**ICELANDIC INTERNATIONAL DEVELOPMENT AGENCY**
**AND THE ICELANDIC AND MOZAMBIQUE RED CROSS**

**COMMUNITY BASED HEALTH CARE,**
**MAPUTO PROVINCE, MOZAMBIQUE**

# PROJECT EVALUATION


*Report written by*

**Geir Gunnlaugsson**



**Reykjavík**
**February 19, 2003**

**EVALUATION TEAM**

**Geir Gunnlaugsson, team leader**
**Ernestina Jorge, MRC Maputo City**
**Pedro Caleilano, MRC Maputo City**
**Ilda João Cuna, MRC Maputo Province**
**Hjördís Gudbjörnsdóttir, IRC Maputo**

**Report written by**

# Geir Gunnlaugsson

**Evaluation carried out in Mozambique**

**December 11-23, 2002**

# CONTENTS

## 5. TERMS OF REFERENCE

## PROLOGUE

In response to a request by the Icelandic International Development Agency (ICEIDA) and the Icelandic (IRC) and Mozambique Red Cross (MRC) Societies, this report is written with the objective to evaluate the Hindane Health Project in Mozambique. Initially, the Terms of Reference were laid out and agreed upon (Annex 1). Subsequently, I was presented to all relevant documents at ICEIDAs and IRCs Headquarters in Reykjavík. The composition of the Evaluation Team was agreed upon among the *Contracting Parties* and a programme for the visit prepared by the Mozambique Red Cross (MRC) and the TA of the IRC in Maputo (Annex 2). The mission was conducted in December 11-23, 2002.

During the stay in Mozambique I had discussions with many people without whose help this work would not have been possible (Annex 3). Further, the Evaluation Team had several internal meetings where all relevant aspects of the *Project* were discussed, guided by the Terms of Reference. All involved persons are gratefully acknowledged; especially I like to forward my gratitude to my collaborators in the Evaluation Team without whose support and genuine interest in the *Project* activities, this work would have been difficult, or impossible, to conclude.

This report reflects my over-all conclusions from the visit and may not necessarily be endorsed by ICEIDA, IRC or MRC. Yet, I hope it rightly reflects what was high on the agenda for involved stakeholders, most importantly the poor population in Hindane village and neighbouring communities.

Reykjavík, February 19, 2003

Geir Gunnlaugsson

## LIST OF ABBREVIATIONS

| | |
|---|---|
| APE | Community Health Worker (Agente Polivalente Elementar) |
| CBHC | Community Based Health Care |
| HQ | Headquarters |
| ICEIDA | Icelandic International Development Agency |
| ICRC | International Committee of Red Cross Societies |
| IFRC | International Federation of Red Cross Societies |
| IRC | Icelandic Red Cross |
| MRC | Mozambique Red Cross |
| NGO | Non-Governmental Organisation |
| PRA | Participatory Rural Appraisal |
| TA | Technical Adviser |
| TBA | Traditional Birth Attendant |

## EXECUTIVE SUMMARY

In December 1999, the Icelandic Red Cross (IRC), Mozambique Red Cross (MRC) and Icelandic International Development Agency (ICEIDA) signed an agreement to collaborate on the implementation of a Community Based Health Care project in the Hindane area, District of Matutuíne, Maputo Province.

The *Project's* key components are: 1) Construction of a Health Centre (Type III); 2) Develop community based health care services including the training of MRCs Community Based Health Care (CBHC) workers, Traditional Birth Attendants (TBAs) and other MRC volunteers; and 3) Strengthening the institutional capacity of the MRC within the context of *Project* activities.

The *Project* period is July 1, 2000 to December 31, 2003. It was agreed to conduct an evaluation of the *Project* before decision on further collaboration after the termination of the *Contract*. This report is the result of this evaluation. It is based on a mutually agreed Terms of Reference between the Consultant and the *Contracting Parties*. Further, to complement and support the Consultant, four professionals with extensive knowledge on *Project* activities were assigned to the evaluation in Maputo. The mission was conducted in the period December 11-23, 2002.

The Terms of Reference refer to five main questions in the context of *Project* activity, i.e., efficiency, effectiveness, impact, relevance and sustainability. Each question is elaborated further, with specific aspects of the *Project* to be considered. To address these issues, in this report essential background information to the *Project* and the setting is initially presented and form the backbone on which the conclusions of the evaluation are drawn.

In the *Project*, the governmental agency ICEIDA collaborates with IRC and MRC, two NGOs. At the outset, the organisational structure was agreed upon and has given all parts ample opportunities to accompany *Project* activities. This trilateral collaboration was a new experience for the *Contracting Parties*. While it has not alleviated ICEIDA or IRC of some of the burdens of running a project of its own, it has been a learning process to the benefit of all involved parties.

The design and implementation of the *Project* is in line with over-all national strategies within the health sector as well as that of MRC. Its set-up is also similar to other MRC donor-funded projects in other provinces.

In line with *Project* objectives regarding the rehabilitation of physical infrastructure of the government health care system, the *Project* has completed the construction of a new Health Centre Type III in Hindane.

The *Project* has been instrumental, and an important actor, for the implementation of health related activities that are expected—in the long run—to improve the health of the population in the *Project* area. This is in line with *Project* objectives.

The *Project* has supported the establishment of MRC-related activities to effectively reach household level in villages with population characterised by poverty and hunger. This is a formidable achievement, to great extent the work of the Programme Co-ordinator with appropriate support from the *Project* and the TA.

At its current state of implementation, the *Project* has invested in the appropriate equipment needed for the activities. The task ahead is how to improve its use and install appropriate mechanisms for maintenance and long-term sustainability.

The *Project* activities have contributed to increase the institutional capacity of the MRC in Maputo Province, from the Provincial Branch office to the local level, and improved the image of the Provincial Branch office. Without external support and income generation activities, the *Project* activity has nevertheless no chance of survival in the long run. This is a serious weakness that needs to be considered and acted upon.

The Project has encountered numerous difficulties regarding financial statements and timely transfer of money for *Project* activities. During implementation, there have been extensive discussions within and between the *Contracting Parties* aimed at refining the administrative procedures for efficient financial management. This process has at times caused confusion and tension within the *Project* structure. Yet, it can be concluded that the implementation of the *Project* has regarding financial management contributed to 1) strengthen MRCs institutional capacity, both at the national and the provincial level; and 2) given ICEIDA and IRC opportunity to refine their common routines in running a common development project, an asset in possible future collaboration.

The *Project's* focus on the MRC Provincial Branch office and its lower organisational levels has contributed to—in many aspects—successful implementation. This moves the actors more closely to those the *Project* is intended to support, i.e., a poor and vulnerable rural population. This grass-

root approach may however also have contributed to confusion between the field, the MRC Headquarters and IRC Reykjavík regarding transfer of money and reporting.

Monitoring and continuous evaluation of the *Project* activities needs further analysis and consideration. Currently, the *Project* does not have baseline data it can measure its successes or failures that concern improved health of the population. Such monitoring would benefit of collaboration with similar MRC projects in other provinces.

Technical assistance (TA) in the *Project* has been an important factor to successfully implement many of the activities, both regarding content and pace. It is not denied however that relations have, for various reasons, at times been strained, in particular between the TA and her superiors at the IRC. Personal differences have however continuously been dealt with and resolved gradually.

It is the over-all conclusion of the Evaluation that the IRC and MRC should, after termination of the current *Contract*, continue its collaboration on health related activity in Maputo Province, in particular the District of Matutuíne, initially at least for 2-3 years. It would be beneficial for the collaboration, and to recommend, that a short-term IRC delegate is assigned to the *Project* to come on regular visits to supervise the activities and support it, as found appropriate. Further involvement of ICEIDA in *Project* activities would thus be terminated.

ICEIDA and IRC have also the option to continue its collaboration with *Project* activities. In such a case, as the proposed continuation is in principle a strict NGO collaboration, ICEIDA should find ways to directly fund or indirectly support some of the *Project* activities but without becoming as involved in practical implementation, as hitherto has been the case.

