stockouts and shortages because national or provincial deliveries are frequently less than the amount requested.
- i. Similarly, the kit distribution system suffers from bureaucratic rigidity or staff ignorance on how to order extra supplies when demand increases. For example, in Zambezia one health center served less than 500 clients monthly and received one kit monthly; now the center serves nearly 2,000 clients monthly but still receives one kit. The result is a shortage of drugs by the end of the first week of the month. Staff members continue to send monthly information to the HIS but were unaware that other forms were needed to increase its monthly shipment of kits. To anticipate increased demand, UNICEF increased the 1995 order by 12 percent over 1994.
- j. Many warehouses offer inadequate storage. Major problems include cramped space, poor physical quality of buildings with consequent water leakage problems, and lack of wooden pallets for stacking boxes to keeping stock dry. UNICEF and the Swiss Corporation are funding three regional warehouses in the provinces of Cabo Delgado (Pemba), Sofala (Beira), and Niassa (Cuamba).
- k. Supervision of the warehouses and drug supply is weak at all levels and when it occurs, there is little follow-up on subsequent visits.

1. Logistics planning and management is not a high priority for most officials, even when they recognize the important role the regular supply of drugs plays in improving health services.

4. Contribution to USAID Country Strategic Plan

This part of the PHCSP is directly related to Program Outcome 3.1: Increased Supply of Quality MCH/FP services, by supplying EDP kits, contraceptives and technical assistance and training for improving logistics management, the logistics management information system and more rational use of drugs by prescribers and clients.

5. Conclusions and Recommendations

The major conclusions of the evaluation team include the following:

- A steady, reliable and adequate supply of essential drugs is crucial if the health system is to provide services to patients; similarly, clients are more likely to utilize the health services if they know that drugs are available. Conversely, shortages and stockouts can easily damage or destroy public confidence in the health system.
- The MOH is unlikely to have an adequate budget for drug procurement for many years; donors provide most of the funds for both the EDP and the *via classica*. Under UNICEF leadership, donors other than USAID (e.g., the Dutch Government and the European Community) have been identified and are committed to providing a portion of the funds for EDP kits during the next few years.
- The EDP is in place and functioning nationally, with varying degrees of success in different provinces and districts.
- Staff training in logistics management, including supervision, has begun but needs strengthening at all levels from central to health post.
- The logistics management and logistics information systems are weak and need strengthening.
- The kit distribution system is somewhat inflexible, and not responsive to health facilities that have increases in clients. The procedures for getting additional kits to meet growing demand is not well known to staff at health centers and health posts.

- There are still shortages and stockouts of EDP kits. The evaluation team found wide variation during brief visits to the three provinces.
- In provinces with good leadership and management, there are fewer problems with EDP kit supplies and distribution.
- There is demand for family planning, but the health system is ill-prepared to respond. Contraceptive prevalence is extremely low throughout Mozambique, with higher rates in urban areas and lower rates in the rural areas. Where health center and health post staff have received some family planning training, contraceptive prevalence is higher. Little IEC or staff training has been done to date.
- The EDP supervisors need to be hired and put in place to reinforce the logistics management system of the kits.

The team has the following recommendations:

- USAID/M should be prepared to supplement funds from other donors to assure an adequate supply of EDP kits and/or medicines.
- USAID/M should continue to supply contraceptives, technical assistance and training in family planning.
- USAID/M should continue to provide funds for more training and TA in logistics management and information systems, rational drug use, and assist in the development of suitable policies and strategies.
- USAID/M should urge and impel UNICEF to hire and put into place the remaining two EDP monitor/supervisors. One apparently had been identified, and her/his placement should be immediate. The third should be identified and placed without further delay.

B. POLICIES SUPPORTING PREVENTION AND PRIMARY HEALTH CARE

To enable the MOH to determine the most appropriate and efficient mix of private and public sector health service delivery to meet the needs of the population, the Project Paper proposed to fund three studies during the first year of project implementation. USAID/M estimated the cost of each study to be \$130,000 for a total cost of \$390,000. The studies were to provide analysis and guidance to the MOH for policy reform in the three areas listed below and be used as a basis for future USAID/M program assistance in 1992/93:

1. Expanding health services outside the public sector;
2. Increasing budgetary transparency for pharmaceuticals and exploring the potential involvement of private organizations in the pharmaceutical sector; and
3. Determining the necessary proportion of MOH resources to be allocated to cost-effective preventive, PHC health services.

1. Inputs and Outputs

USAID/M provided funds for a buy-in to the USAID/W Office of Health's Health Financing and Sustainability Project (HSF) for two policy studies. Although \$263,000 was earmarked for studies, only \$173,000 was committed and just \$136,000 disbursed. Through the HSF's prime contractor, Abt Associates, Inc., two three-person teams visited Mozambique in late 1992 to prepare the studies. These studies were published in 1993 as:

HSF Technical Note No. 18 - The Expansion of Health Services Outside the Public Sector: Mozambique, March 1993.

HSF Technical Note No. 19 - Mozambique Public Sector Budgetary Resource Needs and Allocations in Health.

Study No. 18 was translated into Portuguese and some discussions were held with MOH officials to discuss the recommendations. This stimulated internal discussion at high levels in the MOH, and eventually led to a better definition of a policy for private sector PHC services and health care. Study No. 19 was presented at a meeting in a local hotel. It also stimulated discussion and debate at high levels in the MOH. It is not clear what specific results were produced.

The originally proposed study of the pharmaceutical sector (study #2) was not undertaken for several reasons:

- a. The MOH was not ready to address issues related to the liberalization of the pharmaceutical sector other than allowing the establishment of private drug sales in urban areas;
- b. The MOH had limited analytical capacity; and,
- c. The MOH had not requested additional policy studies. The MOH already has developed reasonable policies in many areas, with some exceptions, such as population/family planning.

As an alternative, in PIL # 8 dated May 4, 1995, USAID/M and the MOH agreed to use up to \$250,000 of project funds for a RAPID population and family planning policy analysis and presentation. The RAPID analysis will take place in 1996.

The PP output for policy studies was development of a better understanding of policy issues which support preventive PHC in Mozambique.

2. Capacity of GRM to Achieve Project Outputs and End of Project Status by Project Assistance Completion Date

It was difficult for the team to gather specific evidence of the impact of the two studies. Nevertheless, according to some MOH officials, discussions provoked by the studies did help to improve the MOH's understanding of these policy issues. Each consultant team worked with MOH counterparts in preparation of each policy study, an important part of institutional capacity building. The MOH leadership has recognized the limited technical and analytical capability of MOH staff and the evaluation team was aware of the many studies undertaken by many donors. USAID/M's technical staff indicated a strong interest in utilizing project resources to assist the MOH in implementing existing policies as a top priority.

3. Project Status: Progress to Date

As mentioned above, two studies were completed in early 1993. The third originally proposed study has been canceled by mutual agreement and replaced with a RAPID analysis and presentation to be undertaken in 1996. Similarly, USAID/M has allocated \$600,000 for the DHS.

It is important to note that there has been a complete turnover of relevant USAID/M staff during the past two years and current staff were only able to provide limited information on the use or benefit of the two completed studies. Similarly, during the team's limited time in Mozambique, it was difficult to identify persons within the MOH with knowledge of the use of the two studies. Nevertheless, some officials did recall discussions within the MOH which had been stimulated by the studies, and one felt that they had had profound influence in focusing attention on their subject areas and provoking pertinent decisions.

4. Contribution to USAID Country Strategic Plan

The two completed studies have made discrete contributions to the achievement of USAID/M SO 3.0, and to PO 3.1. The RAPID assessment and presentation offers hope of influencing GRM population policy development to include greater emphasis on reproductive health and assisting couples who want to space or limit the number of the children they produce. This would also contribute to SO 3.0. The DHS offers even greater potential for contributing to

USAID/M strategic objectives since it will provide the baseline data, both nationally and on a provincial basis, upon which progress of all health assistance can be measured.

5. Conclusions and Recommendations

- The two policy studies appear to have been of some value to the MOH in assisting with policy changes. If USAID/M decides to finance policy studies in the future, the contracts should include funds for Portuguese translations of the studies and seminars and/or workshops involving relevant MOH and other GRM officials to discuss the findings and provide a forum for developing an action plan to implement agreed-upon recommendations for policy changes. Since funds have now been allocated for both a RAPID assessment and presentation and a DHS, USAID/M should make sure that each of these undertakings provide for Portuguese translations and sufficient seminars and workshops to assure that the results are widely publicized.
- The MOH has acceptable policies in many areas. The greatest need now is technical assistance to help implement these existing policies, especially in decentralization, training and management of PHC program. Three exceptions are the following:
 - ✓ The first is population and family planning policy for which the RAPID assessment and presentations are an appropriate initial USAID contribution to policy development.
 - ✓ The second policy topic in which the MOH has indicated interest is cost recovery. This is also an area of interest to USAID/M as it seeks to assist the GRM and the MOH to achieve a greater degree of financial sustainability. In future planning, USAID/M should consider support for such a policy study.
 - ✓ The third regards completion of an IEC policy and development of a national strategy.

C. SUPPORT FOR DECENTRALIZATION

Support for decentralization refers to a decentralized system of planning, budgeting, financial management, supervision, and program management, better defined and implemented at national and provincial levels.

1. Inputs and Outputs

Outputs

This output is appropriate for the purpose of the project. It is perhaps even more timely now than when the Project Paper was developed, as the GRM has since stated explicitly its intention to decentralize government. New legislation outlining district-level government was passed recently. The MOH is ahead of most other sectors of government in progress toward decentralization, and while it has taken its first steps in this direction, it lacks clear guidelines on how to proceed.

It was ambitious to presume, however, that the full output could be achieved in three years. Consideration should be given to revising the wording in the contract to include progress toward achieving this outcome, rather than achieving the output as it is stated. Much more can be achieved if the project is extended as the evaluators recommend.

Inputs

All of the inputs that refer to Output 3 in the Logical Framework from the PP (see Annex 2), are provided under the institutional contract as long-term technical assistance in the form of a Decentralization Advisor (DA). The DA's defined tasks focus on aiding the efforts of the MOH to decentralize responsibility and authority to provinces and districts, and specifically to help develop guidelines for the process.

The contract specifies the DA to also be Chief of Party (COP) and Project Manager (PM). The apparently unforeseen logistical and administrative difficulties that the COP/PM faced in launching this project have precluded full implementation of the decentralization aspect of the project. It was somewhat ambitious to expect one person with little administrative support to perform the duties of the COP, PM and DA, and accomplish the DA objectives in only three years. Perhaps now that the difficulties of getting the project started have given way to more routine matters, and given the recommended two-year extension, the DA, along with appropriate TA, can achieve more in relation to the decentralization process.

The second aspect of decentralization is the long-term technical assistance being provided through the Provincial Advisors who are preparing the DPS to assume responsibility for decentralized services.

2. Capacity of GRM to Achieve Project Outputs and End of Project Status by Project Assistance Completion Date

The GRM, and especially the MOH, seem to be committed to decentralizing services. They have requested assistance in doing so. The DA's counterpart, the Director of Planning, is open to working on decentralization.

The primary difficulty faced in achieving full decentralization lies with the low educational and skill levels of provincial and district personnel. Until the periphery is ready and able to assume responsibility, decentralization cannot proceed. Fortunately, the rapid improvements in management seen in Niassa and Gaza under the guidance of the PAs, shows that decentralization, at least to the provincial level, is a realistic goal in the coming years.

Perhaps ironically, one of the major constraints on full decentralization is the control that donors insist on retaining over how their donations are spent. Bilateral and multilateral aid make up over half the total health budget. This assistance is frequently channeled through the MOH, and when it is destined for provinces and districts, it usually arrives with specific objectives attached. Given USAID's commitment to decentralization, the Agency should consider mechanisms that would allow assistance to be used more in accordance with locally established priorities.

3. Project Status: Progress to Date

The GRM began limited block grants to the provinces several years ago and has announced plans for the deconcentration of personnel in October, 1995.

The DA has established an office in the MOH and has been working with her counterpart, the Director of Planning. Three short-term technical consultants were provided by the project: two in February, 1995 to suggest strategies for decentralization, and another for two months in July and August. A national seminar was held in July, to initiate discussions on the meaning of decentralization, to reach agreement on key concepts, and to consider the government's initiatives for decentralization. Present at the seminar were all National Directors, Chiefs of Divisions, and Provincial Directors. A draft document outlining the conclusions of the meeting was still being prepared at the time of the evaluation.

The third short-term consultant also worked with the Director of Planning on how to proceed with the decentralization process. His report is still pending. The subject of how to proceed with

the issue of decentralization is on the agenda for a meeting scheduled for the end of November, 1995.

Annual seminars for the DPS Directors on leadership and team building are listed in the PP under training activities to improve provincial-level management. This activity is also mentioned in the Logical Framework as an indicator under Output 3, Decentralization Support, with the objective of “45 Provincial staff trained”. These seminars were to be held annually for all DPS Directors (not just those from the three priority Provinces) during annual meetings in Maputo attended by all the Directors. The date for the initiation of the seminars has been postponed numerous times, most recently from October, 1995 to early 1996. The motive for this most recent postponement is that many DPS Directors are likely to be replaced before the end of the year (perhaps by those graduating from the management course that the project is supporting in Maputo).

4. Contribution to USAID Country Strategic Plan

Decentralization support is implied in the health objectives in the country strategic plan, and decentralization fits logically under both the Health and Democracy objectives as described below. As mentioned above, decentralization of health services is GRM policy, is in process to varying degrees in different provinces, but suffers from lack of trained manpower at most operational levels.

Strategic Objective (SO) 3.0: Increase in use of essential MCH/FP services (health SO).

Program Outcome (PO) 3.3: “Strengthened Provincial management of MCH/FP service delivery.” This implies decentralization support at least to the Provincial level.

Sub Program Outcome (SPO) 3.1.1: “Increase outreach to communities and improved referral at all levels.” This implies services more responsive to communities and therefore, management decisions made closer to the community.

SO 2.0: Government more accountable to citizens (democracy SO).

PO 2.4: “Government decentralized in selected districts”, which implies action in the health sector as well as in other areas of government.

5. Conclusions and Recommendations

- Now that URC has resolved the major logistical problems that were encountered at the start of the project, and the DA has established an ongoing relationship with the Director

of Planning, work may proceed with the elaboration of decentralization guidelines. The guidelines are an important step in the decentralization process.

- Increase the amount of short-term and/or long-term TA used for decentralization. Suggested areas to explore:
 - ✓ Assistance in developing national personnel policies, with an emphasis on developing the institutional capacity within the MOH to support the policies at the provincial level.
 - ✓ Investigation into issues relating to mechanisms that would allow donors (and especially USAID) to continue assistance to the MOH, while at the same time loosening the restrictions on the funds so as to give priority to local planning, budgeting, and programming.
- Remove or modify the indicator in the contract specifying “45 provincial staff trained to assume...” to allow more flexibility.

D. MORE PRODUCTIVE HEALTH PROVIDERS AND MORE EFFECTIVE MANAGEMENT SUPPORT TO THOSE PROVIDERS IN ZAMBEZIA, GAZA, AND NIASA PROVINCES

1. Inputs and Outputs

Outputs

The output appears to be an appropriate and timely one that will help achieve the overall project purpose. A focus on the provincial level is appropriate, since significant improvement at that level can be expected to be reflected later at the district and community levels, and particularly because few other donors are working at the provincial level.

The output is timely, perhaps even more timely now than in 1991, when the project was designed, since the MOH is now in the process of decentralization of most areas of management. Proper support in key management areas will assure the success of this process.

Inputs

All inputs related to this output described in the Logical Framework (see Annex 2) were provided under the institutional contract with URC. They are summarized as follows:

- Long-term technical assistance in the form of a provincial advisor (PA) in each of the three provinces, and one training advisor. They are providing on-the-job training and are coordinating short courses and seminars on management issues, focusing on the use of the HIS for planning and monitoring, financial management, improved quality and frequency of supervision, personnel management, improved logistics (especially for medications), and training.
- Financial support for transportation and per diem for Maputo-to-province and province-to-district supervision.
- Limited financing for the rehabilitation of rural health posts and the purchase of some equipment (computers) for the DPS.
- A year-long management training course in Maputo for provincial managers.
- A baseline management survey.

The choice of a strategy emphasizing the use of long-term technical assistance as the means to improve provincial management appears to have been the correct one. Long-term advisors are uniquely positioned to assess the needs of the specific provinces, to understand the unique characteristics of their counterparts, and to develop locally-appropriate strategies for improving provincial management in ways more effectively than courses and short-term advisors.

The significant delays encountered in the initiation of project activities under the contract, combined with somewhat ambitious expectations, have created the impression that little progress has been made concerning decentralization. The duration of the contract (three years) is far too short to produce the desired outcome given the strategy chosen (long-term advisors). Significant logistical difficulties delayed the placement of the advisors in the provinces. In Niassa, for example, a prefabricated house had to be brought in, and a well had to be dug by hand. The project designers also seem to have underestimated the time it takes for long-term technical advisors to establish the credibility necessary to be effective. Once these delays are taken into account, progress toward the achievement of the project objectives has been surprisingly rapid in two of the three provinces, i.e., Niassa and Gaza.

The difficulty in recruiting fully qualified provincial advisors (PAs) and a training advisor also hindered progress toward project objectives. Not all PAs had appropriate backgrounds in health, which interfered with their relationship with their provincial counterparts. Only one of the

provincial advisors spoke Portuguese at the outset of the project (most spoke Spanish¹³), which was cited by some counterparts as having caused initial difficulties¹⁴. The Provincial Advisor in Zambezia and the Training Advisor have been recently removed from their positions, and replacements are being considered. This will further delay full achievement of the project objectives, especially in Zambezia.

Special difficulties arose in Zambezia. The large number of donors already in the Province was inadequately considered in the project design. Save the Children Federation (SCF/UK) already had long-term advisors in place in the NEP, SMI, RAF, and a training advisor in place in the RRH. The presence of these advisors caused delays in finding an appropriate role for the project PA as well as making it difficult for him to work in all the programmatic areas specified in the contract (the HIS, for example, is handled by the NEP). Over the past 18 months, all SCF advisors have been withdrawn except the advisor in the NEP, so this problem should be minimized in the future.

In addition, the project plan gave insufficient attention to the need for material and staffing support for the PAs. The MOH and DPS counterparts are unable to provide this support (indeed, they are barely able to provide physical space and even a desk in some cases).

The **programmatic areas** in which the PAs are working are generally appropriate and timely. Support for provincial planning is especially critical given the UNICEF/MOH planning exercise that was instituted in Niassa and Gaza in 1993 for the first time (it had been functioning in Zambezia the year before). Support for supervision and personnel issues are also very important given the MOH plans to decentralize most personnel in October, 1995. The activity of "introducing" the HIS into Niassa indicated in the contract should be changed to "follow up support", as the HIS had already been introduced in Niassa before the start of contract activities.

The programmatic area of **maternal care** should be brought up-to-date with current thinking. Recent studies show that efforts to decrease maternal mortality must focus on the integration of PHC with secondary level care services. This involves specific attention to upgrading referral centers, improving referral systems, transportation, communication, and IEC. Effective maternal care must include attention to basic surgical referral services and blood banking. These activities

¹³ It was very difficult to locate advisors with the appropriate technical skills who spoke Portuguese. Since the advisors were being sent to Mozambique to provide technical assistance, technical expertise was more important than language ability. The real problem in communication was not that the TAs spoke Spanish (which was a good second choice in lieu of Portuguese), but rather that they had not been adequately trained in Portuguese initially. Had the TAs received intensive language training in Portuguese when they arrived in country, their effectiveness would have been enhanced considerably.

¹⁴ The initial language problems seem to have been largely surmounted by the remaining advisors at the time of the midterm evaluation.

are not included in the original project design, and may be added as part of the two-year project extension. This may require additional TA and financial resources.

The provision of limited **renovation** funds is also appropriate; however specifying their use only for rural health posts is too restrictive. In many cases, small targeted projects, such as repairing the sewer system at a training center, painting an office, repairing a refrigerator, or buying a computer for use in the NEP may quickly remove roadblocks and improve morale, thus enabling other activities to proceed much faster. These funds should not be restricted to exclusive use in rural health posts.

