XD-ABK-785-A

# THE FINAL EVALUATION OF THE PILOT CHILD SURVIVAL PROJECT

(Project No.: 656-0207)

Submitted to: Mary Pat Selvaggio
HPN Officer
USAID/Mozambique

Submitted by: Devres, Inc.
7201 Wisconsin Avenue
Suite 500
Bethesda, MD 20814
Phone: 301-951-5546
Cable: DEVRES, WASHINGTON
Telex: 440184 DEVR-UI
Fax: 301-652-5934

Contract No.: PDC-5929-I-04-1116-00

September 30, 1992

.9

## LIST OF ACRONYMS AND ABBREVIATIONS

| | |
|---|---|
| APE | Agente Polivalente Elementar (Multipurpose Community Health Worker) |
| CHW | Community Health Worker |
| CR | Centro de Reciclagem (Re-training Center - part of DPS/Z) |
| DPS/Z | Direccao Provincial de Saude/Zambezia (Provincial Health Office/Zambezia) |
| EOPS | End of Project Status |
| GR | Government of the Republic of Mozambique |
| HIS | Health Information Systems |
| HP | Health, Population, Nutrition |
| JHU/IIP | Johns Hopkins University/Institute for International Programs |
| LOP | Length of Project |
| MCH | Maternal-Child Health |
| MOH | Ministry of Health (refers to MOH at all levels) |
| MOH-Maputo | Ministry of Health - Central Office in Maputo |
| MOU | Memorandum of Understanding |
| MSF | Medecins san Frontier |
| NEP | Nucleo de Estatistica e Planificacao (Statistics and Planning Office) |
| NGO | Non-Governmental Organization |
| PRICOR | Primary Care Operations Research |
| PP | Project Paper |
| PVO | Private Voluntary Organization |
| RSC | Reparticao de Saude de Comunidade (Community Health Section) |
| SCF(UK) | Save the Children Fund (UK) |
| SMI | Saude Maternal-Infantil (Maternal-Child Health) |
| SOW | Scope of Work |
| TA | Technical assistance |
| TOT | Training of trainers |
| UEM | University of Eduardo Mondlane |
| UNICEF | United Nations Childrens Fund |
| USAID | United States Agency for International Development |
| USD | United States Dollar(s) |
| ZCSP | Zambezia Child Survival Project (also same as Zambezia Pilot Child Survival Project and Mozambique Pilot Child Survival Project) |



- 10

## INTERVIEWS CONDUCTED

### MAPUTO

**Ministry of Health**

Dr. Leonardo Simao, Minister of Health
Dr. Abdul Razak Normohammed, Director of Planning
Dr. Antonio Fernandez, Director of Epidemiology
Dr. Rui Gama Vaz, Director, National Health Institute
Dr. Humberto Cossa, Former Provincial Health Director, Zambezia (interview in Seattle, WA)
Dr. Jorge Cabral, UEM Medical School
Dr. Julie Cliff, UEM Medical School
Sr. Antonio Vasco Sitoi, Department of Planning
Ms. Angela Brown, Advisor, Department of Planning
Dr. Carol Marshall, Formerly Advisor, Maternal Child Health

**USAID**

Mr. Jack Miller, Deputy Director, USAID Mission/Mozambique
Ms. Mary Pat Selvaggio, HPN Officer
Mr. Charles North, Evaluation Officer
Mr. Sidney Bliss, Project Development Officer

**AirServ**

Mr. David Talbot, Pilot
Ms. Barbara Kuyper, Accountant

**World Vision**

Dennis Hanneman, Former Mozambique World Vision Officer (Telephone interview from Los Angeles)

ZAMBEZIA PROVINCE-QUELIMANE CITY

**DPS (Provincial Health Office)**

Dr. Diogo Domingos, Provincial Health Director, Zambezia
Dr. Nazir, Director, Zambezia Provincial Hospital, Acting Medical Chief, Zambezia Province
Sr. Agosto Marquesa, Director, Statistics and Planning(NEP), Acting Health Director, Zambezia Province
Sr. Joao Ausse, Director, Community Health
Sr. Alfredo da Costa Azevedo, Preventive Medicine Tecnico, Provincial EPI head
Sra. Antonia Magalhaes, Provincial MCH head
Sra. Manuela, Provincial Nutrition head
Sra. Gracinda Rosa Abre, Preventive Medicine Agente, Hygiene, and Water laboratory
Dr. Pravin Dubey, Ophthalmologist
Mr. Andrew Swederske (NEP advisor)

**Centro de Reciclagem - DPS**

Sr. Rosario Cosmo, Monitor, Acting head
Sra. Lizete Lechere, Public health nurse
Mr. Mark Beesley, Nurse monitor, SCF(UK)
Sra. Mariamo Paulo Aboobakar, Basic Nurse, USAID local hire
Sr. Luis Matagere, Basic Nurse, USAID local hire

**Zambezia Child Survival Project**

Ms. Mariolina Migliorini, Project Administrative Assistant

ZAMBEZIA PROVINCE-RURAL DISTRICTS

**Milange District**

Sr. Andre Manuel, District Health Director
Sra. Emilia Francisco, MCH Nurse
Sr. Gabriel Aston, Activista
Sr. Armando Raimundo, Activista
Sr. Bernardo Mafaite, Activista



-12'

**Gurue District**

Sr. Luis Almazia Nacarria, Medicine Tecnico, District Health Director
Sr. Jorge Fernandez, Preventive Medicine Agente, Community Health Head
Sra. Catarina Raul Paulino, MCH Nurse
Sra. Celestina Pedro, Basic Nurse
Sr. Inacio Mesa, Preventive Medicine Agente
Sr. Silva Alfredo, Nurse
Sra. Catarina Rocha, Servente
Sr. Castro Julio, Elementary Nurse (Invinha Health Center)
Sra. Sofia Marquesa Alvaro, Elementary Midwife (Invinha Health Center)

**Alto Molocue District**

Sr. Cesar Agosto Milange, District Health Director
Sr. Tome Sande, Community Health head

**Mocuba District**

Sr. Carlos Domingos, District Health Director
Sr. Florencio Armando Andre, Community Health head
Sr. Jose Pedro, Chief Nurse
Dr. Graciela (MSF) with entire MSF team
Sr. Daniel Ernesto, Elementary Nurse, Bive Health Post
Sr. Joaquim Fernando, Activista, Bive
Sr. Ze Farinho Goneliwa, Activista, Bive
Sr. Antonio Jequeira, helper, Bive
Sr. Orlando Socovinha, Activista, Bive

**Lugela District**

Sr. Jose Ecuacua, Head Nurse, Namagoa Health Center
Sr. Ernesto Picareia Tupias, Preventive Medicine Agente, Namagoa
Sra. Joaquina Paulo, Elementary Midwife, Namagoa
Sr. Batista Joao Matara, Activista (MSF), Namagoa
Sr. Descova Mendesso Tomodo, Activista (MSF), Namagoa
MSF nutrition team

**Nicoadala District**

Sr. Martins Miranda Namucua, District Health Director



13

**Johns Hopkins University/IIP** (all by telephone)

Mr. C.W."Chip" Oliver, MPH, ZCSP Epidemiologist
Mr. Paul Seaton, Associate Director, IIP
Dr. Chris Kjolhede, Project Coordinator, ZCSP
Dr. Gilbert Burnham, Consultant
Dr. Hubert Allen, Consultant
Dr. Thelma Leifert, Consultant



14

TABLE OF CONTENTS

ACRONYMS AND ABBREVIATIONS . . . . . i

INTERVIEWS CONDUCTED . . . . . iii

TABLE OF CONTENTS . . . . . vii

EXECUTIVE SUMMARY . . . . . xi

I. INTRODUCTION . . . . . 1

A. Background . . . . . 1

B. Methodology . . . . . 2

C. Project Background . . . . . 2

D. Project Chronology . . . . . 3

II. PROJECT EFFICIENCY AND EFFECTIVENESS . . . . . 7

A. Adequacy of Inputs . . . . . 7

1. MSF . . . . . 7

2. JHU . . . . . 7

a. Long-Term Epidemiologist . . . . . 7

b. Short-Term Consultants . . . . . 8

c. Administrative and Logistics . . . . . 8

d. Training and Supervision . . . . . 9

3. AIRSERV . . . . . 9

4. USAID . . . . . 9

a. Project Management . . . . . 9



16

b. Evaluation/Audit . . . . . 9

c. Commodities . . . . . 10

5. MOH - DPS/Z . . . . . 10

a. Personnel . . . . . 10

b. Transport . . . . . 11

c. Logistics and Administrative . . . . . 11

d. Commodities . . . . . 11

B. Implementation . . . . . 11

1. MSF . . . . . 11

2. JHU . . . . . 12

3. USAID . . . . . 14

4. MOH - DPS/Z . . . . . 14

C. Outputs . . . . . 15

1. Epidemiology/HIS strengthening . . . . . 15

a. Background . . . . . 15

b. Other HIS Activities . . . . . 17

2. Supervision . . . . . 17

a. Background . . . . . 17

3. Training . . . . . 18

a. Background . . . . . 19

D. Effects . . . . . 20

1. HIS . . . . . 20



16

2. Supervision . . . . . 20

3. Training . . . . . 20

4. Other . . . . . 21

E. Sustainability . . . . . 21

III. PROJECT IMPACT . . . . . 23

A. Operations Research Approach . . . . . 23

B. Delivery of Health Services . . . . . 23

C. Community Development/Involvement . . . . . 23

D. Institutional Strengthening . . . . . 24

IV. GENERAL FINDINGS . . . . . 25

V. LESSONS LEARNED . . . . . 27

ANNEXES

1. SOW for Evaluation . . . . . 1-1

2. Project Chronology . . . . . 2-1



17

# EXECUTIVE SUMMARY

## I. Purpose

The purpose of this outside evaluation is to take stock of the Zambezia Pilot Child Survival Project (ZCSP), to learn lessons from its planning, implementation, and outcomes, and to make recommendations for future projects in Mozambique.

The specific objectives of the evaluation are:

- Review the appropriateness, timeliness, and quality of all project and host country inputs (personnel, commodities, and financing) and to provide a descriptive analysis of project status relative to the inputs provided.

- Review project outputs and quantify progress made toward achieving outputs. Provide a detailed explanation of those areas where project outputs have been met or have not been met over the LOP.

- Review the project purpose and EOPS and assess the extent to which project inputs and outputs have, or have not, led to the achievement of the purpose and EOPS.

The evaluation team was comprised of two outside consultants. An official of the District Health Office of Zambezia (DPS/Z) was asked by the outside evaluators to join the team during the site visits in Zambezia province. No other MOH staff participated. There was no participation by Johns Hopkins University (JHU) and USAID.

Because of a major revision in the project after the first year, a replanning session was substituted for the originally planned mid-term evaluation. The team arrived in Mozambique when many of the principal participants in the project had already left.