**GEOPOLITICAL AND SOCIO-ECONOMIC INDICATORS FOR MOZAMBIQUE***

| | |
|---|---|
| Population (2000) | 17.9 million |
| Annual population growth rate (1999-2015) | 1,7% annually |
| Surface area ($km^2$) | 799,380 |
| People per $km^2$ | 22 |
| Per capita GDP (2000)/PPP (1999) (US$) | 230/861 |
| GDP growth rate (%) (1996-99) | ≈10% |
| Human poverty index (%) (2001) | 69,4 |
| Literacy (1999) | |
| • *males (urban/rural)* | 80% (95%/75%) |
| • *females (urban/rural)* | 57% (49%%/82%) |
| Safe water within a distance of 1 km | |
| • *urban* | 74% |
| • *rural* | 32% |
| Adequate sanitation | 24% |
| Contraceptive prevalence rate | |
| • *male* | 7% |
| • *female* | 5% |
| Maternal mortality *per* 100,000 live births | 600-1,5 00 |
| Life expectancy (yrs) at birth (1999) | |
| • *male* | 46 |
| • *female* | 49 |
| Mortality rates *per* 1000 live births | |
| • neonatal mortality | 57 |
| • infant mortality | 135 |
| • under-5-mortality | 203 |
| Undernutrition (%), under-5 years of age | |
| • *low birth weight* | 20 |
| • *wasting* | 8 |
| • *under-weight* | 26 |
| • *stunting* | 36 |
| HIV-seroprevalence (% 15-49 years) | |
| • *1988* | 3,3 |
| • *2002* | 16,7 |
| • *2008* (estimate) | 17,1 |
| One US$ | about 24,000 MT (December 20, 2002) |

From diverse sources, see *References*

# 1. The Setting

## 1.1 GEOGRAPHY AND HISTORY

Mozambique is a country with just less than 18 million people. Its coastline along the Indian Ocean of about 2500 km stretches from 26°52' South to 10° 27' North. The country is divided by the rivers Rio Zambezi, Rio Save and Rio Limpopo into three main regions: North, Central and South. The country is divided further into eleven provinces that in turn are subdivided into 140 districts. The provincial administrations are based in the provincial capitals. Provinces range in surface area between 20,000 to 120,000 km$^2$ with populations varying between 800,000 and 3,5 million. Inhabitants within a district range between 10,000 and 400,000.

Mozambique is one of five former African colonies of Portugal. Under the leadership of *Frente de Libertação Nacional de Moçambique* (FRELIMO), the population fought a liberation war for more than a decade. It was declared an independent Republic on July 25, 1975. The Government of the newly independent country embarked on ambitious development process, characterised by central planning. The social sector expanded with the aim to deliver services of health and education to all of the population.

After independence the country plunged into a devastating civil war that ravaged the country for more than a decade. Up to one million people are estimated to have been killed during the war and still more were wounded and disabled.[1] The country suffered also problems of internal refugees and two millions emigrated to neighbouring countries. To complicate the picture still further, during the civil war the country experienced severe drought in several successive years and hunger affected large groups of the population.

A new constitution for the Republic, introduced in 1990, paved the way for a peace accord in 1992 and a multiparty system. The first democratic elections for parliament and the post of President of the Republic were held in October 1994 and the second in December 1999. In both elections, FRELIMO came out as a winner against their main rival RENAMO, *Resistência Nacional Moçambicana*. In the year 2003 elections are planned in the municipalities, to be followed in 2004 with elections to the Parliament and the post of President.

During the 90's, Mozambique enjoyed rapid annual economic growth of 5-10%, this among the highest in the world. The World Bank and International Monetary Fund have together with the Government been influential in the economic recovery process, characterised by cuts in public expenditure, economy under the laws of the free market, privatisation of the

[1] Many areas are still heavily mined and taking lives and disabling people.

state sector and decentralisation. The economy is also heavily influenced by an outside input of a multitude of international donors.

Between February and April 2000, once again the economy experienced a severe setback when Mozambique suffered its worst floods and cyclone-related damage for 50 years. An estimated 1.2 million people lost their houses, crops, livestock and belongings and 700 people are reported to have died. The following year, in mid-February, throughout the months of June and July, the Central Provinces were severely flooded again, affecting over half a million people in the River Zambezi basin.

Mozambique is one of the poorest countries in the world and ranks number 170 out of 173 countries on the UNDP Human Development Index in the year 2002. The general health of the population of Mozambique is corresponding to this low ranking and the health indicators are among the worst in the world. The morbidity and mortality patterns are in line with those commonly found in low-income countries. Thus, malaria, diarrhoea, respiratory tract infections, skin infections, measles and malnutrition are common childhood conditions. Maternal mortality is among the highest in the world and contraceptive use low. Sexually transmitted diseases affect on average 7-10% of the population and the prevalence of HIV carriers is about 15%.[2] Table on page ix presents key geopolitical and socio-economic indicators for Mozambique.

## 1.2 The Health Sector

At independence the health care delivery system was nationalised and planned according to the principles of *Health for All the Year 2000* policy, formalised by World Health Organisation in the Alma Ata Declaration in 1978. The physical infrastructure was improved and expanded with the aim to reach the rural population. However, during the civil war, the health posts became military targets and it is estimated that about 820 health facilities were either destroyed or closed down during the years 1982-87. This corresponds to just less than 1/3 of all physical health structures in the country and affected 2-3 million people, mainly in rural areas. Since the end of the civil war in 1992, more than 400 health facilities have been rehabilitated.

After the end of the civil war, private health care practice was reintroduced. Nevertheless, within the foreseeable future delivery of health services to the general population will be principally given by public sector health officials. Within this system, the Ministry of Health assumes the role of over-all policy and strategy formulation, supervision and technical

---

[2] There are significant regional differences in prevalence rates. The rates surpass 20% in the Central region while estimated to be 12% and 14% in the South and the North, respectively. In Maputo Province the prevalence rate is estimated at 14,3%. It is estimated that about 700 individuals are infected with HIV every day in Mozambique.

support, human resource development, over-all monitoring and evaluation and procurement of funds for health activities. In the provinces the Provincial Health Directorates function as Ministries that, in turn, delegate responsibility for the delivery of services to the District Health Directorates. The lowest health administrative level is a health centre as the institutional base for health and health care activities in direct contact with the communities.

At the community level the policy has been to promote the establishment of community health posts as the basis for community based health care activity. Initially, this was provided by community health workers called *Agentes Polivalentes Elementares* (APE) and Traditional Birth Attendants (TBAs), called *Parteiras tradicionais*. These health workers were mostly trained by public sector health staff and given few key items to deliver their services, including drugs for malaria and simple infections. Despite its popular appeal and grass-root approach, this system has proved to be difficult to manage for the national health authorities and supervision was inefficient or non-existent. In response, the Ministry of Health has adopted the over-all policy to leave the implementation of community approach of health care delivery to NGOs while at the sama time offering supervision and support at the local level through the health centre.

## 1.3 Mozambique Red Cross

The Mozambique Red Cross (MRC), founded on July 10, 1981, has been a member of the International Federation of Red Cross and Crescent Societies (IFRC) since 1988. Currently, its membership base is estimated at 70,000 with more than 4,400 volunteers. Its executive body is the central headquarters with the Secretary General, the eleven provincial branches with Provincial Secretary and currently 95 district commissions.

MRC sees its fundamental role as the strengthening of the most vulnerable communities, particularly in the sphere of health, so that they may be better prepared to respond to disasters. To achieve the fulfilment of those objectives, the MRC has adopted a policy of grass-root participatory approach in the local communities all over the country, supported by its Provincial Delegations and District Commissions.

Since its foundation, health has been one of core intervention areas for the MRC. The backbone of the MRC current health strategy is in line with that of ARCHI 2010, the African Red Cross and Red Crescent Health Initiative with particular focus on community based health care and HIV/AIDS. Its long-term objectives are to increase the impact of MRCs basic health support to the most vulnerable and strengthen the capacity to respond more significantly to basic health needs. It is based on networks of community volunteers who target the most common causes of morbidity and mortality in Mozambique. In the year 2002, the MRC has 87 working Health

Posts and a network of approximately 2400 active volunteers who have been trained in First Aid and primary health care.

In the MRC's Strategic Plan for 2003-05 the following priorities are set for the community based health programme, to be implemented in at least one district in every province:

- Improve the health conditions of the most vulnerable communities through promotion of primary health care, in particular health education, assistance during cholera outbreak, monitoring of mother and child health and first aid;
- Encourage community initiatives to improve health conditions;
- Provide drinking water and basic sanitation and appropriate training;
- Develop commercial first aid services to support future sustainability; *and*
- Integrate in all activities a disaster preparedness and response component.

Other programmes in the Strategic Plan 2003-05 are those of HIV/AIDS, Social and Youth and Disaster Preparedness and Response Programme. In the HIV/AIDS programme, the priorities are on advocacy, health education among staff and in the communities and home based care. Among priorities of the Social and Youth programme are children in difficult circumstances, community based support to other vulnerable groups, prevention of land mine accidents and promotion of environmental education and protection.