Limited funds for **supervisory support** are also appropriate, and the advisors have been offering them sparingly to minimize dependence (again, moving from a relief mode to a development mode). Activities in supervision have been hampered by the lack of job descriptions (especially for administrative personnel) at the national level. Perhaps this could become a priority for the DA.

The planned **baseline health survey** has encountered difficulties with timing. The MOH is interested in a Demographic and Health Survey (DHS), and it is planned for 1996. Current census data are outdated. This, coupled with the huge population displacements caused by the war, have made it difficult to use population-based information for planning, evaluation, and monitoring. URC staff appropriately decided to perform a baseline management survey in lieu of a health survey. In spite of methodological questions, the survey did serve to focus attention of the DPS on the tremendous needs they have for better management, thus increasing provincial collaboration with project activities.

Comments on training inputs may be found below, in Section E.1.

2. Capacity of GRM to Achieve Project Outputs and End of Project Status by Project Assistance Completion Date

The GRM, and specifically the MOH at all levels, have shown a willingness to, and interest in, improving provincial management in PHC. Important constraints to achieving project outputs include the following:

- The very low educational level of many workers hinders their acquisition of new skills.
- The scarcity of skilled human resources at all levels interferes with implementation. The few trained staff are overextended. This scarcity also leads to a large amount of instability of competent staff as they are frequently transferred between departments.

- The extremely low salaries in the MOH lead to frequent absences from workers' normal responsibilities as they take advantage of per diems paid (often by donors) for training courses and supervisory visits. It also leads to "poaching" by NGOs and PVOs looking for competent local staff for their development projects.

The political will at the national level to improve management also affects the project's effectiveness. This is especially true given the project's design focus on long-term technical assistance. Without establishing policies rewarding good management and better services (recognition, promotions, job stability, reappointment, etc.), there will be little incentive to work harder to improve productivity, efficiency and quality at any level.

Better management also makes it more difficult to hide corruption, and may therefore encounter resistance from those with a vested interest in the existing system. Provincial Directors vary in their degree of commitment to improving management, as it usually requires a change in their personal management styles.

All of these factors appear to be surmountable if advisors are able to establish good relationships with national counterparts and provincial counterparts, and counterparts are genuinely interested in improving management.

3. Project Status: Progress to Date

Only the detailed *inputs* of this section are specified in the project paper and logical framework, and the indicators in the logical framework are somewhat sketchy. In keeping with the focus on impact and outputs, progress to date in achieving "Output 2" will be examined by dividing it into three broad activity areas:

- i. Planning and budgeting, including needs assessment and action plans.
 - ii. Ongoing project management, including supervision, programmatic and financial monitoring, personnel issues, special studies, staff skills, and logistics.
 - iii. Upgrading infrastructure and physical facilities.
- a. Planning, Evaluation, and Budgeting**

All Geographic Areas

The MOH, with the support of UNICEF, began holding annual provincial planning exercises in some provinces in 1992. The first was held in Zambezia at the end of 1992. Niassa and Gaza planning occurred at the end of 1993. All planning exercises were held

before the arrival of the PAs. The PAs began active participation in the planning process in all three provinces in 1994. Provincial action plans were produced, but specific aspects of the process varied by province, including the degree of district participation and the use of local data from the HIS for establishing priorities. Budgeting is not normally included in the planning, as it follows a different process and chronology; however, Niassa has shown considerable progress in the integration of programmatic planning with budgeting. The MOH must approve all provincial plans before they can become official. Unfortunately, approval has not been granted before September of any year, making the process mostly academic. Nevertheless, the participation of the PAs in the process led to improvements (see discussion below for each province).

A **preliminary management survey** was completed toward the end of 1994, and the final report was ready for presentation to the DPS in early 1995. The survey helped to determine educational needs and to define what should be the focus of training activities. Preliminary results were available in time to be used in the 1994 planning exercise for 1995. The survey showed great needs in all management areas. In spite of questions raised about the methodology and the sampling used, the survey had the effect of focusing attention on management deficits, especially in Gaza and Niassa. It was not presented to the DPS in Zambezia, and consequently had little impact there. Results were presented to all DPS at a national meeting.

The Demographic and Health Survey that was to be done as a baseline health survey, is now scheduled for 1996, with results to be available in late 1996 (see D.1.). Unfortunately, this impedes **data-based planning**, as the **HIS** does not include many areas of information, such as tuberculosis and hospital services.

All the provinces complain about the long delays for Maputo's approval of the provincial plans (approval arrived in September for 1995).

Niassa

Niassa Province has shown the most impressive improvement in **planning**. In 1994 the PA visited all the health districts in order to assess needs and establish priorities. HIS data and the management survey were used to establish priorities during the 1994 planning exercise. The PA helped achieve significant integration of program planning and **financial planning** during the 1994 planning exercise. The **action plan**, while now considered too ambitious by the DPS, is being used for monitoring activities.

The PA assisted in a Provincial study of personnel needs and abilities which showed a misallocation of resources in the Province. As a result, four DDS and the head of community health were replaced, and MCH nurses were transferred, in order to distribute

them more equitably among the districts. No such assessment had ever been done before in the Province.

The PA has provided significant **support for the HIS**. The project purchased a computer, and the PA provided assistance in the computerization of the HIS using the system developed by the MOH. The PA also helped develop a system for monitoring the receipt of completed HIS forms at the provincial and district levels. The PA also carried out a study to assess the quality of the data received, though the methodology (designed by the MOH) was very complex and may have to be simplified in order to be made ongoing.

Up-to-date graphs, showing progress toward key indicators, were evident in all health facilities visited by the evaluation team, and staff showed excellent understanding of the meaning of the graphs.

A one-week seminar on introductory concepts for management was held in late September.

Gaza

Gaza showed significant improvement in district participation in the **planning** process. There was reportedly much greater participation of district-level staff in the planning for 1995 than for 1994 (included 10 DDS and donors). Health data and the results of the management survey were used to set health priorities. Unfortunately, **budgeting** has not been integrated into the planning process. There was minimal central input, and the plan was implemented before final approval arrived in September of 1995.

Gaza was one of the last Provinces to implement the new **HIS**. With the help of the PA, the national guide for the HIS was field tested in Gaza, and the local staff are receiving on-the-job training in its use. The PA assisted in the installation of the MOH computer program and on-the-job training for DPS staff in its use. The PA also designed and carried out a study on data quality together with DPS staff. Data are being monitored for quality and completeness on receipt, including the use of a system for tracking which forms arrived from which health facilities (this system is not in place in the districts as of yet). The PA helped conduct a very small study in one district to verify the accuracy of the information received in the HIS. This study showed that accuracy was deficient (40% real coverage vs. 100% coverage reported by the HIS).

The use of graphic information is being stressed, and up-to-date graphs of HIS indicators were evident in all health facilities visited.

Zambezia

Zambezia has shown the least progress in **planning**. SCF/UK has a full-time advisor in the NEP, the department with primary responsibility for planning and the HIS. This fact impeded the activities of the PA in this area.

Nevertheless, the PA participated in the planning exercise in 1994, and a Provincial plan was elaborated. However, the process was reportedly more “top down”, with less participation from Provincial and district personnel than in other Provinces. There is still no integration of **budgeting** in the programmatic planning process, and the plan is reportedly not used for ongoing monitoring. Priorities were reportedly set based on the HIS, but the results of the management survey were not considered in the planning process.

The **HIS** is reportedly functioning in the Province. The PA performed several spot checks to verify the data and identify problems and has provided some help with operation of computers in the NEP. No graphs were evident during the evaluation team’s visits to health facilities, and staff had great difficulty citing information relating to health indicators.

b. Monitoring, Supervision, Improved Staff Skills, and Improved Logistics

All Geographic Areas

There was a decision not to establish new performance indicators for **monitoring** aside from those in the HIS until the latter are better used and understood. Instead, indicators will be developed to measure progress in implementing more effective management.

In all provinces, the PAs have provided on-the-job support for improving the management skills of provincial staff, though the specific person targeted for this support has varied by province. In addition, the project has purchased computers for all provinces to improve management of personnel and the HIS.

The project is supporting a year-long course in management (mid-level) at the Centro Regional de Desenvolvimento de Saúde (CRDS) (the Regional Health Development Center in Maputo), in collaboration with the MOH. Of the 23 current participants, three are from Zambezia and four are from Gaza. Ministry personnel mentioned plans to place course graduates in key positions in the provinces. The lack of participants from Niassa was due to the absence of qualified candidates. In addition, the project has supported **management workshops** in all three provinces, with follow-on workshops in planning scheduled for later this year (see Section E.1. on training below).

One-week workshops on **supervision** were also supported in Gaza and Zambezia, and one is planned for Niassa before the end of 1995. These workshops complement on-the-job supervision training (see Section E.1.). Transportation costs and per diem for supervision are being paid in all provinces, though the need for air charter services has been minimal. Supervision has increased in all provinces as a result, though the effect has been less in Zambezia than in Niassa and Gaza. In addition, support was provided for three supervisory visits from Maputo to various provinces during 1994.

Support for MCH/FP technical training has been minimal, but the technical knowledge of staff at all levels in MCH/FP was observed to be good considering their limited educational opportunities.

Niassa

Niassa has shown the greatest advances in PHC management. The PA has assisted in the development and introduction of a method for discussing priorities in the monthly "Colectivo" ("joint" staff) meetings¹⁵ based on a list of standardized indicators used for **monitoring performance** against the action plan. Agenda and minutes have been introduced into the meetings as well. **Financial monitoring** (pipeline analyses) is also being used in Colectivo meetings in conjunction with program indicators. A methodology for conducting Colectivo meetings has been developed and documented in a guide by the PA and submitted to the MOH and other PAs for review. It was observed that the NEP is still poorly integrated with other sectors (specifically with the "Repartição de Saúde Comunitaria" [RBC]).

Not only has progress been made in using health indicators for monitoring, but **health worker productivity** is routinely analyzed as well. **Personnel management** has improved since the PA provided on-the-job follow-up training to a MOH course in the Lotus 1-2-3 spreadsheet program. As a result, personnel records are being computerized and job categories being defined in preparation for the deconcentration of personnel records in October, 1995. In the absence of leadership from the MOH, job descriptions for NEP and the RBC were drawn up with the help of the PA and submitted to the MOH for review.

The PA has provided intensive support for **supervision** through on-the-job training. All facilities visited were observed to have organigrams on the walls. The PA has helped introduce a new participatory Provincial supervision system, and supervision books were printed with project resources and will soon be distributed to all health facilities. In the

¹⁵ The "colectivo" meetings are joint planning meetings attended by all DPS department heads. "Colectivo" is a Portuguese word which means "colective" or "joint" or "group".

new system, supervisors review the supervision guide before each outing and plan objectives based on observations. Supervisors are briefed and debriefed before and after each outing. Supervision plans are in evidence at the Provincial level, as well as at the district level, in some cases.

A Provincial committee formulated and reviewed criteria for **staff incentives** at the Provincial level. Criteria were approved by the Province and have been submitted to the Primary Health Care Support Project (PHCSP) for review. The first phase of the program is reportedly in place. The incentives reportedly are sustainable, though they were not reviewed by the evaluators.

The project supported **MCH/FP training** for Saúde Materno-Infantil (SMI) nurses in Cuamba. Treatment norms and protocols for various MCH/FP-related diseases were evident on the walls of many of the health facilities visited. The **TBA training** mentioned in the project paper is being supported in collaboration with the UNFPA. Training has been completed in Metarica District with project support, and the last four districts, which have not had such training, have been scheduled to receive it before the end of 1995.

The PA has aided in various improvements in **logistics** management. The PA developed a system for monitoring EDP kit distribution based on consumption. Provincial needs were analyzed facility-by-facility, and as a result, EDP kits were ordered based on real need. The PA also helped develop a system to monitor distribution of medications distributed through the *via classica*. In addition, the project supported a seminar on rational drug use and pharmacy management for all district pharmacy directors in August of 1995. As a result of these efforts, pharmacy management is reportedly much improved over 1994. The team was told that there have been no medication stockouts since March, 1995, and none were observed during site visits. All pharmacies were observed to have up-to-date stock control forms, and no stockouts were observed. A system similar to that being used for medications is being adapted for monitoring surgical supplies. In addition, the project is supporting the per diems of the district radio operators so that they may attend a course, and has introduced vehicle control forms into the Province.

Gaza

Gaza has also shown progress in **project monitoring**. With the help of the PA, agenda and minutes were introduced into Colectivo meetings, but it is unclear how data are being used in the meetings. All health facilities that were visited exhibited up-to-date monthly performance statistics in the form of graphs on walls. **Financial** information reportedly has not been used in the ongoing monitoring of the action plan yet.

Supervision frequency has increased as a result of transportation and per diem support, though the theft of the project vehicle caused difficulties during several months. A participatory supervisory system has been instituted with the assistance of the PA. Books similar to those implemented in Niassa were observed to be in use at all Provincial and district facilities. An integrated supervision plan and schedule has been drawn up with the goal of visiting each district at least once each year. The districts report having similar plans. The Provincial supervision seminar included many district staff and provided reinforcement for the new system, which was already in place. Both supervisors and staff consider the new system more supportive of health workers. All health facilities had organigrams evident on the walls.

In order to further strengthen the system, two seminars on management basics for district personnel were held with the help of the PA (one each for northern and southern districts). Forty-five staff members participated. Provincial directors are holding individual district follow-on sessions on supervision for health facility staff. So far, one session has been held in each of three districts, and two sessions held in one district.

A plan for **staff incentives** has been elaborated with the help of the PA and discussed with the DPS and Colectivo. Concerns about long-term sustainability of the program have been addressed. Incentives will be considered for initiative, productivity, and quality. The plan has not been implemented.

A group of students from the Maputo Training Institute course in “Técnico de Medicina” (“Medical Technician”) received training from the PA in operations research methodology. They have been undertaking **studies** of health sector operations as part of their thesis work. The results should be ready in the coming months. In addition, the project collaborated with Médecines sans Frontières (MSF, Switzerland) in a rapid study testing a community-based census method in Alto Changane.

In the area of **logistics**, the PA has recently helped develop and introduce a spreadsheet that monitors drug stockouts at the Provincial pharmacy warehouse. It is clear that pharmacy personnel will require further training before being able to use the system on an ongoing basis.

Zambezia

The many difficulties in Zambezia described previously have not permitted the same degree of progress as seen in the other two provinces. In Zambezia, the PA worked with the DPS on the more effective use of HIS data and has reportedly introduced the use of data into the Community Health Department technical meetings. It is unclear if Colectivo meetings are using data for **monitoring**. Graphs were seen on the walls in very

few health facilities visited, and where present, were very out-of-date. Workers in most facilities visited had poor knowledge about health data, and had to search for data and forms when these were requested. When these were found, they were often not up-to-date and were incorrectly filled out. **Financial** data are not yet coupled with programmatic data.

A seminar on management was held for Provincial personnel in August, 1995. In addition, three Provincial program or district directors are currently students in the management course at the CRDS in Maputo (the directors of NEP and Programa Alargado de Vaccinas (PAV) and the DDS of Mocuba).

The PA participated in the formation of new integrated **supervision** teams and the development of a supervision guide. These were later discussed in the Colectivo and donor coordinating meetings. Supervision calendars exist for DPS and DDS levels, with plans to visit every health facility one to two times each year. A week-long seminar on supervision was being held during this evaluation, and it is expected that follow-on activities will lead to concrete improvements in supervision. In spite of an apparent lack of specific activities and objective indicators, several DPS workers commented on the improvements in supervision that have resulted from the project efforts. Project resources have been used very sparingly to support transportation due partly to the large number of other donors in the Province, as well as concerns about accountability and creating dependence.

The area of **personnel management** has received some attention since the PAs counterpart is now the Director of the RRH. In preparation for the planned October decentralization of personnel, the PA helped initiate a physical inventory of Provincial health personnel, but it was not possible to complete the effort. Nevertheless, the PA has helped update personnel biodata forms and carry out a "paper" inventory of Provincial personnel. A computer was ordered by the project for the RRH.

Ideas for **staff incentives** have been discussed between the PA, the DPS, and the Colectivo, but no plan has been elaborated.

Project support for **MCH/FP training** was provided through temporary support of a nurse-professor's salary at the ICSQ (Instituto de Ciências de Saúde, Quelimane), the renovation of a health post and health center for nursing practicums, and per diem support for nurse supervisors for the practicums.

Logistic support has been provided to the EDP program. The PA helped develop and introduce a system for monitoring stockouts of EDP, contraceptive, and EPI supplies at Provincial and district levels. In addition, the technician in charge of the Provincial

pharmacy participated in the rational drug management seminar that MSH carried out in Maputo. Nevertheless, on visiting the central Provincial pharmacy, although stock cards were in place, most were not up to date, and many drugs out of stock (about 50%) and expired (about 20% of drugs on the shelves). District and local pharmacies were in even worse condition. EDP kits are apparently arriving at all levels, though quantities are often inappropriate, and control is lax (see section on EDP).

c. Upgrading Infrastructure and Physical Facilities

The following is a list of small infrastructure projects carried out under the “upgrading rural health posts” input. It is obvious that most projects have not been done in “rural health posts”, but have nevertheless been of great benefit to the improvement of health services. All the actions have been taken in agreement with DPS priorities.

Niassa

- Renovation of the electrical network at the DPS.
- Installation of solar panels on the roof of the DPS for cold chain support when there is no electricity.
- Well for the “Centro de Formação”.
- Water pump for the Provincial Hospital.
- Security bars for the DPS.
- Furniture for the NEP.

Gaza

- Repair of the bathrooms and cesspool of the Centro de Formação de Chicumbane.
- Rehabilitation of the Health Post at Mause (walkways, roofs, etc.).
- Painting of the DPS office and renovation of the DPS conference room.
- Renovation of Chibuto and Manjacaze Health Centers.

Zambezia

- Rehabilitation of the Sangaviera health post and Coalane health center (walls, furniture) for use as a practicum site for MCH nursing course. No other work has been done due to other donors.

4. Contribution to USAID Country Strategic Plan

All aspects of Output 2 fit with the USAID country strategic plan. This output fits under PO 3.3: “strengthened provincial management of MCH/FP service delivery”, and specifically to SPO 3.3.1-3 relating to planning, data and information systems, and supervision, respectively.

There is a great need for better personnel management, which is not specifically mentioned in any of the subprogram outcomes under PO 3.3. Nevertheless, personnel management would contribute greatly to the PO 3.3 of “strengthened provincial management of MCH/FP service delivery”.

5. Conclusions and Recommendations

- ▶ In order to prepare the Provinces for the imminent deconcentration of personnel management, specific activities and inputs that relate to personnel management issues should be added to the activities under the contract. These include:

- ✓ the undertaking of a personnel inventory
- ✓ development of job descriptions, personnel policies and procedures
- ✓ performance review, career ladder, and grievance and disciplinary procedures.

Without these actions, supervision and monitoring of performance and productivity cannot be adequately carried out.

- ▶ The DA should work with the Human Resources Department to define in writing the role and function of “Colectivos and Conselhos,”¹⁶ as well as to define and disseminate job descriptions and other personnel policies. This could be done with short-term technical assistance.
- ▶ The DA should work with the Department of Planning to accelerate approval of annual Provincial plans, or work with the MOH to change policies to allow them to be implemented without prior approval from Maputo.
- ▶ Funds earmarked for the rehabilitation of “25 health posts” should be made flexible in order to make them available for the myriad of small infrastructure projects that will assist in the successful completion of the project. One urgent need, for example, is for

¹⁶ “Conselhos” is Portuguese for “counsels” and refers to advisory meetings and organisms. “Colectivos and Conselhos” are joint meetings of department heads, advisors, and others, who meet to make decisions, recommendations and plans.

housing in Niassa to attract more qualified personnel for the DPS Human Resources Department and the Provincial Pharmacy.

- If the project is extended, consideration should be given to adding activities and indicators that relate to the reduction of maternal mortality and bring the project up-to-date with current thinking in this field. These may include such activities as improving referral systems between primary and secondary care levels, secondary care health worker training, assessment and improvement of referral facilities and transportation systems, IEC for maternal health, etc. This could be implemented by URC through the PAs. Short-term technical assistance for a needs assessment would be appropriate, which is likely to require additional resources.
- ▶ Change the task in the contract from “introduce the HIS into Niassa” to “support...”. The HIS was already functioning in Niassa at the initiation of the institutional contract.
- ▶ Together with the DPS, identify priority districts for concentrated activity at the district level. This will also aid in coordinating with existing district-level work being carried out by other PVOs and NGOs.

