

2059

PDBBX 847

AGENCY FOR INTERNATIONAL DEVELOPMENT

PROJECT DATA SHEET

1. TRANSACTION CODE

A = Add
C = Change
D = Delete

Amendment Number

1

DOCUMENT CODE

3

COUNTRY/ENTITY
Mozambique

3. PROJECT NUMBER

4. BUREAU/OFFICE

Africa

06

5. PROJECT TITLE (maximum 40 characters)

Pilot Child Survival

6. PROJECT ASSISTANCE COMPLETION DATE (PACD)

MM DD YY
11 23 91

7. ESTIMATED DATE OF OBLIGATION

(Under "B." below, enter 1, 2, 3, or 4)

A. Initial FY 89

B. Quarter 3

C. Final FY 91

8. COSTS (\$000 OR EQUIVALENT \$1 =)

A. FUNDING SOURCE	FIRST FY 89			LIFE OF PROJECT		
	B. FX	C. L/C	D. Total	E. FX	F. L/C	G. Total
AID Appropriated Total	400		400	800		800
(Grant)	(400)	()	(400)	(800)	()	(800)
(Loan)	()	()	()	()	()	()
Other U.S. 1.						
U.S. 2.						
Host Country		148	148		295	295
Other Donors)	564		564	1,128		1,128
TOTALS	964	148	1,112	1,928	295	2,223

9. SCHEDULE OF AID FUNDING (\$000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH CODE		D. OBLIGATIONS TO DATE		E. AMOUNT APPROVED THIS ACTION		F. LIFE OF PROJECT	
		1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan
(1) DFA	580	530		800				800	
(2)									
(3)									
(4)									
TOTALS				800				800	

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

11. SECONDARY PURPOSE CODE

12. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)

A. Code	GSPN	DEL	NUTR
B. Amount	800	100	100

13. PROJECT PURPOSE (maximum 480 characters)

To develop and test, under insurgency conditions replicable and cost effective measures to reduce infant and child and mortality.

14. SCHEDULED EVALUATIONS

Interim MM YY MM YY

Final 01 49 11

15. SOURCE/ORIGIN OF GOODS AND SERVICES

000 94 Local Other (Specify) 935

16. AMENDMENTS/NATURE OF CHANGE PROPOSED (This is page 1 of a page PP amendments)

Implementing agents will be the Ministry of Health and Johns Hopkins University.

17. APPROVED BY

Signature

Title

Director

Date Signed

MM DD YY
01 11 91

18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION

MM DD YY

PILOT CHILD SURVIVAL PROJECT
(656-0207)
PROJECT PAPER SUPPLEMENT

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UNITED STATES
AGENCY FOR INTERNATIONAL DEVELOPMENT
USAID MISSION TO MOZAMBIQUE

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ACTION MEMORANDUM FOR THE DIRECTOR

Date: 22 January, 1991
From: Mary Pat Selvaggio, HPN
Subject: Amendment of Pilot Child Survival Project (656-0207)

A. PROBLEM: Your approval is required to: a) amend the Project Paper by adding a supplement, and b) revise the amplified project description of the Project Grant Agreement.

B. BACKGROUND: The Pilot Child Survival Project was authorized in June 1989 with a LOP funding of \$800,000 and a PACD of December 31, 1991. Funds were obligated through a Project Grant Agreement with the Government of Mozambique (GOM) in June 1989. A buy-in to an existing cooperative agreement with John Hopkins University (JHU) and a cooperative agreement with Medecins Sans Frontieres, France (MSF) were then executed for purposes of project implementation. Additional funds were reserved for USAID-managed activities including project management, procurement of commodities and contingency.

During the initial year of project implementation, the project team (consisting of JHU, MSF, USAID, and the MOH) decided to emphasize two principal areas of emphasis, epidemiology/health information systems (HIS) and training/supervision, in order to better meet the needs and priorities of the Ministry of Health (MOH) as well as to achieve the project purpose. A workplan describing the specific activities within these two components was submitted to USAID and approved by the mission in July 1990 (ref: PIL No. 7).

Following difficulties experienced during the first year of project implementation, MSF determined that it could not continue to be involved with the project. Through the PP supplement, MSF responsibilities for implementing the training/supervision component are transferred directly to the Ministry of Health's own in-service training center (Centro de Reciclagem) based in Quelimane, and funding is reallocated to JHU for support to the Centro for these activities. The air transportation gap created by MSF's withdrawal will be filled through a direct contract with a local air charter service. The attached PP supplement and revised Amplified Project Description describe the reallocation of these responsibilities and funds.

C. DISCUSSION:

1. Project Goal and Purpose: The goal and purpose of the original project paper remain unchanged.

2. Funding considerations: No additional funds are required to implement the project as revised. The cooperative agreement with MSF was terminated for convenience by mutual consent of USAID and MSF, and unexpended funds have been reprogrammed within the project budget.

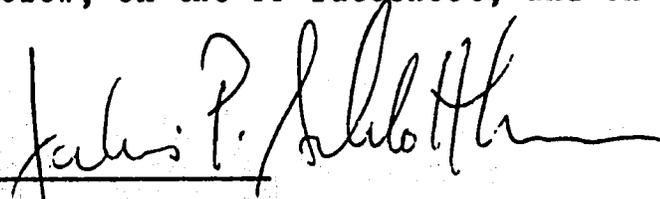
3. Implementation Capability: It is the opinion of the Mission that both the MOH and JHU can undertake the additional responsibilities required under the revised project implementation plan. A contract will be entered into with a local carrier to provide required flight time to ensure effective implementation of the training/supervision component of the project.

4. Approvals: All required Mission approvals have been obtained, and this Action Memorandum has been cleared by the Regional Legal Advisor.

D. YOUR AUTHORITY: State 143941, dated May 5, 1990, accorded USAID/Mozambique Schedule A status. Pursuant to DOA 551 you, as the Mission Director, have the authority to execute the actions requested in this Action Memorandum.

E. RECOMMENDATIONS: That, for the reasons outlined above, you approve a) the supplement to the Pilot Child Survival Project (656-0207); and b) the Revised Amplified Project Description of the Project Grant Agreement, and indicate such approval by signing below, on the PP facesheet, and on the attached PIL.

Approved: _____



Disapproved: _____

Date: _____

6 Feb 91

GLOSSARY

ARI	Acute Respiratory Infections
CDD	Control of Diarrheal Diseases
CR	Centro de Reciclagem (Training Center)/Quelimane
EPI	Expanded Program on Immunization
GOM	Government of Mozambique
HIS	Health Information System
JHU	Johns Hopkins University
MCH	Maternal and Child Health
MOH	Ministry of Health
MSF	Medecins Sans Frontieres
ORS	Oral Rehydration Salts
ORT	Oral Rehydration Therapy
PP	Project Paper
USAID	U.S. Agency for International Development

I. PROGRAM FACTORS

A. INTRODUCTION

This Project Paper (PP) supplement describes changes in project activities and implementation from those noted in the original PP authorized on June 30, 1989. A change in focus results from experience gained through project implementation and newly defined Ministry of Health needs arising from project-funded activities. To better meet the priorities of the Ministry of Health and the overall purpose of the project, the Pilot Child Survival Project narrows its focus to emphasize two principle areas: Epidemiology/Health Information Systems (HIS) and Training/Supervision. This PP supplement describes these two components and corresponding changes in implementation responsibilities between Johns Hopkins University and the Ministry of Health. For these modifications, no additional funding is required.

Both the Epidemiology/HIS and Training/Supervision components are designed as operations research or "tests" of the efficacy of strengthening the delivery of primary health care services. Consistent with the original PP, the revised project is a series of evaluations leading to information on the most appropriate way of delivering health care which effectively reaches the target population residing under insurgency conditions in rural Mozambique.