## II. Project Summary

The Zambezia Pilot Child Survival Project (ZCSP) was designed to help the Government of Mozambique (GRM) find cost-effective ways to expand the coverage of child survival interventions. The stated purpose of the project was "to develop and test, under insurgency conditions, replicable and cost-effective measures to reduce infant and child morbidity and mortality." The project called for a focus on district level training, enhanced supervision, and special studies/research to accomplish the following outputs:

- Complete, accurate, timely, and relevant data collection, reporting, and analysis to be accomplished through simplification and strengthening of district Health Information Systems (HIS) functions, and to some extent, the provincial HIS.

- Regular and adequate supervision of MCH services by MOH personnel through assistance in air travel from Quelimane to the districts for MOH Zambezia supervisory visits and follow-up of district training activities.

- On-going in-service training at the district level, using the Centro de Reciclagem to "test" newly developed guidelines in the target districts.

- Timely provision of vaccines, medicines, and supplies to help reduce shortages of materials and supplies at the clinic level. Transportation assistance would be provided. This output would complement better supervision and management facilitated by improved collection and accuracy of service data.

The project was obligated in June 1989 through a grant agreement with the GRM. Funds were allocated to JHU and MSF to assist the Provincial Health Directorate in Zambezia (DPS/Z) implement all project activities. In July 1990, MSF determined that it could not continue to be involved in the project. Consequently, the project was modified through the Project Supplement, signed January 1991, to transfer MSF's responsibilities for training and supervision to the DPS/Z, JHU, and AirServ, a local air charter service.

## III. Major Findings

The major findings reflect a positive support and strengthening of selected existing DPS/Z activities, but with a weak integration of overall project design and implementation into the ongoing activities of the MOH. In addition, unclear definition of responsibilities among contractors, especially regarding project management, hindered project implementation.

The following is a summary of inputs and the principal effects of the project:

### A. Inputs

The team reviewed the inputs by MSF, JHU, MOH, and USAID. Air transport was extremely helpful to mobilize and strengthen supervision and district-level training. The support of CR staff and per diems was also important to stimulate supervision and training.

MSF input was felt to be weak and poorly integrated from the outset of the project until MSF dropped out in July 1990. The poor Portuguese language ability and lack of integration of the principal JHU participant in the project made joint work with the MOH difficult. Delegation of administrative tasks to a Portuguese-speaking local hire improved the coordination and integration of project activities.

JHU inputs into the HIS were constrained by the poor integration of JHU with NEP on a provincial and national level. A MOU early in the project explicitly asked that the project refrain from HIS activities. Later, the MOH-Maputo requested that the project refrain from computer training that was not consistent with national policy. The community-based household

study was viewed as an independent effort on the part of the JHU epidemiologist. DPS/Z staff said that they had not seen written study results nearly two years after the completion of the first study (Mocuba). Oral presentations to the MOH and USAID were made near the end of the project.

JHU consultants were generally well-qualified although only two of seven consultants spoke Portuguese. The consultancies were planned with minimal MOH input and their work tended to be isolated and of marginal value in improving MOH structure and functioning.

Overall financing from USAID appeared adequate. JHU management of CR inputs was sporadic in the first year of the project and improved considerably in the second year. Some promised financial obligations were not paid: confusion between USAID and JHU continues to exist regarding responsibility for these bills.

B. Effects

1. HIS

The project effect in routine HIS was limited to non-existent. A well-designed baseline study was carried out in Mocuba and Quelimane; however, the staff of the DPS/Z perceived little ownership of the study and the results did not get to the MOH-Maputo or DPS/Z in an effective or timely manner. Overall, the impact of project activities in HIS may actually have been negative. DPS/Z staff were confused by competing systems and time was wasted training in computer training which was not ultimately used.

2. Supervision

The project activities in supervision supported existing priorities and strengthened the program through air travel and per diem support. Overall, province-to-district supervision activities substantially increased over the life of the project, and the evaluators feel that supervision improved morale in the districts. Project technical assistance directed at improving the supervision check-lists was felt by most staff to have marginally helped improve the system. Unfortunately, the late payment of per diems at the beginning of the project, and the unfulfilled promises of per diem payment at the end of the project left a negative impression among DPS/Z staff regarding the overall effect of ZCSP support in supervision.

3. Training

The support of the CR was well placed: it effectively encouraged district-level training provided by the CR. Whether district-level training as such, or the training of activistas was a priority for the CR is not clear. Most of the activistas interviewed had been trained previously one or more times by the MOH or the Mozambican Red Cross. Project-trained activistas were found working in markedly different roles. Some were carrying out clinical activities, others working in community public health promotion, and others mixing the two roles.



20

Whether the training was appropriate to their background and post-training work was not clear to the evaluators.

4. Timely Provision of Commodities

Commodities were ordered late in the project and slow in arriving. The make of vehicle was not felt appropriate for optimal maintenance.

5. Informational Services

Another important effect of the project was the provision of information to JHU and USAID regarding the functioning of the Mozambican health care system. Initially, the MOH and DPS/Z staff perceived that USAID and the ZCSP staff had underestimated the capacity and functioning of the Mozambican system. In the wake of the project, Mozambicans and ZCSP staff agreed that the latter had gained an increased appreciation for the work and achievements of the health system in the context of the obstacles it faces.

## IV. Lessons Learned and Recommendations

**Lesson One:** Care must be taken not to underestimate the capacity of MOH leadership, staffing, or services. Insufficient knowledge of, or regard for, the plans, policies, and context of on-going host country programs leads to serious problems during implementation. The caliber of leadership in Mozambique is high. Most Senior officials are technically competent and know the major problems of their institutions. They also know what is susceptible to change and what is not. In this context they have to juggle the proposals of many donors.

> **Recommendation: The Mission can avoid many of the problems experienced on this project by a country-oriented analysis which incorporates key officials at several levels to sort out critical problems amenable to change. This in itself is a contribution to country development. The Mission then can look at its own country strategy and performance indicators and find a fit that is mutually acceptable. This process builds respect and a relationship that pays off in crisis situations.**

**Lesson Two:** Project activities should be planned and implemented jointly with Mozambicans at all levels. Jointness in strategies, work plans, and activities is difficult to achieve, particularly in Mozambique with absences, staff changes and heavy demands on decision makers. However, without jointness the opportunities for misunderstanding and misuse of technical assistance are significantly multiplied.

> **Recommendation: For many reasons MOH institutions may sign off on activities which are not totally compatible with their policies. Technical advisers need to obtain commitment of key participants to broader objectives and then challenge and assist them at each level to find innovative steps that will lead in that direction. The**

**expatriate role is to help focus the problem and provide perspective in the search for solutions which are jointly discovered.**

**Lesson Three**: Contractors must be competent and sensitive to project goals and existing government policies. The careful selection of contractors and collaborators matched to the objectives of the project is critical to both effective implementation and achievement of objectives.

> **Recommendation: A joint examination of both cooperating agencies and contractors should be undertaken prior to determining responsibilities and relationships for implementation.**

**Lesson Four**: Avoid emphasizing short-term, measurable goals over long-term process goals. Although focusing on easily measurable outcomes instead of process can provide initial indicators of progress, longer term objectives of institutional strengthening are sometimes sacrificed.

> **Recommendation: Specifically measurable performance indicators should be buttressed with broader long-term human and organizational development objectives whose progress can be measured by successive milestones.**

**Lesson Five**: Clarify SOWs of participating parties. Lack of a clear understanding of the specific objectives and responsibilities of each party to the project leads to both misunderstanding and ineffective project implementation. The diverse of objectives of MSF, JHU, DPS, MOH, and USAID were never constructively examined with a view to defining project responsibilities.

> **Recommendation: Broad objectives can be vague in order to broaden support; however, specific objectives have to be discussed openly so that everyone is clear from the beginning on their roles and responsibilities. There are many ways to bring together all participants at an early stage to obtain agreement on relationships and responsibilities.**

**Lesson Six**: Select and hire personnel who are competent to work with national staff. Lack of preparation of key personnel, particularly in Portuguese proficiency and understanding the formal and informal operations of institutional structures, severely hampers the project implementation.

> **Recommendation: Project coordinators in Mozambique should have functional Portuguese and management experience in addition to their technical capacity. They have to develop a detailed understanding of the policies and procedures of the host country institutions. They should be able to move easily within the institutional hierarchy and develop collegial relationships with a broad range host country personnel. This allows them to jointly plan technical inputs to meet institutional needs.**



22

**Lesson Seven**: Long-term technical advisors, cooperantes, who work directly within the health structure are often more effective than personnel loosely connected to health structures. Cooperantes can develop credibility and influence the changes envisioned by the project. They can also improve the relationships among the cooperating agencies.

> **Recommendation: Project staffing plans should include people who work within the structure of country organizations. They should be key elements in the ongoing implementation planning.**

**Lesson Eight**: Small negative effects (e.g., personality conflicts, misunderstandings, perceived commitments which are unfulfilled) can so color the project as to obscure the positive benefits that occur.

> **Recommendation: In Mozambique responsible officials of participating agencies should touch base with each of the different parties in a project on a regular basis for short discussions on the process variables and the personal relationships. Reports rarely provide clues to minor but potentially significant problems.**

**Lesson Nine**: Communication regarding project plans and activities among MOH officials in different sections or levels of responsibility is sometimes haphazard. Frequent absences of critical officials add to communication difficulties. Resulting gaps in communication often undermine the integration of project plans and activities with MOH priorities as well as the overall perception of the project by DPS/Z staff.

> **Recommendation: Project staff should make great efforts to insure that all appropriate MOH officials are appraised of project status and plans. Sending written documents is necessary but not always sufficient; personal and informal approaches to communication complement formal ones.**

**Lesson Ten**: In conditions of insurgency one of the most difficult problems is isolation of field workers. Morale and motivation of field staff are improved by supervision and training visits which bring central and local officials together.

> **Recommendation: USAID in Mozambique should continue to encourage special efforts to either visit or bring in field workers where they can share experiences, received training, resolve technical or administrative problems, and receive assistance. All of these activities build morale.**

**Lesson Eleven**: Working with a strong and effective organization (e.g., the Centro De Reciclagem) with consonant objectives can significantly increase implementation capacity and contribute to project sustainability.

> **Recommendation: USAID Mozambique should build on its successful efforts demonstrated in this case to promote the participation of other organizations already**

**functioning that can be incorporated in to the process of achieving project objectives in both the project development stage and during implementation.**

Lesson Twelve: Sustainability is critically influenced by the way the latter stages of the project are handled. In Mozambique lack of effective communication and planning for the turnover of projects dooms even well designed projects to gradual extinction.