E. Training

1. Inputs and Outputs

Outputs

Training is not specified in the PP as one of the six outputs of the PHCSP¹⁷; yet it is one of the principal strategies used to achieve the outputs. Training is an inherent and essential part of all of the six outputs, and serves as objectively verifiable indicators for several of them. In reality, training is a major product as well as being a principal input.

Achievement of the PHCSP program purpose depends on training. The purpose is stated as follows: To enable the GRM to more efficiently and productively utilize resources in the health sector, especially for decentralized, preventive, primary health care. Any “enabling” actions require training to learn “how to do it,” especially if it is anticipated that the results will have long-term effects. Training should accomplish two basic results: 1) produce trained personnel

¹⁷ USAID: Primary Health Care Support Project, Mozambique (656-0226), Project Paper. 1991. & USAID: Primary Health Care Support Project, Mozambique (656-0226), Amendment No. 1. 1992

who have acquired knowledge, attitudes and skills that enable them to perform more efficiently and effectively; and 2) develop an improved institutional capacity to use resources through the presence of appropriately trained personnel and the implementation of more efficient and productive activities, procedures, and programs.

The specific results to be produced through training for each of the project outputs, as indicated in the PP Logical Framework (see Annex 2), are described below.¹⁸

Output 1. Health facilities supplied with essential drugs and contraceptives on a steady and reliable basis.

Output 1 requires training with regard to logistics and supply management, assessment and determination of needs based on epidemiological factors and pharmaceutical utilization by health facilities, rational use of pharmaceuticals by clinicians, etc.

Output 2. More productive health providers and more effective management support to those providers in Zambezia and Niassa Provinces.

Training is a significant product of Output 2, which correspondingly has the following objectively verifiable indicators:

1. More consistent and effective supervision and management support to district personnel.
2. 400 health care staff trained in personnel management, leadership, planning, HIS, financial management, MCH/FP interventions, and supervision in Zambezia and Niassa Provinces.
3. 100 TBAs trained in safe motherhood techniques.

Output 3. A decentralized system of planning, budgeting, financial management, supervision and program management better defined and implemented at national and provincial levels.

Training is a crucial ingredient of Output 3, and it has the following objectively verifiable indicator:

1. 45 provincial-level staff trained to assume greater responsibility for decentralized management and planning.

¹⁸

Ibid.

Output 4. IEC messages for MCH/FP are more regularly and effectively delivered to Mozambican families in Zambezia, Niassa, and Gaza Provinces.

Again, training is a fundamental aspect of Output 4, which has the following objectively verifiable indicators:

1. Train MOH staff in IEC process.
2. A local NGO is strengthened as a leader for MCH/FP IEC.

Inputs

Training is the main strategy for achieving the project outputs. This is both reasonable and appropriate. Training was to be accomplished through two basic methodologies, constituting the two specific training inputs: 1) long-term TA: TA which provides on-the-job or in-service training; and 2) in-country training: organized training activities, such as workshops, seminars and courses. More specifically, the PHCSP was to provide management, technical and educational training.

The Training Advisor was to provide 36 person-months of TA and be based in Quelimane, Zambezia Province, at the Retraining Center (CR = “Centro de Reciclagem”). The Advisor would assist the CR in organizing training for health personnel at the district level in the three provinces (Zambezia, Gaza and Niassa). S/he would also work with the provincial advisors to organize personnel management and leadership training for DPS and DDS staff, and would organize traditional birth attendant (TBA) training for Niassa. The Training Advisor counterpart was to be the director of the CR, and s/he would also work closely with the heads of community health (including MCH/FP) and human resources in each province.¹⁹

The in-country training²⁰ was to finance the costs of training in the areas of health information systems (HIS), planning, personnel management, leadership, and MCH/FP interventions. The courses should strengthen the MOH institutional capacity in planning, management, and service delivery. The PHCSP would provide four types of training:

- Personnel management training for provincial health staff.
- Leadership training for DPS directors.
- Technical training for district health staff.
- Technical training for TBAs.

¹⁹ Ibid.

²⁰ Ibid, & PHCSP Contract No. 656-0226-C-00-3019-00.

The following in-country training activities were to be organized, financed, and conducted:

1. Training to introduce or implement new HIS.
2. Training for improved health planning.
3. Annual leadership seminar in Maputo for DPS directors.
4. Annual provincial workshops on personnel management, leadership, and supervision.
5. One-week on-site refresher courses through the CR for district-level health staff in the three project provinces in MCH/FP interventions (ARI, CDD, EPI, FP, STD/AIDS control, prenatal care, nutrition and GMD [Growth Monitoring and Development], and health education).
6. TBA training in Niassa.

2. Capacity of GRM to Achieve Project Outputs and End of Project Status by Project Assistance Completion Date

The capacity of the MOH to achieve the training outputs and products, and achieve EOPS is very good. Training is a priority to the MOH, and the subject areas addressed by the PHCSP are also priorities. The MOH at the national level is collaborating as much as could be expected with project personnel, and the same is now occurring in the provinces.

The advisors had some difficulties in initiating activities in the provinces at the beginning, due to the lack of coordination between the MOH and the DPSs involved, and a lack of understanding as to what the advisors were supposed to do in the provinces. Taking into account the unanticipated length of start-up time, and the relatively short original time line (3 years) for the institutional contract, it appears unlikely that EOPS will be reached within the PACD. This is not unreasonable given the scope of the contract, the amount of work to be done, the people involved, and the relatively short amount of time to complete the scope. On the other hand, if the institutional contract is extended at least two years, the contractor would have enough time to reach EOPS by the PACD.

3. Project Status: Progress to Date

The National Director of Human Resources is responsible for organizing, coordinating and supervising the training of health personnel for the MOH. He indicated that the training inputs and activities of the PHCSP were very important for the MOH, even though they were only implemented in the three project provinces. He also indicated that they hoped to replicate project actions in other provinces. In addition, the National Director of Human Resources requested that the training advisor help the Human Resource Directorate at the central level to improve national educational policies and strategies.

The Directors of the CR and ICSQ (both in Quelimane) indicated that the Training Advisor was very important to their institutions. It was anticipated that he would: provide TA with regard to curriculum development and program organization to better respond to current needs; help them organize and plan their educational activities; train teachers so as to improve the faculties of both institutions; and, as a highly qualified public health professional, enhance the stature of their faculties by his presence. To date, he has not been able to dedicate sufficient time to fulfill these expectations.

The PHCSP provincial advisors in Gaza and Niassa also indicated that they require more assistance from the Training Advisor, and they felt that the Advisor had not dedicated sufficient time to their needs. They indicated that the workshops that had been organized thus far were very good, but that they needed to have more.

The Training Advisor indicated that he felt that he was attending to the tasks expected of him as well as could be expected considering the magnitude of the job. The Training Advisor resigned recently and Development Associates is in the process of replacing him.

Progress to date with relation to the technical assistance and in-country training inputs, is as follows:

Technical Assistance Results

The Training Advisor, and a short-term TA consultant, evaluated the training currently being done at the Health Science Institute of Quelimane (ICSQ = “Instituto de Ciências de Saúde, Quelimane”). They recommended that the PHCSP assist in the development of a training plan including formal and continuous training. The Training Advisor also evaluated the continuing education curriculum at the CR, coordinated a two-week training-of-trainers course at the ICSQ, and participated in district seminars on computers. He traveled to Milange to assist in evaluating returnees and to help plan their training upgrade. The Training Advisor assisted in the curriculum design for the new Multipurpose Elementary Health Agent (APES = “Agente Polivalente Elemental de Saúde”) course at the Mocuba, Zambezia training center.

In-Country Training Results

i. Training to introduce or implement new HIS

The Provincial Advisor in Niassa provided on-the-job training for more effective implementation of the newly established HIS at the DPS. He also assisted them in understanding the use of their computers for the HIS. NEP personnel indicated that the Provincial Advisor had given them significant assistance in helping them to understand and operate the new HIS. The Provincial Advisor in Gaza performed similarly, assisting

the NEP staff of the Gaza DPS with on-the-job training to better understand and implement their HIS, and use their computers more effectively. He provided follow-up training to initial MOH training. The Provincial Advisor in Zambezia did not work with HIS as there was another full-time advisor placed in the Zambezia NEP by SCF/UK, who was dedicated exclusively to the HIS and planning.

ii. Training for improved health planning.

On-the-job training in planning was provided in Niassa and Gaza by the provincial advisors. DPS staff in both provinces stated that the TA helped them considerably to improve their planning skills. This was confirmed by the DPS directors. Some aspects of planning are included in the management seminars (see # 4 below).

iii. Annual leadership seminar in Maputo for DPS directors.

No leadership seminars have been held yet. One is planned for the first quarter of 1996. It had been planned for the first quarter of 1995, but had been postponed several times at the request of the MOH. It is anticipated that up to six of the 11 DPS directors will be changed by February 1996, and the MOH would like the new directors to attend the leadership seminar.

iv. Provincial workshops on personnel management, leadership, and supervision.

A five-day workshop on management, including general management, time management, communication, report writing, leadership, interpersonal relations, etc., was given to DPS staff in each of the three provinces. Two district follow-on workshops were given in Gaza by provincial staff and the Provincial Advisor. A total of 45 persons attended the two district workshops. A five-day seminar on supervision was conducted in Gaza and Zambezia and is planned for Niassa in the near future.

On-the-job training (OTJ) in personnel management, leadership and supervision has been provided by all three provincial advisors, though it was limited in Zambezia. The Advisor in Niassa helped to develop a new system for supervision. The Advisor in Zambezia provided TA and OTJ training in human resource management, including preparation for the decentralization of personnel files, and the organization of a Provincial human resource inventory.

The Provincial Advisor in Niassa supported a workshop on administration paid for by Doctors without Borders (MSF). He also paid the per diem for radio operator training in one of the districts. The advisor in Gaza taught and supervised students at the

Chicumbane training center to do operations research, and qualitative and KAP studies, and to pretest radio spots.

A ten-month course in Public Health Management, given at the CRDS in Maputo was partially financed by the PHCSP at the request of the MOH. A total of 22 mid-level administrators are attending the course, including three from Gaza and three from Zambezia.

- v. **One-week on-site refresher courses through the CR for district-level health staff in the three project provinces in MCH/FP interventions (ARI, CDD, EPI, FP, STD/AIDS control, prenatal care, nutrition and GMD, and health education).**

The Training Advisor participated in district seminars on diagnoses and treatment, and another on pharmacy. The Provincial Advisor in Niassa supported and financed an MCH seminar organized with UNICEF for all DDS MCH nurses in the District of Cuamba. Two MCH training nurses from Maputo were financed to assist in tutoring student nurses from the ICSQ, and one MCH nurse was financed for five months to participate in the training.

Courses on rational drug use were conducted by the Management Sciences for Health (MSH) Rational Pharmaceutical Management (RPM) Project, in Maputo, Niassa, and Zambezia.

- vi. **TBA Training in Niassa.**

TBA training was coordinated with UNFPA which conducted several courses in Niassa. Several more courses are planned.

4. Contribution to USAID Country Strategic Plan

Training contributes directly to preparing health personnel to be able to provide appropriate, effective and efficient curative and preventive services. Thus they are enabled to contribute to the achievement of the Mission's strategic objectives. The strategic objective (SO), and the program (PO), and subprogram (SPO) outcomes which benefit significantly from training are outlined as follows²¹:

²¹ USAID: Mozambique, Country Strategic Plan, FY 1996-FY 2001. 1995

Goal: Enhanced Human Productivity.

Sub-Goal: Improved Health for Women and Children.

SO 3: Increased use of essential MCH/FP services in focus areas (Gaza, Niassa, Zambezia).

PO 3.1: Increased Supply and Quality of MCH/FP Services.

SPO 3.1.1: Increased Outreach to Communities and Improved Referral at All Levels.

SPO 3.1.2: More Health Facilities Equipped to Provide Essential Services.

SPO 3.1.3: More Health Facilities with Trained Staff.

PO 3.2: Improved Family Health Knowledge and Changed Behavior.

PO 3.3: Strengthened Provincial Management of MCH/FP Service Delivery.

SPO 3.3.1: Improved Planning and Budgeting Systems.

SPO 3.3.2: Improved MCH/FP Data and Information System.

SPO 3.3.3: Improved Supervisory Systems.

5. Conclusions and Recommendations

The Training Advisor: The Training Advisor is an important element of the PHCSP, both in terms of providing TA to the MOH and assistance to the PHCSP provincial advisors. S/he is also a key element for sustainability: preparing the MOH to continue project innovations and activities.

Some of the advisor's time could be dedicated to national needs, which has the potential of contributing to the improvement of human resource development nationally and of providing better support to improvements in the three project provinces. This would mean that the advisor would have three foci for her/his work: 1) improving the effectiveness of health educational institutions in Zambezia; 2) providing educational and training TA to the three provincial management advisors; and 3) providing TA to the National Directorate of Human Resources.

These are all important areas of work for a training advisor, and in aggregate have the potential of being more effective than originally anticipated, albeit it adds up to a tremendous workload. Consequently, more resources may be required to be able to implement the training component of the project more effectively. This might mean employing another person to assist with implementation of training activities, or subcontracting an organization to carry out activities, or employing more short-term TA.

Recommendations:

1. Replace the training advisor as soon as possible. The replacement should be a person who has suitable knowledge and skills in the areas of public health management, community-implemented primary health care, MCH/FP interventions, adult education, participatory and experiential learning techniques,

educational needs assessment, educational planning, curriculum design, and educational evaluation.

2. Specific training activities could be conducted by short-term TA. There should be at least five workshops in each province, and this sequence should be repeated in selected DDS. The five workshops should include the following: leadership, collective decision making, introductory management, planning (strategic and operational planning), and supervision. Other workshop themes should be offered in accord with identified needs of DPSs, and might include personnel management and financial management, among others.
3. Define three three foci for the training advisor: 1) improving the effectiveness of health educational institutions in Zambezia; 2) providing educational and training TA to the three provincial management advisors; and 3) providing TA to the National Directorate of Human Resources.

Public Health Management Course: MOH officials have indicated that they feel that the ten-month intensive Public Health Management course given at the CRDS is very good and responds to important needs of the health sector. They would like to see the course repeated in the provinces.

Recommendation: Adapt the management course to the provincial level, and give it in the three project provinces. Some health care workers from neighboring provinces could be invited to participate as well. Students could perform management practice in the DPS and DDS. This would help to establish a permanent management training capacity in the MOH human resource development system.

Institutionalized Management Training: Management training is a vital area for the MOH, especially considering the efforts being expended on decentralization. It is important that managers have access to continuing education in management, to be able to refine and reinforce their knowledge and skills, and to learn new procedures and techniques.

Recommendation: As mentioned previously, a permanent management training capacity should be developed in the MOH. This capacity should include the formation of a cadre of trainers and workshop facilitators, as well as the ability to design and develop appropriate seminars and workshops. Management training should also be taught in the training centers and health science institutes, and the University. Permanent courses and curricula should be developed which respond to the management and administrative needs of the MOH, DPS and DDS.

Management is a Technical Area: Management is a technical area which requires specialized training and education, much the same as is required for health services delivery.

Recommendation: Specialized management and administrative training should be prerequisites for employment for those who want to work in health management and administrative positions. This may require more project resources.

F. INFORMATION, EDUCATION, AND COMMUNICATION

Information, Education, and Communication (IEC) is the link between the public and public health providers. IEC contributes significantly to the success of public health programs and activities. In fact, most public health measures will not succeed without it. IEC refers to health promotion and education, disseminated through various channels of communication, including mass media, interpersonal, and self-instructional activities and materials. These include posters, pamphlets, radio and TV programs, talks, classes, multimedia campaigns, etc.

There are several purposes and benefits of IEC. Among these are the following: 1) inform an appropriate population-at-risk of health threats, factors, and conditions which contribute to morbidity and mortality; 2) increase the demand for, and use of, specific actions and services, which can prevent, protect against, detect, and treat health problems; 3) mobilize people and populations to participate in health programs and campaigns; and 4) help people to learn and adopt healthier practices and behaviors, and develop a healthier lifestyle.

Effective IEC depends on following a systematic process. For example, a physician should follow a systemic process before prescribing medicines, to be sure that s/he treats the cause of a health problem and does not simply alleviate temporarily a person's complaints. This should include taking a clinical history, conducting a physical exam, and performing pertinent laboratory exams to arrive at a diagnosis, before deciding on an appropriate therapeutic program to restore and maintain the health of an individual. The therapy should also take into account not only the person's complaints, but also her/his current health status, health history, and lifestyle.

IEC should follow a similar process to determine which messages and communication channels will be effective in changing how people do things. The end result of almost all IEC is changed behavior and/or practices (e.g., such as to convince people to avoid a health threat, to use a health service, to participate in a public health program, to live healthier, etc.). This process requires finding out how people behave at the present time, why they behave that way, what would impede them from changing, what would facilitate the change, and then developing a communication plan incorporating appropriate activities and materials to accomplish the targeted change. The plan should also include the pretesting of specific actions and materials to ensure that they accomplish what they were designed to do.

1. Inputs and Outputs

Outputs

The principal output for the IEC component is described similarly in the PP logframe and the institutional contract, with slight differences. In the PP logframe, the output is to deliver more regular and effective messages to Mozambican families to improve maternal and child health (MCH), and family planning (FP).¹ In the institutional contract, the output is described as improving the national- and provincial-level IEC in support of MCH/FP and STD prevention services.² The PHCSP is currently working in the Provinces of Zambezia, Niassa and Gaza. The PP indicates that the IEC component should be implemented in the Provinces of Zambezia, Niassa, Gaza and Cabo Delgado.³

There are four objectively verifiable indicators for this output:

- 1) To conduct formative research on health problems and related behaviors among Mozambican families in the three provinces where the PHCSP is working. This was defined as being special KAP studies.
- 2) To design, develop, pretest, and disseminate radio messages and print materials in the three provinces.
- 3) To evaluate on a regular basis IEC messages for understanding and impact.
- 4) To strengthen a local NGO (AMODEFA) to be a leader for MCH/FP IEC.

The indicators were to be verified through the following means: reports of data analysis of the formative research; ad hoc monitoring of radio and TV spots; brochures and posters evident in all MOH facilities; field and site visits; evaluation reports; and other donor reports.⁴

Inputs

The IEC component inputs are appropriate and very timely, though some modifications should be contemplated (see # 5 Recommendations, below). The principal input was 36 person-months of a full-time long-term expert advisor, to provide IEC technical assistance (TA) and training. In

¹ USAID: Project Paper, Primary Health Care Support Project, Project Number 656-0226, Amendment No. 1, approved 09/31/92, Logframe.

² USAID: Contract No. 656-0226-C-00-3019-00, Primary Health Care Support, Mozambique. Page 9.

³ USAID: Project Paper, Op. Cit., page 15.

⁴ Ibid, Annex A, Logframe.

the PP, the advisor was to work within the Mozambican Association for Family Development (AMODEFA), to provide overall coordination of IEC activities undertaken by the organization. AMODEFA staff were to be trained in formative research techniques, data analysis, message formulation, message dissemination, and evaluation of message effectiveness. The advisor was to assist AMODEFA in focusing their IEC efforts on MCH/FP and implement these activities in the provinces of Zambezia, Niassa and Cabo Delgado. The advisor's counterpart would be the chief liaison officer of AMODEFA.²⁶

In reality, the IEC Advisor was headquartered in Maputo, and provided TA and training at the national level, to the MOH, and the provincial level, through visits to the three project provinces. In addition, the project provided \$337,072 for IEC with AMODEFA. This includes \$37,072 for per diem for AMODEFA staff travel to the provinces; \$225,000 for the development of IEC materials with AMODEFA, such as posters, radio spots, pamphlets, etc.; and \$75,000 for IEC workshops and other activities.²⁷ Along with this, AMODEFA was to provide \$109,000 of in-kind inputs, including staff, office space, and office support.²⁸

In general, considering the importance of IEC to the MOH and public health, and its prominence in the USAID Country Strategic Plan (see the Strategic Plan, Annex 8, and number 4 below), the inputs, reflected in the level of effort and resources planned for the IEC component in the PHCSP, are not sufficient. Therefore, more resources should be contemplated, including more human and financial resources.