The Epidemiology/HIS component is designed to determine the nature and extent of specific clinical and managerial problems among rural populations and rural health facilities. It also seeks to improve the operation and usefulness of the Ministry supervisory and Health Information systems (HIS) by improving the collection, accuracy, analysis, and use of clinic based health data from the district to provincial level.

The Training/Supervision component is identified by the MOH and project staff as a viable means of strengthening the rural primary health care system through in-service training and follow-up supervision of district PHC workers. Accordingly, this PP supplement includes new activities for refresher training at the district level.

Originally, the Training/Supervision activities were to be implemented by Medecins Sans Frontieres, but their withdrawal from the project has necessitated a re-organization and re-allocation of responsibilities for this component. The Provincial MOH in Zambezia will take primary responsibility for implementing this component through the Centro de Reciclagem (CR) in Quelimane, with support from Johns Hopkins University (JHU).

This PP supplement is organized to provide a review of the overall health problem in Mozambique, a description of the

revised project activities, changes in implementation responsibilities, and a revised logframe which reflects changes in inputs and outputs from the original Project Paper.

B. REVIEW OF THE PROBLEM

Recent data indicates that infant and child mortality rates in rural Mozambique during 1988 are the second highest in the world after Angola. The infant mortality rate is estimated at 172 per 100 live births (UNICEF, 1990). The most common causes of child death continue to be diseases which are easily prevented and treated: measles, malaria, infectious diseases, and diarrhea.

The overwhelming majority of Mozambique's population live in rural areas under conditions similar to those of Zambezia Province. Despite a reduction in war activity in rural Zambezia, the disastrous state of health conditions and health facilities throughout rural Mozambique makes it necessary to focus efforts there. MOH statistics distinguish between populations who live in the relative normalcy of an urban environment with access to some social services, and those who are displaced or continue to live in areas affected by armed insurgency. In Zambezia Province, where family life has been severely disrupted, the incidence of morbidity and mortality among mothers and children is much higher than normal.

Child malnutrition is rampant in Zambezia and coverage of the Ministry's Expanded Program of Immunization (EPI) and Control of Diarrheal Diseases (CDD) services is limited. Analysis of data derived from the project baseline survey in Mocuba district found among children under five years of age widespread clinical evidence of malnutrition (43%), anemia (97%), malaria (16%), and hookworm infections (15%). Also children reportedly recently suffered from fever (70%), diarrhea (53%), and/or other symptoms of acute respiratory infection (ARI) (41%).

Low coverage of child survival services reflects the high incidence of preventable or easily treatable diseases and low utilization of health facilities. Only 17% of children in Mocuba were fully immunized, only 36% of the mothers knew how to prepare ORS, while only 38.5% understood the purpose of growth monitoring. Finally, maternal morbidity, an often neglected risk factor related to child survival, was found to be seriously high in terms of anemia, malaria, and other parasitic infections.

While most rural health clinics have the basic technologies to deliver primary health care (vaccines, ORS, essential drugs, and growth monitoring scales are generally available), poor management of these resources is severely constraining the Ministry's ability to effectively expand coverage. Further strengthening of service delivery through better training,

management, supervision, and data collection is imperative to more effectively address the institutional weaknesses in the health care system. If services are better delivered, child health presumably improves.

C. GOVERNMENT POLICY

Following independence in 1975, Mozambique established a nationalized health care system with the intent of developing broad-based primary health care. Indeed, the new Constitution contained a number of articles dealing with the principle of health for all citizens. The 1977 FRELIMO Third Congress espoused a commitment to preventive medicine as a priority of the Ministry of Health which was followed by a strategy of expanding the network of health care posts and health centers while stressing preventive and rural health.

The GOM continues to show strong commitment to improved maternal and child health. The Ministry of Health includes among urgent immediate needs of Mozambique reducing infant and maternal mortality, improving basic nutrition, and refugee and emergency health. Some of the Ministry's specific short-term planning objectives evident of this commitment are:

- to continue to give priority, whenever possible, to the rural zones and areas most affected by disaster;
- to maximize efficiency of all facilities, coordinate and mobilize resources at the national and international levels in order to increase the Government's capacity to achieve these goals;
- to maintain priority for training, especially in-service and informal training; and

Despite the Ministry's correct policy intentions and efforts to extend basic health care into rural as well as urban areas, coverage continues to be inadequate due to shortage of trained health care providers and reduced availability of budgetary resources to manage and support these personnel. The Child Survival Project, as revised under this PP supplement, corresponds to the Ministry's priorities and constraints by assisting with refresher training of district health personnel and their supervisors, and by more efficiently utilizing HIS data to measure the efficiencies and effectiveness of rural services.

D. PROJECT PROGRESS TO DATE

The Pilot Child Survival Project was originally implemented by two entities to meet the project's goal and purpose - Medecins

Sans Frontieres (MSF) and John Hopkins University (JHU). Implementation began in 1990, and numerous start-up activities were begun. A survey was conducted among dislocated and more permanent residents of Mocuba district, district level training activities were designed, and several JHU consultancies were completed. However, project implementation suffered several unavoidable delays and setbacks since the project agreement was signed on June 30, 1989: JHU was only able to field the project Epidemiologist in late January, 1990; registration of MSF as an AID authorized PVO was also delayed six months; MSF experienced a series of staff changes which culminated in their withdrawal from the project in July 1990.

Despite these delays, progress has occurred in project implementation. A project workplan was developed and approved by USAID which identified the strategies for HIS/Epidemiology and Training/Supervision and which provides details on exact activities in these components (see section II.B. below for further explanation). JHU consultancies were conducted on clinic management and clinic operations to better define constraints to service delivery. A new national supervisory checklist was designed by the Ministry of Health (with input from JHU consultants) and will be field tested under the project prior to implementation throughout the country. A population-based health survey was conducted in the district of Mocuba in June 1990, and data analysis and the survey report were completed in November 1990. Also, the project epidemiologist was requested by the MOH/Quelimane to assist in analyzing data during the recent cholera outbreak in Zambezia Province.

Based on the training and supervision constraints identified in project implementation, a JHU training consultant assisted to prepare guidelines for in-service training at the district level (vs. provincial capitals). These guidelines will serve to extend and decentralize refresher training from the Ministry's training institute in Quelimane (Centro de Reciclagem) out to the four districts where the project is being implemented.

All computer commodities for the project have been delivered, and the vehicle and Vitamin A capsules are ordered for delivery later in 1990. Finally, a USAID-based project manager was recruited to monitor project implementation and procure commodities.

In July 1990, MSF withdrew from the Project due to its inability to fully integrate the project's more long-term development activities with its ongoing relief and emergency activities. As described below, the project's training/supervision component will be transferred directly to the Provincial MOH in Zambezia Province coordinated by JHU field personnel. Specific details of the project's two major components (Epidemiology/HIS and Training/Supervision) which are now emphasized as a result of experience gained in project implementation are found in Section II. B. below

II. PROJECT DESCRIPTION

A. GOAL PURPOSE

The goal of the Pilot Child Survival Project, as stated in the original PP, is to improve child health and survival in Mozambique. This goal continues to be relevant within this PP supplement.

The purpose of the Project, is to develop and test, under insurgency conditions, replicable and cost-effective measures to reduce infant and child morbidity and mortality. This purpose continues to be relevant within this PP supplement.

B. REQUIREMENTS FOR AMENDMENT - REVISED PROJECT ACTIVITIES

Consistent with the original Project Paper, the project continues to focus on service delivery of three major child survival interventions: immunizations, diarrheal disease control, and nutrition (growth monitoring and vitamin A supplementation). Support to service delivery, namely health information systems (HIS) encompassing statistical reporting and special surveys, are also retained as major project activities under this supplement.