The new Strategic Plan 2003-05 implies institutional development that aims at a stronger National Society with active participation of its members. In particular, it pinpoints improved governance and volunteer management and strengthened financial capacity through the implementation of an income generation plan and the consolidation of its accounting system. Thus, in the year 2003 the MRC headquarters will have one person dedicated to stimulate and support the Provincial Branches in income generation activity.

# 2. PROJECT HISTORY

## 2.1 THE COLLABORATION

The MRC has for years been one of the main international partners of the Icelandic Red Cross (IRC). Since the civil war years the two organisations have collaborated mainly on emergency operations and social activities. From 1996 the collaboration became more structured and bilateral through the IRC support to a project targeted at street children in Maputo and Beira.

In the Strategic Plan 1998-2003 of the IRC the main focus was on institutional development of sister societies and health related programmes.

ICEIDA—Icelandic International Development Agency—has worked in Mozambique since late 1995. It has concentrated its efforts mainly in the fisheries sector, in co-operation with the Ministry of Fisheries.[3] Since the year 2000 ICEIDA has expanded its activities with Mozambique to include co-operation with the Ministry of Women and Social Action.

In response to a general review of the activities of ICEIDA in 1997, it was decided to expand ICEIDAs activities to include projects within the health and education sector as well as to engage in co-operation with Icelandic non-governmental organisations (NGOs). Consequently, the IRC and ICEIDA decided to initiate collaboration in Mozambique within the health sector.

In 1998, representatives from ICEIDA and IRC visited Mozambique and initiated discussion with MRC. During this mission it was decided that Maputo Province was an appropriate project site, considering other ICEIDA related activity in the country concentrated in Maputo City. In January 1999, a joint mission was carried out in Maputo Province with representatives from ICEIDA, IRC and MRC, followed with a mission by MRC for complementary data collection.

## 2.2 PROJECT OBJECTIVES

On December 14, 1999, the representatives of the MRC, IRC and ICEIDA, hereinafter called the *Contracting Parties*, signed a *Development Contract* concerning Community Based Health Care Programme 2000-2003, hereinafter called the *Project*. The contract was elaborated further in a separate *Programme Document*.

*Development objectives*

- Contribute to the ongoing reform process within the MRC with capacity strengthening and self-reliance;
- Contribute to the rehabilitation of the government health care system; *and*
- Develop community based health activities and have a health care system in the area of implementation.

*Immediate objectives*

- Rehabilitation of government health system with the construction and equipment of one Health Centre Type III;
- Functioning community based health care activities in communities in the catchment area; *and*

[3] ICEIDA has supported one community based project with a youth group in one of the urban areas of Maputo.

- Capacity strengthening of the MRC at the level of the district sub-branch, provincial branch and at headquarters as far as support activities for the programme is concerned.

## 2.3 Organisation and Management of the Project

In the *Contract*, all responsibility for co-ordination, supervision and day-to-day administration was delegated to the MRCs Provincial Branch in Matola, the administrative capital in Maputo Province. Annex III to the *Contract* and the *Programme Document* include detailed guidelines on financial management, reporting and auditing for the *Project*. Later, on September 27, 2001, the *Contracting Parties* signed an amendment to the *Contract* regarding financial requirements and assistance to Maputo Province delegation.

In order to support the fulfilment of *Project* objectives, the *Contracting Parties* agree in Article III of the *Contract* to recruit a Programme Co-ordinator (Provincial Health Officer) and one Technical Adviser (TA). The Programme Co-ordinator (Provincial Health Officer) should:

- Carry the responsibility for the detailed project planning and implementation, including administration of financial and other resources;
- Ensure close collaboration between relevant Governmental institutions, agencies and local authorities involved in the programme; *and*
- Ensure that the programme is implemented in accordance with the Plan of Action and the enclosed Time Schedule (Annex II to the Contract).

These duties are further elaborated in Annex 1 of the *Programme Document*.

According to the *Contract*, the Technical Adviser should:

- Assist and advise the Programme Co-ordinator and supervise the work in close co-operation with Director of Programmes and Health Programme Co-ordinator at the MRC Headquarters.

In the *Programme Document* the TA is to work in close co-operation with the Provincial Branch as well as with the MRC's Headquarters. In addition, Annex 1 includes a detailed job description where it is explicitly stated that the delegate's counterpart is the provincial branch health officer.

In Article IV it is agreed to establish a *Steering Group* with representatives from MRC, IRC and ICEIDA. It should regularly consult and advice on the need for review and revision of the annual plans and budget. In the *Programme Document*, it is agreed that the *Steering Group* should meet twice a year. Further, it outlines the composition of a *Management Group* that should consist of representatives from the MRC Headquarters, Maputo Province Branch, the Programme Co-ordinator, the TA and the local representative of ICEIDA. It should meet on a regular basis to review

performance and make corrections and adjustments and approve plan of actions.

In the *Contract*, the Budget for the Project is presented in Annex 1. The estimated total cost was 808,000 US dollars, at the exchange rate 1 US$=72,74 Icelandic Crowns=13239 Mozambique meticais.

In Article VII of the *Contract* it was explicitly agreed that all equipment, vehicles and supplies procured for the Project were to be exclusively used for the planned activities and by authorised programme personnel. This should be the property of the programme until the expiry of the contract or extension period. Upon completion of the programme period, a complete inventory of all equipment should be prepared by MRC for the purpose of formally transferring ownership to the MRC.

## 2.4 PROJECT IMPLEMENTATION

In the *Programme Document* it is defined that the *Project* site will be Hindane and nearby villages, in the District of Matutuíne, Maputo Province. The strategy to be applied was the following: First, construct a Health Centre Type III in Hindane. Second, train MRC volunteers to become community based health care (CBHC) workers (prevention and community activities) and train TBAs to improve assistance to pregnant and delivering mothers. Third, train community health workers (formerly APE) for simple curative services. Fourth, conduct participatory micro planning and map households as well as infrastructures, health problems and their possible solutions. Fifth, carry out a baseline survey on the main health and social problems to produce comprehensive plan of activities for MRC intervention.

In what concerns institutional development of MRC, the *Programme Document* implies that the *Project* was to be implemented by the Provincial Branch office with supervision and support from the Headquarters. In particular, human resources directly involved in *Project* management were to be supported.

The *Programme Document* states that the activities of the local MRC committee should be strengthened and institutional training and support provided to elected bodies at district/sub-branch level. At the community level, the local MRC committee should govern community health activities in consultation with community members while the MRC sub-committee should monitor MRC activities in the *Project* area. Overall responsibility and accountability should rest with the Provincial Branch Secretary.

The *Programme Document* includes detailed descriptions on specific programme objectives, divided in several distinct areas: construction, training of volunteers and TBAs, maternal care and family planning, child health care and sexually transmitted diseases. Each specific objective is elaborated further in an attempt to be able to measure the successes (or failures) of the *Project* at its termination as well as for monitoring purposes.

Further, a *Project* matrix is presented with summary of objectives, indicators, expected outcome and external factors of relevance for Project implementation.

At the same time as the *Contract* was signed by the *Contracting Parties*, ICEIDA and IRC signed a special agreement of collaboration for the execution of the *Project*. It was decided that ICEIDA should cover 50% of *Project* costs, IRC 40% and MRC 10% (in manpower and facilities). Thus, in practice, ICEIDA has covered 55% and IRC 45% of *Project* costs. In this special agreement there are over-all guidelines on procedures for, e.g., reporting, transfer of funds and TA.[4]

The project period was initially from January 1, 2000, to December 31, 2002, but was later extended for one year because of delays suffered because of the floods. On April 6, 2000, it was declared by ICEIDAs representative in the *Steering Group* that its contributions to the Project would be considered emergency aid until the formal start of the *Project*.

An external final evaluation was to be conducted in the third quarter of third year of *Project* implementation.[5]

# 3. EVALUATION METHODOLOGY

## 3.1 THE MISSION

As laid out in the *Terms of Reference* (Annex 1), the evaluation is to provide information for decision makers, both in Mozambique and Iceland, while also being a learning exercise for the stakeholders, in particular MRC and its sub-branches. In separate sub-headings, the *Terms of Reference* specifies the issues to be covered and these are adhered to in the presentation that follows.