2. Capacity of GRM to Achieve Project Outputs and End of Project Status by Project Assistance Completion Date

The purpose of the PHCSP is to enable the GRM/MOH to more efficiently and productively utilize resources in the health sector, especially for decentralized, preventive, primary health care (PHC). IEC is an essential part of public health services and is particularly vital for preventive PHC.

As indicated previously, IEC contributes significantly to improving the effectiveness of MOH services and to improving the health of the population. For example, IEC contributes directly to increasing the coverage of MOH services by informing the population as to what services and programs the MOH facilities offer, and encouraging and stimulating the population to use the services. IEC also educates the population as to when they should seek certain services. This

²⁶ Ibid, page 36.

²⁷ Ibid, pages 27 and 6 of Annex E.

²⁸ Ibid, page 39.

contributes to the early and timely diagnosis of health problems, which could enable MOH health providers to prevent serious, possibly incapacitating, complications and death. It also helps to mobilize the population to participate in MOH campaigns and activities. Another valuable contribution of IEC is to teach the members of high risk subpopulations to adopt healthier behaviors and practices which will help to reduce the demand on MOH resources.

The PP indicates that the IEC technical assistance should concentrate on AMODEFA rather than the MOH, so that it is necessary to comment on AMODEFA's capacity to complete the outputs and EOPS by the PACD. At the same time, this seems to disagree with the purpose of the PHCSP, which essentially is to improve the efficiency and effectivity of the GRM/MOH. Consequently, we will comment on the capacity of both institutions to absorb the inputs and achieve the outputs.

AMODEFA is a Mozambican NGO financed by the International Planned Parenthood Federation (IPPF). AMODEFA did not prove to be a consistent counterpart, due to a lack of personnel. While it did provide a desk, it did not provide adequate office space, as it did not have sufficient space either. Soon after the arrival of the IEC Advisor, the Executive Director of AMODEFA resigned and was only recently (one month ago) replaced. Thus, AMODEFA has not been able to provide the in-kind support as described in the PP.

AMODEFA staff indicated that they benefited from the technical assistance provided by the IEC Advisor. They also said that they would like him to spend more time with them. In addition, they said that they had a problem with "overhead" with regard to the PHCSP, and that they lacked sufficient transportation to carry out activities.

It is apparent that AMODEFA cannot achieve EOPS. It lacks the technical capacity to do so without extensive training. More importantly, it does not seem interested in fulfilling the outputs of the PHCSP. AMODEFA staff would like the IEC Advisor to assist them on a full-time basis; but did not do much to support the Advisor or make a place for him in their offices.

The MOH, on the other hand, has provided office space, office support, and staff to work with the IEC Advisor in the Health Education Office ("Repartição da Educação da Saúde" = RES). Most of what the Advisor has accomplished, has been achieved in collaboration with the RES. Nevertheless, the counterpart provided by the MOH has changed twice since the Advisor has been at work. Also, the RES seems somewhat relegated and does not occupy an organizational position commensurate with its functional importance to the MOH.

The MOH will have difficulties in achieving the project outputs by the current end-of-project date of 08/31/97. The most significant difficulty is the relatively low levels of appropriate knowledge and skills on the part of the MOH personnel, which is particularly accentuated in the area of IEC. The MOH has not yet defined a national IEC policy, and the health education

department within the MCH Department of the MOH is too small to accomplish what should be done. As is fairly common throughout the world, the prevalent attitude regarding IEC seems to be that it should prepare materials that health providers can distribute to patients. If the PHCSP is extended for at least two years, that should give enough time to train personnel and achieve the EOPS.

3. Project Status: Progress to Date

When the IEC Advisor arrived, he was not able to establish an office at AMODEFA, as they indicated they had no space for him. They also had severe staff shortages, and lost their Executive Director. Consequently, the Advisor set up an office at the MOH and began to work with the RES. He also worked with AMODEFA to help them develop a triennial work plan for AIDS workshops and seminars for students and community groups. The advisors participated in two AIDS/STD seminars for adolescents and community leaders. He also assisted in coordinating activities with the PSI Jeito campaign.

The Advisor helped the MOH develop an IEC policy document for a national health plan. He traveled with his counterpart in Zambezia to collect knowledge, attitudes and practice (KAP) data and establish priorities for 1994-95. The advisor visited Niassa, and helped AMODEFA include work with youth in Niassa. Gaza did not have IEC human resources at the provincial level.

The health survey was postponed until 1996, when a Demographic and Health Survey (DHS) and a RAPID study are scheduled to be conducted. Data for AID/STD KAP studies in Zambezia, Gaza, and Niassa were collected with local personnel. The Advisor assisted Save the Children Foundation/US conduct a maternal and child health KAP in Gaza.

There have been a number of activities related to the development, testing, production and dissemination of IEC materials. The Provincial Advisor in Niassa provided technical assistance (TA) for the mother and child campaign there. The IEC Advisor provided TA to AMODEFA for the design of an AIDS project for youth, including a newsletter, and radio and TV spots. He also assisted AMODEFA in developing a TV spot to promote their image, and in developing an awareness program for world AIDS day, including radio spots, T-shirts, banners, theater, and TV spots.

Together with UNICEF, the Advisor assisted the MOH in developing a campaign to promote iodized salt in the Northern Provinces, including Niassa. With the Danish International Development Agency (DANIDA) he helped the MOH with a TV interview of the Minister of Health and with an advertisement for vaccinations, produced for World Health Day. The Advisor coordinated with UNDP, UNICEF, WHO, and World Vision in Zambezia (WVZ) to

assist the MOH in producing radio spots for the mother and child day campaign. Four TV spots were produced in Maputo.

The Advisor attempted to hire the Institute for Social Communication (ISC) to pretest radio spots with focus groups in Zambezia, Gaza, and Niassa. They told him that they could do it for \$30,000, if he taught them how to do focus groups. Medical agents were taught to pretest radio spots in Gaza.

The Advisor has provided considerable on-the-job training with regard to the formulation of communication plans, and the components of the plans. He has also taught MOH personnel technical skills to better use their equipment, such as cameras, mixer, recorders, etc. Due to lack of trained personnel, and the relatively recent implementation of materials and messages, there has not yet been any evaluation of the effectiveness of the materials/messages. The evaluation of impact will be initiated next year.

4. Contribution to USAID Country Strategic Plan

The overall goal of the Mission's strategic objectives (SO) is to enhance human productivity. IEC contributes directly to achieving this goal, and the subgoal, which is to improve health for women and children. IEC is an essential and vital component to the activities which will be enacted to fulfill SO 3.0: Increased use of essential MCH/FP services in focus areas. (Gaza, Niassa, Zambezia). It is also very important for the achievement of the program outcomes:

- PO 3.1: Increased Supply and Quality of MCH/FP Services in focus areas.
SPO 3.1.1: Increased Outreach to Communities and Improved Referral at All Levels.
- PO 3.2: Improved Family Health Knowledge and Changed Behavior.

The specific contributions of IEC to these goals and objectives were described in previous sections.

5. Conclusions and Recommendations

The recommendations are summarized as follows:

- **Change counterpart:** AMODEFA has shown that it does not yet have the capacity to be the primary IEC counterpart. When this became apparent, the IEC Advisor began to work with the MOH, which in practice became the primary counterpart.

Therefore, the logframe and institutional contract should be modified so that the MOH is recognized and indicated as the primary counterpart. This would also be in greater accord

with the general purpose of the project. Some TA should still be given to AMODEFA as expectations have been established through initial agreements, and it would be of value to strengthen their institutional and technical capabilities in IEC. This might require some additional resources, such as supplemental short-term TA.

- **National policy/strategy:** The MOH would like to develop a coherent and productive national IEC policy. Formulation of a national IEC policy was initiated last year, but was not finished. The Advisor could help the MOH to formulate national and provincial policies and strategies, and develop a simple strategic plan.

The MOH should also be assisted to give better institutional recognition and importance to the RES, which should be a department and not just an office. The RES should also receive more staff, and specific provincial counterparts should be identified.

- **Develop MOH capabilities:** In addition to recognizing that IEC is important and developing national and provincial policies and strategies, it is appropriate to develop and improve the IEC capabilities of the MOH at national and provincial levels. More staff should be aware of a systematic process to design and develop effective IEC, including the steps to formulate a communication plan, and the design and development of effective messages and materials. Other organizations, such as NGOs should be helped to develop the same capabilities so as to complement and supplement MOH resources and activities.

The IEC Advisor is currently adapting an IEC training curriculum written by the Academy for Educational Development (AED). As stated above, both MOH and NGO staff could attend the course. More resources may be required to implement this.

- **Institutionalize training:** The capacity to provide basic training and continuing education in IEC, should be made permanent in the training institutions of the MOH. Training should be developed and offered for programmatic and technical aspects of IEC. To accomplish this, the AED course could be established and taught at the MOH training institutes.
- **Increase resources for IEC:** The emphasis of the IEC advisor's activities should be on training and capacity building of MOH and NGO staff and personnel, which could be mechanisms for the production of specific IEC materials. Messages and materials should be developed to exemplify the IEC process, and to give practical experience as well as to respond to immediate needs of the MOH. More funds and IEC staff, either long- or short-term and local or expatriate, will be required to carry this out.

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- **Eliminate Cabo Delgado:** Cabo Delgado is mentioned in the PP as a control, and as a recipient of IEC materials. These references should be eliminated and changed. In effect, Gaza has replaced Cabo Delgado.

IV. General Project Conclusions and Recommendations

A. INPUTS AND OUTPUTS

The inputs and outputs of the Primary Health Care Support Project are appropriate and germane to the current situation and needs of Mozambique. Though the PHCSP was designed in 1991, and was not fully operational until 1994, nevertheless its program goal and purpose, and its objectives and outputs still respond to cogent and vital needs of the health sector.

The program goal is of paramount importance for Mozambique, which was rated the third worst country in the world with regard to health indicators (only Niger and Angola have worse health indicators). The goal, to contribute to overall improvement of health status, especially among women and children, will not be achieved by the PHCSP. But the PHCSP makes a significant and long lasting contribution to accomplishing the program purpose goal of enabling the GRM to more efficiently and productively utilize resources in the health sector, especially for decentralized, preventive, primary health care.

1. Outputs

The PHCSP outputs can be classified into two categories: 1) responds to emergencies, and mobilizes resources to satisfy urgent needs; 2) responds to the developmental needs of the health sector. Once the emergency has been resolved, the urgent outputs should be refocused to become developmental.

Of the six outputs summarized in the logframe, two (Numbers 1 and 6 in the list that follows) were oriented towards responding to emergencies, and four (Numbers 2 through 5 below) were essentially developmental. These are listed below.

- a. Health facilities supplied with essential drugs and contraceptives on a steady and reliable basis.
- b. More productive health providers and more effective management support to those providers in Zambezia and Niassa Provinces.
- c. A decentralized system of planning, budgeting, financial management, supervision and program management, better defined and implemented at the national and provincial levels.

- d. IEC messages for MCH/FP are more regularly and effectively delivered to Mozambican families in Zambezia, Niassa, and Gaza Provinces.
- e. Development of a better understanding of policy issues which support preventive PHC.
- f. Construction of water supplies to meet the needs of drought-affected populations.

The conditions of the country have changed since the PHCSP was designed. The emergency conditions have improved with the contributions of the PHCSP, and are no longer urgencies. **The six outputs are still of imperative importance to the development of the health sector.**

2. Inputs

The PHCSP has three basic classes of inputs: 1) financial; 2) operational; and 3) assistance. The project interventions, designed to achieve the outputs, have been implemented or performed by the MOH with the aid of the project inputs. As stated above, in general the inputs are appropriate and timely. More specifically, while all of the inputs were appropriate at the beginning of the project in 1992, improvements in the conditions addressed indicate that some modifications should be considered.

USAID has provided overall financing for the project, amounting to a total of \$29,500,000 (see Table 3, Summary of PIL No. 11, page 6). USAID/M also provides general project administration and supervision. USAID/M contracted Abt Associates to prepare the two policy studies done for Output No. 5.

Outputs Nos. 1 and 6, concerning essential drugs and water, were implemented principally by UNICEF, mainly through operational activities. UNICEF supplied essential drug kits to the MOH, and drilled wells in conjunction with the National Rural Water Program in drought-afflicted areas. The Essential Drugs Program (EDP) continues to supply kits, and is organizing training activities to facilitate kit distribution and utilization.

Outputs Nos. 2, 3, and 4, were implemented by University Research Corporation (URC) through a three-year contract, which has been half completed. URC provides long- and short-term technical assistance, training, and financing for specific activities.

B. Capacity of GRM to Achieve Project Outputs and End of Project Status by Project Assistance Completion Date

The MOH is collaborating and cooperating with the project, and considers its inputs and outputs to be priorities and of significant importance to the development of the health sector. Within its

context of limited resources, both financial and human, the MOH is participating as much as possible in the project interventions. The MOH has the capacity to make great strides in the implementation of the outputs. But, while not impossible, due to human resource limitations at both the national and provincial levels, it is doubtful that it can achieve end of project status by the current project assistance completion date. The current PACD is somewhat unrealistic and overly ambitious in relation to the existing conditions in Mozambique.

C. Project Status: Progress to Date

Progress with regard to some of the outputs has already been described in previous sections. Some project interventions were initiated somewhat late, notably, the URC institutional contract. All of the URC interventions demanded more start-up time than anticipated, due to unforeseen logistical problems and the general situation in Mozambique.

As described previously, there has been very good progress with relation to some of the interventions, and more limited progress with regard to others. Three of the six technical advisors to be placed by the institutional contractor are functional and beginning to produce: the two Provincial Advisors in Niassa and Gaza, and the IEC Advisor. The efforts of the Decentralization Advisor have been limited by administrative requirements, and some lack of coordination within the MOH. Both of these limitations appear to be resolving themselves. The Provincial Advisor in Zambezia and the Training Advisor have not been able to establish functional relationships due to personality difficulties and adverse working relationships. The last two are in the process of being replaced.

D. Contribution to the USAID Country Strategic Plan

The PHCSP contributes significantly to virtually all aspects of the health strategic objective (SO) of the USAID/M Country Strategic Plan. The overall goal of the Strategic Plan is to enhance human productivity in Mozambique. The Strategic Plan contains three strategic objectives:

- SO 1.0: Rural household income increased in targeted areas.
- SO 2.0: Government more accountable to citizens.
- SO 3.0: Use of essential MCH/FP services increased.

A sub-goal, improved health for women and children, was established as an important contributor to the goal. SO 3.0 has the following program and subprogram outcomes (PO and SPO, respectively). The PHCSP is addressing all three of the POs, with more emphasis on PO 3.2 and 3.3.

PO 3.1: Increased Supply and Quality of MCH/FP Services.

SPO 3.1.1: Increased Outreach to Communities and Improved Referral at All Levels.

SPO 3.1.2: More Health Facilities Equipped to Provide Essential Services.

SPO 3.1.3: More Health Facilities with Trained Staff.

PO 3.2: Improved Family Health Knowledge and Changed Behavior.

PO 3.3: Strengthened Provincial Management of MCH/FP Service Delivery.

SPO 3.3.1: Improved Planning and Budgeting Systems.

SPO 3.3.2: Improved MCH/FP Data and Information System.

SPO 3.3.3: Improved Supervisory Systems.

E. Conclusions and Recommendations

The following conclusions and recommendations complement those made in previous sections and apply to the project as a whole.

- The PHCSP was originally designed in an atmosphere of emergency and need to provide immediate relief, but with the intention of providing a transition from temporary urgent responses to sustainable development. The overall situation has improved significantly. Consequently, the tenor and focus of project components should now be towards development. All project interventions and outputs should include capacity building and training to enable the MOH to effectively continue project activities without external assistance.
- The time period originally scheduled for the institutional contract was too short. Unexpected contingencies delayed the full initiation of contract activities. Considerable investments have been made to establish advisors in Maputo and the three project provinces, and achieve functional effectivity. These investments have recently begun to produce their expected achievements. It would be inefficient and unreasonable to waste the investments by curtailing project activities. Therefore, the institutional contract should be extended at least two years.
- The ultimate success of the project depends on enabling the MOH to function more efficiently and effectively. This in turn depends on training and capacity building. In addition to forming a cadre of trained personnel capable of implementing efficient and productive procedures, the MOH needs the capacity to train future human resources and to provide continuing education to current staff. Therefore, through the long-term training advisor under the URC contract, the project should assist the MOH in institutionalizing training in its human resource development system. URC may require more resources, such as more staff, either long-term or short-term TA, and more financial resources, to implement this recommendation.

- The project suffered initially from poor coordination and unclear communication between the principal executors: USAID, the MOH, and URC. In particular, the provincial advisors encountered considerable difficulties due to the lack of coordination of the MOH with the DPSs. Therefore, USAID, the MOH (at national and provincial levels), and URC should make more specific efforts to improve communication and coordination concerning the project.
- The institutional contractor, URC, has found that it is difficult for the Chief of Party (COP) to function as both head administrator and decentralization advisor. The project entails a considerable amount of administrative and management work, including coordination and communication as commented on above. Technical assistance in support of decentralization also requires a lot of time. Therefore, URC should be authorized to hire another person to assume much of the administrative work of the COP, or alternatively, to be the decentralization advisor.
- The original PP contemplated working with an NGO. Private sector development is an important goal, and would considerably strengthen the health sector. Strong, effective private sector organizations not only offer viable alternatives for essential services, but usually are more effective and cost-efficient than governmental efforts. The existence of NGOs in the health sector also provides an opportunity for comparison to the public sector, which can serve to stimulate efficiency and productivity.

The current context of Mozambique offers some constraints which should be taken into account. First, the private sector in Mozambique is very small and limited. There are very few Mozambican NGOs, and those that do exist are relatively weak. This is not surprising, since Mozambique until recently had a socialist government which expected to provide all services to the population, and consequently there were not any NGOs. The private sector in Mozambique is new, and needs to be developed.

The NGO selected as a counterpart for IEC is not ready to assume that responsibility. Like other private sector organizations, it needs to be developed. Expecting it to work beyond its current capacity is not reasonable.

Therefore, AMODEFA should be relieved from being the principle IEC counterpart. And, there should be some specific efforts to develop organizations in the private sector. This could be accomplished through institutional strengthening workshops, and management training for NGOs. The GRM should be assisted in developing favorable policies to stimulate the private sector as well as providing appropriate regulations and standards. These actions may go beyond the scope of the current PHCSP, though some

Midterm Evaluation: Primary Health Care Support Project, Mozambique

activities should be possible. USAID/M should consider funding a project to focus on the development of local NGOs and private sector organizations.

V. Lessons Learned

The Primary Health Care Support Project is being implemented in Mozambique at a time when the whole country is rebuilding and reforming itself. A focus on capacity building and training contributes to this spirit.

- Technical assistance and training are mutually reinforcing and synergistic, and produce better results when used together. Also, training alone is generally not sufficient.
- Projects should have the flexibility to adapt to changing conditions, including the possibility to extend their time frame to compensate for unforeseen constraints, and/or to take advantage of unanticipated opportunities.
- The establishment of long-term technical advisors should be recognized as a relatively long process that requires adequate preparation as well as optimum communication, clarification of expectations and responsibilities, and coordination among all parties involved. It is particularly important to involve provincial and/or district personnel in communication and coordinating activities if the advisors will be working beyond the national MOH level.
- Advisors and counterpart personnel should be adequately prepared to perform their responsibilities and work together. This requires clear definition of goals and objectives, inputs and outputs, and expectations and constraints by all, and for all, personnel involved. It also requires specific team-building efforts which include advisors and counterparts.

The qualities and characteristics of advisors need to be carefully considered. They should not only possess requisite technical knowledge and skills, and have the appropriate educational background and practical experience, but should also have adequate interpersonal and communication skills, and be able to integrate a team. Language ability is an important part of communication; but, it is easier to teach advisors a language than to teach them the technical knowledge, skills, and experience that will constitute their technical assistance (see Footnote No. 13).

- Provincial activities need adequate national support to be effective and vice versa. National policies and strategies should be adapted and replicated in provincial policies and activities.