Also consistent with the original PP, operations research continue to be the primary mechanism for addressing improvements in EPI, CDD, nutrition, and HIS. Constraints to service delivery and HIS are identified through surveys which are then the basis for designing strategies to improve these services. These strategies are "tested", under difficult and/or insurgency conditions, to determine their utility and eventual replicability in other parts of the country. The strategies of Epidemiology/HIS and Training/Supervision, described in more detail below, were identified as major areas for improvement of MCH services based on the initial assessment and further experience of the project team during project implementation. The Project also continues to concentrate on service delivery at the district level in four districts of Zambezia Province: Alto Molocue, Mocuba, Gile, and Chinde. The last two districts are new geographic areas for project activities, substituting (at the request of the Ministry of Health) for Ile and Gurue which were targetted in the original PP. Both Gile and Chinde, like the other districts, have experienced a large influx of refugees over the last four years.

The following is a discussion of the changes in project focus which gave rise to the two project components and a discription of the logistical and administrative support requirements necessary to facilitate their implementation.

(1) Training/Supervision at District Level

When the Training/Supervision component was initially conceived and designed, MSF had primary responsibility for implementation in conjunction with the MOH and JHU. Under MSF direction, a training manual and curriculum for district training were developed with assistance from a JHU consultant. With MSF's subsequent withdrawal from the project, several options were considered for continuing Training/Supervision activities: (a) involving another NGO to assume MSF's responsibilities; (b) transferring implementation responsibility directly to the MOH and Centro de Reciclagem; or (c) transferring this component to JHU. Due to the difficulties in orienting new organizations or staff to the project in view of the limited time remaining, option (b) was viewed as the most expeditious and effective means to implementing this component. The Ministry of Health concurs in this decision (see Annex B) and is prepared to proceed within the four target districts in carrying out supervisory visits and district level training. JHU will assist the Ministry through providing administrative and periodic technical assistance.

A more detailed description of the training and supervision activities to be implemented follows.

(i) Training

Although the original Project Paper described limited funding for occasional training courses, the need for on-going, in-service training as a major project activity was not anticipated. Rather, on-the-job supervision, instead of more formal training courses, was expected to be used as the "training" mechanism to improve service delivery in the technical project areas of EPI, CDD, nutrition, vitamin A, and HIS.

However, based on the results of two JHU consultancies and development of the project workplan, the project team (MOH, JHU, and MSF) determined that regular, in-service training at the district-level was critical for improving MCH service delivery and HIS. On-the-job supervision as the primary means to improving service delivery could not succeed because:

- a) there are limited numbers of supervisory staff in Zambesia Province;
- b) logistical difficulties in traveling frequently to the districts render on-the-job training (through more intensive supervision) difficult; and
- c) supervisory skills of these individuals are very weak and would require substantial strengthening for effective on-the-job training.

Furthermore, because the Ministry's personnel system lacks clearly defined job descriptions for those currently holding supervisory positions, considerable confusion exists over specific supervisory responsibilities of provincial and district level staff. Consequently, it was concluded that improved supervision alone, as a means of providing on-the-job training, was not an

effective means to upgrading child survival services in the districts.

In service training, however, was identified as critical to upgrade and strengthen the skills of nurses and health staff at the district level. Many of these individuals received formal training more than four years ago and their skills are considerably less extensive than recent graduates of MOH training institutions. Moreover, as the "frontline" staff who offer medical assistance to the majority of rural populations, often without basic support and assistance of other health personnel, there is even greater need for regularly upgrading the preventive and curative skills of district health personnel.

Indeed, the need for refresher training was recognized more than five years ago by Save the Children Fund and the Ministry of Health, who responded by establishing a provincial in-service training institution in Quelimane - the Centro de Reciclagem (or Refresher Training Center). As discussed in Annex D, the Center has conducted many courses for provincial health workers in Zambezia Province since 1986. Recently, however, both the Center and the Ministry of Health identified the need to decentralize the Center's training activities toward the districts themselves. The central problem noted by both, as well as the project team, is that the participants rarely transfer their new found skills and knowledge to their colleagues in the districts following attendance at training courses in Quelimane. To address this constraint, the Ministry is embarking on a series of district-based training courses to promote more effective service delivery. The project will assist the CR in decentralizing their activities in the four districts where the project is located.

Annex D describes the Center's decentralized refresher training approach - that is, training former participants in teaching methods and then helping these persons effectively transfer their technical skills to their colleagues. Each district-level course is five days in duration followed by a monitoring visit from the Center six weeks later. The emphasis of the district level training course is on MCH (EPI, CDD, nutrition, HIS, as well as family planning and ARI) and community level education. The approach and content of the district level training is consistent with the goals and objectives of the Project, and as such, the project will provide the Center with support for conducting district level training in the project areas. Because one district level training course has already been conducted in Alto Molocue without project funds, the project will fund the costs of conducting district level training in the three other districts.

One new feature of the training courses conducted by the CR in the four project areas, distinct from those conducted elsewhere in the Province, will be the inclusion of additional follow-up monitoring visits. The Center and Project team have noted the

need to monitor more intensively the impact of district level training, but scarce resources for air travel and personnel have precluded more than one follow-up visit. To test whether the investment in district level training will be sustained for the long-term, more frequent, regular follow-up visits to the districts will be conducted under the project with support from JHU. Additional personnel and funding for air travel is provided for this purpose.

(ii) Supervision

As prescribed in the original Project Paper, strengthening provincial-to-district supervision remains in the project, although it now serves as an extension of decentralized training. EPI, CDD, nutrition, and HIS managers based in Quelimane will accompany Centro de Reciclagem staff in providing follow-up support and supervision to the district trainers and their trainees. CR staff will focus their follow-up visits on community education while program supervisors will examine service delivery and clinic management.

In addition, within the four target districts, the project will test both a new MOH supervisory checklist and the implementation of new vitamin A protocols. As described earlier, JHU consultants provided input into the development of a new supervisory checklist. This checklist will be field tested with support of the project and recommendations will be made to the MOH for finalization and implementation nationwide. Vitamin A protocols were developed by the MOH, but are not widely or effectively implemented. Accordingly, the project will assist in the more expansive implementation of this program and make recommendations to the MOH for possible modifications in program management.

Project support for enhanced supervision will be provided through funding air travel of MOH/Quelimane supervisors to the four target districts for conducting supervisory visits. Data derived from the checklist will be incorporated into the provincial level HIS database in Quelimane (see section on HIS below) to assist the MOH in identifying further areas for improved service delivery - either through better supervision, additional training, or improved administration. Recommendations will also be made to MOH/Maputo on the utility of the new checklist and the need for any modifications prior to final distribution nationwide.

To fill the logistical and technical support gap created by MSF's withdrawal, and to support the Ministry's efforts in implementing the activities in the Training/Supervision component, the project will fund: (i) air transport to the districts through a contract with a local organization; (ii) support for the production of additional training materials; (iii) the salaries of locally-hired logistical and

administrative staff; and (iv) additional consultancies from JHU to the MOH for implementing this training/supervision component. Funds provided to JHU will be utilized for the costs of additional materials production as well as additional staff for follow-up monitoring visits. The nature and extent of this support is described in section (3) below.

(2) Epidemiology/Health Information Systems (HIS)

Activities within this component include conducting special surveys of health status and clinic operations; developing a supervision database as a management tool for decision making; and improving the district and provincial level health information systems. All these activities are integrated with the Training/Supervision component so as to maximize achievement of project outputs and use of project inputs. Johns Hopkins University is responsible for implementing the activities under this component.

Within the original PP, an epidemiologist from JHU was funded for one year to assist in carrying out a baseline survey of MCH services at the clinic level in the four target districts. The original intent of this clinic-based survey was to obtain sufficient information on clinic level management and operations so as to design strategies for improved service delivery. However, prior to the epidemiologist's arrival in January 1990, two JHU consultants conducted separate qualitative reviews of clinic operations in the target districts. Their conclusions gave rise to the decision to pursue in-service training and supervision at the district level. The results of these two reports are being aggregated into a single analysis of clinic operations and management in Zambezia Province.