**Recommendation: Particularly in a short-term institutional strengthening effort such as this one, a special review, including all project participants, should take place in the later stages of the project. At this review the participants should assess the status of project and its sustainability potential and requirements. The review could provide a strategy for gradual and effective transition of the project into and ongoing national activity. Jointness throughout the project stages also can have a major influence.**



24

# I. INTRODUCTION

The purpose of the Mozambique (Zambezia) Pilot Child Survival Project (ZCSP) was to develop and test, under insurgency conditions, replicable and cost-effective measures to reduce infant and child morbidity and mortality. The original project paper included four components: 1) initial baseline assessment, 2) operations research on diarrhea management, growth monitoring, immunizations, and vitamin A deficiency, 3) improved health information systems (HIS), and 4) logistic support and limited commodities. Implementing organizations were Medicine Sans Frontieres (MSF), Johns Hopkins University (JHU), and USAID/Maputo.

A supplemental project paper was written at the end of year one, after MSF dropped out of the project. Project activities were revised to focus on 1) strengthening of district and provincial HIS, 2) district-level supervision of Maternal Child Health (MCH) services, 3) district-level training, and 4) limited provision of transportation and commodities. The overall budget remained the same, with responsibilities shifting from MSF to JHU and AirServ.

The scope of work for this evaluation focuses on the performance of the project subsequent to the MSF withdrawal from the project.

## A. Background of the Evaluation

The specific objectives of the evaluation are the following:

- Review the appropriateness, timeliness, and quality of all project and host country inputs (personnel, commodities, and financing) and to provide a descriptive analysis of project status relative to the inputs provided;

- Review project outputs and quantify progress made toward achieving outputs. Provide a detailed explanation of those areas where project outputs have been met or have not been met over the LOP;

- Review the project purpose and EOPS and assess the extent to which project inputs and outputs have, or have not, led to the achievement of the purpose and EOPS.

This final evaluation is the first formal evaluation of the ZCSP. The original project proposal envisioned a mid-term evaluation toward the end of 1990 and a final evaluation toward the end of 1991. However, the first task force meeting of the project was not held until June of 1990--one year after project approval. At that meeting, the major contractor withdrew from the project. The meeting in lieu of the mid-term evaluation was only attended by the USAID and donor contract staff and focused on future implementation options available. It was not a formal review of project progress. As a result, the evaluation team had a limited base of information and experience to evaluate the first year of the project.



25

The new supplemental project paper was signed in January 1991 and is the principal basis for this evaluation. Under the new project supplement a final external evaluation was planned between July and September 1991 with the explicit participation of the Ministry of Health (MOH) and JHU. The evaluation was to be arranged by USAID. The scope of work for the final project evaluation (Appendix 1) had already been designed. The evaluation was delayed by factors which included a delay in the start-up from February to late March at the Mission's request because the project's administrative assistant went to Italy due to a family illness, contract negotiations, resignation of an original member of the team, and the illness of another member. The evaluation took place in April and May 1992.

Since many of the major participants in the project were in the United States as the time of the evaluation, the evaluation team obtained agreement from Devres and USAID to provide USAID with a preliminary report and a presentation after two and one-half weeks of site visits in Mozambique and then to prepare a final report after more interviews with project participants now in the US. This draft of the final evaluation was written after interviews with project participants from JHU and agencies.

## B. Methodology

The evaluation team consisted of two fluent Portuguese-speaking evaluators: one with ten years experience working in Mozambique and the other with thirty years experience in developing countries.

Sources of evaluation information included document reviews, site visits, observation of ongoing activities, and key informant interviews. Site visits and observations included one week in Zambezia Province. Visits to four of the project's target districts were made. Wherever possible the evaluators orally presented their points of view and those of all other project participants in order to gain insight and perspective. This process was hampered by geography and timing. Nevertheless, the evaluators eventually spoke to all the participants at JHU after leaving Mozambique.

Although the MOH did not formally participate in the evaluation, the team incorporated a senior member of the DPS/Z as a team member during field trips and discussions while in Zambezia. However, no provision was made for him to come to Maputo to work on the report with us.

## C. Project Background

The project had a variety of roots. The Mission responded to a request by MOH through the American Ambassador to investigate eye disease and associated health conditions in Zambezia. There were no USAID health projects in Mozambique at the time. Senior MOH officials were acutely aware of the need to set priorities and to reinforce and expand coverage of maternal and child health care. In addition, Child Survival is an earmarked part of the Foreign



26

Assistance Act. Therefore, when USAID came forward with a Child Survival project for the Province of Zambezia, there was a clear basis for common interest.

Medicins sans Frontieres (MSF)-France was selected as the principal participant during the development of the project. The selection of MSF was apparently based on the USAID Mission Program Officer's belief in the importance of action-oriented activities and his personal relationships with MSF officials. The MOH had no role in the selection of MSF nor in the later selection of JHU as a project participant.

D. Chronology of the Project

The original project proposal was approved on June 30, 1989. The agreement with JHU was completed on October 11, 1989. The agreement with MSF was not completed until December 29, 1989 because of the delay in registering MSF with AID. (Appendix No. 3 summarizes the chronology of project activities in graphic form.)

During the early period between the project approval and the end of 1989, a consultancy by Chris Kjolhede, JHU Project Coordinator, and Elizabeth Gundy in August resulted in an initial work plan and recommendations about program operations. In another JHU consultancy in October, Linda Perez studied and reported on the health services and organizations. Apparently there was also an MSF consultant during this period.

Charles W. "Chip" Oliver, the JHU Epidemiologist, arrived in Mozambique at the end of January 1990. New work plans were developed with MSF. The MSF Project Coordinator and Mr. Oliver prepared a simplified version of the work plan which was translated into Portuguese and discussed with all parties. Planning for the baseline survey started in February. In March, Dr. Cossa, Mr. Oliver, and representatives from MSF and SCF(UK) signed an agreement which stated that project personnel would not participate in health information systems (HIS) work unless specifically asked to do so. The first survey was carried out in Mocuba during June of 1990.

At the first task force meeting on June 21, 1990 problems between USAID, JHU, and MSF resulted in serious differences of opinion regarding responsibilities for the project. At a subsequent meeting the next day between USAID and MSF, MSF withdrew from the project.

MSF reports indicate that they found the project incompatible with their basic operational objectives of emergency assistance and that their responsibilities had not been carefully defined. Particular issues included the extent of the support expected by MSF for Oliver, the role of MSF in training, the logistic support budgets, and several technical issues which had not been properly addressed. They also complained of "ultimatums" from USAID staff.

USAID's position was that MSF was not living up to its contractual obligations and was not involved in developing or supporting MOH child survival programs. Informally there appears to have been considerable non-cooperation by MSF staff with both the MSF Project Coordinator



27

and other ZCSP project staff. One important factor may be that MSF is a short-term volunteer organization and as such has a quite different management approach.

Thelma Leifert, a JHU training consultant, arrived just before these events took place. Although the departure of MSF required a change in her scope of work, she developed and tested a training manual in Gurue which was provided to the Centro de Reciclagem (CR).

On August 6 a project team which included USAID staff and Mr. Oliver met to consider an options paper developed by the Project Monitor. The Provincial Director of Health, Dr. Humberto Cossa, sent a letter in mid-August supporting the continuation of the project and suggested it be under the direct auspices of the Provincial Health Office (Direccao Provincial de Saude de Zambezia, DPS/Z). The new Project Paper Supplement was signed on January 7, 1991.

Meanwhile, the July-December hiatus is reported to have created many problems for all participants. The supporting assistance of the project coordinator was terminated and the transport for provincial supervisors and training staff was significantly reduced. However, Oliver was able to continue his data entry and preliminary analysis which was completed in September 1990.

While the objectives, EOPS and outputs were not changed, the PP supplement modified the original PP to:

- Transfer some of the responsibilities and financial support to the DPS/Z with consulting support;
- Support the expansion of the Centro de Reciclagem's field training;
- Finance transport for supervision and training through AirServ, a local charter aircraft service;
- Transfer the overall field coordination for project implementation to JHU; and
- Support JHU's increased responsibilities with additional local staff.

Beginning in January 1991 there was a significant increase in the number of field visits supported by AirServ. Mr. Oliver participated in discussions on supervision and proposed the testing of a PRICOR supervision document along with the MOH supervision checklist that had been developed by the DPS/Z. He also developed some other forms that were requested.

The Centro de Reciclagem, buttressed by project-supported personnel and financial support, intensified its field activities through district training seminars, practical training sessions, and supervision of residency activities, as well as their follow-up evaluation activities. Mr. Oliver expanded his survey activities with additional studies in the peri-urban areas around Quelimane. The project also increased its target districts from four to ten.

Also, in January 1991 Hubert Allen, a consultant from JHU, set up new computerized health information systems (HIS) at the DPS/Z and trained some local people in their use. He was followed up by Keith Goshler, a locally hired computer expert to train members of the Provincial Statistics and Planning Office (Nucleo de Estatisticas e Planificacao, NEP) in the use of computers.

In March, Mariolina Migliorini was hired as an Administrative Assistant to Mr. Oliver. She prepared flight schedules, provided translation services, and assisted DPS/Z, Centro de Reciclagem, and JHU personnel in planning and logistical arrangements. In May 1991, Chris Kjolhede made a consulting visit during which he reviewed the progress of the project with DPS/Z and project participants and made recommendations for actions during the remainder of the project.

During the course of 1991 a new and much larger health project for Zambezia and Niassa Provinces was being designed by the USAID mission.

Hubert Allen returned in September and prepared a strategy paper on HIS that made a series of recommendations. Also in September Gilbert Burnham of JHU consulted on the supervision system.

Later in the fall, efforts were undertaken to extend Mr. Oliver's stay beyond December and to continue the financing of project activities to overlap with the new project. These efforts were unsuccessful, and Mr. Oliver departed in November. However, Ms. Migliorini planned to stay on until the end of the project in May 1992 at which time the air transport services were to be discontinued.

In November, just before he left Mozambique, Mr. Oliver made an oral presentation of his findings to both the DPS/Z and MOH.

## II. PROJECT EFFICIENCY AND EFFECTIVENESS

### A. Adequacy of Inputs

#### 1. MSF Inputs (Prior to Supplemental Project Paper)

It was difficult for the evaluation team to adequately assess the MSF inputs or project implementation since no MSF staff member who participated in ZCSP was available for interview. The information we obtained was derived from MSF project reports, interviews with MSF personnel with no direct experience with the ZCSP, interviews with non-MSF personnel who worked with MSF in the ZCSP, and project documents from the ZCSP in Quelimane and Maputo.

Input from MSF occurred only in the first year of the project. The input included full-time salary support for Dr. Angela Gago, one short-term consultancy about whom little information was available, and financial as well as logistic support for air transport. According to our varied sources, MSF input to ZCSP training and supervision activities was minimal. MSF had worked rather independently from the DPS/Z, was principally involved in emergency food distribution and curative activities, and its mode of operation did not substantially change with their involvement in the ZCSP.