The following persons were recruited to conduct the evaluation:

- *Geir Gunnlaugsson*, paediatrician, team leader
- Ms. *Ernestina Jorge*, health co-ordinator, MRC Headquarters
- Mr. *Pedro Caleilano*, health technician, MRC Maputo Headquarters
- Ms. *Ilda João Cuna*, Programme Co-ordinator, MRC, Provincial Branch Office
- Ms. *Hjördís Gudbjörnsdóttir*, IRC, Technical Adviser

---

[4] In the agreement, among other things, the TA was to be an IRC delegate while ICEIDA assumed the responsibility to assist the TA upon arrival and in other matters as needed.

[5] Review after 12-18 months of *Project* implementation, as envisioned in the *Programme Document*, did not take place.

In Reykjavík, Iceland, the team leader was presented with relevant documents and had discussions with those involved in project activities on behalf of ICEIDA and IRC.

The mission was conducted in Mozambique in December 10-23, 2002. Upon arrival in Maputo, the evaluation team met for the first time and the programme for the evaluation was agreed upon (Annex 2). Initially, the team leader had individual discussions with persons who have in one way or another relation to the *Project* (Annex 3). Further, the evaluation included field visits by all in the team and discussions were held with local leaders, volunteers and the local population in involved *Project* communities. The evaluation team had also extensive discussions in the group concerning the issues to be covered as laid out in the *Terms of Reference*.

The Report with the conclusions of the evaluation was to be written by the team leader and presented for comments to ICEIDA, IRC and MRC before the end of January 2003 with a final version completed before mid of February 2003.

# 4. Project Activities

In the *Programme Document*, the over-all costs of the *Project* were estimated to be about 808,000 US$; with the current one-year extension estimated costs are about 971,000 US$. Currently the total expenditure is just over 760,000 US$. Excluding delegate costs, the construction component and recurrent costs for the day-to-day running of the *Project* amount to just less than half of the total.

## 4.1 Project Site

Maputo Province is the southernmost and the smallest of eleven provinces in Mozambique with a surface area of 23276 km$^2$; the province is divided into eight districts (*see* Map and Table 1, page 10). It is sparsely populated with about 835,000 inhabitants mainly of the ethnic group Tsonga. The administrative capital is Matola City.

The District of Matutuíne is one of eight districts in Maputo Province, and it is divided into six administrative posts, of which Bela Vista is one. The district covers 5403 km$^2$ and is, compared to other districts in the Province, sparsely populated with about seven inhabitants *per* km$^2$.

Table 1. *Districts in Maputo Province and their respective geographical size, population and population density.*

| | | Population in 1999 | | |
|---|---|---|---|---|
| **DISTRICT** | **Surface area (km²)** | **N** | **%** | **per km²** |
| *BOANE* | 820 | 59298 | 7,1 | 72 |
| *Magude* | 6960 | 44168 | 5,3 | 6 |
| *Manhiça* | 2380 | 133629 | 16,0 | 56 |
| *Marracuene* | 666 | 42744 | 5,1 | 64 |
| *Matutuíne* | 5403 | 37514 | 4,5 | 7 |
| *Moamba* | 4528 | 44496 | 5,3 | 10 |
| *Namaacha* | 2144 | 32236 | 3,9 | 15 |
| *Matola City* | 375 | 441057 | 52,8 | 1176 |
| **Province** | **23276** | **835142** | **100** | **36** |

The *Project* area of Hindane falls under the administrative jurisdiction of Bela Vista. Seven out of eight communities are involved in *Project* activities (Table 2).

Table 2. *Population in the Hindane area involved in Project activities.*

| **Village** | **Population (n)** |
|---|---|
| *Hindane* | 700 |
| *Mphochane* | 900 |
| *Muchocolate* | 347 |
| *Djabissa* | 549 |
| *Manhihane* | 552 |
| *Kwache* | 447 |
| *Djabula* | 600 |
| **Total** | **4095** |

**Source**; *Project Document*, 1999.

## 4.2 INSTITUTIONAL DEVELOPMENT

Since the beginning of the *Project*, it has supported the MRC Provincial Branch office in Matola. Thus, out of nine employees, the *Project* pays the salaries of three, i.e., Programme Co-ordinator of Health, the Finance Administrator and a Project Driver.[6] It financially supported the rehabilitation of the office in the year 2000 and pays the current rent of the house. The *Project* has bought and maintains two Toyota Hilux cars,

[6] The Spanish Red Cross pays the salaries for three employees (HIV/AIDS project) and the MRC Headquarters the rest.

earmarked for implementation of the activities in the Hindane area.[7] It has also bought furniture and office equipment, including two computers. Further, it supports the recurrent costs of the Branch office, including telephone/e-mail, electricity and water.

Regarding training of staff, the *Project* has supported and stimulated staff to take course in the English language and on the use of computers. Further, the Financial Administrator and Programme Co-ordinator attended a course on financial management and another on file systems, organised by IFRC.

The *Project* has supported on site visit of staff to Inhambane in September 2001 where the Danish Red Cross, funded by DANIDA, is implementing a similar project together with the MRC. The Programme Co-ordinator is now expected to visit Zimbabwe for an informal working experience regarding HIV/AIDS.

During the *Project* period three different persons have been working as Programme Co-ordinators of health in Maputo Province, i.e., the formal counterpart of the IRC TA. The first one suffered an accident in October 2000 in which he lost one of his legs. After the accident, one of the MRCs health workers at the Headquarters temporarily substituted him before a new one was recruited, in effect from February 2001 to date. Obviously, this negatively affected the work in the field; fortunately, the new Programme Co-ordinator, a medical assistant by training, is a dynamic person who speaks the local language with keen interest in the *Project* activities. She is in good contact with the population in the *Project area* and her collaboration with the IRC TA is excellent.

The income generation activity of the Maputo Provincial Branch office is limited.[8] It has access to an old truck it hires for transport of goods, e.g., for the World Food Programme. This activity lacks transparent accounting routines for the income and is a constant source of conflict. There have been discussions to introduce other activities but these have not yet been materialised.[9]

The IRC is the most important collaborator of the MRC Provincial Branch office. Recently, the Spanish Red Cross has initiated HIV/AIDS project in the province in collaboration with the Branch office.

---

7 The use of one of the *Project* car has resulted in conflicts as the Provincial Secretary has claimed he also has the right to use the car for some of his activities.

8 In the Country Assistance Strategy (CAS) of the MRC, one of the objectives is to increase the financial sustainability of the MRC, among other things through the establishment and implementation of a revenue generation policy. Such activity was not specifically addressed in the *Programme Document*.

9 Activities that were mentioned with income generation potential were: sewing co-operative, produce and commercialisation of agricultural products, a guesthouse and training theatre groups for various activities, e.g., on HIV/AIDS prevention.

The *Project* activities have stimulated and supported the establishment of the Hindane MRC local committee as well as its sub-committees in the seven communities. However, the District Branch in Bela Vista is not functional and has no space for its activities, including for training and disaster preparedness stock. They also lack transport vehicles to be able to supervise the local committees and sub-committees. Their membership base is also low.

## 4.3 Hindane Health Centre

As set out in the *Contract*, after initial delays the construction work of the Hindane health centre was initiated on June 6, 2001 and formally completed in November 2002.[10] The work has been hampered with many problems, such as mistakes in tender documents and old standard drawings that needed alterations, e.g., toilet for expectant mothers and closed kitchen for staff. During the construction period regular meetings were to be held with representatives from IRC, ICEIDA, MRC and their construction supervisor and the construction company. The representatives of the MRC however often failed to meet and the construction has been a time consuming process for the IRC TA. No one from the Ministry of Health participated in these meetings.[11]

During the construction work, errors in design and necessary alterations that followed delayed and complicated the construction work. It is also evident that lack of proper supervision has contributed to many of the encountered difficulties.[12] Also, as is a common experience in other construction works, companies tend to come up with a low bid in order to secure the contract. Subsequently they tend to recover some of the "losses" through additional work that is normally required in the process. Such negotiations take time and energy from those involved. The MRCs responsible persons for the construction claim the buildings are of good quality and in general praise the work of the construction company.[13] The formal construction work is now completed with most financial matters resolved concerning the construction.[14]

---

[10] The initiation of construction was preceded by a ceremony on May 3, 2001, where the traditional ceremony 'Ku-PHAHLA' was performed with traditional leaders and other guests.

[11] The *Programme Document* did not envision such participation.

[12] Just before inauguration of the health centre the TA discovered that there was no running water in the facilities. The two water systems had not been connected, i.e., from the water tank into the health facilities and the other into the staff houses. This added to the cost of the construction.