Rather than duplicate the clinic-based assessment undertaken by the JHU consultants, and to respond to the the information needs of the MOH, the epidemiologist determined that a population-based demographic and health survey was required. Although not originally anticipated in the original PP, the paucity of reliable, population-based health information in Mozambican communities (upon which clinic services are based) justified the inclusion of this activity in the project.

Conducted in June 1990, this community survey provides data on utilization and access to MCH services as well as estimates of risk factors affecting child survival (anemia, malnutrition, diarrheal disease, ARI, malaria, and intestinal parasites). Additional demographic and socio-economic data regarding child mortality and fertility rates; household size; migration; and access to food, water, and sanitation resources were also collected. The sample of 2,160 women and children in Mocuba reflects the various socio-economic groups present in rural Mozambique - recently arrived rural refugees (deslocados); more settled deslocados; and wa affected town residents

(affectados). The final results of the survey were submitted to USAID and the MOH in November 1990

A similar, but smaller, sample survey is planned for the peri-urban areas of Quelimane. This survey, to be conducted in March 1991, will further delineate those MCH problems affecting peri-urban populations groups as compared to the more rural groups noted in the Mocuba sample.

Aside from the clinic assessment and the community surveys described above, additional survey work on effectiveness of district health personnel and services delivery will be collected through focus group discussions among health workers and from the supervisory checklist. The focus group information will be gathered during the district-level training sessions described above.

Finally, JHU will assist the MOH in Quelimane to develop an overall strategy report based on information collected from the special surveys, the supervision database, and from the district level HIS. This report will provide definite recommendations for appropriate interventions, for the further development and implementation of supervision and health information systems, and for long-term MCH and MHC programming.

Implementing these Epidemiology/HIS activities requires an extension of the project epidemiologist for one additional year. Extra JHU consultancies will also be required to assist in implementation. Finally, to fill the support gap created by MSF's withdrawal, additional funding to JHU will be provided for logistical support to the Epidemiologist and JHU consultants. These are further delineated in (3) below).

With MSF's withdrawal, a significant logistical/administrative gap exists in implementing project activities. Secretarial and communications support, air travel, logistical assistance, and technical oversight for the supervision/training component was provided by MSF to the MOH, the Epidemiologist, and JHU consultants. In order to sustain project implementation, these services must continue for both the MOH and JHU to facilitate project implementation. Accordingly, the project will provide funding for (i) air travel to the districts, (ii) logistical and administrative support, and (iii) production of training materials. A detailed breakdown of these and other project costs is provided in the Revised Financial Plan (see section F below) and Annex C. Financial Analysis

(i) Air Travel to the Districts

USAID will contract with a local air service company to provide

208 hours of flying time from Quelimane to the target four districts for project activities. Several private air charter companies operate out of Quelimane, but based on an informal survey of cost and availability, AirServe International appears to have the capacity to meet the project's needs in a timely and cost effective manner. The other companies cannot commit to regular service or their costs exceed those of AirServe's. Based on their current rate of \$400 per hour for flight time, \$83,200 will be provided for this service.

(ii) Logistical/Administrative Personnel and Support

Because the Ministry of Health has extremely limited resources available to support the project (in terms of office space, personnel, transport, communications, secretarial services, materials and supplies, and vehicle maintenance), external, project funded administrative support is imperative to project implementation. The original PP described most of these services as being derived from MSF's base in Quelimane. Unfortunately, with MSF's withdrawal, additional funds must be provided to JHU to cover these needs.

The project will provide JHU with funds for office space and salaries of four staff contracted by JHU: a part-time administrative officer in Maputo, a full-time logistician in Quelimane, a full-time secretary in Quelimane, and a full-time training supervisor based at the Centro de Reciclagem.

Re-allocated funds will also be provided to JHU for procuring materials and office supplies for the training activities to be implemented by the Centro de Reciclagem

C. PROJECT OUTPUTS AND INPUTS

The focal project implementation areas of HIS/Epidemiology and Training/Supervision necessitate a change in project outputs. While three of the original outputs remain unchanged, one is modified to correspond with the new emphasis on in-service training. The former output, emphasizing the better integration of curative and preventive services, was originally formulated to address Medecins Sans Frontieres' absence of integrated preventive and curative assistance in the districts where they operated. Ministry of Health services, however, are fairly well integrated at the district level. Consequently, with MSF's withdrawal, this output is not critical to achievement of the project purpose. Thus, the revised outputs are as follows:

1. Complete, accurate, timely, and relevant data collection, reporting, and analysis will be accomplished through simplification and strengthening of district HIS functions and, to some extent, the provincial HIS. Data incorporated

from the supervisor's checklist, focus groups of district health workers, community based health surveys, monitoring of vitamin A supplementation program, and monthly service delivery data will all serve as management tools for monitoring the effectiveness and efficiency of service delivery and the training/Supervision components.

2. Regular and adequate supervision of NCH services by MOH personnel through assistance in air travel from Quelimane to the four districts for MOH/Zambezia supervisory visits and follow-up of district training activities. Supervisory visits will focus on the delivery of EPI, CDD, and nutrition services as well as data collection/reporting and overall clinic management.
3. Ongoing in-service training at the district level. The CR will "test" the newly developed training guidelines in the target districts. Approximately 10 trainers and 80 trainees in 4 districts will receive in-service training in management/supervisory techniques, HIS, child survival interventions, and public education methodologies.
4. Timely provision of vaccines, medicines, and supplies. Better and more accurate service data combined with better supervision and management should give rise to a reduction in shortages of materials and supplies at the clinic level. Transportation assistance will also expedite the delivery of medical supplies to the target districts.

To achieve these outputs, the Project will finance the following inputs:

Long-term epidemiologist	183,275
Short-term consultants	192,535
Administrative and Logistics Assistance	79,730
Training/Supervision Support	45,240
Air Travel	83,200
MSF	65,065
Commodities	47,000
Project Management	35,000
Evaluation and Audit	45,000
Project Contingency	23,955
	<hr/>
TOTAL	\$800,000

D. REVISED IMPLEMENTATION RESPONSIBILITIES AND PLAN

The implementation responsibilities of each agency involved in the project are described below. The coordinated relationships between the MOH, JHU and USAID will be further outlined in a new memorandum of understanding covering the period October 1990 through december 1991 to be signed by each party.

(1) Ministry of Health

- Ensure all activities described in the workplan are effectively carried out;
- Ensure that relevant MOH/Quelimane and district staff fully participate in implementing both district and provincial level project activities (Epidemiology/HIS and Supervision/Training);
- Ensure that MOH/Quelimane MCH supervisors are made available twice/month to make supervisory visits in the target district;
- Work closely with all JHU staff and consultants to develop improvements in delivery of child survival services and HIS;
- Submit monthly reports on the progress of Training/Supervision activities in the target district;
- Maintains project vehicle and computer equipment provided for the project implementation;
- Distributes vitamin A within target districts and monitors implementation of vitamin A protocols;
- Participate in Project Coordination meetings;
- Participate in final evaluation.

(2) John Hopkins University (JHU)

- Provide long-term Epidemiological technical assistance for implementing the epidemiology/HIS component and provide overall field coordination for project implementation;
- Provide short-term consultants to assist in devising improvements in child survival services as delineated in the two project components of Training/Supervision and Epidemiology/HIS;
- Liaise closely with the MOH in coordinating activities between the two components of Epidemiology/HIS and Training/Supervision;

- Provide USAID and the MOH with quarterly progress and financial reports;
- Provide logistical and administrative support to the MOH and the project epidemiologist in implementing the two project components of Epidemiology/HIS and Training/Supervision, including scheduling of air transport to the districts from Quelimane;
- Participate in Project Coordination meetings;
- Participate in the final evaluation.