Interviews with MOH officials indicate that MSF was well known as an organization focused on short-term emergency curative care. In addition, MSF's relations with the MOH were frequently strained by their tendency to operate independently. Early in the project Dr. Cossa, the provincial director, expressed his dissatisfaction with the operational methods of MSF and was assured of forthcoming changes. MSF documents suggest that the first MSF coordinator tried to modify the MSF approach. With a subsequent change of MSF leadership, these changes apparently did not happen.

#### 2. JHU INPUTS

##### a. Long-Term Epidemiologist

JHU presented five candidates for the long-term epidemiologist to the USAID mission. Mr. Oliver, a PhD candidate at the University of Hawaii, was selected for the post and funded as a JHU Child Survival Fellow. Mr. Oliver had previous experience as a Peace Corps Volunteer in Nigeria and had also worked in the Philippines.

Although he took a short course in Portuguese prior to the Zambezia assignment, Mr. Oliver never learned to speak Portuguese well. According to Dr. Cossa, because of language deficiencies, many of Mr. Oliver's meetings with the Community Health Section (Reparticao de Saude de Comunidade, RSC) and NEP had to include Dr. Cossa as translator. DPS/Z officials all commented that Mr. Oliver's lack of language proficiency created substantial obstacles to integration of Mr. Oliver's activities into DPS/Z programs. The DPS/Z staff to whom we spoke



30

said that they saw Mr. Oliver infrequently. Mr. Oliver's principal contact at the DPS/Z was Dr. Cossa.

b. Field Coordination

After MSF dropped out of the project, JHU assumed responsibility for field coordination for project implementation, according to the Supplemental Project Paper. Although the budget to JHU was increased by $38,000 to support the project epidemiologist, there remained some confusion about who was to manage the project.

c. Short-Term Consultants

The following short-term consultants participated in the ZCSP:

| Consultant | Dates | Output |
|---|---|---|
| Chris Kjolhede | 8/89 | Defined JHU role, SOWs |
| Elizabeth Gundy | 8/89 | SOW (with Kjolhede) |
| Linda Perez | 10/89 | Analysis of MOH programs |
| Thelma Leifert | 7/90 | Prepared, tested TOT manual |
| Hubert Allen | 1/91 | HIS, installed Epi-info |
| Keith Goshler | 2/91 | HIS computerization |
| Chris Kjolhede | 5/91 | Project review, recommendations |
| Hubert Allen | 9/91 | HIS strategy paper |
| Gilbert Burnham | 9/91 | Supervision system strategy |

All consultants were contracted by JHU. Only Thelma Leifert and Keith Goshler spoke Portuguese. Mr. Oliver did submit reports translated to Portuguese by project staff. Although Chris Kjolhede and Linda Perez spoke Spanish, DPS/Z staff stated they had difficulty communicating with all of the consultants except Leifert and Goschler.

Paul Seaton, Associate Director of JHU/Institute for International Programs (IIP), made a visit to the project in April 1990. He was not considered a consultant of the project. His visit was financed by JHU/IIP internal funds.

Evaluation of consultant's activities are covered in Part II, Sections B, C, and D.

d. Administrative and Logistics Assistance

JHU contracted with World Vision in Maputo to provide assistance with communication and project logistics. They also contracted Sandy Jackson, formerly with world Vision, from April through September, 1991, to help with project logistics.

In Quelimane, JHU hired a logistician and a secretary, both of whom were Mozambicans who spoke Portuguese and English. Both played a major role in Portuguese translation for Mr. Oliver. In March 1991 an expatriate administrative assistant, Mariolina Migliorini, was hired locally in Quelimane. She spoke fluent Portuguese and English. Ms. Migliorini was contracted to work until April 1992. JHU also hired workers to carry out the community survey, including Sr. Ernesto, who was a DPS/Z-NEP staff member.

e. Training and Supervision Support

In the second year of the project, JHU hired two nurses, Mariamo Paulo Aboobacar and Luis Mutequere Mulato, to work as training follow-up supervisors in the CR. They returned to their positions in the provincial hospital when project payment stopped in December 1991. Other project inputs included per diem payments for travel of CR trainers and RSC supervisors. JHU also arranged per diem payment of trainers and supervisors (see page 12).

T-shirts and bags were designed by CR staff and were ordered by the ZCSP in Maputo. They were delivered to the USAID mission in the fall of 1991 and had only partially been transported to the CR at the time of the evaluation (April 1992). At that time the supplier of the bags and T-shirts had not yet been paid. USAID and JHU disagreed whether they were to have been paid out of the commodities line item of USAID or from the JHU portion of the budget.

3. AirServ Inputs

The project signed an agreement with AirServ Mozambique to provide air transport to the project, most of which was designated for supervision and training flights. Scheduling was done by JHU staff (Oliver and Migliorini). The flights occurred as scheduled on a regular basis.

4. USAID Inputs

a. Project Management

Carol Lidsker was hired as an assistant project manager to Ms. Selvaggio to help coordinate the project in its first year. In the second year of the project, the USAID mission did not have a person explicitly responsible for project management. As HPN officer at the Mission, Ms. Selvaggio was involved with the development of other projects during this time. JHU staff complained that USAID management was poor in the second year of the project. However, it was not clear to the evaluation team whether JHU or USAID was ultimately responsible for project management after MSF left. It was clear that overall project management and communication with the MOH was weak.

It was not clear to the evaluation team who was responsible for overall project management. For example, the Project Paper Supplement implementation plan did not state who should initiate the coordination meetings and it appears that none were held after October 1990. Similarly, with the project extension to May 1992, DPS expected to be reimbursed for per diem



32

payments and the cost of a seminar during the extension period. While there are two letters to JHU stating that the project was to be extended and the cost of the administrative assistant was covered, we were unable to determine why the DPS per diem and seminar costs were not paid during that period.

b. Evaluation/Audit

After the withdrawal of MSF, USAID held a meeting with JHU "in lieu of an evaluation" which, according to the report, reviewed the current status of project implementation and outlined the options available. USAID staff consulted with several groups, held a task force meeting, and then prepared a Project Paper Supplement which retained the purposes and goals of the original project. It called for a final evaluation in the last calendar quarter of 1991. With hindsight, a more comprehensive review of purposes and goals might have been undertaken. A decision was made at this time to make no further mid-term evaluation, despite the fact that the project made a significant change in course. With hindsight, some kind of review might have been useful after six to eight months to assess project performance.

c. Commodities

The following commodities were purchased for project use:

- Vehicle: An Isuzu 4X4 pick-up vehicle was ordered for ZCSP in April 1990, but was not delivered to Zambezia until November 1991 when the project was nearly finished and Mr. Oliver had already left. The vehicle had been held up at the port in Maputo for customs clearance for 12 months. Apparently, the MOH was slow in carrying out their agreement to pay customs duties. The car arrived in Quelimane with the back window broken and with no spare parts. The car is not the standard type of vehicle used by the Ministry of Health and may be a difficult vehicle to maintain since parts are more difficult to obtain and mechanics have less experience with Isuzu vehicles.

- Medicines and Vaccines: Vitamin A capsules (4000) were ordered through UNIPAC in early 1990 and asked to be sent to the project via UNICEF. The vitamin A arrived via a UNICEF shipment and was distributed to Ile, Alto Molocue, Milange, and Gurue by UNICEF and the DPS/Z without project staff knowledge at the time. Most of those at the DPS/Z with whom we spoke (in April 1992) were still unaware of the arrival or distribution of the vitamin A. Apparently Sr. Ausse of the RSC was asked to include in the supervision visits questions about the distribution of the vitamin A. According to Ms. Migliorini, this never happened. Her explanation was that the supervision activities were already overloaded.

- Office Equipment: The equipment was ordered and delivered by January 1991. The equipment included three computers (a Zenith XT laptop, an NEC 286 laptop,

and an IBM desktop), a HP III printer, a Diconix printer, a Canon copier, a universal power source, and assorted supporting equipment. All but the desktop computer were in operating condition at the time of the evaluation (April 1992). The mission stated that it would turn over the equipment to the DPS at the end of the project in May 1992.

- T-shirts and Bags: These were ordered in Maputo by the ZCSP for the CR. As mentioned above, payment had not been made by the time of the evaluation.

5. MOH-DPS/Z Inputs

a. Personnel

Personnel of the NEP, RSC, and CR worked with project staff and participated in project activities; however, the agreement to not work in the HIS area compromised project implementation with the NEP section of the DPS. In addition, staff of all of the ten participant districts helped implement project activities. A trained NEP staff member participated in Mr. Oliver's study. CR staff were considered especially strong in management and completion of agreed-upon activities.

Although there was a shift in DPS/Z leadership in June, 1990, when Dr. Cossa left for training in the USA, the DPS/Z staff remained relatively stable throughout the duration of the project. Sr. Henrique Pinto, head of the RSC at the beginning of the project, was designated as a counterpart to Mr. Oliver. When Sr. Pinto left in December 1990, he was replaced by Sr. Ausse. Since he was taking up a new post, Dr. Cossa did not ask Sr. Ausse to assume the role of counterpart. Sra. Antonia Magalhaes, provincial head of MCH programs, was to have assumed this role. From conversations with both Sr. Ausse and Sra. Antonia it appeared neither of them worked very closely with Mr. Oliver. The inadequacy of counterpart relations did not help project management and implementation.

b. Transport

The DPS/Z loaned a motorcycle to Mr. Oliver since his vehicle never arrived in time for him to use it. The DPS/Z and all of the districts provided ground transport for the project.

c. Logistics and Administrative Assistance

There is general agreement that the internal communication within the MOH was weak. Information about project activities and consultants often did not get passed from one department to another within and between both the MOH-Maputo and the DPS/Z. Nevertheless, the DPS/Z and district staff helped plan, organize, and implement project activities when they were requested to do so.



34

d. Commodities

Teaching materials from the CR and immunization materials from the DPS/Z warehouse were used in project activities.

The capacity of the MOH in terms of readily availability of transport, materials, and trained personnel is obviously limited. Nevertheless, the DPS/Z provided substantial technical and material support to project objectives.

B. Implementation

In general, most project activities were implemented within what the evaluation team considered a reasonable time frame. The following summarizes the implementation of project activities by the participating agencies.

1. MSF

The following includes only those activities which occurred prior to the June 1990 meeting when MSF dropped out of the project:

Starting in July 1989, MSF reported having added one flight per month to the four target districts. Dr. Gago accompanied most of these visits. Reports suggest that district officials were visited to determine priorities and support of diarrhea management, growth monitoring, immunizations, and vitamin A supplementation. MSF reports also mentioned having planned TOT; however, there is no clarification as to who was to be trained or who was to do the training. When Dr. Leifert, the JHU training consultant, came to Zambezia in June 1991, she reported little cooperation from MSF.