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- Misuse of resources and corruption need to be dealt with directly and continuously. These issues have not been specific concerns of the PHCSP; nevertheless, they were mentioned by a number of persons, indicating that they are concerns of staff, donors, and the beneficiary population. They have a direct effect on leadership and credibility, morale and motivation, and efficient and effective management.

Annex I
Map of the Republic of Mozambique

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Annex 2
Logical Framework

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REVISED LOGICAL FRAMEWORK

Primary Health Care Support Project

Mozambique

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Program or Sector Goal	Measures of Goal Achievement		
To contribute to overall improvement of health status, especially among women and children.	Decreased mortality and morbidity among women and children under five years of age from current levels of IMR = 190, CMR = 297, MMR = 300, LBW = 20%, Growth Faltering = 11 - 16%.	<ul style="list-style-type: none"> - National and regional statistics on service delivery, morbidity, facility admissions, mortality, nutritional status, etc. - Surveys and field trip reports. - Census information. - Evaluation results. - Other donor documents. 	<ul style="list-style-type: none"> - No worsening of security. - GRM and donor support for the health sector will continue at least at current levels. - No worsening of food security situation at household level. - No expansion of unhealthy health care practices at home.
Program or Sector Purpose	Conditions Indicating Achievement of End of Program Status (EOPS)		
To enable to GRM to more efficiently and productively utilize resources in the health sector, especially for decentralized, preventive, primary health care.	<ul style="list-style-type: none"> - Increased coverage as measured by increased numbers of women and children receiving MCH/FP and PHC services, including prenatal care, EPI, COD, malaria, family planning, nutrition, and STD preventive and treatment services and education. - Increased quality of care as measured by reduced discontinuation, increased provider-patient contact, diminished vaccine failure, better sterilization practices, etc. 	<ul style="list-style-type: none"> - Service statistics. - MOH operational and clinical records. - Field and site visits. - Evaluation reports. - Studies and surveys. - Pre- and post-project analyses. 	<ul style="list-style-type: none"> - GRM continues to endorse strategies for primary and preventive health care, including family planning. - Other donors will continue to support the public health sector for nutrition and water/sanitation services. - Donor support for health interventions continues at current levels. - Increased availability of information & improved technical/managerial training will lead to increased utilization of services.
Outputs			
1. Health facilities supplied with essential drugs and contraceptives on a steady and reliable basis.	<ul style="list-style-type: none"> - Adequate reserves of essential drugs and contraceptives maintained at all levels of the delivery system (national, provincial, district and facility). - Distribution of contraceptives included in EDP kits. - Reduced stockouts, wastage of MCH/FP supplies for PHC. 	<ul style="list-style-type: none"> - Commodity receiving reports and receipts. - EDP and contraceptive inventory records at all levels of the health system. - UNICEF records. 	<ul style="list-style-type: none"> - Other drugs, vaccines and MCH/FP supplies are consistently available for level I facilities. - Security situation does not preclude implementation of project activities at provincial level. - MOH continues to endorse child spacing and family planning activities.
2. More productive health providers and more effective management support to those providers in Zambezia and Niassa Provinces.	<ul style="list-style-type: none"> - Provincial action plans (with budgets) produced for Zambezia and Niassa Province based on needs assessment and established priorities. - More consistent and effective supervision and management support to district personnel. - Preventive, PHC (including FP) more effectively integrated into district curative services. - 500 health care staff trained in personnel management, leadership, planning, HIS, financial management, MCH/FP interventions and supervision in Zambezia and Niassa Provinces. - 150 TBAs trained in safe motherhood techniques. - 25 rural health posts upgraded. 	<ul style="list-style-type: none"> - Program plans and budgets. - Supervision reports. - Evaluation reports. - Field and site visits. - MOH/FP staff in place. - Project progress reports. - Consultancy reports. - Evaluations of training sessions. - MOH operational and clinical records. - Studies and surveys. - Pre- and post-project analyses. - Other donor reports. 	<ul style="list-style-type: none"> - Coordination between World Bank, UNICEF, FINNIDA, DANIDA and AID in strengthening the MOH continues constructively. - MOH can retain trained staff. - MOH assigns sufficient human & material resources for successful implementation of project activities. - Improvements can be made within cultural, economic and bureaucratic environment.

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<p>3. A decentralized system of planning, budgeting, financial management, supervision and program management better defined and implemented at national & provincial level.</p>	<ul style="list-style-type: none"> - Study conducted on decentralization issues and requirements. - Decentralization guidelines produced at national level. - 65 provincial level staff trained to assume greater responsibility for decentralized management and planning. 	<ul style="list-style-type: none"> - Study reports. - Project progress reports. - Guidelines document. 	
<p>4. IEC messages for MCH/FP are more regularly and effectively delivered to Mozambican families in Zambezia, Niassa and Cabo Delgado Provinces.</p>	<ul style="list-style-type: none"> - Formative research conducted on health problems and behaviors among Mozambican families in the three provinces. - Radio messages, printed materials developed, pre-tested and disseminated in the 3 provinces. - Messages regularly evaluated for impact and understanding. - A local NGO is strengthened as a leader for MCH/FP IEC. 	<ul style="list-style-type: none"> - Data analysis reports. - Ad hoc monitoring of radio & TV spots. - Brochures/posters evident in all MOH facilities. - Field and site visits. - Evaluation reports. - Other donor reports. 	
<p>5. Development of a better understanding of policy issues which support preventive, PHC.</p>	<ul style="list-style-type: none"> - Three studies conducted on (1) the role of the private sector in service delivery; (2) improvements in the functioning and financing of the pharmaceutical sector; (3) the appropriate allocation of MOH budgetary resources toward preventive, PHC services. 	<ul style="list-style-type: none"> - Study reports. 	
<p>6. Construction of water supplies to meet the needs of drought affected populations.</p>	<ul style="list-style-type: none"> - Provide sufficient wells to serve 400,000 people. 	<ul style="list-style-type: none"> - UNICEF reports. - Site visits. 	<ul style="list-style-type: none"> - That UNICEF & PRONAR are able to meet projected drilling work load, and that the wet/dry ratio remains unchanged.
Inputs		Funding Targets	
Essential Drugs/Contraceptives		\$ 12.35 million	<ul style="list-style-type: none"> - Qualified expatriates can be hired and housed. - Local or international procurement of commodities conforms to AID regulations in cost-effective manner. - MOH staff available for training.
Drought Medicines		4.00 million	
Drought Water Supplies		2.00 million	
Drought TA for Water/Pharmaceuticals		0.60 million	
Technical Assistance (216 pm long-term TA and 29 pm short-term TA and contract administration)		6.70 million	
In-Country Training		0.38 million	
Supervision Travel/Transport		0.87 million	
Commodities/Materials		0.71 million	
Construction/Rehabilitation		0.29 million	
Research, Monitoring, Evaluation/Audits		1.51 million	
Contingency		0.08 million	
ROUNDED TOTAL		\$ 29.50 million	

Annex 3
Scope of Work

Scope of Work

Article I. Title: Primary Health Care Support Project
Mozambique (656-0226) Midterm Evaluation

Article II. Introduction

This document presents a scope of work for conducting an evaluation of Mozambique's Primary Health Care Support (HCS) Project (656-0226). The general goal of the project is to contribute to the overall improvement of health status in Mozambique, especially among women and children. The more specific purpose of the project is to enable the Government of the Republic of Mozambique (GRM), to more efficiently and productively utilize existing health resources, especially for decentralized preventive, primary health care (PHC) services.

There are three components the project: (1) Essential Drugs and Contraceptives, (2) Institutional Strengthening- Decentralization and Management-Planning Support to Provincial Health Directorates, and (3) Policy Studies for Preventive, Primary Health Care.

Article III. Background

The approach taken in the design of the Primary Health Care Support Project was to identify a limited number of key areas within primary health care which, if given priority attention, would make a substantial impact on preventive, primary health care in Mozambique. USAID and Ministry of Health (MOH) concluded that a major effort in three areas would have the most impact: (1) Essential Drugs and Contraceptives, (2) Strengthening of MOH institutional capacity to plan, manage, and deliver preventive PHC services, and (3) Analysis of three policy areas which influence the effectiveness of PHC in Mozambique.

Essential Drugs and Contraceptives

Insufficient supplies of essential drugs and contraceptives are a serious constraint to the delivery of effective primary health care in Mozambique. Frequent stock outs occur as a result of inadequate supply and poor management of existing stocks within the country. In view of the shortfalls in supplies, this project funds the costs of procurement and shipping of Essential Drugs Program (EDP) Kits through UNICEF to Mozambique and the costs of UNICEF administrative support over the life of project (LOP). In accordance with USAID rules regarding programs of public international organizations for which USAID is not the only contributor, UNICEF uses its own procedures for procurement of the EDP kits.

In addition to the Essential Drugs provided to the country's PHC system through a Grant with UNICEF (\$11,679,818), AID-Mozambique budgeted and purchased \$1.7 million worth of pharmaceuticals in the U.S. which contributed to drought emergency efforts in Mozambique. An additional \$1.8 million worth of contraceptives (condoms, pills, IUDs and Depo-Provera) have also been provided to Mozambique's PHC system.

Strengthening of MOH Institutional Capacity to Plan, Manage, and Deliver Preventive PHC Services.

At all levels of the MOH, the processes of planning, budgeting, and managing health resources require strengthening. At the provincial level, inadequate planning and budgeting capacity diminishes the provinces' authority over their health programs and their ability to adequately address the most critical needs. At the same time, concentration of authority at

the central level only minimally supports those aspects of the planning, programming, and budgeting processes that are nominally assigned to the provincial level. On the operational side of services delivery, there is a shortage of adequate trained personnel to diagnose and treat the major health problems among the population.

While many of the problems plaguing the public health system can be explained by the past insecurity in Mozambique and the severe economic stress experienced in the health sector. USAID believes that more and better quality services can be delivered within the existing health system without concomitant increases in budgetary resources.

The objective of the long-term institutional contract for technical assistance with University Research Corporation is to assist the GRM to more efficiently and productively utilize existing health resources, especially for decentralized preventive, primary health care services.

Policy Studies for Preventive, Primary Health Care

To assist the MOH to obtain more information regarding pertinent policy issues, the project proposed to fund three studies to be conducted in year 1 of project implementation. The studies were to provide analysis and guidance to the MOH for: (1) expanding health services outside the public sector, (2) increasing budgetary transparency for pharmaceuticals and exploring the potential involvement of private organizations in the pharmaceutical sector, and (3) determining the necessary proportion of MOH resources to be allocated to cost-effective preventive, PHC health services.

Article IV. Objectives

The objectives of this Scope of Work will vary slightly by component:

- (a) The essential drugs component with UNICEF will be completed or near completion at the time of the evaluation.
- (b) Procurement of family planning commodities will be on-going.
- (c) The institutional contract will be halfway completed.
- (d) Two of the three anticipated policy studies have been completed.

The following objectives apply, but will vary depending upon stage of completion of the component.

- (1) Review the appropriateness, timeliness and quality of project inputs. Assess the validity of design assumptions, eligible activities and impact indicators. Provide a descriptive analysis of project status relative to the inputs provided.
- (2) Review project outputs and evaluate progress made towards achieving outputs. Provide a detailed explanation of those areas where project outputs have been exceeded or are not likely to be achieved over the life of the component.
- (3) Review the project purpose and assess the extent to which project inputs and outputs are, or are not, leading to the achievement of the purpose of the project assistance completion date (PACD).
- (4) Make recommendations for the next phase of project implementation.

Article V. Requirements

A. General Requirements

The Contractor will perform a project evaluation over a four-week period sometime within a three-month time frame between September 1 and November 30, 1995. The evaluation team will be composed of three full-time members provided by the Contractor, with background and expertise consistent with the requirements presented in Article VI. The Contractor will appoint one member as team leader. A fourth team member may be provided by USAID or REDSO-ESA as a resource person.

Two days of team building activities in Washington D.C. is authorized, prior to the team's arrival in Mozambique.

The team will arrive and begin work in Mozambique on a date and at a time that has been concurred in by the Primary Health Care Support Project Manager or by the General Development Officer. The team will coordinate its work through the General Development Office at USAID-Mozambique. In carrying out its task, the team will review project documentation, and will meet with officers of USAID, the GRM, grant recipients (UNICEF, AMODEFA, Population Services International (PSI), and the institutional contractor). The team may make selected site visits together with USAID and other project, GRM, UNICEF, or institutional contractor representatives.

The evaluation team will present a complete draft report (20 copies) in English, and will provide oral briefings to USAID, representatives of the GRM and representatives of UNICEF, and the institutional contractor no later than the seventeenth working day of this assignment. USAID, representatives of the GRM and representatives of UNICEF and the institutional contractor will provide the team with comments, verbal or written, within five working days following the oral presentation of the draft report. A final evaluation report (20 copies), including a completed Evaluation Summary (Form USAID 1330), is to be submitted to and accepted in fulfillment of the terms of the evaluation team's work by the Project Officer and the Mission Evaluation Officer no later than 30 calendar days after the comments and suggested modifications have been given to the evaluation team's leader.

B. Specific Requirements

The team will address the following specific questions and topics:

- (1) Have the quality and quantity of USAID inputs (TA and financial inputs) been adequate to achieve project outputs at this time, and are sufficient resources available during the remaining life of project components?
- (2) Is the absorptive capacity of the GRM adequate to achieve project outputs and end-of-project status (EOPS) by PACD?
- (3) Are the activities described in the Project Paper being carried out? What has been the impact of these activities on project outputs and EOPS?

The institutional contract component has specific tasks and targets. They are presented in Table 1, below. The team will use points 1 and 2 above assess progress to date and, based on the experience of the institutional contractor, perceived potential for achieving the tasks as targeted. The team should make any recommendations deemed appropriate.

- (4) After approximately 18 months of operation and experience of the institutional contractor, does the team have recommendations for altering any of the tasks, realigning personnel skills with project tasks, etc.?

**Table 1. Primary Health Care Support Project, Mozambique - Mid-Term Evaluation
INSTITUTIONAL CONTRACT TASKS AND TARGETS**

TASK	TARGET DATE	OBSERVATIONS/ RECOMMENDATIONS
A. IMPROVING PROVINCIAL LEVEL PLANNING		
A.1 Assessing Health Needs		
Introduce new HIS in Niassa.	Year 1	
Follow-up support for new HIS in Gaza & Zambezia.	On-Going	
Conduct base-line health survey in 4 provinces.	Year 1	
Establish health priorities for service delivery.	Year 1	
A.2 Measuring Performance		
Implement action plans in all provinces.	Year 3	
Institute data-based planning & decision making of the on-going health systems.	On-Going	
Financial management & budgeting training.	Year 3	
Establish performance indicators.	Year 2	
Conduct special studies on clinical operations.	Year 2	
B. IMPROVING PROVINCIAL LEVEL PROGRAM & HUMAN RESOURCE MANAGEMENT		
B.1 Upgrading Staff Skills		
Personnel management training for DPS & DDS staff.	Annually	
Leadership training for provincial health directors.	Annually	
MCH/FP training for district level staff.	Annually	
TBA training for Niassa.	On-Going	
B.2 Improving Supervision		
Transportation and per diem support for increased number of supervisory visits.	On-Going	
On-the-job support to upgrade supervisory skills.	Annually	
B.3 Staff Incentives		

TASK	TARGET DATE	OBSERVATIONS/ RECOMMENDATIONS
Establish performance indicators and reward system.	Year 2	
B.4 Improving Logistics Management		
Provide TA and training for improved supply management.	Year 2	
Identification of alternative distribution channels	Year 2	
Implementation of alternative distribution channels.	Year 3	
C. SUPPORT FOR DECENTRALIZATION		
Define decentralization principles.	Year 2	
Prepare guidelines for decentralization.	Year 2	
Decentralize specific actions negotiated with MOH.	Year 3	
D. UPGRADING RURAL FACILITIES		
Rehabilitate 15 health posts.	Year 3	
E. IMPROVING IEC FOR MCH/FP		
Collect data via health survey.	Year 1	
Conduct special KAP surveys.	Year 1	
Develop, test, produce & disseminate IEC materials & messages (radio & print).	Year 2	
Evaluate effectiveness/impact of materials/ messages.	Year 3	

Article VI. Qualifications of Contract Evaluation Team

All members of the Contractor's evaluation team should have extensive experience with field operations of health and-or family planning projects and previous experience working in field-base projects in African countries.

The skills required for this evaluation are likely to be represented in a three-person team:

Team Member No. 1 A senior person with in-the-field project management experience. Ideally one who has been chief of party or held a senior-team member position in a field-based health or family planning project.

Team Member No. 2 Public health specialist with previous experience working with ministries of health. Experience working in MCH activities in Africa.

Team Member No. 3 Social scientist with project impact, data analysis, MIS-HIS experience.

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One or more of the team members must have experience with IEC activities from formative research to development and dissemination of materials-messages.

One or more of the team members must have experience with efforts to decentralize health systems.

A resource person to the team may be provided by USAID. The Contractor will not be responsible for any cost associated with this team member.

Article VII. Reports

The evaluation team shall provide a draft outline of the evaluation by the tenth working day of this assignment as part of an oral progress briefing to the USAID Mission.

The evaluation team shall provide a draft final report (20 copies) and make oral presentations (summary of findings, conclusions, recommendations) to USAID, appropriate officers of the GRM and representatives of UNICEF and the institutional contractor. The draft report shall be submitted to and be accepted in partial fulfillment of the terms of reference by the Project Officer. Submission of the draft report will constitute 50% partial payment. Comments on the draft report will be submitted by all the reviewers to the evaluation team leader within ten working days of the report's distribution.

The USAID Project Officer is responsible for distribution of the final draft version of the evaluation within the Mission, to appropriate offices within the GRM and to selected representatives of the government and non-governmental organization community in Mozambique.

The final report will be produced with Word Perfect 5.1 word processing software. The Contractor shall submit to USAID-Mozambique fifteen (15) bound copies and one (1) unbound copy of the final report. Three (3) bound copies should be dispatched by the Contractor via express courier service (DHL) To the following address:

Laura L Slobey
General Development Officer
USAID-Mozambique
Rua Faria de Sousa, 107
Maputo, Mozambique

The remaining twelve (12) bound copies and one (1) unbound copy should be dispatched by Contractor via U.S. Government diplomatic pouch to the following address:

Laura L. Slobey
General Development Officer
Maputo-Department of State
Washington, D.C. 20521-2330

A diskette of the final report and all supporting annexes is also to be submitted with the copies to be dispatched by diplomatic pouch.

Article VIII. Relationships and Responsibilities

The team leader will be responsible for coordinating the work of the members of the evaluations team. The evaluation team will be responsible for conducting the evaluation and assuring that its objectives are met in accordance with the schedule provided in Article IX below.

Article IX. Terms of Performance

The evaluation team will begin work o/a September 11, 1995 in Maputo, Mozambique. Two days of team-building before departure for Maputo are authorized. Work will continue uninterrupted (except for U.S. and Mozambican holidays) for a period of 15 working days for all members of the Contractor's team. A six-day work week is authorized. All field work on the evaluation to be performed in Mozambique as described above is expected to be completed within 15 working days.

The evaluation team leader (and another team member if deemed appropriate) is allowed up to an additional 10 working days in total to incorporate comments on the draft report and to make any further modifications as may be required. The ten days of this additional time will be done in Mozambique, or at the Contractor's place of work, or at the team leader's place of choice, as long as USAID and Contractor's are in agreement as to the suitability of the place to accomplish the task. If the team leader's workplace is in his her city of residence, per diem is not authorized.

Article X. Work Days Ordered and Timing of Deliverables

A six-day work week is authorized. Total days authorized:

Two days team-building-all three team members,

Up to 2 travel days (international)- all three team members,

Up to 15 working days (over a four week period)-all four team members,

Up to 2 travel days (international) - all three team members, and,

Up to 10 additional working days-to finalize the document and draft the USAID Evaluation Summary.

NOTE: Sufficient time is to be allotted for printing and binding the final copies of the evaluation, and for dispatching the specified number of copies to USAID via courier service and the diplomatic air pouch.

Article XI. Miscellaneous

Duty Post: Mozambique.

Language: Fluency in written and spoken English. Knowledge of Portuguese by at least one of the team members is essential, and it would be advantageous for the other team members.