(3) USAID/Mozambique

- Monitor overall project progress and report regularly to MOH/Maputo and USAID management;
- Arrange short-term TA and facilitate in-country travel as necessary;
- Procure commodities;
- Keep MOH/Maputo informed of the project progress;
- Participate in Project Coordination meetings;
- Arrange final evaluation and audit.

A revised implementation plan is presented to reflect the changes in project activities. Activities which have already occurred prior to this PP supplement are not listed.

Oct. 1990	<p>PP Supplement finalized and PIL revising Amplified Project Description signed with the MOH.</p> <p>Project Coordination meeting held to discuss changes in project activities and responsibilities.</p> <p>Final report of community survey produced and disseminated to MOH and USAID.</p> <p>Memorandum of Understanding signed by JHU, MOH, and USAID.</p> <p>JHU budget increased to reflect additional responsibilities and costs.</p>
Nov. 1990	<p>JHU recruits administrative and logistical personnel to be based in Maputo and Quelimane</p>

Vehicle arrives in Quelimane.

Vitamin A capsules arrive in Quelimane.

Consultancy in Health Information Systems.

Contract signed with local air charter service company.

Focus group discussions held with district health staff.

Training/Supervision activities begin under the leadership of the MOH Centro de Reciclagem.

Project monthly reports submitted.

Dec. 1990

HIS consultancy report reviewed with USAID and MOH;

Training/Supervision activities continue.

Protocols for Vitamin A supplementation reviewed with district health staff and "testing" of implementation begins.

Procedures for incorporating qualitative supervisory reports into Quelimane HIS established and implementation begins.

Project monthly reports submitted.

Jan-Mar 1991

Project coordination Meeting held.

Implementation of HIS/Epidemiology and Training/Supervision continues.

Monthly reports submitted.

Results of health worker focus group discussion presented and disseminated to USAID and MOH.

Second peri-urban survey planned and started.

Follow-up JHU training consultancy to MOH.

Workplan reviewed and revised accordingly.

Apr-June 1991

Results of peri-urban study produced and disseminated to MOH and USAID.

Mid-course changes in training/supervision as result of JHU training consultancy.

Project Coordination meeting held.

Implementation of HIS/Epidemiology and Training/Supervisor, continues.

Monthly report submitted.

Jul-Sep 1991 Project Coordination Meeting held

Implementation of HIS/Epidemiology and Training/Supervision continues.

Monthly reports submitted.

Follow-up JHU consultancy in HIS conducted.

HIS Strategy report prepared and presented to MOH and USAID.

Final evaluation planned

Oct-Dec 1991 Implementation of HIS/Epidemiology and Training/Supervision continues.

Monthly reports submitted.

Follow-up JHU consultancy in HIS conducted.

Final project evaluation completed.

Determination of audit requirements.

E. MONITORING AND EVALUATION

(i) Project Monitoring

As indicated in the original PP, one of the major project activities involves regular monitoring of MCH services delivery through the health information system. Improvements to the HIS, in conjunction with data derived from surveys, will enable both AID, the Ministry of Health, and JHU to more accurately monitor project impact and progress.

Project monitoring also consists of regular meetings between all three implementing agencies. To date three such meetings have been held, and another is scheduled for early January 1991. In general, such meetings every two or three months appear to be sufficient for undertaking mid-course corrections. The benchmarks for project progress which appeared in the original PP are modified to reflect the changes within this supplement. Such benchmarks are listed as tentative indicators of progress

toward the implementation of project activities and achievement of End-of-Project Status Indicators:

- Long-term JHU Epidemiologist arrives -- January 1990
- Work Plan developed and approved -- April 1990
- All commodities purchased and delivered to site -- November 1990
- Procedures for district-level training developed -- November 1990
- Baseline survey completed -- October 1990
- Second peri-urban survey completed -- March 1991
- Overall epidemiology/His strategy developed -- September 1991
- Supervisory visits for MCH and training undertaken -- ongoing

(ii) USAID Monitoring Responsibilities

The monitoring responsibilities delineated in the original PP continue to be relevant within this PP supplement.

(iii) Evaluation Plan

Due to the changes in project activities as described above, only the final evaluation will be conducted under the project instead of the two evaluations described in the original PP. A mid-term evaluation is not advised due to delays in project start-up and mid-course corrections made as result of project implementation and MSF's withdrawal. The final evaluation will assess the implementation of activities described within this PP supplement to document the impact of project activities toward the achievement of the goal and purpose. An external evaluation team will be contracted to conduct the final evaluation.

F. REVISED FINANCIAL PLAN AND SUMMARY OF FINANCIAL ANALYSIS

Annex C provides a revised financial analysis which reflects the modifications in project activities described within this document. While the Ministry of Health is responsible for project implementation, it receives assistance from John Hopkins University. Reallocated funds from Medecins Sans Frontieres and USAID to JHU will be used for implementing the training and supervision component. Funds originally obligated for purchasing cold chain and other commodities (solar powered refrigerators and medicines, antibiotics, etc) are not needed under this supplement because of available funding from other donors.

A buy-in to an existing AID/Washington Cooperative Agreement with JHU was completed for \$330,000 in late 1989. An additional \$170,000 will be provided to the same Cooperative Agreement with JHU to provide funding for the additional

activities within the project component of Training/Supervision and to cover the additional travel costs of consultants due to airfare increases. A direct contract with AirServe will finance air travel to the districts during the remaining months of project implementation. Finally, USAID retains \$150,900 for project management, commodities, evaluation, and contingency.

TABLE I
ILLUSTRATIVE PROJECT BUDGET
A.I.D. CONTRIBUTION BY
COLLABORATING INSTITUTION AND ACTIVITY

<u>Institution</u>	<u>Previous Funding Level</u>	<u>Adjustments</u>	<u>Total Funding</u>
(1) JOHNS HOPKINS UNIV.			
- Epidemiologist	145,000	38,270	183,270
- Short-term Consultants	185,000	7,535	192,535
- Logistical Support	-0-	79,730	79,730
- Training/Supervision Support	-0-	45,240	45,240
 (2) AIR TRAVEL SERVICE	 -0-	 83,200	 83,200
 (3) MEDECINS SANS FRONTIERES			
- Long-term Staff	72,400	(50,010)	22,390
- Short-term Consultancies	45,000	(36,940)	8,060
- Air Travel	117,600	(82,980)	34,620
 (4) USAID			
- Commodities	83,600	(36,600)	47,000
- Project Management	35,000	-0-	35,000
- Evaluation/Audit	30,000	15,000	45,000
- Training	50,000	(50,000)	-0-
- Project Contingency	36,400	(12,445)	23,955
 TOTAL	 800,000	 -0-	 800,000

September 1990

REVISED LOGICAL FRAMEWORK
Pilot Child Survival Project (656-0207)