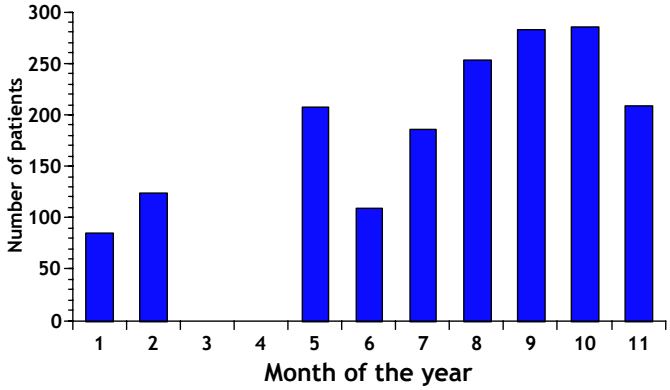
[13] To stress this point the construction supervisors call attention to newly constructed houses for the MRC in Gaza Province that are already falling down as a result of deficient supervision and quality control.

[14] The only outstanding claim is the cost of the pavement to the health centre. The construction company claims it made an error in their cost estimation in one of the cells in an Excel workbook. They are subsequently asking for 7000 US$ more

The Hindane health centre was inaugurated on April 30, 2002 and handed over to the Ministry of Health. Initially, the health centre was temporarily staffed with several short-term nurses. Then, a midwife was sent to the health centre; she is however not trained for services in general outpatient departments. Yet, she is doing her best to fulfil her duties and she gives a good impression. She is however alone with associated long working hours seven days a week.[15]

The attendance to the health centre is as to be expected, considering the low number of population living in the catchment area (Figure, page 18). Children less than 15 years of age are about 2/5 of all attendance. The most common diagnosis is malaria, ranging from 35-56% of all diagnosis, depending on age. Other diagnosis registered are, e.g., respiratory infections, sexually transmitted diseases, wounds, headache, gastritis, scabies and allergy. Further, the midwife is assisting one to three births a month as most women still give birth at home. She refers also to Bela Vista some women in labour classified with high obstetrical risk. She offers immunisation at the health centre and had good record keeping of the temperature of the refrigerator. However, she is not involved in any community work as she has no transport.[16] Further, she is not involved in out-reach activity in the neighbouring communities, organised and executed by the District Health Team in Bela Vista.

Figure. *Attendance figures for the Hindane Health Centre (2002).*




According to information given during the evaluation, the midwife will in 2003 be transferred to another health centre and substituted with a general nurse. This should be a qualitative improvement for the outpatient services.

---

for the construction than initially agreed upon. This claim has been rejected by IRC, MRC and ICEIDA.

[15] Two staff houses were constructed to accommodate one general nurse and one midwife.

[16] The purchase of a motorbike for staff, as envisioned in the *Programme Document*, has not been realised.

However, the prospects of having two qualified nurses/midwife there within the next few months are dim.

There is a general lack of health staff in Maputo Province. According to national norms the province would need some 2500 staff to be compared to the 900 they actually have. Further still, cleaners have been the only staff at two health centres in the province. The province has also difficulties in recruiting cleaners as it is required they have at least seven years of school education before enrolment on a public sector pay-roll. It is claimed to be difficult in Hindane to find such a person as well as finding funds to pay the costs. The Provincial health authorities declared willingness to resolve this problem within the next few weeks and months. Currently, the midwife keeps the Hindane health centre clean with help from some of the MRC volunteers in the community.

In community meetings with the Evaluation Team it was evident that the population appreciated the new health centre and they would seek care there for their sick children or attend themselves in case of need. They also claimed that if the house for expectant mothers would be built close to the health centre they would like to give birth there. Considering the distances in the district it is not to be expected that women already in labour will walk the long distance necessary to give birth at the health centre rather than give birth at home, now with the assistance of a trained TBA. In 2003, a simple building for expectant mothers will be constructed at the health centre, hopefully with increased number of assisted births in the health centre as a result.[17]

In Hindane two staff houses were constructed and one is currently empty. All the facilities have running water, pumped to a large water tank by an electric pump in a nearby well, unfortunately situated outside the health centre area.[18] A trained volunteer attends the pump and it is currently functioning.[19] The potential quantity of water is however in doubt but it is expected to produce 1000 l per day. The opinion was expressed that it might have been a mistake to have the water for staff houses and the health centre to come from the same source. With more staff and activity the water quantity might not be enough in the long run for all what is necessary, e.g., water toilets and laundry.

---

[17] The construction of this building was not envisioned in the *Programme Document*.

[18] This is due to the difficult water situation in the area.

[19] Reportedly, the Ministry of Health is currently not in favour of implementing pumps run by solar energy. These are expensive to run and need sophisticated maintenance, despite their attractive appeal.

## 4.4 COMMUNITY BASED HEALTH CARE

### 4.4.1 CBHC VOLUNTEERS

In the *Project* period three courses have been held in Bela Vista to train volunteers. [20] Thirty-seven CBHC volunteers out of 40 planned have been trained in two training courses in community based health work, each course with duration of four weeks. [21] The respective communities select their own CBHCs, guided by minimum requirements set up by the MRC as to qualify.[22] On average, there are four to seven CBHC volunteers in each community.

The training of CBHC volunteers is based on a newly revised MRC training programme. Currently, 34 volunteers are working within the programme.[23] The volunteers get kit for their work including aspirine, chloroquine and oral rehydration salts for diarrhoea. They are however expected to do more preventive work in their communities than be engaged in curative activities. Thus, regular home visitations are part of their work in which they discuss issues like hygiene, latrines and water. In November 2002, 17 of the CBHC volunteers participated in a 5-day ARCHI 2010 course and the rest are expected to do the course in early 2003.

The Evaluation Team met 20 of the CBHC volunteers in a community meeting in Hindane. They expressed their satisfaction about their training. It was evident that they showed interest in and knowledge on basic aspects of health and prevention. Thus, they became engaged in discussion on diarrhoea and cholera, latrines, water treatment, growth charts for children and prevention of malaria and HIV/AIDS. They experienced difficulties in having people to construct latrines and then to use them (latrine=disease) and the use of condoms was by some of the population considered a sign of prostitution. The volunteers expressed discontent with their inability to give drugs to sick people, to lack talc for gloves and not to have light lamps for work at night. They also mentioned the importance to have identification cards.[24] They received bicycles in early 2002 but already many are broken down.

---

[20] In the *Programme Document* it was envisioned to also train community health workers (APEs). This policy of the Ministry of Health is now no longer implemented and the *Project* has not become engaged in such training.

[21] The first training course was conducted in March 2001 and the second in December 2001.

[22] Volunteers have to be at least 18 years of age, live in the community, have minimum of schooling to be able to read and write, be respected and trusted in the community and speak the language. MRC is also keen to have gender balance among the volunteers that sometime may cause difficulties as women, generally, have less schooling than do men.

[23] Two volunteers have moved to Maputo and one has died.

[24] Identification cards will be distributed in 2003.

### 4.4.2 Traditional Birth Attendants

In September and October 2001, 18 TBAs were trained in basic skills to assist pregnant women during pregnancy and in giving clean birth.[25] The training material shown to me was appropriate and well prepared for the purpose. After training the TBAs received kits that consist of appropriate material to assist women in birth.

The Evaluation Team met 13 out of the 18 TBAs in a community meeting in Hindane. In discussion they expressed satisfaction with the training and confirmed that they had learned much on clean birth and signs of high obstetrical risk during pregnancy.[26] They said they lacked basin, talc for gloves, suction apparatus for aspiration of newborns, disinfectants and medicines to improve the labour work. They said that on average they assisted about three births a month.

### 4.4.3 Water and Sanitation Volunteers

The *Project* has trained 16 water and sanitation volunteers in the communities out of 20 as planned initially. They receive training for two weeks according to manuals prepared by MRC. The theoretical part of the training was conducted in Bela Vista while practical skills were trained locally. They are responsible for the maintenance of water points as well as the training of the population in basic hygienic measures.

The Evaluation Team met 11 out of the 16 trained water and sanitation volunteers in a community meeting in Hindane. They lack material for maintenance but the population has not been eager to pay such costs. Also, the water committees are not functioning and the people were not so interested to pay for water they did not like the taste of. They also said they needed ladders to be able to go into the wells for maintenance and inspection, and bicycles for transport. They also felt lack of supervision from the MRCs water and sanitation department.

### 4.4.4 Reimbursement of Volunteers

The MRC volunteers do not get paid for their work. However, quarterly they receive incentives in the form of uniforms and other material for work. They are also paid allowances during training.

### 4.4.6 Local MRC Committees

The Evaluation Team met the local MRC committee in the Hindane area as well as the sub-committee in Kwache village. In general, they expressed interest in the MRC community based work. They could however not give an

---

[25] Training of 40 TBAs was envisioned in the *Project*. Of the 18 trained TBAs, one has died.