As the final evaluation SOW is focused on the supplemental PP (after the departure of MSF), no further discussion of MSF project implementation will be included in this document.

2. JHU

Input by JHU was originally designed to provide only an epidemiologist for HIS/baseline study and TA through consultants. When MSF dropped out of the project, JHU did not create an effective mechanism to assume overall project management. JHU officials said that they asked USAID to provide funding for a project manager but that such funding was not provided. The evaluation team was not provided with documentary evidence of this request.

The liaison and coordination of project activities with the MOH was perceived by most MOH personnel as poor. Mr. Oliver and Ms. Migliorini did make monthly and later quarterly reports to USAID/Maputo and all reports were passed on to appropriate sectors of the MOH-Maputo by USAID staff. Most monthly and quarterly reports were well-written narrative summaries of what had occurred in the preceding month(s) including a useful contextual



35

framework. However, there was little evidence of monitoring yardsticks of project performance. No real project performance monitoring was done and no final project report was written. No responsibility for a final report was delineated in the PP.

JHU did not have a representative in Maputo and the JHU person in Quelimane, Mr. Oliver, was not prepared to manage the project. He was already assuming a full-time job when he assumed de facto overall project responsibility. He had arrived in January 1990, six months after the PP was signed. Mr. Oliver did have extensive briefings with the MOH, UNICEF, and USAID when he first arrived in Maputo. He developed a strong relationship with Dr. Cossa. He made at least two trips to Maputo in May (Child Survival Conference), August, and December of 1990 and apparently made contacts with the national NEP and RSC sections of the MOH.

Mr. Oliver worked out of his home for the first months of the project; thereafter, a project office rented by the DPS/Z was set up 3-4 blocks from the DPS/Z office. Dr. Cossa said he had suggested that Mr. Oliver find a separate office because of space problems.

Mr. Oliver's inadequate fluency in Portuguese and his lack of integration in the NEP limited his role in the implementation of HIS systems. A memorandum of understanding (MOU) signed on March 23, 1990 between the ZCSP, MSF, SCF(UK), and DPS/Z further constrained meaningful project activities in the routine HIS area. It stated that the ZCSP would not participate in provincial HIS activities unless expressly requested to do so. Neither Mr. Oliver nor other project staff attended the February 1991 national conference on the new HIS. According to USAID staff, they were not invited to attend.

Mr. Oliver's limited Portuguese language capacity also seriously undermined his ability to coordinate activities in the RSC and at the CR. After the MOU regarding his participation in the NEP, he apparently never became an active member of either the RSC or the CR. Consultancies were said to have been planned principally with JHU and USAID rather than with the RSC, CR, or other sectors of the MOH. The evaluation team saw no evidence of significant MOH input in requesting TA.

There were only two coordination meetings during the course of the project; the Project Paper required one per quarter. In light of the problems that were described to the evaluation team, it is clear that more coordination meetings with included all parties might have improved relations and helped facilitate the overall functioning of the project.

Regarding support of training and supervision visits, CR staff complained that at the outset of the project, payments for per diem often came late and caused cancellation of at least one training trip. Timeliness of payments improved substantially after Ms. Migliorini was hired. Most of the planning and administrative activities were carried out by Ms. Migliorini who was well known to the CR staff and who made efforts to plan flights and per diem payments consistent with CR programming.

CR staff and Ms. Migliorini said they were told that JHU support for the project was to have continued through December 1991 and possibly through May 1992. A letter from USAID/Mozambique to Mr. Oliver on September 25 stated that an extension would be supported until February 1, 1992 and that arrangements with JHU would be made to obtain the necessary support. JHU officials said that they expected the funding to come from USAID/Mozambique.

JHU funding ceased when Mr. Oliver left in November 1991. As a result, a CR seminar held in December 1991 was not reimbursed, and CR staff have had to assume a debt of 1,600,000 MT (US$800). Similar complaints of non-payment of promised per diems were voiced by the trainers and trainees at Gurue.

Mr. Oliver planned and implemented the baseline survey in Mocuba and Quelimane. Although Sr. Ernesto of the NEP was assigned to Mr. Oliver to help supervise survey activities, according to the heads of the NEP and RSC sections, the involvement of the DPS/Z in the planning and analysis of the study was minimal. No Mozambican to whom we spoke was involved in the analysis. We were told that Mr. Oliver was asked to include Maputo medical students in the community study. This idea apparently did not work out because the study was planned to take place several months before the students would have been available.

According to DPS/Z staff, Mr. Oliver left Quelimane with little advance notice and none of the commodities at the ZCSP office were turned over to DPS/Z officials.

With regard to the final evaluation, JHU officials said they were not directly invited to participate by USAID/Mozambique. USAID staff report having asked JHU to participate but with their own funds, which apparently had been expended. The supplemental PP and the SOW for the final evaluation (prepared by USAID/Mozambique) both state that JHU (and the MOH) should participate in the final evaluation. The PP budgeted $45,000 for the final evaluation and audit. Neither JHU nor the MOH participated.

3. <u>USAID/Mozambique</u>

Project activities were monitored regularly via regular reports and occasional visits by Ms. Selvaggio to Zambezia. Reports by Mr. Oliver, Ms. Migliorini, and project consultants were routinely forwarded to the appropriate sectors of the MOH by the USAID office. Nevertheless, considering the weakness of communication within and between sectors of the MOH, project monitoring might have included stronger efforts to improve the formal or informal communication network between project staff and the sectors of the MOH.

Ms. Selvaggio took the lead in the redesign of the project after the departure of MSF from the project. Ms Selvaggio stated that her active project monitoring diminished substantially in 1991, principally due to other demands on her time. The only two visits of the HPN officer of the Mission in 1991 were primarily related to the development of the new follow-up project.



-31-

In-country travel and logistic arrangements for consultants was arranged by USAID in the first year of the project. In the second year, most of these responsibilities were handled principally by Ms. Jackson with support from World Vision.

4. MOH

Although the project supplement specified that the MOH should ensure that all activities of the workplan be carried out, such a task was difficult at best. The resources and organizational capacity of the MOH is obviously limited. It is clear that communication within the MOH was an inhibiting factor in the achievement of the project objectives. People at the MOH-Maputo often were not aware of activities carried out at provincial levels and vice-versa. Inadequate communication could easily have contributed to the feeling that consultancies, for example, were planned without sufficient MOH participation.

The large number of donors with whom the MOH must deal, the multitude of requests from these donors, and the lack of both technical and management depth with which to manage them is a constant source of stress on the MOH. In Zambezia alone, the DPS/Z had to juggle the varied programs of 15 donor agencies, all of which had different geographic and programmatic operations. (See Appendix 3.) Staff of donor agencies in Mozambique should be cognizant of the stress placed on government agencies by the plethora of donors and their myriad requirements.

The selection of MSF as the principal project agency made project implementation difficult since MSF operated almost independently of the MOH with little regard for MOH policies and protocols. In addition, frequent revisions in the workplan and the sudden departure of MSF made project implementation even more complex. Finally, inadequate communication between project staff and staff of the NEP and RSC made it difficult for the DPS/Z and district staff to fully participate in planning and implementation project activities, particularly in HIS.

The decision by the project task force to directly support activities of the CR made direct MOH participation much more viable. The DPS/Z and district health staff did participate in project supervision/training activities and to a lesser extent in the community study. From all indications, MCH supervisors were made available to make the twice monthly supervisory visits.

The supplemental PP indicated that the DPS/Z should submit monthly reports regarding project activities. It is not clear to the evaluation team where the reports were to go and which sector of the MOH had responsibility for these reports. No such reports were encountered at the USAID mission. A single review of CR activities by CR staff was sent to USAID near the end of the project.

Vehicle and equipment maintenance was moot for the DPS/Z since neither the computers nor the car were available to the DPS/Z for nearly the entire project. Vitamin A was apparently distributed according to UNICEF protocols.



38

## C. Outputs

The three principal project outputs are listed below, including a brief description of each from the supplemental PP. A short background provides some context regarding the degree to which the project might have been expected to contribute to each area.

### 1. Epidemiology/HIS Strengthening

"Complete, accurate, timely, and relevant data collection, reporting, and analysis through simplification and strengthening of district HIS."

#### a. Background

The NEP of the DPS/Z had been involved in developing a new HIS for the country since 1988. Zambezia and Cabo Delgado were the two provinces which were responsible for developing, testing, and revising the new system. The new HIS was designed to simplify and improve the collection, compilation, analysis, and dissemination of routine HIS data. Angela Brown, an expatriate advisor from SCF(UK) and part of the Zambezia Province NEP, was involved in this effort.

The HIS activities of the ZCSP were viewed by NEP staff and their expatriate advisors as duplicating and unnecessary. Furthermore, the new HIS development was seen as a vital process within the MOH. The ZCSP HIS interventions were considered foreign. In addition, the ZCSP approach was perceived as computer-driven and too high-tech for provincial-level HIS. They felt that the provincial HIS activities should be focused on reliable data collection rather than directed toward sophisticated computer analysis. Furthermore, according to the NEP, the DPS/Z had not asked for help in this area. Enmity toward USAID by SCF(UK) expatriates may also have contributed to this perception.

The HIS conflict appeared shortly after the arrival of Mr. Oliver. This certainly did not help build his relationship with the DPS/Z.

After the trials of the new HIS were completed in Zambezia, Ms. Brown moved to Maputo where she became advisor of the national NEP office under the direction of Mr. Sitoi. The MOH began plans to implement the new HIS in a standardized format province by province throughout Mozambique. The February 1991 national conference on HIS (to which ZCSP staff were not apparently invited) was essentially devoted to discussion of the new HIS system.

The strained ZCSP-NEP relationship made HIS-related contributions by consultants extremely difficult. Dr. Allen's visits were apparently planned with little consultation among MOH officials either in Maputo or in Quelimane. Dr. Allen attempted to introduce provincial-level HIS computerization using the Epi-Info program. The program is excellent for this purpose and is a standard for HIS in many countries of the world. However, the Mozambique national HIS system was based on a Lotus 1-2-3 format, and Dr. Allen's efforts were felt

inappropriate by the national level NEP. Teaching of Epi-Info was blocked during the follow-up consultancy by Mr. Goshler. Mr. Goshler's subsequent efforts to teach computer methods using Lotus 1-2-3 were poorly attended. The people we spoke to indicated that to date they have made little use of Mr. Gohsler's training.

One significant contribution of the project in HIS was Dr. Allen's suggestion that districts record the receipt of reports from health posts. The provincial NEP staff felt that although this approach was already under discussion, Dr. Allen's encouragement may have facilitated an earlier introduction of this monitoring. During the April 1992 evaluation visits, district-level monitoring of health post reports was being monitored at least in Mocuba district.