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>Project Goal</p> <p>To improve child health and survival in Mozambique</p>	<p>Measures of Goal Achievement</p> <ul style="list-style-type: none"> - Mortality and morbidity statistics for children - Statistics on malaria, diarrhea, measles, and malnutrition among children 	<ul style="list-style-type: none"> National and regional statistics on MCH services and clinic visits Special surveys 	<ul style="list-style-type: none"> - No worsening of security - Effective improvements in child survival are possible despite insurgency and economic crisis - Donor assistance continues at current levels
<p>Project Purpose</p> <p>To develop and test, under insurgency conditions, replicable and cost-effective measures to reduce infant and child morbidity and mortality</p>	<p>Conditions Indicating Achievement</p> <ul style="list-style-type: none"> - Increased understanding of factors contributing to mother/child morbidity and mortality in Zambezia Province - A draft model of a functioning rural health care system with limited resources in conditions of insurgency 	<ul style="list-style-type: none"> - Expert observations and evaluations - Anecdotal reports - Project progress reports - MOH statistics and supervisory records in Zambezia - Evaluation reports 	<ul style="list-style-type: none"> - Given insurgency, adequate field testing and supervision is possible - Lessons can be replicated elsewhere with adjustments - MOH limited resources and capacities can sustain follow-on implementation - Adequate and timely provision of food is provided
<p>Outputs</p> <ol style="list-style-type: none"> 1) Complete, accurate, timely, and relevant data collection, reporting, and analysis 2) Regular and adequate supervision of MCH services by MOH personnel 3) Ongoing in-service training at the district level 4) Timely provision of vaccines, medicines, and supplies 	<p>Magnitude of Outputs</p> <ul style="list-style-type: none"> - Procedures for maintaining cold chain effectively in place - ORT effectively taught to mothers - Nutrition counseling provided in growth monitoring sessions - Vitamin A delivered according to MOH protocols - MCH supplies consistently available - Health staff trained in improved MCH service delivery - Regular supervision of district MCH services 	<ul style="list-style-type: none"> - Project reports - MOH clinical and supervisory records - Field site visits - Expert evaluation of clinical practice - Results of special surveys 	<ul style="list-style-type: none"> - MOH and JHU coordinate in implementing improvements to PHC services - MOH commits staff resources to making field visits and implementing training programs - JHU consultants effectively impart new ideas - Health facilities are secure from attacks
<p>Inputs</p> <ul style="list-style-type: none"> - Long-term Epidemiologist (\$183,275) - Short-term Consultants (\$192,535) - Administrative and Logistics Assistance (\$19,730) - Training Support (\$45,240) - Air Travel (\$83,200) - Commodities (\$47,000) - Project Management (\$35,000) - MSF (\$65,065) - Project Contingency (\$23,955) - Evaluation/Audit (\$45,000) 	<p>Funding Targets</p> <ul style="list-style-type: none"> - 24 p/m epidemiological assistance - 27 p/wks consultancies - 45 p/m administrative assistance - training materials produced - 80 persons trained in child survival interventions - two visits per month made to districts by Quelimane MOH Supervisors - 12 p/m project management assistance - one evaluation - 12 p/m on-site coordination - 208 hours flying time - computers, software, clinical equipment for survey 	<ul style="list-style-type: none"> - NGO financial reports - Evaluation reports - Field site visits - Progress reports 	<ul style="list-style-type: none"> - Can amend centrally-funded buy-in - Commodities arrive in a timely fashion - Satisfactory working relationships between AID, MOH, and implementing agencies - Security situation does not preclude implementation of training/supervision and HIS/epidemiology programs - Availability of planes for travel - Authorization to travel given

July 19, 1990

Nota n.º 689/8PS-2/Dr
21/7/90

Mr. Julius Schlotthauer
Director
U. S. Agency for International Development
Maputo, Mozambique

Dear Mr. Schlotthauer:

After meetings with the medical coordinator of Medicins Sans Frontieres, the USAID Health Population Nutrition Officer, and Project staff, I have been informed that Medicins Sans Frontieres has decided to terminate all of its contractual obligations and involvement with the Zambezia Pilot Child Survival Project as of July 31, 1990.

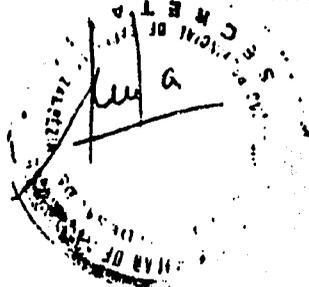
However, the Ministry of Health considers that this project is an integral part of our on-going plans for the development of an effective primary health care program in Zambezia Province.

My primary concern at this point is that every effort will be made by USAID to continue the project via whatever mechanism you deem appropriate. Perhaps it would be most expedient for project staff to work directly under the auspices of the Ministry of Health, Zambezia Province to prevent a similar situation from occurring in the future.

Also, in order to successfully implement both components of the project, it would seem essential for the key project staff, the Project Coordinator and Project Epidemiologist, to be able to carry out their duties here until the end of the project in November 1991 as agreed upon in the project workplan. I look forward to discussing these issues with you and Dr. Cabral in the near future during my next trip to Maputo.

Sincerely,

Dr. Humberto Cossa
Provincial Director of Health
Ministry of Health, Zambezia Province
Mozambique





REPÚBLICA POPULAR DE MOÇAMBIQUE
MINISTÉRIO DA SAÚDE
DIRECÇÃO NACIONAL DA SAÚDE

- 9 AUG 1990

- Mary Pat
- D. Mutchler

AO
EXCM. SENHOR
DAVID MUTCHLER
DIRECTOR EXECUTIVO
USAID

R E P U T O

Assunto: Projecto Sobrevivência da Criança/Embésia.

6.8.90

Nº 1077/EIS 5/DNS/90

Excm. Senhor,

Agradecemos a recepção da vossa carta de 12.07.90, ref.º 90/622, que muito agradecemos.

Aguardamos informações da DPS Embésia sobre o incidente ocorrido com a Organização MSF/França, que parece ter decidido afastar-se da execução do projecto. Aguardamos que a DPS Embésia nos indique formalmente se tal decisão foi tomada pela MSF/França, e propostas da DPS Embésia sobre CIG's já operando naquela Província e que possam substituir os MSF como agência executiva deste projecto.

Se, outro assunto de momento, aproveito para lhe apresentar as minhas mais cordiais saudações.

O DIRECTOR
Dr. António dos Reis Rebelo

... Sr. DPS
Sr. DPS Embésia

21



17 AUG 1990

MARY PA!

República Popular da Zâmbia

MINISTÉRIO DA SAÚDE
DIRECÇÃO PROVINCIAL DE SAÚDE DA ZÂMBIA
GABINETE DO DIRECTOR

ERLIO SENHOR:
DAVID MUTOMBER
USAID - LAFUTO

L A P U T

Assunto

Assunto

Referência

48/CIS-3/UD-PC 2/50 93/1

Assunto

MODIFICAÇÃO AO PROJECTO DE SOBREVIVÊNCIA DA CRIANÇA.

Tomamos conhecimento das modificações propostas para o projecto de sobrevivência da criança em face da retirada da Organização MCF.

Temos os seguintes comentários sobre a proposta:

1) Implementação e Direcção do projecto.

Concordamos plenamente que a actividade de formação reciclagem/ supervisão seja feita coordenada e dirigida pelo Centro de reciclagem.

Apreciamos a extensão da permanência do epidemiologista o que está de acordo com o plano operacional do projecto.

É necessário que haja um assistente para trabalhar com o epidemiologista para apoio nas tarefas administrativas.

2) Resultados do projecto.

Os pontos apresentados são os que tem norteado a actividade, do Ministério de Saúde. O projecto irá melhorar estes aspectos.

3) Insunhos do Projecto.

De acordo com todos.

Seria bom definir a situação dos veículos 4x4 que até agora não chegam.

28

UNIDADE TRABALHO VIGILÂNCIA

O DIRECTOR PROVINCIAL DE SAUDE

DR. HUMBERTO A. ESCOBAR
(Médico-Chefe)



C/C - DIRECTOR NACIONAL DE SAUDE.-

ANNEX C
REVISED FINANCIAL ANALYSIS

I. BUDGET ASSUMPTIONS

This annex replaces the Financial Analysis presented in the original PP. With the substantive shift in project activities resulting from this PP supplement, combined with a reorganization of project responsibilities among the implementing agencies, budget assumptions and necessary allocations have modified.

While the Ministry of Health is responsible for project implementation, it receives assistance from Johns Hopkins University and, until recently, from Medecins Sans Frontieres. To ensure that the assistance which MSF had provided will continue through the LOP, the project transfers unused funds from MSF to both JHU and to a locally contracted air service company for implementing various aspects of the project.