[26] In the discussion they mentioned at least eight danger signs during pregnancy.

indication on the number of MRC members in their respective communities who would be willing to pay membership fees.[27]

### 4.4.7 Local Leaders

The Evaluation Team met local leaders in a community meeting in Hindane and in the village of Kwache. They expressed their satisfaction with the community based health care work of the MRC. They had good relation with the MRCs volunteers. The principal problems felt was improved attention to the needs of old people who are always sick and cannot themselves go to the health centre.

### 4.4.8 First Aid Posts

First Aid Posts are to be constructed by the involved seven communities in the area. For the construction the *Project* supports the community with appropriate material while the community members themselves do the construction. Five of the seven communities have initiated the work but none is concluded.

The Evaluation Team inspected one post in Kwache village that has been under construction since 4-5 months. The walls were almost finished but the post was without a roof. When inquired about the reason for the delay of completing the work, the community members pointed out that they were engaged in construction work in another village where they get food-for-work. This is only a reflection of the low socio-economic status of the population in the *Project* area.

### 4.4.9 Community Meetings

The Evaluation Team had two general community meetings with the population, first in Hindane and then in Kwache. In the meetings, the population was engaged in discussion on the current health situation in their respective communities.[28] Both men and women vividly expressed satisfaction with the new health centre and the work of the MRCs volunteers with improved access to health care. Yet, there were issues of particular concern, most importantly the following:

- Hindane health centre
  - clinical consultations by a medical practitioner at least once a week as there are many diseases and health problems that need a doctor for a proper evaluation
  - more trained health staff
  - house for expectant mothers

---

[27] In the discussion it could be felt they hardly understood the meaning of being a member in the MRC, except working as a volunteer.

[28] There was an estimated 80-100 participants in the meeting in Hindane and 40-50 in Kwache.

- Lack of school, especially 6th and 7th year.
- Hunger and poverty, especially among the old, widows and orphans.
- Lack of rains
- More drugs for the volunteers
- A place to get tested for HIV status
- Preventive measures such as latrines, water and condoms for HIV/AIDS.

In general, as evidenced by the above, it can be concluded that the community is highly capable to express their views on health related matters, most likely stimulated by the MRC health related work in the area. At the same time the community is experiencing difficult time characterised by poverty and hunger they wish would be partially relieved through distribution of food to the general population.

#### 4.4.10 BASELINE DATA

No baseline data, as envisioned in the *Programme Document*, exist on the general health of the population in the *Project* area. However, so-called Participatory Rural Appraisal (PRA) has been conducted twice, the last one just recently completed.[29] The results of the first one in February 2001 are stated to substitute the baseline study that was intended to measure the general progress of the *Project* activities.

### 4.5. WATER AND SANITATION

In collaboration with the Spanish Red Cross, several hydro-geological investigations have been conducted to find water in the *Project* area. This has only confirmed the difficult water situation in the area. Water is found in only small quantities and it is often undrinkable because of its content of salt. It was opted for the construction of shallow wells and these have been constructed in the seven communities. In this work, the TA has collaborated with the Spanish Red Cross and its help has been crucial for the completion of this work. Nevertheless, the well in Kwache had no water at inspection by the Evaluation Team despite being several meters deep (the wells are usually 7-9 metres deep), This only illustrates the difficulties the communities face to have secure access to clean water.

In May 2002, the IRC, MRC and the Spanish Red Cross signed a co-operation agreement on a water and sanitation project to be implemented in the Matutuíne District. The project aims to construct 30 shallow wells and targets about 16,000 people. Despite not being directly within the *Project* area, these are adjacent communities where the population has a hard time to find decent water to drink.

---

[29] In the PRA each village is visited and basic data collected about the community: history, access to water, latrines, health and hygiene and food security.

# 5. TERMS OF REFERENCE

## 5.1 Efficiency

*Results achieved (inputs-outputs).*
*Have resources been effectively used in the project? What problems have arisen? Could they be avoided in similar projects?*

### 5.1.1 OVER-ALL MANAGEMENT

For ICEIDA and IRC, the conception and implementation of the *Project* is the first of its kind. ICEIDA, a governmental agency, has formerly worked within the framework of bilateral agreements between two governments. In this *Project*, the Icelandic government through ICEIDA signed an agreement of collaboration with the IRC, a NGO, to co-operate with MRC, another NGO, in the implementation of a community based health care project.

The *Project's* development objectives were the first of its kind for both organisations. ICEIDAs expertise had formerly been mostly concentrated within the fisheries sector but had nevertheless included support within the social sector. It had also limited experience in working with grass-root organisations at the community level. Regarding the IRC, it had most experience in multilateral collaboration through IFRC and ICRC with delegates usually contracted on a short-term basis but some worked on long-term contracts for development projects. Further, IRC had some experience in bilateral activities, e.g. organisational support to the MRC since the civil war years but without a delegate.

In order to implement the *Project* the two Icelandic organisations have been going through a learning process, at times a difficult one, to smooth out routines, in particular regarding the transfer of funds and reporting. Change of personnel, in some cases without proper hand-over and clear guidelines on respective responsibilities, within the IRC Reykjavík and ICEIDA Maputo has also strained the collaboration and the organisational structure. At the same time, the two Icelandic organisations have been co-operating with two partners in Mozambique, i.e. the MRC and to a limited extent also the Ministry of Health. Thus, organisational stakeholders in this *Project* can be said to be four, each with their own dynamics, routines and organisational culture.

During the *Project* period the *Steering Group* has held two annual meetings as agreed among the *Contracting Parties*. It is evident from agreed minutes that the MRCs Provincial Secretary has only attended two of the meetings, i.e., on September 27, 2001 and April 29, 2002. Despite legitimate

reasons for absence, this has not been favourable for implementation of the *Project* as the Secretary has been rather detached from his over-all responsibility and accountability for *Project* activities, by far the largest in his Provincial Branch office.

The *Management Group* has held regular meetings with agreed minutes during *Project* implementation. In the year 2002, five meetings were held in which the Provincial Secretary participated in three. In a meeting on October 24, 2002, he discussed that he felt decisions were sometimes taken above his head, without being able to give an appropriate example.[30]

It has been noted in minutes that the *Management Group* meetings should have more the character of decision taking rather than that of day-to-day running of the Project. Such matters are currently discussed in weekly meetings that have since the year 2002, taken place in the IRC office in Maputo[31] attended by the Programme Co-ordinator and Finance Administrator in Matola, a health technician from the MRC Headquarters and the TA.

Collaboration of ICEIDA with a NGO should, at least in theory, alleviate the Agency of some of the burdens of running a project on its own. This has not been the case in the implementation of this *Project*. Current Icelandic law for ICEIDA are given as a reason for the extensive involvement of the Agency in the implementation of this *Project* that in essence is collaboration between two NGOs.[32] If further collaboration of ICEIDA with NGOs is to be established it is to recommend to reconsider current law to enable the Agency to only transfer money directly to the collaborating NGO, in this case IRC, with proper routines in place for supervision of *Project* activities and fund expenditure.

### 5.1.2 Financial Management

In the *Programme Document* the flow of money is defined. Thus, a separate bank account in the name of MRC should be opened for the *Project*. The MRC Headquarters was entitled to sign for the account. ICEIDA and IRC were to transfer funds every three months to the bank account in accordance with budget and Plan of Action. From this bank account, money was to be transferred to a separate bank account of the MRC Provincial Branch office in Matola, based on accountability for how funds had been used.

This initial plan for transfer of money rapidly proved to be difficult to implement, e.g., because of delayed financial reporting that resulted in no

---

[30] He mentioned rules concerning the use of *Project* car, rules that are generally applied for all MRC cars.

[31] The IRC office is in the home of the TA.

[32] Law nr. 43:1981, article 3b, states that ICEIDA should plan, implement and/or have over-all responsibility of management, and supervise projects financed by the Agency.

transfer of funds was possible. In April 2000, it was decided that expenses related to the TA (petite cash) should be transferred to a special bank account from the programme account. In May 2001, the financial report of the MRC for the *Project* was still missing for the year 2000 and, consequently, no money was transferred to the MRC account. Thus, to implement some of *Project* activities, the MRC borrowed money from other projects. Further still, to avoid delays in construction work, it was agreed that ICEIDA would pay the agreed sums directly to the construction company rather than through the MRC bank account, as stipulated in the *Programme Document*.