Mr. Oliver's baseline study was one HIS output which was completed. It is an example of a potentially important contribution which was not recognized as such by the DPS/Z staff. We noted little perception of DPS/Z ownership of the study. At the time when results of the Mocuba study were presented in Washington, DC (September 1990), no oral or written reports in Portuguese had been made in Mozambique. The only report in Mozambique was one written in English which had been delivered to Dr. Cossa. The first oral presentation of the results in Mozambique was about two weeks before Mr.Oliver left the country in November 1991.

At the time of our evaluation, no one with whom we spoke at the DPS/Z or MOH-Maputo had seen a copy of the results. The evaluators did find English language tables and graphs of the study in the ZCSP and USAID offices in Quelimane and Maputo. Mr. Oliver said he thought the study had been translated; however, despite efforts in Quelimane and Maputo, the evaluators did not encounter copies of the report in Portuguese.

District HIS functions may have been strengthened by the increase in supervision visits. However, there is no evidence of any significant change in practices. (See Section IID.)

b. Other HIS Activities

Early in the project, in 1989, consultancies by Chris Kjolhede, Elizabeth Gundy, and Linda Perez provided thoughtful descriptions of MOH clinic operations and management in Zambezia. Another visit by Chris Kjoljede in 1991 further described the structure of health services in Zambezia. Although the latter contained some minor misrepresentations, it helped fill in the picture of the history and adequacy of service delivery in peripheral areas. However, most of the reports did not reach DPS/Z staff. One expatriate adviser who did see one of the reports said that what he read did not contain any new information as the reports were descriptions of what most DPS/Z staff already knew. The documents were probably most useful to JHU and USAID staff.

No reports of focus group sessions were found. Monitoring of vitamin A distribution was not possible after the UNICEF distribution of the capsules. There was no evidence of operations research having been carried out.



- 40

Although the project brought considerable technical expertise and materials to the DPS/Z, the impact was limited by the lack of integration of the project staff with the NEP and RSC. Nevertheless, the raising of issues and the provision of alternative systems probably built an awareness of the importance of the existing system and indirectly may have encouraged other changes in addition to the one form that was incorporated.

2. Supervision

"Regular and adequate supervision of MCH services by MOH personnel through assistance in air travel and follow-up of training activities."

Background

District-level supervision has long been a high priority of the MOH. A province-to-district supervision system had been in place as a matter of MOH policy for several years prior to the onset of the project. A twelve to fifteen page check-list form was being developed in the year the project was designed. In spite of supervision being a major priority of the MOH, at the outset of the project, formal supervision visits to districts were sporadic and the supervision form which had been developed had not yet been put into service. Supervision was the primary responsibility of the RSC of the DPS/Z.

The most important aspect of project support for supervision was the provision of air transport. Three supervision visits to the ten target districts were reported in 1989, six in 1990, and thirty-two visits reported in the last year of the project. The increased frequency of visits was felt to have substantially improved morale among health workers, especially those in isolated, security-poor rural areas.

The first project notes regarding the supervision system was during the visit by Dr. Kjolhede in 1989. He left supervision materials with the DPS/Z . Later Mr. Oliver developed a supervision check-list based on a model by PRICOR to replace the check-list developed a few months earlier by the MOH. The PRICOR form was a little simpler and included mostly "yes/no" questions which facilitated an overall numerical assessment of each supervision visit. The PRICOR form also was easier to computerize.

Initially, RSC staff were reluctant to change the supervision form before the just-developed MOH form had been tested. Mr. Ausse, the RSC head, told us he had personally put considerable amount of effort toward developing this new form in the previous six months. There was also some concern among DPS staff about the need for open- ended questions. Some felt a one-day supervision visit was sufficient; others felt two or three days were necessary to adequately review district health activities. Finally, some were not keen on a form that would act as a grading system for districts rather than a form of communication, feedback, and support for health care improvement.



41

The PRICOR checklist ultimately was implemented in selected areas and tested against the MOH form. Dr. Burnham set up a mechanism to formally compare the two methods. In the end, some aspects of the PRICOR form were incorporated into the DPS/Z supervision form. An overall score was developed similar to PRICOR. A shorter form was developed by Mr. Oliver to be used for district-to- peripheral health post/center supervision.

By 1991 supervision check-list forms were nearly universally used and most of the supervisors we spoke to were positive about the form. They all felt that the forms helped organize supervision visits. Three of the four district directors to whom we spoke were positive about the new supervision activities and the forms. The fourth felt the new supervision check-list was marginally useful since the feedback process was mostly one way and little was done to address the issues encountered during the supervision visits.

After returning to Quelimane, supervisors reported directly to the chief of the RSC. We found most of the completed check-list forms archived in a RSC notebook. Whether the supervision results got to other sectors of the DPS/Z or were fed back to the districts was not clear to the evaluators. Overall, the evaluation team felt that the project provided substantial support to an already growing enthusiasm for the concept of supervision.

At the time of the evaluation, the evaluators were told by staff of the Provincial RSC and the District Health Director of Gurue that the supervision visits had been canceled for lack of per diem support of supervisors. This occurred in spite of readily available air transport free of cost to the DPS/Z. The RSC had incurred a debt of over 400,000 MT (about US$200) to individual health workers who had worked as supervisors in the first months of 1992. Project staff had apparently promised reimbursement to the RSC. Three to four months later, the health workers were still not paid. This was a point of great concern to all at the RSC.

3. TRAINING

"Ongoing in-service training at the district level....Test newly developed guidelines in target districts."

Background

The CR was established in 1985 as model in-service, retraining center in Zambezia. It is the only such retraining center in Mozambique. At the time of the evaluation, the CR had a full complement of courses scheduled. They had planned to carry out, on the average, one two-week course every five to six weeks to allow sufficient time for planning and evaluation of each course. The CR had also studied the training needs of all MOH and other health workers in the province over the last 5 years.

They demonstrated a sophisticated understanding of training needs from the perspective of preventive and curative health programs and developed an overall strategy for addressing these needs. The CR strategy included TOT and occasional training carried out in the districts.



47

The project focus on district-level training resulted from discussions with Ms. Selvaggio and Mr. Salato in July 1990 after the departure of MSF from the project. According to Ms. Selvaggio, the project offered to support district-level training since it fit the overall design of the project (which did not include Quelimane as a target area). The project also expressed interest in supporting the training of activistas, lay community-based health workers. Technical assistance by Thelma Leifert supported the TOT concept.

With project support for air transport and per diems, district-level seminars increased from three in 1989, six in 1990, and sixteen in 1991. The 1991 figure includes seminars, practical training, and apprenticeship activities. In addition, twenty-four training follow-up visits were made to the districts in 1991.

Province-wide, we estimate that well over thirty trainers were trained; twenty-three were trained in the four districts we visited. During the district visits, we were told that fifteen activistas had been trained in Mocuba, twelve in Alto Molocue, and six in Gurue. The evaluation team was unable to determine the total number of activistas trained in independent "courses" after the initial project input of TOT.

One staff member of the CR questioned whether activistas were the best group to focus on. He suggested that of all the training needs in the province, the elementary public health and clinical personnel (a step up from activistas) were potentially the most productive and the group most in need of re-training (measured by time since last training). He felt that, in general, it was inefficient to train the higher levels of health workers in the districts because of the low numbers of potential trainees who would be able to leave their district posts.

The training approach and manual developed by Dr. Leifert were tested and found useful by those she helped train in Gurue. The CR staff, however, told us that they considered Dr. Leifert's manual too complex and long and preferred their own shorter version. The CR opinion was supported by the DPS/Z Director, Dr. Cossa. The CR staff also preferred a lengthier TOT mechanism involving the target trainees in the process. As a result, the Dr. Leifert's training manual was not further used and the training approach she suggested was discontinued after the Gurue experience.

The continuation of the CR's district training program was compromised in all of the four districts we visited by lack of per diem support for trainees, according to the district staff with whom we spoke. Nevertheless, all of the trainers we spoke to were enthusiastic about continuation of the training process.

In sum, the project's training output was probably achieved, although the numbers of trainers and activistas trained was not clearly documented. This activity was felt to be one of the strongest aspects of the project, despite the complaints of per diems paid late or not at all. The critical factors that we judged which influenced the impact of this output were the institutional capacity of the CR, the integration of project activities with the CR, and support of air transport.



13

D. Effects

1. HIS

The project effect in HIS was limited to non-existent. Only the baseline study was carried out and the results were not presented to the MOH-Maputo or DPS/Z in an effective or timely manner. The impact of project activities in this area may actually have been negative. DPS/Z staff were confused by competing systems and time was wasted training in computer training which was not ultimately used.

2. Supervision

The project activities in supervision supported existing priorities and strengthened the program through air travel and per diem support. Overall, province-to-district supervision activities substantially increased over the life of the project, and the evaluators feel that supervision improved morale in the districts. Project technical assistance directed at improving the supervision check-lists was felt by most staff to have marginally helped improve the system. Unfortunately, the late payment of per diems at the beginning of the project, and the unfulfilled promises of per diem payment at the end of the project left a negative impression among DPS/Z staff regarding the overall effect of ZCSP support in supervision.

3. Training

The support of the CR effectively encouraged district-level training. Many existing community health workers were given refresher courses and some new activistas were trained. Of the activistas interviewed, several had substantially improved community involvement through health education, improving sanitation, and provision of a linkage between community members and the health services.

Whether district-level training, or the training of activistas was a priority for the CR is not clear. Peripheral level TOT is not without potential limitations: the content of training is usually variable, the frequency is sporadic, and the focus is necessarily at a low level of health care worker. Most of the activistas with whom we spoke had been trained previously one or more times by the MOH or the Mozambican Red Cross. We found project-trained activistas working in markedly different roles. Some were carrying out purely clinical work, others working in community public health promotion, and others mixing the two roles. Whether the training was appropriate for their post-training work was not clear to the evaluators.

4. Other

Another important effect of the project was the information provided to JHU and USAID about the functioning of the Mozambican health care system. Initially, the MOH and DPS/Z staff perceived that the ZCSP staff had underestimated the capacity and functioning of the Mozambican system. In the wake of the project, Mozambicans and ZCSP staff (including



44

USAID personnel) agreed that the latter had gained an increased appreciation for the work and achievements of the system in spite of tremendous obstacles it faces.

E. Sustainability

Sustainability is difficult if not impossible to achieve in the context of war, drought, a limping economy, and an extremely limited MOH budget. In fact, many of the project inputs were specifically intended to temporarily support obviously non-sustainable inputs (e.g., air transport). In addition, the community-based survey by Mr. Oliver was apparently intended to be a one-time effort to permit a greater understanding of health status and health care utilization in rural and urban areas of Zambezia.

Other aspects of the project can be fairly judged for sustainability, assuming a continuing difficult economic situation but an end to the war. The Allen suggestion to include local registry of reporting was permanently incorporated into the HIS shortly after his visit and should improve the understanding of health service data.