The life-of project funding remains at \$800,000 as indicated in the original Project Paper. Table A in this annex illustrates total USAID funding by institution and by year.

A. Johns Hopkins University

The long-term epidemiologist, stationed in Quelimane, will be extended for an additional 12 months or 24 months of TA in total. Nine consultancies, each approximately three weeks in duration, will be also provided over the life-of-project. JHU will also locally employ administrative personnel in Maputo and Quelimane to provide the Epidemiologist and the MOH with administrative support for project activities. Finally, JHU will cover the costs of conducting the district level training program which is implemented through the Centro de Reciclagem in Quelimane. The total JHU cost of \$500,778 is based on the following estimates:

Salaries: The Epidemiologist's salary, travel, and benefits is estimated at \$58,000/year for a total two year period (\$116,000). Salaries for nine consultancies are budgeted for 16 work days over a three week period at a maximum rate of \$270/day (\$4,860/consultancy or \$43,740 for nine consultancies over the LOP). The salary of a Maputo-based Administrative Assistant is calculated at a rate of \$18,000/year for half-time work. This person will be employed over the 15 months from October 1990 - December 1991 (totalling \$22,500). Two locally-hired staff in Quelimane will be supervised by the Epidemiologist. A Logistical Assistant will be hired at an annual rate of \$5,000/year (\$5,250 over a 15 month period) and the secretary will be hired at an annual rate of \$3,200/year (or \$4,000 over a 15 month period). A training supervisor based at the Centro de Reciclagem will be hired under JHU at an annual rate of \$7,000. Finally, JHU backstopping will include the salary of a Baltimore coordinator budgeted at \$15,000 year over the LOP (\$10,000 total).

Travel: International Travel is calculated at \$5,000 per round trip U.S. - Mozambique for three consultancies and one trip for the long term Epidemiologist during years one and \$6,000 per round trip for six consultancies and one trip for the Epidemiologist in years two and three (\$62,000). Per diem for the consultants is calculated at \$116.00/day for 21 days for each of nine consultancies (\$21,924). Local travel between Maputo-Quelimane is budgeted at \$150/round trip for six consultants, and six trips for the Epidemiologist during years one and two. Local travel is calculated at \$180/round trip for six trips for the Epidemiologist and three consultants and six trips for the Administrative Assistant in year three (\$4,500).

Training/Supervision Support to the MOH: Funding will be provided to the Centro de Reciclagem through JHU for production of training materials and per diem costs for trainers and trainees. According to the cost estimates provided by the CR, materials will total \$17,000 for pens, books, health education materials, paper, printing, etc. Per diem for the training and supervision activities of four supervisors, the CR staff, and ten trainers (16 persons total) is calculated at \$5.00/day for one week/month for each person over a total of 2 months (a total of \$4,300). Per diem for approximately 100 district-level trainees traveling into district capitals for training is calculated at \$5.00/day for 15 days of training over the LOP per participant (or \$6,000 total).

Miscellaneous Costs: The JHU budget also includes funding for communications, telephone, postage (\$20,000), rental in Quelimane (\$500/month for 15 months or \$7,500), salaries and storage for the Quelimane based Epidemiologist \$11,564. Finally, overhead/fee is estimated at 30% of the above \$115,564.

B. Air Travel Service

To accommodate the travel needs of the CR and JHU staff at their work at the district level, USAID will contract local air charter service for 208 hours flying time (estimated \$400/hour) or a total of \$83,200. Round trip to each district is approximately two hours per trip. 16 trips per month to each district (8 trips per month to each of two districts) estimated 16 hours/month air time over a thirteen month period yields approximately 208 total hours of flying time or \$83,200 total in costs.

C. Medecins Sans Frontieres

Actual costs incurred by MSF are noted in Table A. Between August 1989 and July 1990, MSF spent \$22,091 on long-term staff, \$8,060 on short-term TA, and \$14,616 for air travel to the districts.

D. USAID

A total \$150,955 will be directly committed by USAID for project management, commodities, evaluation, and project contingency. USAID will procure project commodities totalling \$47,000: One 4x4 vehicle (25,000) and with spare parts and maintenance (\$5,000), two computers, printers, and UPS (\$14,000) and vitamin A capsules (\$3,000): (In the original PP, funding was allocated for the purchase of solar powered refrigerators and drugs, but as other donors have provided sufficient supplies of these to Zambezia Province, these funds are being reallocated for training/supervision support through JHU.)

Project Management is recruited locally at a cost of \$35,000 over the LOP for half-time work. The final evaluation and audit are budgeted at \$45,000 for the participation of 5 person weeks of external technical assistance. Finally, \$23,955 is retained for project contingency to cover increases in fuel costs for air travel or other unforeseen costs.

II. LOCAL CONTRIBUTION TO THE PROJECT

As stated in the original PP, the Ministry of Health's contribution to the project is estimated at \$295,200 for personnel, supplies, equipment, and transport at the district level, and the cost of health facilities. Details of this contribution can be found in the original Project Paper.

INSTITUTION AND ACTIVITY	YEAR 1 (Aug-Dec 89)	YEAR 2 1990	YEAR 3 1991	TOTAL	CATEGORY TOTAL
I. JOHNS HOPKINS UNIVERSITY					500,778
A. Salaries					229,490
- Epidemiologist	-0-	58,000	58,000	116,000	
- Consultants (3-3-3)	14,580	14,580	14,580	43,740	
- Maputo Admin Asst.	-0-	4,500	18,000	22,500	
- Quelim. Logist. Asst.	-0-	1,250	5,000	6,250	
- Quelim. Training Superv.	-0-	-0-	7,000	7,000	
- Quelim. Secretary	-0-	800	3,200	4,000	
- Baltimore Support	-0-	15,000	15,000	30,000	
B. Travel					88,424
- Int'l Epidem.	5,000	-0-	6,000	11,000	
- Int'l Consultants (3-3-3)	15,000	18,000	8,000	51,000	
- Per Diem Consultants (3-3-3)	7,308	7,308	7,308	21,924	
- Local Epidem.	-0-	900	1,080	1,980	
- Local Consultants (3-3-3)	450	450	540	1,440	
- Local Maputo Admin. Asst.	-0-	-0-	1,080	1,080	
C. Training Support					27,800
- Materials	-0-	5,000	12,000	17,000	
- Per Diem	-0-	-0-	10,800	10,800	
D. Miscellaneous					20,500
- Communic., Postage, Teleph.	2,000	8,000	10,000	20,000	
- Office Rental and Support	-0-	1,000	6,500	7,500	
- Allowances, Storage	-0-	6,000	6,000	12,000	
E. Overhead (30% of above)	13,301	42,237	60,026	115,564	115,564
II. AIR TRAVEL COMPANY	-0-	-0-	83,200	83,200	83,200
III. MEDECINS SANS FRONTIERES					65,067
A. Long Term Staff	13,000	9,391	-0-	22,391	
B. Short-term TA	-0-	8,060	-0-	8,060	
C. Air Travel	14,000	20,616	-0-	34,616	
IV. USAID					150,955
A. Commodities					
- Vehicle and Maintenance	-0-	25,000	5,000	30,000	
- Computer Equipment	-0-	14,000	-0-	14,000	
- Medical Supplies/Vitamin A	-0-	3,000	-0-	3,000	
B. Project Management	10,000	16,000	9,000	35,000	
C. Evaluation	-0-	-0-	15,000	15,000	
D. Project Contingency	-0-	-0-	13,955	13,955	
TOTAL	94,639	279,092	426,269	800,000	800,000

ANNEX D

SUPPLEMENTAL INSTITUTIONAL ANALYSIS

Introduction

This analysis describes the activities of the Centro de Reciclagem (CR) in Quelimane who, under this PP supplement, assumes a more direct role in Project implementation. The information within this annex supplements, and does not replace, the administrative analysis provided within the original Project Paper. Rather, this annex provides a description of the history and general organization of the Centro de Reciclagem, an analysis of the district-level training courses offered at the center, and the capacity of the center to undertake the additional project activities described within this PP Supplement.