On September 27, 2001, the *Contracting Parties* signed an amendment to the *Contract* concerning financial requirements. In the amendment it is specifically stated that MRC is responsible for financial accounting of funds. It should submit quarterly financial reports while ICEIDA and IRC would quarterly transfer money in response to cash requests, approved budget and Plan of Activities. It was also decided to give special support to the Provincial Branch office in Matola regarding the financial reporting.

Despite these efforts, the transfer of money to MRC has been irregular and often delayed.[33] This has resulted in a new routine to be implemented in 2003. In this new plan, the MRC will present directly to the ICEIDA office in Maputo the narrative report with financial statements for each passed quarter and at the same time present their cash requests and Plan of Action for the coming quarter. When all eventual questions regarding the request are resolved by ICEIDA Maputo it will be forwarded to ICEIDA and IRC in Reykjavík for review and, subsequently, IRC will transfer money in accordance to their respective share of *Project* costs.[34]

PriceWaterhouseCoopers in Maputo have done auditing of the financial statements for the years 2000 and 2001.[35] In general, they have not found any severe irregularities in the statements while at the same time they present suggestions for improvement, when appropriate.[36]

---

[33] I was shown a letter to IRC, dated October 16, 2002, with a request for the transfer to MRC of about 52,000 US$, based on approved budget and financial statements. On December 2 a reminder was sent. On December 11, 2002, no money had been transferred to MRC for activities in the IV Quarter of 2002. Reasons given for the delay are, e.g., that the required documents were not properly signed and that the request was only based on budget plans, e.g. including the cost of the current evaluation. After correction, about 8400 US$ were transferred to MRC.

[34] In the bilateral collaboration of ICEIDA and IRC, hitherto the balance of their respective "share" of Project costs has not been strictly adhered to.

[35] The audit does not include costs regarding the construction or the TA, only costs related to MRC.

[36] The auditing of the financial statements from the year 2000 PWC found a difference of 2853 US$ that was not properly accounted for. This money was later correctly accounted for.

In March 2002, the Administration and Finance department of the MRC Headquarters, in collaboration with the IFRC Finance Development Delegate, conducted an internal audit of all the MRC Provincial Branch offices, including Matola. In a special report on the Matola office they recommend a series of improvements to be implemented regarding financial management. This audit has been followed with special support from MRCs finance department.[37]

Budgeting for *Project* activities for the year 2003 has caused some confusion within the MRC and IRC. Apparently, the lack of a mutually agreed channel of communication between MRC and IRC Reykjavík regarding financial matters has resulted in unnecessary confusion on budget lines and how to deal with them.

### 5.1.3 TECHNICAL ASSISTANCE

At the outset, at the request of ICEIDA, it was decided to technically back-up the *Project* with a TA to support the implementation of the *Project*. The TA was to be a nurse and an IRC delegate. In many aspects the TA has experienced many difficulties during *Project* implementation.

First, neither she nor IRC had participated in a bilateral development project implementation of this size before. For all it became a learning process, at times a difficult one.

Second, she had only four weeks of Portuguese language course before embarking[38] and her deficient Portuguese has been one obstacle for efficient *Project* implementation. She has gradually improved her language skills and with that her cultural competence. Further, she had no additional training, nor personal experience, on the particularities of health care service delivery in Africa before arrival to Mozambique except for aspects that were related to Red Cross activities.[39] More attention given to these aspects in the planning phase of the *Project* could have been beneficial for implementation of *Project* activities.[40]

Third, at arrival Mozambique was experiencing one of its worst floods in its history and, understandably, nobody at the MRC Headquarters had the necessary time to introduce her to the field or the organisation. In this respect, her lack of experience in working with a national Red Cross organisation may have been a handicap.

---

[37] Surprisingly, the MRC Provincial Secretary declared, supported by his Finance Administrator, that he had never been presented to the report on this internal auditing.

[38] Many development organisations that work in Portuguese speaking countries in Africa send their workers on an intensive training course in Portuguese for at least 3 months before sending them to the field.

[39] There is great variety of courses available in Scandinavia and elsewhere in Europe.

[40] Appropriate training is no guarantee for successful implementation but can hardly be to the detriment of the activities.

Fourth, she became involved in various activities that normally fall outside the duties of a health worker—and a nurse—in high-income countries.[41] Normally a Red Cross health delegate would work in a more organised back-up structure for logistics, finances and administration, something that has not been the case in this *Project*.[42] In this respect, she has had crucial help from ICEIDA, both in Maputo and Reykjavík, while at times feeling as an outsider within the IRC.

Fifth, at the outset she was not given clear guidance on reporting of activities expected by the IRC. Thus, reporting routines have caused tension, in particular on financial matters, that may have resulted in unnecessary misunderstanding between IRCs Headquarters and the TA.

Six, she worked with two different Programme Co-ordinators in the MRC Provincial Branch office during the first year of implementation of the *Project* and one on a short term contract immediately after the accident.[43]

Seven, during the *Project* period the TA has had a 'fluid' working space. As a consequence of the floods her main tasks were initially within the sphere of IFRC emergency activities in Maputo. After the floods she moved her office to the Provincial Branch office in Matola. However, because of rehabilitation of the building she had to move out again. In the beginning of 2001, when the office allocated for health was available again, she installed herself in the office again. She however gradually withdrew herself from the office to give space for her counterpart. Finally, in 2002, she created an office in a spare room at her home in Maputo with the approval of the IRC at the same time she was appointed the official IRC Representative in Mozambique. Despite much of the work is done outside the office, e.g., in Maputo for necessary contacts, e.g., with MRC Headquarters and community work in Hindane, to have no proper working space within the Provincial Branch office has limited to some extent her contacts with the staff, including the Branch Secretary. Yet, she has visited the office on a regular basis and in particular the Hindane area. She is also in daily contact with her counterpart and has had weekly meetings in her office in Maputo. Nevertheless, all MRC staff stressed that the TA had been instrumental in having things done and had created contacts that had been beneficial for the development of the *Project* and improved the name of the MRC in the province.

---

41 It suffices to mention a few of the tasks, such as construction work, water and sanitation, community participation, finance and accounting and driving vehicles under difficult conditions.

42 IRC Reykjavík is of the opinion that this was guaranteed through the special agreement, signed with ICEIDA on December 14, 1999, regarding practical help to the delegate, as found appropriate.

43 The reason for this was the tragic accident in October 2000 that involved her counterpart in the Project.

Eight, during the *Project* period important and sudden changes of staff within the IRC negatively affected the working relation of the TA to her principal counterparts in Reykjavík. Change of staff also occurred within ICEIDA Maputo. Lack of clear guidelines on responsibilities and proper hand-over may have contributed to some of the encountered difficulties.

Finally, the TA is a woman who has most of the *Project* period lived alone and been without a driver. Considering that personal security is increasingly under threat in Maputo and driving alone can be dangerous under difficult road conditions in the *Project* area, the *Project* would have benefited with more attention given to these aspects of the daily life of the TA.[44]

### 5.1.4 MRCs Headquarters

The *Programme Document* stipulates clearly that the focus of the *Project* is on the provincial and local level in Maputo province. Consequently, it has not been on *Project* agenda to directly support staff development at the MRC Headquarters. Rather, the Headquarters have indirectly been involved in *Project* implementation and through that gained more experience in finance administration, construction work, water and sanitation—as well as donor administration.

### 5.1.5 MRCs Provincial Branch

The *Project* has constructively supported the MRC Provincial Branch office. First, it financed the rehabilitation of the office, to the benefit for the internal organisation of the office. Second, it financed the purchase of appropriate office equipment. Of particular importance has been the purchase of computers, printers and photocopy machine as well as transport vehicles.[45] Without such support the office would not have a fair possibility to implement relevant activities in the field.

On behalf of the MRC, the Provincial Secretary in Maputo Province is financially responsible for all activities of the *Project* in the field. Thus, to execute *Project* activities the Programme Co-ordinator has to present her programme to him and have him sign all bills. The Secretary has however generally not been visible in the *Project* activities, neither centrally nor locally.

Other staff of the MRC Provincial Branch office have directly benefited from *Project* activities through participation in appropriate courses, e.g. English, or visits to other similar projects. They have also been given important tools to execute their services, e.g., computers and transport vehicles. In this respect, the Provincial Branch office has been strengthened.

---

[44] A driver has recently been recruited.

[45] I am of the opinion that improving computer competence of the Provincial Secretary lies within the *Project* objectives. This may need the purchase of an extra computer with well defined objectives for use.