On the other hand, three-day supervision visits may be more difficult to sustain after hostilities cease when ground transport will be the principal method of reaching the districts. Ground transport will have to be financed by the DPS/Z, and travel time will increase, as will need for per diem support. When health workers are away from the DPS/Z or provincial hospital a longer time, a greater strain will be left for those in Quelimane.

The fact that these supervision visits were stopped for lack of per diem funding prior to project completion (when air transport was still available at no cost to the DPS/Z ) does not bode well for continuation of supervision at the level of the last year of the project.

The CR appeared to be a low-cost, effective mechanism for continuing education among health workers. The CR's TOT approach may be minimally burdensome on provincial training resources and offers the possibility of having a multiplier effect on training. Thus, the TOT has characteristics suggesting sustainability.

Whether the activistas themselves are a sustainable cadre of health workers is less certain. The variability of training and activities of the several types of activistas gives rise for concern regarding their health care role and relationship with MOH structures. Furthermore, the almost universal lack of community economic support for activistas makes their continued work uncertain at best. The APE program in the 1970s and 1980s trained well over 1,000 APEs in a standardized six-month training course with an expectation to return to their communities. They carried out health promotion and provided simple curative care. Compared to the activistas, they had stronger training and a better-defined community role. Nevertheless, their lack of sustained community support and poor level of supervision contributed to an extremely high abandonment rate. We saw little reason to believe the current heterogeneous group of activistas will fare any better.



45

The idea of having CR staff make follow-up visits to supervise activista training did not seem to be a high priority of the CR. The practice was discontinued shortly after the ZCSP follow-up staff working in the CR were terminated.

Finally, the rather abrupt project termination and non-payment of bills left a sour impression of the project. The enthusiastic response to support for supervision was muted by a few months of promised but not delivered per diem support. Failure to present study reports leaves a negative impression of an otherwise impressive and potentially useful investigation. The particular manner by which the project terminated did not improve the likelihood of sustainability of the positive project effects.



46

## III. PROJECT IMPACT

### A. Operations Research Approach

There was no evidence that the project carried out any operations research.

### B. Delivery of Health Services (Coverage and Quality)

After the departure of MSF, the project played little role in the actual delivery of health services. The project as defined in the supplemental project paper was not designed to directly support health services delivery.

Improving supervision should have a positive impact on the effectiveness of health service delivery; however, one year is inadequate to assess the impact of supervision in any context. It was not clear if the supervision feedback reached the responsible officials in the DPS/Z who might be able to help improve conditions for program implementation. The lack of a mechanism for responding to problems encountered in supervision visits and the fact that no explicit provision was made for improvement of conditions appears to be a deficiency in the supervision system. It also suggests that little measurable improvement of health services is likely to have occurred.

Our estimates indicate that more than 40 activistas took part in TOT activities, most of whom had already been trained. We doubt that activista training had, by the time of the evaluation, any significant impact on delivery of health services.

The evaluators considered measuring a few indicators of health service delivery, but felt there was no reason to believe the project should have had any measurable effect on health service indicators.

### C. Community Development/Involvement

The project activities (HIS, supervision, and training) were designed principally to strengthen the DPS/Z and MOH in general. Project impact in community development might have occurred as a spin-off of support to the DPS/Z for strengthening provision of community-based health services. However, it would have been difficult for a project of such a short duration to have made a real impact.

The training of activistas may have contributed to community development or involvement in certain communities. Several of the activistas we saw in Milange suggested that they may have initiated community health promotion activities. New latrines were built in one accommodation center. The activistas said that they accompanied community members to health posts. Although the evidence is minimal, it does suggest that the activistas involved in community public health may have encouraged community involvement in environmental sanitation and in improving health behaviors.



47

## D. Institutional Strengthening

The principal recipient of institutional strengthening was the CR. Already a strong institution, the provision of air transport and staffing facilitated an increased presence in the districts.

The increased supervision by the RSC increased provincial DPS contact with the districts. This contact undoubtably strengthened the flow of information between district and province and probably increased morale in the districts.

There was no evidence that the project strengthened the NEP.

The policy of the MOH is to decentralize management and financing of health services and strengthen the Provincial and District Health Offices. The policy of USAID to provide technical assistance at the provincial level with a focus on district training and supervision seems quite appropriate to the evaluators. The project role in decentralization would have been more effective had the project staff been more fully integrated with the provincial health team and participated in their day-to-day activities. Project team members could also have helped strengthen communication between different levels of the MOH.



48

## IV. GENERAL FINDINGS

Although the evaluation team was hampered by the absence of major project participants, the findings are adequately grounded in fact. Persuasive combinations of documentation and interviews consistently corroborated the information upon which these findings and recommendations are based.

The major findings reflect a positive support and strengthening of selected existing DPS/Z activities, but with a weak integration of overall project design and implementation into the ongoing activities of the MOH. In addition, unclear definition of responsibilities among contractors, especially regarding project management, hindered project implementation.

The following is a summary of the principal findings of the evaluation team:

- The support of air transportation was a positive contribution to DPS/Z capacity to provide health services. The flights increased supervision, training, and communication with the districts targeted. The increased contact between provincial and peripheral health providers affected by the war significantly improved morale as well.

- The use of an established training institution (the CR) which had a clear concept of training needs and the skills to respond to them was an important contribution to guide the project staff and help formulate the objectives of the project. It was also an effective way to learn about the achievements and problems of the Mozambican health sector.

- Integration with MOH and DPS objectives and activities were consistently hampered by the limited and apparently superficial contacts of long term JHU and USAID personnel with the needed range of national and provincial officials. This problem manifested itself in the timing and the handling of consultants, the inadequate communication of project plans and activities to appropriate levels of the MOH, and in the lack of information on MOH plans and programs to project staff and consultants.

- The design of the project did not take into account the wishes of the Ministry of Health in choice of contractors. The precipitate departure of MSF was only partially related to this problem. The lack of adequate collaboration developing the scope of work of the consultants created additional problems and affected the attitude towards the project by national officials.

- Neither the project documents themselves, nor subsequent actions related in communications and interviews with different parties indicated that operational responsibilities of the parties were ever clearly spelled out. This contributed to the excess of misunderstandings that occurred throughout the project.

- Management responsibilities, in particular, were only defined in very general terms. The use of "support", "coordinate", and "monitor" are not definitive in situations in which different parties have different interests and perspectives and in which communications are long distance and difficult.

## V. LESSONS LEARNED AND RECOMMENDATIONS

All of the lessons learned emanate from observations of project participants and the evaluators' synthesis. The lessons are directed toward improving future USAID health project, particularly those implemented at peripheral levels of the health system.

**Lesson One**: Care must be taken not to underestimate the capacity of MOH leadership, staffing, or services. Insufficient knowledge of, or regard for, the plans, policies, and context of on-going host country programs leads to serious problems during implementation. The caliber of leadership in Mozambique is high. Most Senior officials are technically competent and know the major problems of their institutions. They also know what is susceptible to change and what is not. In this context they have to juggle the proposals of many donors.

- **Recommendation: The Mission can avoid many of the problems experienced on this project by a country-oriented analysis which incorporates key officials at several levels to sort out critical problems amenable to change. This in itself is a contribution to country development. The Mission then can look at its own country strategy and performance indicators and find a fit that is mutually acceptable. This process builds respect and a relationship that pays off in crisis situations.**

**Lesson Two**: Project activities should be planned and implemented jointly with Mozambicans at all levels. Jointness in strategies, work plans, and activities is difficult to achieve, particularly in Mozambique with absences, staff changes and heavy demands on decision makers. However, without jointness the opportunities for misunderstanding and misuse of technical assistance are significantly multiplied.

- **Recommendation: For many reasons MOH institutions may sign off on activities which are not totally compatible with their policies. Technical advisers need to obtain commitment of key participants to broader objectives and then challenge and assist them at each level to find innovative steps that will lead in that direction. The expatriate role is to help focus the problem and provide perspective in the search for solutions which are jointly discovered.**

**Lesson Three**: Contractors must be competent and sensitive to project goals and existing government policies. The careful selection of contractors and collaborators matched to the objectives of the project is critical to both effective implementation and achievement of objectives.

**Recommendation: A joint examination of both cooperating agencies and contractors should be undertaken prior to determining responsibilities and relationships for implementation.**

**Lesson Four:** Avoid emphasizing short-term, measurable goals over long-term process goals. Although focusing on easily measurable outcomes instead of process can provide initial indicators of progress, longer term objectives of institutional strengthening are sometimes sacrificed.

> **Recommendation: Specifically measurable performance indicators should be buttressed with broader long-term human and organizational development objectives whose progress can be measured by successive milestones.**

**Lesson Five:** Clarify SOWs of participating parties. Lack of a clear understanding of the specific objectives and responsibilities of each party to the project leads to both misunderstanding and ineffective project implementation. The diverse of objectives of MSF, JHU, DPS, MOH, and USAID were never constructively examined with a view to defining project responsibilities.

> **Recommendation: Broad objectives can be vague in order to broaden support; however, specific objectives have to be discussed openly so that everyone is clear from the beginning on their roles and responsibilities. There are many ways to bring together all participants at an early stage to obtain agreement on relationships and responsibilities.**

**Lesson Six:** Select and hire personnel who are competent to work with national staff. Lack of preparation of key personnel, particularly in Portuguese proficiency and understanding the formal and informal operations of institutional structures, severely hampers the project implementation.

> **Recommendation: Project coordinators in Mozambique should have functional Portuguese and management experience in addition to their technical capacity. They have to develop a detailed understanding of the policies and procedures of the host country institutions. They should be able to move easily within the institutional hierarchy and develop collegial relationships with a broad range host country personnel. This allows them to jointly plan technical inputs to meet institutional needs.**

**Lesson Seven:** Long-term technical advisors, cooperantes, who work directly within the health structure are often more effective than personnel loosely connected to health structures. Cooperantes can develop credibility and influence the changes envisioned by the project. They can also improve the relationships among the cooperating agencies. Expatriate staff who are felt to be part of the MOH team have a better chance of gaining the trust required to be involved in management decisions. Adequate integration with national staff is especially important in strengthening provincial- and district-level management for administrative decentralization.

> **Recommendation: Project staffing plans should include people who work within the structure of country organizations. They should be key elements in the ongoing implementation planning.**



52

**Lesson Eight:** Small negative effects (e.g., personality conflicts, misunderstandings, perceived commitments which are unfulfilled) can so color the project as to obscure the positive benefits that occur.

> **Recommendation: In Mozambique responsible officials of participating agencies should touch base with each of the different parties in a project on a regular basis for short discussions on the process variables and the personal relationships. Reports rarely provide clues to minor but potentially significant problems.**

**Lesson Nine:** Communication regarding project plans and activities among MOH officials in different sections or levels of responsibility is sometimes haphazard. Frequent absences of critical officials add to communication difficulties. Resulting gaps in communication often undermine the integration of project plans and activities with MOH priorities as well as the overall perception of the project by DPS/Z staff. Communication gaps can be particularly problematic in projects operating at the periphery.