History of the Centro de Reciclagem

The Centro de Reciclagem is an in-service training institution located within the Provincial Directorate of Health of Zambezia Province. Unlike other Ministry of Health training institutions, the Center does not train new Ministry staff, but instead upgrades the skills of existing employees in Zambezia Province through refresher training in technical and administrative areas.

The Center was established in 1986 with assistance from Save the Children Fund (U.K.) who provided funding for the construction of the facility in Quelimane and technical assistance in designing and implementing in-service training courses. At that time, most of the courses were conducted by expatriate SCF staff with limited assistance from Mozambican staff based in the province. Initially, the CR offered courses in administration, epidemiology, health information systems, and MCH technologies (EPI, CDD, malaria, nutrition, family planning, pregnancy, AIDS, etc) for provincial and district heads. The courses, conducted in Quelimane, were generally of 1-3 weeks in duration and were highly didactic in approach. As the center and the courses evolved, more practical and participatory approaches in teaching were incorporated into the curriculum.

In 1988, localization of CR staff was initiated with the assignment of three Mozambicans in the posts of director and administrative staff. Unfortunately, the positions of monitors (instructors) continue to be held by SCF-funded expatriates due to difficulties by the Ministry of Health in establishing new posts for non-clinical teaching personnel. Neither SCF nor the MOH know when these posts will be established so that Mozambicans can fill the positions of instructors.

In 1989, the CR began emphasizing district level training in addition to the courses offered in Quelimane. The rationale for this shift was based on the need to expand coverage of the refresher training to lower level personnel in the environment in which they worked. Many of the students who earlier attended CR courses in Quelimane were unsuccessful in incorporating their new skills into daily clinical and administrative routines. Furthermore, these former students lacked the necessary "training" skills to extend their new skills to their colleagues in the district. Consequently, the CR developed a district-level training course to strengthen the skills of former students and their colleagues alike.

The district-level courses utilize the former CR students as trainers for their own staff within the district. The emphasis is on MCH and community level education. A more elaborate discussion of the course is found in the following section.

USAID/Mozambique has local language copies of the overview of the center and its general functions (as of August 1990). In summary, the CR currently teaches clinical, administrative, and educational skills for provincial, district, and local health staff. Planning, implementation, and evaluation skills are also taught for each of the three skills areas. An organizational chart for the Center is also in Figure 1.

District Level Training Courses

The five day district-level training courses are designed to accomplish two objectives: (1) teach the former participants of CR courses how to teach (on a regular basis and on-the-job) their colleagues in the districts; and (2) give refresher public health and MCH training to these "colleagues".

The curriculum of the district-level health course focuses on birth spacing, growth monitoring, ARI, safe motherhood, hygiene, maternal nutrition, diarrhea, malaria, AIDS and sexually transmitted diseases. Because of the "refresher" nature of the training courses, many topics are covered in a relatively short period of time. Three types of persons are involved in these courses: students, teachers, and monitors.

The "STUDENTS" of these courses are generally district-level health staff (nurses, tecnicos, etc.) who have not previously attended courses at the CR or they are auxiliary health personnel, such as community health workers or preventive medical agents. These individuals generally received limited training more than 4 years ago, and have not had an opportunity to upgrade or refresh their skills. Some of these staff actually manage remote health posts within the district, others are auxiliary staff within the district capital health center

or health post. Many of these students, especially the community health workers, have limited literacy skills. The course thus is designed to utilize more verbal instruction, active participation, hands-on practice sessions, and pictorial graphic materials rather than wordy technical manuals, reading, and lectures. The training course is designed to rely heavily on the use of the UNICEF "Facts of Life" brochure, as it provides good pictorial reminders of critical MCH interventions (such as pre-natal care, breastfeeding, child feeding, ORT, EPI, ARI, sanitation, and growth monitoring).

The "TEACHERS" (or trainers) of the course are those district staff who previously attended a course at the CR in Quelimane. These are usually more educated and skilled MCH nurses, basic level nurses, or district health administrators. Because of their higher level training and their earlier opportunity to refresh these skills through the Center in Quelimane, these individuals possess relatively good technical skills in MCH and preventive health. They lack, however, the necessary teaching skills to pass this information on to their colleagues (the students described above). The first day of the district level training course, therefore, is designed to provide these persons with teaching skills (through a training of trainers (TOT) session) prior to commencing the course itself with the students. It is these "teachers" themselves who actually conduct the district-level training courses with the guidance of the monitors.

The "MONITORS" are the instructors and staff from the CR in Quelimane. These individuals travel to the district to organize and guide the district level training. These are the same CR staff indicated in the organizational chart in Figure 1. An instructor from the Institute of Health (the pre-service training school in Quelimane) often participates in these training sessions as well. The monitors' primary responsibility is to provide the "teachers" with teaching and educational skills, and to monitor and guide their implementation of the district-level course. The monitors also provide administrative support for organizing the district level training course.

Throughout the district level training session, "learning-by-doing" principles apply. While the trainers gain limited teaching skills during the first day seminar, they only really develop these skills by actually conducting the training course itself. For the students, the course's emphasis on practice and participation develops their skills for better service delivery in MCH and preventive care.

Six weeks following the course, the monitors from the district level course return to the district to conduct a follow-up supervisory visit. The focus of this visit is to assess how well the students and trainers are utilizing their new clinical and teaching skills, and to identify weaknesses in the delivery

of MCH services and education to the general public. Aside from this one visit, the CR monitors from Quelimane do not undertake any further follow-up of the district level training.

Formal evaluation data for these district level training courses does not exist. Anecdotal information indicates that the courses are quite successful in facilitating improved services and better coverage, but limited data is not available to support this. According to the Provincial Director of Health in Zambezia, however, other provinces have expressed interest in replicating the CR model for continued education in their provinces. The Ministry of Health in Maputo has also expressed its interest in expanding the CR model throughout the nation.

Relationship of CR Activities to Overall Project

Technically, the approach of the district level training course is sound and consistent with the objectives and priorities within the Pilot Child Survival Project. The emphasis on MCH services, participatory learning techniques, and regular on-the-job training corresponds to the project's central purpose of improving clinic services in the rural areas.

As noted within this supplemental PP, regular, on-the-job training is identified as a critical intervention for improvement of MCH services in Zambezia Province. The project could not, however, utilize Quelimane based supervisors for this purpose and so the district level training course is promoted as a mechanism to promote on-the-job training through the staff in the districts themselves. The training activities of the Centro de Reciclagem adequately address this need in a technical sense - i.e. the curriculum is designed to strengthen those MCH and preventive services which will attack the most prevalent health problems in rural Zambezia. The "teachers are given skills to promote on-the-job training for these MCH areas.

One technical constraint, however, is the lack of good evaluation data for measuring effectiveness of the training courses. Under this project, the incorporation of the supervisor's checklist into the follow-up visits in addition to improved HIS information will assist in obtaining regular data on the impact of the training sessions.

Operationally, there is also a need for more frequent and intensive supervisory follow-up from Quelimane. One follow-up visit is insufficient to assess whether the training investment in skills development indeed translates to improved services. The CR, however, lacks sufficient capacity to conduct more than six district level training courses per year (and six follow-up visits) due to limited resources for air travel, materials development, and staff. The Center does not know, at this

point in time, whether the initial improvements in service delivery are sustained beyond the six-week period between the course and the supervisory visit.

To address these constraints, the project supports additional staff, funding for materials development, and funding for transportation to the pilot districts. With these resources, the CR should have adequate capacity to conduct additional district level training courses in the project's pilot areas, and to incorporate a more comprehensive and regular evaluation and monitoring system of program effectiveness and needs.

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