Limited office space may be provided for the use of the evaluation team. In the event that adequate space cannot be found within the Mission, Contractor is allowed to make arrangements for such space, such as leasing temporary quarters. Consequently, the Contractor should budget for office space.

The Contractor is expected to provide all required secretarial assistance.

The Contractor is expected to arrange for all computer support, although printers at USAID can be used, on a "time available", or "after hours" basis.

The Contractor is expected to provide for the evaluation team's transportation in Mozambique.

Upon request of the Contractor, the Primary Health Care Support Project Manager will assist in making arrangements for car rental, hotel reservations, appointments with USAID, GRM, UNICEF, the grantees and the institutional contractor.

Annex 4
Documents Reviewed

Documents Reviewed

A. USAID Documents

Contract No. 656-0226-C-00-3019-00, Primary Health Care Support Project, Mozambique.

Mozambique Country Strategic Plan, FY 1996-FY 2001.

Mozambique Pilot Child Survival, 656-0207, Project Paper. USAID. June 30, 1989.

Project Implementation Letters, Nos. 8 & 11.

Project Implementation Reports for Mozambique Primary Health Care Support Project, 10/1/93 to 3/30/94; 4/1/94 to 9/30/94; 10/1/94 to 3/30/95.

Project Paper, Mozambique Primary Health Care Support Project (656-0226), August 1991

Project Paper Amendment 1, Mozambique Primary Health Care Support Project (656-0226), September 1992

Rocha, C.: Assessment of Health in Mozambique: Presentation to Social Sector Task Force, 1994.

B. University Research Corporation Documents

Annual Work Plans for 1994 and 1995

Destexhe P., Holmgren B., Rocuts, F.: Health Management Survey in Gaza, Niassa and Zambézia. MOH, Directorate of Planning and Cooperation, Primary Health Care Project, USAID. 1995.

Muianga M., Novela C., Tembe A., Artur A, Monaho F., Masivila M., Rocuts, F.: Gestão de Saúde, Inquérito na Província de Gaza. Ministério da Saúde, Direcção de Planificação e Cooperação; Direcção Provincial de Saúde de Gaza, Projecto de Cuidados Primários de Saúde, USAID. 1995.

Primary Health Care Support Project, Quarterly Reports: April-June 1994; July-September 1994; October-December, 1994; January-March 1995; April-June 1995.

Rocuts, F.: Ideias Orientadoras para o Futuro do Projecto de Cuidados Primários de Saúde (URC - DA/USAID). September, 1995.

Romero, J.: Plan Integral 1995-1996 do Componente IE&C do Projecto de Apoio aos Cuidados de Saúde Primarios. December 1994.

Tarrago, O.: Primary Health Care Support Project, Training Plan 1995-96.

C. Other PHCSP Documents

Bossert T., Connerley, E.: Mozambique Decentralization Planning. Primary Health Care Support Project, USAID. 03/14/1995.

Gnesotto, R.: Draft Consultancy Report on Decentralization of Planning. August, 1995.

Kazilimani-Pale, E.: Primary Health Care Support Project, Consultancy Report. 5/1/1995.

Mariani, E.: Trip Report, 20 June-5 July 1995.

McInnes, K., Cabral, A.J., & Simões, J.A.: HFS Technical Note No. 18, The Expansion of Health Services Outside the Public Sector, Mozambique. Health Financing and Sustainability (HFS) Project; Health Services Division, Office of Health, Bureau for Research and Development, USAID. March, 1993.

McInnes, K., Polania, E., & Ramos, F.: HFS Technical Note No. 19, Mozambique Public Sector Budgetary Resource Needs and Allocations in Health. Health Financing and Sustainability (HFS) Project; Health Services Division, Office of Health, Bureau for Research and Development, USAID. January, 1993.

D. GRM/MOH Documents

Campos, J. : Estratégias do Sector Saúde para o Pós-Guerra. June, 1993

Chonguiça, C., Vettorazzi M.: Manual de Operações para Pessoal de Farmácia. Programa de Medicamentos Essenciais, Ministério da Saúde. April, 1989.

Departamento de Informação para a Saúde (DIS): Programa de Acção do Ministério da Saúde - 1995. Direcção Nacional de Planificação e Cooperação, Ministério da Saúde. April, 1995.

Direcção Nacional de Planificação e Cooperação, Departamento de Informação para a Saúde: Informação Estatística Anual - 1992. Ministério da Saúde. August, 1994.

Durão, J.: Manual de Normas e Procedimentos para Distribuição e Cobrança de Medicamentos. Ministério da Saúde, Departamento Farmacéutico. April 17, 1989.

Gnesotto, R., Sitoi, A., Brown, A.: Manual de Procedimentos para o Sistema de Informação de Saúde - S.I.S, Nível Provincial. Ministério da Saúde, Direcção Nacional de Planificação e Cooperação, Repartição de Estatística e Demografia. 1991.

Gish, O., Pavignani, E.: Health Manpower Development Plan 1992 - 2002. Ministério da Saúde. December, 1991.

Programa de Medicamentos Essenciais: Manual de Medicamentos Essenciais para Cuidados Primários de Saúde. Ministério da Saúde. April, 1986.

Sitoi, A., Gnesotto, R., Brown, A., Swiderski, A.: Manual do Sistema de Informação para a Saúde - S.I.S., Níveis Distrital, Local e Centros de Formação. Direcção Nacional de

Planificação e Cooperação, Departamento de Informação para a Saúde, Ministério da Saúde. 4/23/1993.

Stuckey, J., Mendez, L., Cumbi, A., Vettorazzi, M.: Programa de Medicamentos Essenciais, Guia de Supervisão das Unidades Sanitárias. Direção Nacional de Saúde, Ministério da Saúde. July, 1988.

Stuckey, J., Mendez, L., Vettorazzi, M.: Manual para Cuidados Primários de Saúde, Racionalização do Uso do Medicamento. March, 1988.

E. Other Documents

Booth, E.M., Mata, J.I., Carneiro, J.T.: La Comunicación Educativa para la Salud (Educational Communication for Health). Academy for Educational Development, 1993.

Center for International Health Information: Mozambique, Country Health Profile 1995. CIHI, USAID. 1995.

Coelho, M., Barca, A.: Atlas Geográfico, vol. 1. Instituto Nacional do Desenvolvimento da Educação. 1986.

Grant, J.: State of the World's Children, 1994. UNICEF.

Ministério da Educação: Atlas Geográfico. República Popular de Moçambique. 1986.

Organização Mundial de Saúde (OMS): Avaliação da Estratégia Nacional de Saúde para Todos no Ano 2000. Documento HST/90.1 REV. 3. October, 1993.

Patterson, G., Becker, M., Braun, J., Barber-Madden, R., & McGunnigle, M.: Recommended USAID Health and Family Planning Sectorial Strategy for Mozambique, 1995-2000. BASICS Trip Report, USAID. May 1994.

Razak, A.: Evolution and Future Direction of Health Care Policies and Systems in Mozambique since Independence. January, 1991.

Savelli, A., Haak, H.: Ministry of Health of Mozambique, Rational Pharmaceutical Management Project, Mozambique Pharmaceutical Sector Assessment Final Report. Management Sciences for Health (MSH); U. S. Pharmacopeia (USP); USAID. January, 1994.

Annex 5

Names of Persons Visited and Interviewed

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Names of Persons Visited and Interviewed

“Associação Moçambicana para o Desenvolvimento da Família” (AMODEFA) = Mozambican Association for Family Development

Olinda D. Mugabe, Executive Director
Américo José Ubisse, Program Officer

Fundação Esperança

Irene Escher Boger, Public Health Management Course Coordinator and instructor
Lindanor Ferreira, Public Health Management Course Coordinator and instructor

Ministry of Health, Republic of Mozambique (MOH)

Dr. Alexandre Manghuele, National Medical Director

MOH, Department of Community Health

Dr. Mondlane, Chief of Community Health
Dra. Maria da Luz, Chief of MCH
Bonifácio Mahumane, Health Educator, formerly of the Health Education Department.

MOH, Department of Pharmacy

Elisabete Bangugro, Chief
Isaura Possolo, Program Coordinator
Alexandre Pacheco Nhantumbo, Chief of the Office of Pharmaceutical Inspection
Kumudchandra B. Rathod, Coordinating Consultant of the EMP

MOH, National Directorate of Human Resources

Lucas Chomera Jeremias, National Director of Human Resources
Lidia Justina Mondlane, Chief of Curriculum Planning

MOH, National Directorate of Planning and Cooperation

Dr. Humberto Cossa, Chief of the Directorate of Planning and Cooperation
Jorge Fernando Manuel Tomo, Director, Office of Cooperation
António Sitei, Chief of Statistics, Department of Health Information

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MOH, Provincial Directorate of Health (DPS = “Direcção Provincial de Saúde”), Gaza Province

Eduardo Naere, Director DPS

Fernando Novela, Chief of the Provincial Statistics and Planning Nucleus

Alda Francisca Dava, Provincial Nurse Supervisor

João Mário Tembe, Director, District of Xai-Xai (Chicumbane)

Cecília Camilo Muiambo, Director, District Training Center, District of Xai-Xai (Chicumbane)

—, Director of Courses, District Training Center, District of Xai-Xai (Chicumbane)

—, Hospital Director, Rural Hospital, District of Manjacaze

Sebastião Tembe, Director, District of Manjacaze

Francisco Muianga, Director, Health Post of Mause, District of Manjacaze

Aissa Chuanga, Parteira, Health Post of Mause, District of Manjacaze

João Mandlate, Interim Head, Provincial Pharmaceutical Warehouse

Maria de Graca Américo de Mande Dimas, Director, District of Xai Xai city.

—, Medical Director, Provincial Hospital, Gaza Province

MOH, Provincial Directorate of Health (DPS), Niassa Province

Dr. Bernardo Leite Munarapa, DPS Director

Dr. João Baptista Paulo, DPS Medical Chief

Filipe Sarde, Epidemiologist

Eduardo Mendes, Head of Human Resources

José Eduardo Miguel, Head, Office of Community Health

Tomás Barnabê Metal, EPI Head

Dr. Fergal Flynn, MCH Advisor

Judite Balói, MCH Nurse, Head of MCH

F. Kondehat, Instrumental Nurse

Miguel Andissome, PMT

Celeste Farahane, Head of Provisions

Juma Valigy Molide, Supervisor of TB/Lepr.

Alberto Pereira, Nurse Supervisor Represen.

Pedro Uane, Head, Statistics and Planning Nucleus (NEP)

Antônio Maruzanbier, Subchief of Finances

Jaime Dário, BasicNurse, Province, Mechanelas Health Center

Sebastião Matias, Basic Pharmaceutical Agent, Head, Mechanelas HC Pharmacy

Matias Simão Mpandagulo, Basic Nurse, Interim District Director, Mandimba HCenter

João Henriques Mcheche, Elementary Nurse, Mandimba Health Center

Cristina Ambale, Elementary Birth Attendant, Mandimba Health Center

Pedro Airone, Pharmacy Assistant, District Pharmaceutical Warehouse, Mandimba

Dr. Isa Rabbebe, Physician, Mandimba

MOH, Provincial Directorate of Health (DPS), Zambezia Province

Dr. Domingos Dias Diogo, Director, DPS

Dr. Noar Amude, Director, Provincial Hospital

Raimundo João, Director, SPN

Ana Maria Feijão, Chief of Human Resources

Gomes João Ausse, Chief of Community Health

José Salato, PMT, Director of the Retraining Center (CR)

Francisco Silvestre Cacecussa, Director, Institute of Health Sciences of Quelimane (ICSQ)
Ricardo V.M. Limenu, Academic Director, ICSQ
Jean Roca, Architects Without Borders, Mocuba Training Center
Caetano R. Chiruro, Director, Mocuba Training Center
Eusébio Olímpio, Secretary, District Health Directorate (DDS), Mocuba
Georgina Surige, Basic Nurse, Responsible for the SPN, Mocuba Health Center
Maria das Dores, Social Action Agent, Mocuba Health Center
Rosa Lourenço, PMT, Mocuba Health Center
Ludovico João Amilay, Basic Nurse, Mocuba Health Center
Francisco Carlos da Silva, PMA, Mocuba Health Center
Inácio Sapeia, Pharmaceutical Agent, Mocuba Health Center Pharmacy
Juliano Mariano Norte, Pharm. Tech. (PT), Mocuba District Pharmaceutical Warehouse
Antônio Vidrigo, Basic Nurse, Director, Coalane Health Center
Moisés Luis Agostinho, Basic Nurse, Coalane Health Center
Virgínia José Saraiva, Basic Nurse, Coalane Health Center
Elisa Eugénio Sousa Mamaja, General Nurse, Coalane Health Center
Emiliano Olímpio, Basic Nurse, Coalane Health Center
Amélia Sampaio, Basic Nurse, Coalane Health Center
Armando Abdul dos Santos, Medical Agent, Coalane Health Center
Maria Adelaide, Pediatric Nurse, ICSQ Student Monitor, Coalane Health Center
Eugénia Menete, Midwife Nurse, Coalane Health Center
Natália Canivete Bengala, "Servente", Pharmacy, Coalane Health Center
Horácio Massaude, Elementary Nurse, Interem, Director, Sangaviera Health Post
Judite Santiago, Elementary Midwife, Sangaviera Health Post
Deolinda Manuel, Elementary Nurse, Sangaviera Health Post
Cristina Ambrociano, Serving Agent, Pharmacy, Sangaviera Health Post
Hilário Amado Jonas, Pharmaceutical Technician, Provincial Pharmaceutical Warehouse
Abudo Jonas, Pharmaceutical Technician, Provincial Pharmaceutical Warehouse

MOH, Provincial Directorate of Health (DPS), Manica Province

Dr. Saraiva Simão, Director, Manica DPS

Save the Children Foundation/United Kingdom (Quelimane)

Jane Gibreel, Program Manager
Francisco A. Chihale, Deputy Program Manager

Save the Children Foundation/United States (Xai Xai)

Karen Z. Waltensperger, MA, MPH, Chief, Health Program

TvT-HTS/Arlington, VA

Charles Johnson, MA, MPH, Social Scientist of Evaluation Team
Dr. Donald Whitson, MD, MPH, Public Health Specialist of Evaluation Team

Dr. Peter Boddy, MD, MPH, Team Leader of Evaluation
Denise Lionetti, HTS Project Manager
Judith Oki, Team Facilitator

United Nations International Children's Education Fund (UNICEF)

Dr. Gloria Kodwa, Chief, Health & Nutrition Sector
Jonas Chambule, EDP Project Manager
Dr. Osvaldo Legón, Health Project Officer

United States Agency for International Development (USAID)/Maputo, Mozambique

Roger Carlson, Mission Director
James T. Smith, Mission Deputy Director
Laura L. Slobey, General Development Officer.
Armand Utshudi-Lumbu, GD/HPN Project Manager
Modupe Broderick, Project Development and Management
Dr. Mussa Mamud Calú, GD/HPN Prosthetics Aid Project Coordinator
Yolanda Filipe, Controller
Natércia Remane, Chief Accountant
Vanessa Coelho, General Development Office
Martin Karlson, Office of Financial Management/Financial Analysis Supervisor
Alison Jones, Participant Training Officer

University Research Corporation (URC)/Mozambique

Mary Ann Abeyta-Behnke, Chief of Party
Frederico Rocuts, Technical Advisor, Gaza Province
Dr. Pierre Destexhe, Technical Advisor, Niassa Province
Bjorn Holmgren, Technical Advisor, Zambezia Province
José Romero, IEC Advisor
Dr. Oscar Tarrago, MD, MPH, former Training Advisor.

World Vision (Zambezia)

Veronica Kollhoff, Health Director
Eduardo Gumbua, MCH Project Director

Annex 6

***Assessment of Progress to Date, Observation and Impact of Specific
Tasks and Targets of the Institutional Contract***

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Assessment of Progress to Date, Observations, and Impact of Specific Tasks and Targets of the Institutional Contract.

ABBREVIATIONS USED IN MATRIX

CF	Centro de Formação (Chicumbane, Gaza Province; Lichinga, Niassa Province; Mocuba, Zambézia Province)
Coa	Centro de Saúde Coalane, Distrito de Quelimane, Zambézia Province
CR	Centro de Reciclagem (Retraining Center), Quelimane, Zambézia
CRDS	Centro Regional de Desenvolvimento em Saúde, training center in Maputo
DDS	District Health Directorate (or Director)
DM	Director Médico (Medical Director or Chief Medical Officer)
DPS	Provincial Health Directorate (or Director)
DRH	Departamento de Recursos Humanos--national level
DSC	Departamento de Saúde Comunitária--national level
G	Gaza Province
GNZ	Gaza, Niassa, and Zambezia Provinces
I	Interview: example "I AMODEFA" = Interview with AMODEFA, "I PA"=Interview with Provincial Advisor
IA	IEC Advisor
ICSQ	Instituto de Ciências de Saúde, Quelimane
JN	Health Post Julius Nyerere, Distrito de Xai-xai rural (Chicumbane), Gaza
M	Maputo (national level)
Man	Mandimba District, Niassa Province
Manj	District of Manjericaze, Gaza Province
Mec	Mecanheles District, Niassa Province
Moc	Mocuba District, Zambézia Province
MOH	Ministry of Health
MSF	Médecins sans Frontières
N	Niassa Province
NEP	Núcleo de Estatística e Planeamento (Division of Statistics and Planning)
Obs	Direct observation on site visits
PA	Provincial advisor
PAV	Programa Ampliado de Vacinação (EPI) NB: under RSC
PIR3/94	USAID/Mozambique Project Implementation Report, October 1, 1993-March 31, 1994
PIR3/95	USAID/Mozambique Project Implementation Report, October 1, 1994-March 31, 1995
PIR9/94	USAID/Mozambique Project Implementation Report, April 1, 1994-September 30, 1994
q1'94	URC quarterly report, 1st quarter, 1994
q1'95	URC quarterly report, 1st quarter, 1995
q2'94	URC quarterly report, 2nd quarter, 1994
q2'95	URC quarterly report, 2nd quarter, 1995
q3'94	URC quarterly report, 3rd quarter, 1994
q4'94	URC quarterly report, 4th quarter, 1994
Qu	Questionnaire given to Provincial Advisors (Niassa, Gaza, Zambézia)
RAF	Repartição de Administração e Finanças (Administration and Finances Division)

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RRH	Repartição de Recursos Humanos (Human Resources Division)
RSC	Repartição de Saúde Comunitária (Community Health Division)
SCF	Save the Children Federation (UK) or (US)
Si	Antônio Sitei, Head of the Department of Health Information, Statistics, and Planning.
SMI	Saúde Materno Infantil (MCH department)
TA	Training advisor
WV	World Vision
XX	Xai-xai, Gaza Province; may refer to DDS at Xai-xai
Z	Zambézia Province

Assessment of Progress to Date, Observations, and Impact of Specific Tasks and Targets of the Institutional Contract.
Primary Health Care Support Project, Mozambique - Mid-Term Evaluation. September 1995.

Task	Target Date	Progress to Date on Activities and Inputs	Observations, Comments, and Constraints	Evidence of Impact	Suggestions
A. IMPROVING PROVINCIAL LEVEL PLANNING					
		GNZ: Provincial health plans drawn up (q1'95)	<ul style="list-style-type: none"> G: approved plan arrived from MOH six months into the year (q2'94). Z: MOH brigade dominated action plan development in 1995 (Qu). 	<ul style="list-style-type: none"> N: Provincial planning is much better; District is not (I DPS). Z: Districts seem to have good grasp of annual planning process (Qu). 	
A.1. Assessing Health Needs					
		G: Advisor assisted DPS and division chiefs in analyzing health activities by district for 1994 Provincial Annual Report (q1'95).	DHS survey to be available in about 9/96 (I AID).		
A.1.a. Introduce new HIS in Niassa.	Year 1	<ul style="list-style-type: none"> N: MOH computerized HIS system installed. OTJ training in use (I PA, NEP, Qu, ;q2'95). Epson printer ordered to print graphics (q2'95). N: Form designed to monitor reception of HIS forms (Qu). N: Study measuring quality of HIS data in 1 districts plan 4 more (q1'95), (I NEP, PA; Qu). 	<ul style="list-style-type: none"> N: HIS already introduced before project began (1992) (I NEP). Methodology of quality study was MOH model, very complex (I PA, NEP). 	<ul style="list-style-type: none"> N: MOH computerized HIS system in use, graphs on walls, good understanding of data in NEP, form being used to monitor reception of HIS forms (Obs). 	
A.1.b. Follow-up support for new HIS in Zambezia & Gaza (Continues)	On-going	<ul style="list-style-type: none"> G: PA participated in field testing of national guide for new HIS (q2'94). HIS manuals printed and distributed by project (Qu). G: Study on quality of data performed in 5 Districts (I PA,XX; q2'95). 	<ul style="list-style-type: none"> GNZ: MOH unable to print sufficient forms (q2'95) Stockout of forms observed on site visits (Obs). G: new HIS implemented 1993 (I NEP) Gaza was the last Province (Qu). 	<ul style="list-style-type: none"> G: Quality of data survey done, will be done routinely (I PA, XX, Qu, Obs). G: Data received from districts being monitored for accuracy (q1'95; I NEP, PA; q2'95). 	