> **Recommendation: Project staff should make great efforts to insure that all appropriate MOH and USAID officials are appraised of project status and plans. Sending written documents is necessary but not always sufficient; personal and informal approaches to communication complement formal ones.**

**Lesson Ten:** In conditions of insurgency one of the most difficult problems is isolation of field workers. Morale and motivation of field staff are improved by supervision and training visits which bring central and local officials together.

> **Recommendation: USAID in Mozambique should continue to encourage special efforts to either visit or bring in field workers where they can share experiences, received training, resolve technical or administrative problems, and receive assistance. All of these activities build morale.**

**Lesson Eleven:** Working with a strong and effective organization (e.g., the Centro De Reciclagem) with consonant objectives can significantly increase implementation capacity and contribute to project sustainability.

> **Recommendation: USAID Mozambique should build on its successful efforts demonstrated in this case to promote the participation of other organizations already functioning that can be incorporated in to the process of achieving project objectives in both the project development stage and during implementation.**

**Lesson Twelve:** Sustainability is critically influenced by the way the latter stages of the project are handled. In Mozambique lack of effective communication and planning for the turnover of projects dooms even well designed projects to gradual extinction.



53

Recommendation: Particularly in a short-term institutional strengthening effort such as this one, a special review, including all project participants, should take place in the later stages of the project. At this review the participants should assess the status of project and its sustainability potential and requirements. The review could provide a strategy for gradual and effective transition of the project into and ongoing national activity. Jointness throughout the project stages also can have a major influence.

ANNEX 1

SOW for Evaluation



65

Annex 1

STATEMENT OF WORK FOR FINAL PROJECT EVALUATION

Mozambique Pilot Child Survival Project (656-0207)

I. BACKGROUND:

Mozambique has presented one of the most difficult development challenges in Africa. The health status of its people reflects the dire standard of living of the large majority of Mozambicans. Although available data on health status and epidemiology is limited, 1989 estimates of basic health indicators show an infant mortality rate of 200 deaths per 1000 live births and an under five mortality rate of 325-375 deaths per 1000 live births. Nearly fifty percent of all deaths in Mozambique occur in children under the age of five, with infectious diseases, principally malaria, diarrheal diseases, and respiratory infections the major causes of morbidity and mortality.

Since the mid-1980's in most of rural Mozambique, civil strife has severely restricted the area safe for human habitation and for normal agricultural production. More than a third of the population continues to be dependent on emergency food supplies, and the GRM's human and financial resources are insufficient to cope with increasing infant and child mortality which are already among the highest in the world.

Against this backdrop, the Pilot Child Survival Project was designed to help the GRM find cost-effective ways to expand the coverage of cost-effective child survival interventions. The purpose of the project was "to develop and test, under insurgency conditions, replicable and cost effective measures to reduce infant and child morbidity and mortality". At the heart of the project was testing increased supervision of district and community services and training local health workers in basic child survival interventions. The project design also called for operations research in four child survival interventions to determine effective approaches for service delivery. The project was designed to focus on only a few districts in Zambezia Province in the north of the country.

The project was obligated in June 1989 through a grant agreement with the Government of Mozambique (GRM). Funds were then allocated to Johns Hopkins University (JHU) and Medecins Sans Frontieres (MSF)/France to assist the Provincial Health Directorate (DPS) in Zambezia Province to implement all project activities.

In July 1990, MSF determined that it could not continue to be

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.

The project focused on achieving the above outputs through provision of the following inputs:

a) One long-term project Epidemiologist: 24 person months - based in Quelimane.

b) Numerous short-term consultants

c) Administrative and Logistics Assistance: several locally-hired personnel in Zambezia Province and in Maputo.

d) Training/Supervision Support: On-the job training and support to Training/Supervisory staff in Zambezia Province; support for air charter services from the provincial capital to the districts; funding for district-level training.

e) Commodities: computer equipment, a vehicle, training materials, vitamin A.

## II. EVALUATION SCOPE OF WORK:

ARTICLE I: Title

Pilot Child Survival Project (656-0207)
Final Evaluation

ARTICLE II: Objectives

1. Review the appropriateness, timeliness, and quality of all Project and host country inputs (personnel, commodities, and financing). Provide a descriptive analysis of project status relative to the inputs provided.

2. Review project outputs and quantify progress made toward achieving outputs. Provide a detailed explanation of those areas where project outputs have been exceeded or have not achieved project targets over the LOP.

2. Have the quality and quantity of A.I.D. inputs been adequate for achieving Project outputs during the LOP? Has the absorptive capacity of the GRM (and the GRM's inputs to the project) been adequate to achieve Project outputs and EOPS over the LOP?

3. Have the activities described in the Project Paper and the Project Paper Supplement been carried out? What has been the impact of these activities in relation to project outputs and EOPS?

4. Are critical project activities being institutionalized through the project so that they will be sustained following the PACD?

5. Has the DPS's management of child survival services improved since the Project began? To what extent can any improvements be attributed to Project activities?

6. Do MOH personnel understand and support the objectives of the project? Are the project's purpose and outputs consistent with GRM health policies, plans, and priorities?

ARTICLE IV: Qualifications of Contract Evaluation Team Members

The Pilot Child Survival Project covers a wide range of activities related to training, supervision, and research. It is essential that each Contract evaluation team member, while focusing on one or more specialized project areas, be able to relate to the overall project as a whole.

In addition to the individuals listed below, Johns Hopkins University will assign one person to participate in the evaluation, and one MOH/Maputo representative may also participate in evaluating the performance of the Provincial Health Directorate.

1. Team Leader/Public Health Specialist:

Advanced degree in Public Health, Medicine, or related field, with emphasis in administration and delivery of public health programs. At least seven years professional experience in developing countries, preferably in Africa.

Demonstrable experience in public health program evaluation. Experience as evaluation team leader desirable.

Proficiency in Portuguese or Spanish at FSI 2+/2- level is essential.

BEST AVAILABLE COPY

58

ARTICLE VIII: Work Days Ordered

A six-day work week is authorized in Mozambique.

ARTICLE IX: Miscellaneous

Duty Post: Mozambique

Language: Portuguese or Spanish proficiency required at 2+/2+ level.

Logistical Support: USAID/Maputo will make available all pertinent documents and files relating to the Child Survival Project Project. Limited office space will be provided for evaluation team use. The Contractor is expected to arrange for all secretarial assistance and computer support, as well as transport in Maputo for the team members. USAID/Maputo will assist in reserving air charter services for site visits to Zambezia Province. USAID/Maputo will also assist in making hotel and car rental reservations, appointments with GRM and other officials.

ARTICLE X: Evaluation Report - Suggested Format

Executive Summary
- Purpose
- Project Summary
- Major Findings
- Recommendations
- Lessons Learned

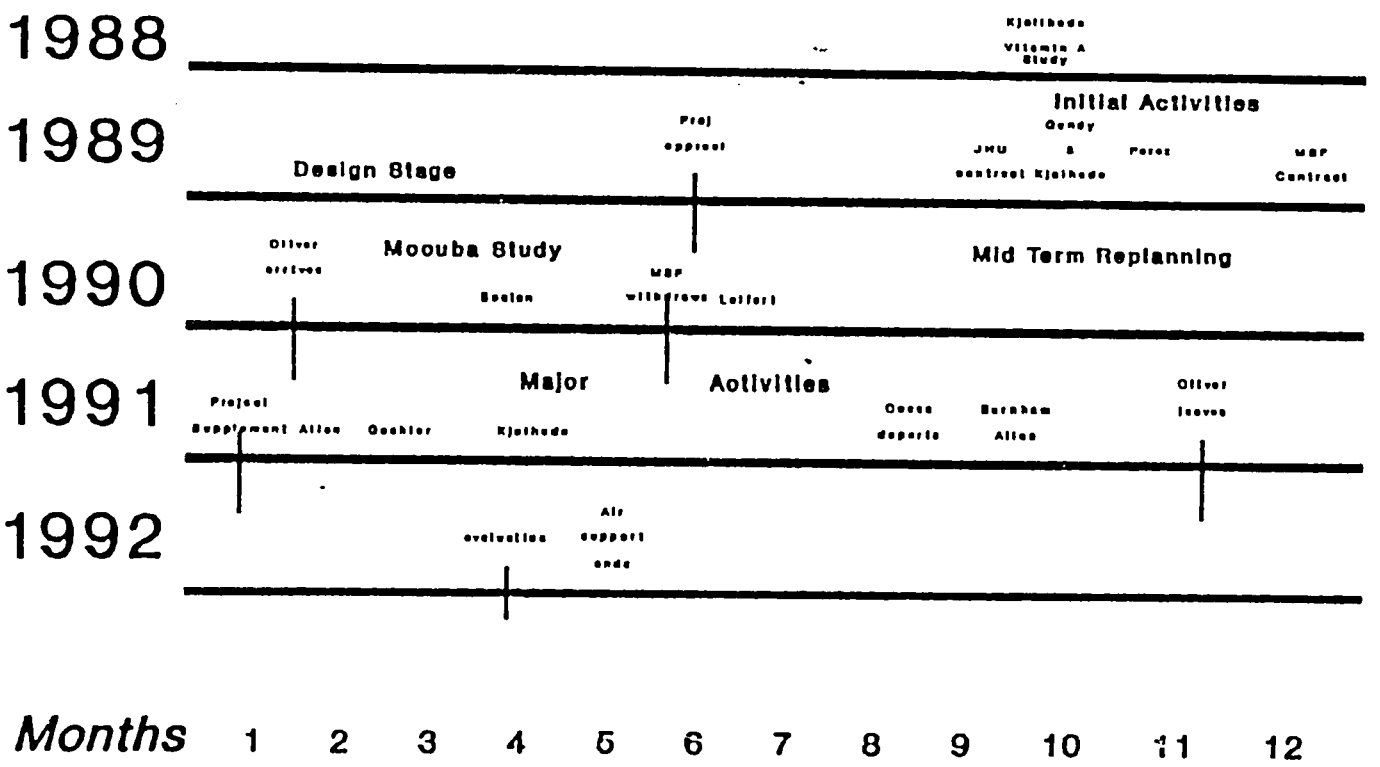
I. Introduction
- A. Background to Evaluation Assignment
- B. Members of the Evaluation Team
- C. Scope of Work
- D. Methodology
- E. Project Background

II. Project Efficiency and Effectiveness
- A Inputs (Personnel, Commodities, Financing)
- B. Implementation Activities
- C Outputs
- D Recipient Effects (user/institutional change)
- E Sustainability and Longer-term Institutional Viability

ANNEX 2

Project Chronology

Appendix 2. Project Chronology

# CHILD SURVIVAL PROJECT

## CHRONOLOGY OF ACTIVITIES