Task	Target Date	Progress to Date on Activities and Inputs	Observations, Comments, and Constraints	Evidence of Impact	Suggestions
(Continued) A.1.b. Follow-up support for new HIS in Zambezia & Gaza	On-going	<ul style="list-style-type: none"> • G: Installed MOH HIS computer program, OTJ follow-up training after initial MOH training (Qu). • G: Guide of forms needed and received by level of health worker and service developed and distributed (I PA, NEP). • G: Small study in 1 district done to verify coverage reported by HIS. 100% vs. 40%! (I NEP). • Z: Spot checks indicate problems with HIS (q4'94). • Z: Advisor "taking steps" to strengthen capacity of DDS staff to use HIS data (q1'95). • Z: PA provided OTJ training with computers sporadically (I NEP). 	<ul style="list-style-type: none"> • GNZ: Hospitals, Leprosy, TB don't appear in HIS (I PAG). • Z: SCF(UK) has full-time advisor in NEP (I SCF). 	<ul style="list-style-type: none"> • G: Director of human resources says he is more organized in XX city district after management course (I XX). 	Make some of rehabilitation money available to print HIS forms.
A.1.c. Baseline health survey in four provinces	Year 1	<ul style="list-style-type: none"> • GNZ: Management survey carried out (in place of health survey--DHS will substitute, 1996) (q4'94). Report written and translated into Portuguese and English (Obs). • G: Results of survey presented DPS and DDS. Recommendations made (I DPS, NEP). 	<ul style="list-style-type: none"> • Tested in Maputo, designed with staff with MOH (q3'94). • Methodology of survey and validity of data questioned (QuZ; I CRDS). 	<ul style="list-style-type: none"> • Management survey carried out and report available in English and Portuguese (Obs). • GN: Results of survey called attention to the problems, helped DPS prioritize problems (Qu, I PA, DPS). 	
A.1.d. Establish health priorities for service delivery	Year 1	<ul style="list-style-type: none"> • N: Methodology developed for discussing health priorities in Colectivo meetings. (q1'95). • N: PA working to create a Community Health colectivo (q2'95). 	<ul style="list-style-type: none"> • N: Same methodology NOT accepted by RSC. 	<ul style="list-style-type: none"> • N: Visits to ALL Districts by PA and Medical Officer identified priorities for work (I DM). • N: Indicators are being used in Colectivo meetings (Qu). • N: Financial information being used in colectivo meetings (Qu) 	
A.2 Measuring Performance					

Task	Target Date	Progress to Date on Activities and Inputs	Observations, Comments, and Constraints	Evidence of Impact	Suggestions
A.2.a. Implement action plans in all provinces.	Year 3	<ul style="list-style-type: none"> • GNZ: Action plans developed and implemented (I PA, DPS; QuZ). • N: Provincial plan developed based on HIS and Management Survey (Qu). 	<ul style="list-style-type: none"> • 1994 work plans were too ambitious (q4'94) 1995 plans too ambitious (q2'95). • 1st quarter 1995 activity was not focused on action plans for 1995 for various reasons (q1'95). 	<ul style="list-style-type: none"> • GNZ: Provincial plans developed with UNICEF/MOH brigades. 	
A.2.b. Institute data-based planning & decision making of the health systems on-going.	On-going	<ul style="list-style-type: none"> • GZN: PAs participated annual in planning brigade in all Provinces (q4'94). • G: DPS (with advisor) coord planning meetings with 10 DDS directors, Centro Director, donors--better planning resulted (q4'94). • GN: data reviewed regularly from districts to offer assistance in improving quality (q4'94). • N: PA provided follow-on OTJ training after MOH computer course in Lotus 1-2-3 (I PA, DPS). • Z: PA working in Community Health technical meetings to introduce health data for decisions (q2'95). 	<ul style="list-style-type: none"> • G: Districts don't have written plans yet (I PA). • N: SMI isn't using NEP's computer graphs--they elaborate their own (I SMI). • N: Annual plan-no feedback from MOH (I PA) Plan approved 2nd quarter of the year (I DPS). • G: Financial planning and budget integration are on different timetable from programmatic planning (Qu). • Z: Weekly donor coord meetings being held beginning 1994 (q2'94). • Z: Nobody had graphs on walls, had to dig for statistics (Obs). 	<ul style="list-style-type: none"> • G: Planning exercise for 1995 much more participatory. Done in November, Modified from Maputo in April, Province implemented own goals (final approval only in 9/95!) (I PA, Manj). • N: Computer graphs on walls in NEP and conference room (Obs, I DPS). • N: Data used in planning exercise, including budget (I NEP; Qu). • N: All facilities visited have coverage graphs (Obs). • N: NEP feels that there is more sharing of information, improved working conditions since PA came. "Before, I had to look for work, now they ask me" (I NEP) 	

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Task	Target Date	Progress to Date on Activities and Inputs	Observations, Comments, and Constraints	Evidence of Impact	Suggestions
A.2.c. Financial management and budgeting training service delivery.	Year 3	N: PA developed spreadsheet for pipeline financial analysis for RAF (I PA, RAF).	<ul style="list-style-type: none"> N: Expressed interest in financial training for Districts, but MOH prohibits training for serventes (I RAF). Z: Financial planning is carried out independently from program planning. (Qu). 	<ul style="list-style-type: none"> N: Budget/vinancial planning integrated into planning exercise (I PA, RAF). N: Financial information not being used before, now it's being used (I NEP), Pipeline being used (Qu). N: Budget information on vehicle maintenance used in planning and available to maintenance department (Qu). G: Now it is possible to monitor budget together with program implementation (Qu). 	Decentralize project budget; make it more tranparent (I UNICEF, PAGNZ).
A.2.d. Establish performance indicators.	Year 2	<ul style="list-style-type: none"> GNZ: Gant charts established for monitoring action plan implementation (q2'95). N: Performance indicators established for monitoring action plan implementation in monthly colectivo meetings (q2'95). 	<ul style="list-style-type: none"> GNZ: Decision not to introduce new indicators until eisting system strengthened (q1'95). 	<ul style="list-style-type: none"> N: PA helped begin ongoing analysis of health worker productivity (I RRH), progress toward program goals (Qu) (c.f. HHRR section). N: Monthly Colectivo meetings monitor indicators and use them for decision-making (q2'95). GNZ: All provinces are using MOH key indicators to monitor performance monthly and quarterly (q2'95). 	
A.3. Conduct special studies on clinic operations					
(Continues)		<ul style="list-style-type: none"> N: Productivity study designed to analyze number visits per level of health worker (q3'94). 			

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Task	Target Date	Progress to Date on Activities and Inputs	Observations, Comments, and Constraints	Evidence of Impact	Suggestions
(Continued)		<ul style="list-style-type: none"> G: PA trained Técnico de Medicina students in rotation to do special studies (mainly operations research). Studies done as part of thesis work. (I PA, Obs, Qu). G: Collaborated with MSF(Switzerland) in rapid study using community-based census in Alto Changane (I PA; Qu). 			
B. IMPROVING PROVINCIAL-LEVEL PROGRAM AND HUMAN RESOURCES MANAGEMENT					
		<ul style="list-style-type: none"> N: PA beginning process of job descriptions, quality of human resources (Qu). 	<ul style="list-style-type: none"> Lack of job descriptions at DPS and DDS levels hampers activities (q3'94). G: There was delay of 1 year before DPS accepted project (I PA). M: Director of HR requested project assistance in personnel deconcentration: inventory, updating records, review of training needs (q2'95). 		
B.1. Upgrading Skills of Staff					
(Continues)		<ul style="list-style-type: none"> GNZ: Computers ordered for Provinces (q2'95). Z: TA+Consultant evaluated training (curriculum, etc.) at ICSQ (q3'94). Z: TA coordinated in development, supervision, technical support of course on biosafety at the provincial hospital (q3'94). Z: TA arranges repair of AV equipment for ICSQ and CR (q3'94). 	<ul style="list-style-type: none"> Results of consultancy recommended formal and continuous training. A training plan is <u>being developed</u>. (q4'94). Z: Epi-Info course (for NEP, CF, RSC) postponed due to administrative miscommunication (q1'95) Not done yet (Obs). Z: SCF(UK) training advisor less qualified than TA (I CR). 		

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Task	Target Date	Progress to Date on Activities and Inputs	Observations, Comments, and Constraints	Evidence of Impact	Suggestions
(Continued)		<ul style="list-style-type: none"> • Z: TA coordinated 2-week pedagogical training course for ICSQ (q1'95), (I ICSQ). • Z: TA participated in District seminars on Diagnoses and Treatments, seminar on computers, another on pharmacy (I ICSQ). • Z: TA travelled to Milange to evaluate level of training of returnees. Helped plan training upgrade (2 phases already finished) (I CR). • NG: Brief assessment made of computer-training needs (q1'95). 			
B.1.a. Personnel management training for DPS and DDS staff. (Continues)	Annually	<ul style="list-style-type: none"> • GNZ: On the job training occurring (q3'94). • Training plan detailing strategy developed by TA and submitted for approval by USAID/MOH together with 1995 action plan approval (q4'94). • G: Seminars (basic management 1-wk) given in July for Provincial personnel (18). 2 District follow-on workshops (22 and 23). 	<ul style="list-style-type: none"> • N: Not included in PHM course due to low level (q1'95). • M: current CRDS students may be future DPS (I Si). • Z: SCF(UK) has advisors in NEP, had advisors in RAF and RSC. (I SCF [UK]). • Z: Physical inventory of personnel stagnated (I PA, RRH). • Z: No organigrams on walls or available in any facilities (Obs). 	<ul style="list-style-type: none"> • G: All facilities at all levels have organogram on wall, monthly graphs of statistics on walls (Obs). • G: Meetings have minutes, agendas (I DPS). • N: Four DDS substituted to improve result, redistributed SMI nurses, replaced head of RSC (I DPS, RRH, PA). • N: PA helped institute ongoing analysis of health worker productivity (I RRH) 	M: Next management training course should include TOT for replication (I Si).
B.1.a. Personnel management training for DPS and DDS staff. (Continues)	Annually	Series of management sessions being carried out in situ in 4 districts, with plans for 4 sessions each. (So far, 1 each in 3 Districts, 2 sessions in 1 District) (I PA, NEP; Qu).		<ul style="list-style-type: none"> • N: All facilities have organograms, staffing charts-elaborated last year with PA (Obs, I NEP). • N: Colectivos now meeting, have minutes and agenda (I NEP). 	

Task	Target Date	Progress to Date on Activities and Inputs	Observations, Comments, and Constraints	Evidence of Impact	Suggestions
(Continued) B.1.a. Personnel management training for DPS and DDS staff.	Annually	<ul style="list-style-type: none"> • GZ: 10-month course in Public Health Management begins in Maputo (at CRDS, faculty, Fundação Esperança) (q1'95) Participant in course: G: 4 (1 CRDS); Z: 3 (head of NEP, PAV, and DDS Moc) (1 DPS). • N: PA helping computerize personnel records, defining job categories-not completed yet (1 RRH; Qu). • N: Supported seminar on Administration (paid by MSF) • Z: Provincial seminar on management held 8/95. (1 DPS, WV,) • Z: Personnel inventory done by level and in data bank (1 RSC) • Z: TA reviewed continuing education curriculum for CR (1 RSC) • Z: PA helped prepare employee bio-data forms with RRH (1 RRH) 		<ul style="list-style-type: none"> • Z: Results of management survey used in reviewing CR curriculum (1 RSC). • N: Draft of responsibilities for RSC and NEP being reviewed (Qu). • N: "Guide for Monthly Provincial Meetings" developed by PA, distributed for review to MOH, PAs (q2'95). 	N: M should define roles of Colectivos, Repartições, etc. (1 PA).
B.1.b. Leadership training for provincial health directors.	Annually	Planned for early 1996 (1 DA).	Originally scheduled for March, 1995 (q4'94), then Aug. (q1'95), then Oct., 1995. Delayed again to early 1996 due to impending replacement of 4 of 10 DPS (1 DA).		
B.1.c. MCH/FP training for district level staff. (Continues)	Annually	<ul style="list-style-type: none"> • N: SMI seminar for all DDS SMI nurses with UNICEF in Cuamba. Financed by AID (1 DPS; Qu). • Z: Rehabilitation of health post and Coalane health center (walls, furniture) for use as MCH practicum (q1'95). 	<ul style="list-style-type: none"> • GNZ: Coverage and goals in FP are VERY low except in XX city and Man (1 XX, Man). • GNZ: No APES trained from 1973-1981 remain (Cons Tr, 1 Farm Moc). 	<ul style="list-style-type: none"> • G: Impressive technical level of peripheral health workers (1 JN). • N: Norms/routines for treatment on wall in Health Center (not directly result of project) (Obs Mec). 	

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Task	Target Date	Progress to Date on Activities and Inputs	Observations, Comments, and Constraints	Evidence of Impact	Suggestions
(Continued) B.I.c. MCH/FP training for district level staff	Annually	<ul style="list-style-type: none"> • Z: Financing two MCH nurses from Maputo per diem and transportation, temporary transportation of students to practicum site. (q1'95). • Z: TA helped curriculum design for APES training (1st group to graduate 11/95) (I CF). • Z: Project financed nurse for MCH class at ICSQ (q2'95). • G: PAcoordinating with facilitators of Provincial MCH course to be held (Qu). 			
B.I.d. TBA training for Niassa	On-going	<ul style="list-style-type: none"> • N: Coordinating with UNFPA in several courses throughout the province. Done in Metarca District, 4 other Districts planned for 1995 (q1'95; Qu). 		<ul style="list-style-type: none"> • N: 5 Districts will receive training by year end (Qu). 	
B.2. Supervision improvements					
		<ul style="list-style-type: none"> • G: 6/94 revision (PA, DPS, SCF(UK)) of annual workplan targetted super-vision as the priority activity. Schedule of supervisory visits elaborated for 2nd semester 1994 (q2'94). 	<ul style="list-style-type: none"> • Z: Stolen vehicle impeded effective supervision support. Takes advantage of Maputo-Xai xai visits (q1'95). 		

Task	Target Date	Progress to Date on Activities and Inputs	Observations, Comments, and Constraints	Evidence of Impact	Suggestions
<p>B.2.a. Transportation and per diem support for increased supervisory visits.</p> <p>(Continues)</p>	<p>On-going</p>	<ul style="list-style-type: none"> • GNZ: paid transportation and per diem for supervision (q3'94), (I PAZ). • GNZ: Supervision visits carried out together with survey (q4'94). • GNZ: Three trips from Maputo to Provinces for supervision (q4'94). • N: Financed at least one visit to each District. Visit by Chief Medical Officer and Pharmacist to Cuamba pharmacy (q1'95; Qu). 	<ul style="list-style-type: none"> • N: There has been only 1 supervisory visit from MOH to DPS since Pas arrival. They don't "supervise", rather do specific activities. (I PA) Z: Using as little as possible due to concerns about sustainability (Qu). 	<ul style="list-style-type: none"> • GNZ: Increased supervision frequency withing Provinces (I PA, DPS; Qu). 	
<p>(Continued) B.2.a. Transportation and per diem support for increased supervisory visits</p>	<p>On-going</p>	<p>N: Paying per-diem for radio operator training in District (Qu)</p>			

Task	Target Date	Progress to Date on Activities and Inputs	Observations, Comments, and Constraints	Evidence of Impact	Suggestions
B.2.b. On-the-job support to upgrade supervisory skills.	Annually	<ul style="list-style-type: none"> • G: Supervision seminar for Provincial and District staff (22) done (I PA, DPS; Qu). • N: Instituted briefings and debriefings for supervisory teams, using reports as preparation for visits (q1'95). • N: Supervision books developed and printed. (I PA; Qu), Supervision guide developed and in use before and after supervision (Qu). Supervision manuals revised, drafts made available to supervision teams. (q1'95) • Z: Supervision seminar held 9/95. • Z: Teams for integrated supervision formed (TA,DPS,other donors). Protocol established. Supervision guide developed. First trip, August (q3'94) • Z: Integrated supervision effort analyzed and discussed by donor coord/DPS (q4'94) • Z: 1995 Action plan has recommendations on how to strengthen supervision. Coordinating committee meeting held focusing on supervision (q1'95, q2'95) for Provincial personnel held 9/95 (Qu; Obs). • Z: PA+SCF(UK) working with NEP t(q2'95) define supervisory responsibilities. (q2'95). 	<ul style="list-style-type: none"> • Z: Discovery that some districts had no supervision at all 1993, 1994 (q4'94). • Z: No supervision schedule for Moc, forms filled out after return (I RSC). • GNZ: Priority districts not identified as of evaluation (I DA, PA). 	<ul style="list-style-type: none"> • G: Supervision visits in District being done 1-2 X per facility per year (I Manj). • G: Participatory supervision system in place (supervision books in facilities with recommendations) (Obs) "More supportive, workers like it better" (I XX). • G: Supervision 1X/year per Dist per program planned (I NEP, DPS, Obs). • N: Supervision books to be distributed (Obs). • N: Supervision plan in place (I Mec). • N: Supervision in Mec to posts every 3 months each (4X/yr each facility) (I Mec). • Z: There is a supervision calendar for DPS to DDS supervision. 1-2X/year each (Obs, I RSC). • Z: "PA was the one who taught us to supervise"(I CR). • Z: Using new supervision system. Seminar helped a lot (I RRH). 	

Task	Target Date	Progress to Date on Activities and Inputs	Observations, Comments, and Constraints	Evidence of Impact	Suggestions
B.3. Staff incentives					
B.3.1. Establish performance indicators and reward system.	Year 2	<ul style="list-style-type: none"> • G: Purchase computers as incentives. No other policy set for remaining funds (q1'95). • G: Plan elaborated. Incentives to be given for initiative, productivity, and work quality. Not yet implemented (Qu). • N: Purchase computers and provide training as motivation (NEP, RRH, RSC) (q1'95). • N: Incentive committee formed to decide who gets. DPS has veto (I PA). Using national criteria (Qu) Policy outlined, submitted to PHCS project office for review (q2'95). • Z: Computer purchased for RRH. No policy for remaining funds. (q1'95). • Z: "Nothing has been done yet" (I DPS). Thought about it, have ideas; no criteria (I RRH). 	<ul style="list-style-type: none"> • Need job descriptions before can begin (q4'94). • N: There are no computers yet in RSC, RRH. (Obs) 	<ul style="list-style-type: none"> • G: Plan elaborated. Incentives for initiative, productivity, and quality. Not implemented yet (Qu). • N: First phase of incentive system implemented (Qu). 	
B.4 Logistics Management Improvements					
		<ul style="list-style-type: none"> • N: Project paying radio operator for DPS (I PA, Obs). 			
B.4.1. Provide TA and training for improved supply management. (Continues)	Year 2	<ul style="list-style-type: none"> • M: Rational drug use course financed by project (20/6/95 X 2 weeks), MSH. (I PAG, DA, PharmG) all three provinces represented (q2'95). • G: Spreadsheet developed to monitor stockouts, costs, etc. (Obs). 	<ul style="list-style-type: none"> • N: Provincial pharmacy director jailed for theft.. No director 1-5/95. New director weak. Want a técnico. (I Farm). • Z: Info analysis system was not seen in observations (Obs). 	<ul style="list-style-type: none"> • G: Spreadsheet in place in pharmacy analyzing stockouts, costs, etc. (Obs). • N: Spreadsheet in pharmacy analyzing consults vs. drug use (Obs). 	Integrate contraceptives with via clásica.

Task	Target Date	Progress to Date on Activities and Inputs	Observations, Comments, and Constraints	Evidence of Impact	Suggestions
(Continued) B.4.1. Provide TA and training for improved supply management.	Year 2	<ul style="list-style-type: none"> • N: Plan developed for monitoring EDP kit distribution based on consumption. Improved management surgical materials. (q1'95; Obs, I PA & pharm; Qu). • N: Plan for 1995 order analyzed post by post, ordered more reasonable amount of drugs. (q1'95; Obs, I PA & pharm; Qu) PA providing OTJ support to provincial pharmacy (q1'95). Introduction of use of consumption figures to calculate needs (I PA) System developed to monitor distribution of via classica (q2'95). • N: Seminar on rational drug use and pharmacy management for all pharmacy directors at District level 8/95 (I PA, DPS; Qu). • N: Vehicle control forms introduced (Qu). • Z: System of continuous information analysis developed for EDP and EPI (q1'95). System developed to monitor contraceptive distribution in Province (q2'95). Seminar on RDM--pharm tech and TA participated (I Coa) 	<ul style="list-style-type: none"> • Z: Pharmacies with stockouts, poor monitoring, expired drugs at all levels (Obs). 	<ul style="list-style-type: none"> • N: Medical Director says pharmacy management is much better (I DM). • N: Planning and ordering of drugs now based on consumption (Qu, Obs) • N: Sentinal system for monitoring drug distribution in place (q2'95). • N: No serious problems with medication system reported or observed at any level during evaluation (Obs). • N: Vehicle control forms in use (Qu). • Z: System developed and in place for monitoring stockouts of EDP, contraceptive, and EPI supplies at Provincial and district levels (Qu; Obs). 	Integrate vaccine distribution with emergency drug distribution.

Task	Target Date	Progress to Date on Activities and Inputs	Observations, Comments, and Constraints	Evidence of Impact	Suggestions
B.4.2-3 Identification of alternative distribution channels and implementation	Year 2-3		<ul style="list-style-type: none"> Z: Financial department of DPS does not make payments on time. Commercial distributors don't want to deal with DPS (Qu, I PA). 		
C. SUPPORT FOR DECENTRALIZATION					
		<ul style="list-style-type: none"> M: Indirect work has begun with Director of Human Resources by analyzing job descriptions, establishing database for provincial personnel (q1'95). GNZ: PAs assisting in definition of "demonstration Districts" (q4'94). N: Chief Medical Officer agrees with "semi-privatization" of mechanics workshop. Partially done (q1'95; Qu). Z: OTJ training and planning in RRH for deconcentration of personnel files 10/95 (Qu; I RRH, PA). 	<ul style="list-style-type: none"> GNZ: No specific "demonstration Districts" defined as of evaluation (Obs). N: Mechanics workshop not privatized as of evaluation (Obs). M: All basic personnel will be decentralized October, 1995 (I RH). 	<ul style="list-style-type: none"> G: Planning exercise more independent in 1995 (I DPS, PA). N: Semi-privatization of vehicle mechanics workshop (Qu). 	
C.1. Define decentralization principles	Year 1	<ul style="list-style-type: none"> M: Two decentralization consultants develop strategy plan for decentralization, 2/95 (q4'94), (PIR3/95). M: Decentralization meeting held without consultants, all division heads, all DPS. Draft document prepared stating principles and direction for decentralization. (I DA). 	<ul style="list-style-type: none"> N: Observation made that decentralization is not realistic until capability of human resources improves (q3'94). 		

Task	Target Date	Progress to Date on Activities and Inputs	Observations, Comments, and Constraints	Evidence of Impact	Suggestions
C.2. Prepare guidelines for decentralization	Year 2		<ul style="list-style-type: none"> <li data-bbox="846 247 1349 313">M: Decentralization guidelines "will take years" (I/DA). 		
C.3. Decentralize specific actions negotiated with MOH.	Year 2				
D. UPGRADING RURAL FACILITIES-REHABILITATE 15 HEALTH POSTS					

Task	Target Date	Progress to Date on Activities and Inputs	Observations, Comments, and Constraints	Evidence of Impact	Suggestions
	Year 3	<ul style="list-style-type: none"> • GNZ: Criteria for site selection established (q1'94). • GNZ: Micriplanning work committees established to plan rehabilitation (q4'94). • N: Renovation electrical network at DPS, construction of well for CF (q1'95). Installation solar panels on DPS for cold chain. (I PA, DPS, Obs) Water pump for Provincial hospital, security bars for DPS, furniture for NEP (Qu). • G: Repair of bathrooms and cesspool of Training Center (q1'95). Rehabilitation of Health Post at Mause (walkways, roofs, etc.), (Obs) paint DPS office, renovation of DPS conference room (Obs, Qu) Chibuto and Manjacaze Health Centers (q2'95). • Z: TA arranged repair of AV equipment for ICSQ and CF (q3'94). • Z: Rehabilitation of health post and Coalane health center (walls, furniture) and Sangariveira Health Post renovated for use as MCH practicum (q4'94), (q1'95). DPS will not be using more renovation funds due to other donor funds available (q1'95). 	<ul style="list-style-type: none"> • GNZ: There are many other donors with more money. Must coordinate (q2'94). • N: Need provincial housing to attract qualified human resources (técnico de farmácia). Need warehouse rehabilitation (I DA). 	<ul style="list-style-type: none"> • G: Visit to Mause post showed improvements. Community appreciated greatly (Obs). 	<p>Need more flexibility in renovation money to put it where it's needed (I PAG,DA).</p>

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Task	Target Date	Progress to Date on Activities and Inputs	Observations, Comments, and Constraints	Evidence of Impact	Suggestions
E. IMPROVING IEC FOR MCH/FP					
		<ul style="list-style-type: none"> • GNZ: participation of all PAs in MOH national Mother and Child campaign--assistance in planning, implementation, and evaluation. (q2'94). • M: IA met with MOH and AMODEFA to clarify plans, activities for rest of year and documentation of existing research into dmCH IEC (q2'94). • M: IA Worked with AMODEFA to develop triennial work plan (AIDS workshops, seminars for students and community groups) (q3'94). • M: IA participated in 2 seminars 6/94 for adolescents and community leaders re: AIDS/STD. (q2'94). • M: IA participated with MOH in development of IEC policy document for national health plan (q3'94). • Z: IA travelled with counterpart to collect existing KAP data, establish priorities for rest of 94-95. • N: AMODEFA included work with youth in Niassa in 1995 work plan with help from IA (q3'94). • M: IA coord activities with PSI Jeito campaign. (q1'95). • N: IA visited one time (6/94) (I PA). 	<ul style="list-style-type: none"> • IA placed in MOH, not AMODEFA due tu space limitations (I AMODEFA). • M: Existing IEC research does not correspond to project needs (q2'94). • M: AMODEFA extremely limited in capacity due to staff shortages (q2'94). • M: AMODEFA acquires new offices (q2'94). • M: AMODEFA loses director (q3'94). • N: Annual provincial plan AIDS/STD exists, not implemented due to lack of funds and it not being in annual Provincial plan.(q2'94). • G: No human resources at Provincial level (I PA) 	<ul style="list-style-type: none"> • N: IEC has improved . Dir of DTS/SIDA núcleo designated as responsible for IEC. (I PA; Qu). • GNZ: STD/AIDS CAP carried out (Qu; Obs). 	<p>AMODEFA may be able to get money from PVO support project (I AID); why not bring in Hopkins for IEC TA (I AID). M: Should do TOT for reproducibility and Provinces (I DSC).</p>

Task	Target Date	Progress to Date on Activities and Inputs	Observations, Comments, and Constraints	Evidence of Impact	Suggestions
E.1. Collect data via health survey.	Year 1		Survey postponed until 1996: RAPID and DHS surveys to be carried out (I IA, DA).		
E.2. Conduct special KAP studies.	Year 1	<ul style="list-style-type: none"> • Z: Data collected by IA for planning IEC activities for 1995 (q3'94). • GNZ: IA+UNICEF+MOHT+ActionAID design of AIDS/STD survey for priority districts (q3'94). Instrument developed. PSI using project STD/AIDS instrument developed in Z (q4'94). Questionnaire and protocol reviewed by national AIDS office. Survey implemented in Z (later G and N) finished 9/95 (Obs) (q1'95). • G: Students (agente course at CF) trained by PA and doing qualitative KAP studies for IEC (Obs G) • G: Collaborated with SCF(US) in KAP on MCH in 2 Districts (Qu) 			

Task	Target Date	Progress to Date on Activities and Inputs	Observations, Comments, and Constraints	Evidence of Impact	Suggestions
<p>E.3. Develop, test, produce, and disseminate IEC materials and messages (radio and print).</p> <p>(Continues)</p>	<p>Year 2</p>	<ul style="list-style-type: none"> • N: PA participated in M&C campaign: developing work guides, PVO coordination, planning, evaluation (q2'94). • M: IA helped AMODEFA designing "CRESCER" project-newsletter, radio, TV for youth about AIDS. Seeking donors (q3'94). • M: IA+UNICEF assisted MOH in developing salt iodization campaign for northwestern provinces (including Niassa) (q4'94). ISC pretested advertisement (q1'95). • M: IA assisted AMODEFA and MONASO in World AIDS Day awareness program. Radio spots, T-shirts, theater, banners. Project purchased video cassettes for TV (q4'94). 	<ul style="list-style-type: none"> • Z: WV is paying salary of "Carlos" to train Districts in health education (I WV). • G: Note that after testing and disseminating MCH radio messages, plan developed to order more medications due to increased demand (Qu) 		

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Task	Target Date	Progress to Date on Activities and Inputs	Observations, Comments, and Constraints	Evidence of Impact	Suggestions
(Continued) E.3. Develop, test, produce, and disseminate IEC materials and messages (radio and print)	Year 2	<ul style="list-style-type: none"> • M: IA assisted AMODEFA in designing radio spot for Christmas and New Year's holidays for increasing AMODEFA's image (q4'94). • M: IA + DANIDA assisting MOH with television of interview with health Minister and vaccination advertisement for World Health Day (April 7) (q1'95). • M: IA coord with MOH, UNDP, UNICEF, WHO, WVZ for M&C day campaign, June. Radio spots developed (q1'95; q2'95; I IA). • M: TV spots produced (q2'95). • G: Agentes of Medicina trained to test radio spots (I IA). 			
E.4. Evaluate effectiveness of materials/ messages.	Year 3				

Annex 7
Essential Drug Program Kit Contents

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**PROGRAMA DE MEDICAMENTOS ESSENCIAIS
COMPOSIÇÃO DO KIT A - 1992/1993**

CONSULTAS EXTERNAS: 1.000
 CATEGORIA PESSOAL: MEDICO, TECNICO DE MEDICINA, AGENTE DE MEDICINA,
 ENFERMEIRO BASICO
 UNIDADE SANITARIA: CENTRO DE SAUDE

no.	Descrição	KIT A	Item Quantidade
			1
	Adesivo 25 mm x 10 m		8
2	Ligaduras 75 mm x 9 m		100
3	Algodão Hidrófilo		4
4	Envelope de plástico		1.500
5	Gaze 200 mm x 6 m		20
6	Sabão 450 g		3
7	Fios de sutura 45 cm, agulhas 24 mm		20
8	Cetremida (15%) + Clorexidina (1.5%) conc. Solução 1 l		1
9	Povidone (10%) solução 500 ml		1
10	Acido Benzoico (6%) + Acido Salicílico (3%) pomada 500 g		1
11	Violeta Genciana PO 25 g		1
12	Lidocaína (2%) + Epinefrina (1: 100 000) Inj. 50 ml		1
13	Adrenalina 1 mg/ml inj. 1 ml		10
14	Diazepam 5 mg/ml inj. 2 ml		40
15	Metilergometrina 0,2 mg/ml inj. 2 ml		40
16	Clorpromazina 25 mg/ml inj. 2 ml		10
17	Penicilina Benzatínica 2.4 mu (1.44 g) inj.		50
18	Penicilina Procaína 3 MU (3 g) inj.		100
19	Kanamicina 2 g inj.		75
20	Amoxiciclina suspensão oral 250 mg/5 ml 60 ml		30
21	Fenoximetil Penicilina 250 mg comp.		500
22	Sulfametaxazole (400 mg) + Trimetoprim (80 mg) comp.		2.000
23	Metronidazole 250 mg comp.		1.000
24	Nistatin 100 000 IU supositórios vaginais		75
25	Tetraciclina 1% pomada oftalm. 5 g		75
26	Cloroquina 259 mg (150 mg base) inj. 5 ml		20
27	Cloroquina 259 mg (150 mg base) inj. 5 ml		20
28	Mebendazole 100 mg comp.		800
29	Praziquantel 600 mg comp.		100
30	Lactato de Ringer inj. 500 ml		5
31	Sais de Reidratação Oral, pacote para 1 l		300
32	Sal Ferroso (60 mg) + Acido Fólico (0,25 mg) comp.		4.000
33	Hidróxido de Alumínio 500 mg comp.		400
34	Salbutanol 4 mg comp.		600
35	Clorfenaramina 4 mg comp.		300
36	Acido Acetil-Salicílico 500 mg comp.		1.000
37	Paracetamol 500 mg comp.		600

38	Benzoato de Benzilo conc. (90%) solução 1 l	2
39	Retinol (vitamina A) 60 mg (200 IU) cápsulas	100

**PROGRAMA DE MEDICAMENTOS ESSENCIAIS
COMPOSIÇÃO DO KIT B - 1992/1993**

CONSULTAS EXTERNAS: 500
 CATEGORIA DO PESSOAL: ENFERMEIRO ELEMENTAR, ENFERMEIRO DE SMI
 UNIDADE SANITARIA: POSTO DE SAUDE

Item no.	Descrição	KIT B	Quantidade
1	Adesivo 25 mm x 10 m		4
2	Ligaduras 75 mm x 9 m		50
3	Algodão Hidrófilo 50 g		2
4	Envelope de plástico		500
5	Gaze 200 mm x 6 m		10
6	Sabão 450 g		2
7	Cetremida (15%) + Clorexidina (1.5%) conc. Solução 1 l		1
8	Acido Benzóico (6%) + Acido Salicílico (3%) pomada 500 g		1
9	Violeta Genciana po 25 g		1
10	Penicilina Procaína 3 MU (3 g) inj.		100
11	Sulfametaxazole (400 mg) + Trimetoprim (80 mg) comp.		1.000
12	Cloroquina 150 mg base comp.		1.000
13	Mebendazole 100 mg comp.		300
14	Sais de Reidratação Oral, pacote para 1 l		200
15	Tetraciclina 1% pomada oftalm. 5 g		40
16	Sal Ferroso (60 mg) + Acido Fólico (0,25 mg) comp.		2.000
17	Salbutamol 4 mg comp.		200
18	Acido Acetil-Salicílico 500 mg comp.		1.000
19	Paracetamol 500 mg comp.		200
20	Probencid 500 mg comp.		50
21	Benzoato de Benzilo conc. (90%) solução 1 l		1

**PROGRAMA DE MEDICAMENTOS ESSENCIAIS
COMPOSIÇÃO DO KIT C- 1992/1993**

CONSULTAS EXTERNAS: 250
 CATEGORIA DO PESSOAL: APE'S, SOCORRISTA, SERVENTE
 UNIDADE SANITARIA: P.S.L.T. OU APE'S

Item no.	Descrição	KIT C	Quantidade
1	Adesivo 25 mm x 10 m		3
2	Ligaduras 75 mm x 9 m		50
3	Algodão Hidrófilo 500 g		2
4	Envelope de plástico		500
5	Gaze 200 mm x 6 m		3
6	Sabão 450 g		2

7	Cetremida (15%) + Clorexidina (1.5%) conc. Solução 1 l	1
8	Acido Benzóico (6%) + Acido Salicílico (3%) pomada 500 g	1
9	Cloroquina 150 mg base comp.	500
10	Mebendazole 100 mg comp.	100
11	Sais de Reidratação Oral, pacote para 1 l	100
12	Tetraciclina 1% pomada oftalm. 5 g	25
13	Sal Ferroso (60 mg) + Acido Fólico (0,25 mg) comp.	1.000
14	Acido Acetil-Salicílico 500 mg comp.	200
15	Benzoato de Benzilo conc. (90%) solução 1 l	1

Annex 8

Schematic of Mission Strategic Objectives for Health USAID/Mozambique

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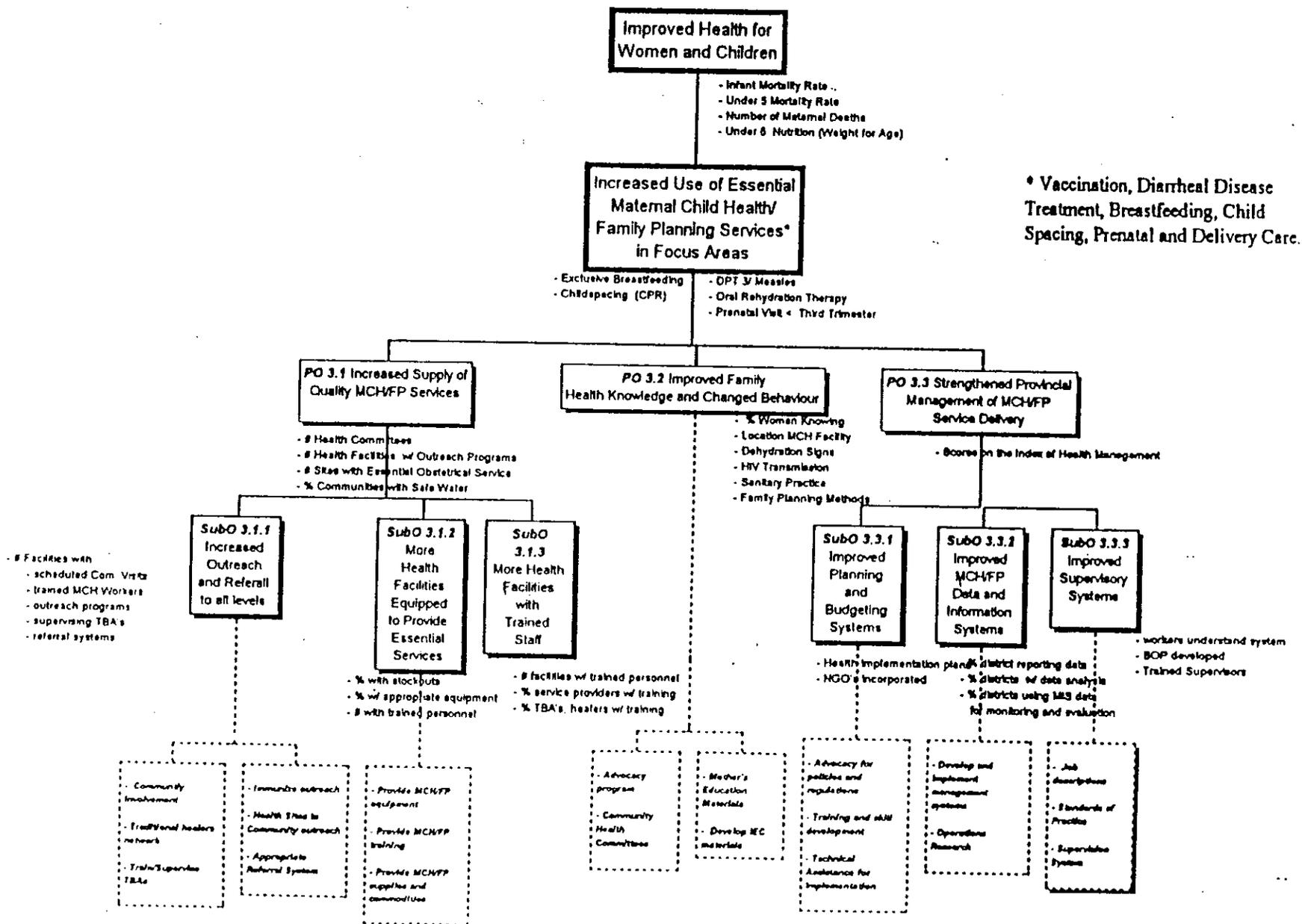
Health Sector Objective Tree

Sub-Goal

Strategic Objective

Program Outcomes

Illustrative Activities



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