### 5.1.6 MRCs District Branch

The *Project* has hitherto not supported the development of the MRC District Branch in Bela Vista.[46] That structure is weak and membership base limited.[47] There is on-going discussion on how to strengthen this structure, e.g., with the construction of simple space for meetings, training and stockpiling of MRC materials. Before embarking on such construction work, however, the activities in the district should merit such an upgrading. At the same time lack of transport should be taken into consideration as it influences the possibilities of the Branch, situated in Bela Vista, to supervise MRCs activities in the district, rather than from Matola Branch office

### 5.1.7 MRCs Local Committees

At the local level, the *Project* has been instrumental in establishing a local MRC committee in the Hindane area and sub-committees at the community level, supported by the local leaders in the area. Despite being in place, this MRC structure is weak and the membership base limited, if not non-existent. The committees receive support and training by the Programme Co-ordinator and this is to continue in 2003.

### 5.1.8 MRCs Volunteers

Through *Project* activities the Hindane area has now more than 60 trained volunteers in different aspects of community based health care work. The group is motivated and has acquired knowledge on many aspects of health, of importance to their communities. They are also integrated in their respective communities and make up an important link to the MRC provincial network with the potential to be activated in case of emergency.

Equipment bought for the volunteers is appropriate for their activity. However, only the CBHC volunteers have received kits delivered in durable bags.[48] The TBAs are rightly requesting similar bags for their activities, a valuable piece of item in the community. Instead, they received carboard boxes that are gradually being worn down by use and humidity and—probably also—ants.

The purchase of bicycles for the volunteers is questionable as many are already broken and not in use. Their maintenance and future use needs a general reconsideration within the *Project*.

---

[46] In the *Programme Document* institutional training of the District Branch was envisioned.

[47] Apparently, this is a common problem within the MRC in all the provinces.

[48] After the community meeting in Hindane the CBHC volunteers received their second bag of materials.

### 5.1.9 HINDANE HEALTH CENTRE

The construction of Hindane health centre is an important, visible achievement of the *Project*. Inspection of the facilities gives a good impression and the houses are spacious and functional for the intended activities. The staff houses are also a nice addition. Plans to add a simple house for expectant mothers at a low cost is appropriate and was unanimously requested by the population during the community meetings, in particular the women, the prospective users.

The purchase of the equipment to the facilities was deficient, partially because of change of design during the construction work but probably also because of lack of routine on the part of MRC in conducting such activity. Interestingly, the purchase was the responsibility of the health department of the MRC Headquarters, not personnel of the Ministry of Health.[49]

There is no way a health facility can be properly run without access to sufficient quantity of water. The facilities are supplied with a water tank of 1000 litres and running water in all the facilities. During the mission there was raised concern that the expansion of the running water system to include staff houses might jeopardise available water for the health centre, especially when the health centre will be fully staffed and large families living in the staff houses. Further, the maintenance of the electric pump may in the long run prove to be problematic.

Solar panels are a wonderful technology and appropriate in sun-stricken Africa. On the other hand, they need maintenance and the batteries will probably need replacement within the next few years. Responsibility for supervision, maintenance of the system and associated recurrent costs has to be clearly defined if the system is to have any chance of survival.

The *Project* has not supported any staff development at the health centre level.[50] It cannot be expected that the health care workers at the health centre supervise activity in which they experience neither ownership nor personal professional development.

### 5.1.10 REPORTING

On top of the regular meetings with agreed minutes, the *Project* has produced several reports on quarterly and annual basis, written both by the TA and collaborators in the MRC Provincial Branch office. Also, several Plans of Activities have been elaborated in line with that of conventional Logical Framework Approach. Added to this are so-called situational reports (in Icelandic), for the use of the TA and the IRC, mainly to guide follow-up on budget spending and activities of the *Project* according to Plan of Activity.

---

[49] It is fair to note that the purchase was based on old standard equipment description for a health centre type III, given to the MRC by the Ministry of Health.

[50] In the *Programme Document* it is stated that the staff should supervise the community health workers and TBAs together with the Programme Co-ordinator.

In the *Programme Document* the flow of information on *Project* activities is described but individual responsibility for the reporting is not clearly demarcated, in particular concerning compilation and synthesis of *Project* activities. Nevertheless, reading through piles of *Project* documents gives one a reasonable good feeling of the activities in the field.

#### 5.1.11 BASELINE DATA AND MONITORING

Currently the *Project* does not have appropriate mechanisms to monitor the successes (or failures) of the activities. Unfortunately, the conducted PRA exercises cannot substitute such important monitoring, despite being a useful and necessary process. Consequently, there does not exist any baseline study with data that the *Project* can use to properly monitor the progress towards improved health of the population. The *Programme Document* gives examples of indicators that could be used but information on these is lacking for the area.

#### 5.1.12 CONCLUSION

The general organisational structure of the *Project* is logical and gives the *Contracting Parties* good opportunities to accompany *Project* activities. The absence of an active participation of a representative for the Ministry of Health is however striking—and never envisioned in the *Programme Document.* An important part of the investment concerns the building of a health centre that at completion was handed over to the Ministry of Health. Thus, it might have been advantageous if the Ministry of Health had been more involved in the conception and organisational structure of the *Project*.

Financial management has improved during the *Project* period. First, ICEIDA and IRC have been refining their collaboration while their share of costs has not yet been balanced. This process has contributed, among other things, in delayed transfer of money for *Project* activities. This internal ICEIDA/IRC collaboration has caused some confusion within the MRC finance department, to the detriment of *Project* activities. Second, the MRC has been managing over 80 different projects with more than 40 donors, each with their own accounting routines. There is on-going work to put in place a common accounting and financial reporting for all these projects. Third, the MRC Provincial Branch office has had a weak financial management routine, recognised the MRCs Headquarters and acted upon by giving additional support to the Branch office Administrator. It can thus be concluded that the implementation of the *Project* has contributed to strengthen MRCs institutional capacity on financial management, both at the national and the provincial level.

The *Project* has supported the establishment of MRC-related activities down to the community level. This is a vertical structure that brings *Project* activities effectively to household level in villages with population

characterised by poverty and hunger. This is a formidable achievement, to great extent the work of the Programme Co-ordinator who has received appropriate support from the *Project* and the TA. She has to be strengthened still further in her work to improve and consolidate this grass-root movement, to the benefit of the population involved. During this consolidation process, the involvement of the health centre and the staff there is crucial for successful and sustainable outcome in the long-run.

The *Project* has at its current state of implementation invested in the appropriate equipment needed for the activities. The task ahead is how to improve its use and install appropriate mechanisms for maintenance and long-term sustainability. Further, the construction of the health centre was also concluded to the satisfaction of all those involved, despite encountered problems during the process. It is now the responsibility of the Ministry of Health to run the centre and maintain the current standard of the equipment.

Monitoring and continuous evaluation of the *Project* activities needs further analysis and consideration. In this context, I find of particular interest the so-called PIMES methodology,[51] based on participatory bottom-up approach with the aim to encourage an on-going improvement of management and project activities. The development PIMES has been done by the Danish and Vietnam Red Cross Societies and implemented in Vietnam for almost a decade.[52] Thus, it is appropriate and urgent to consider if a methodology like this one can be introduced already in 2003. This monitoring could be harmonised with similar MRC projects, e.g., the one in Inhambane and supported by the Danish Red Cross.

Despite all the difficulties, personal differences and at times frustration among involved parties, it was the conclusion of all I met during the mission that without the technical backup of the TA the *Project* would not have developed as positively the Evaluation Team could verify in the field, both in content and pace. The technical backup of the TA has further been complemented and strengthened with the support given by ICEIDA personnel in Maputo and Reykjavík, and to some extent the IRC in Reykjavík. In particular, this support has been crucial in everything regarding the finances and the construction of the health centre. She has also had complementary training opportunities through IRC, e.g. regarding programme planning.

---

[51] PIMES is the Acronym for Planning, Implementation, Monitoring and Evaluation System.

[52] Coincidentally, the author of the PIMES report lives now in Maputo and is willing to share her experience with the *Project*.

## 5.2 EFFECTIVENESS

*Has the project achieved its objectives? What has facilitated or prevented the effectiveness of the Project?*

### 5.2.1 HEALTH SERVICE DELIVERY

The overall objective of the project is to improve the health conditions of the most vulnerable ones in the population by prevention of communicable diseases. To achieve this goal, at the outset of the *Project,* both developmental and immediate objectives were set out in the *Contract*.

In principle, it is difficult to measure if the *Project* has contributed to improved health conditions of the most vulnerable in the *Project* area. For proper assessment, a baseline study followed with predefined monitoring system of relevant indicators would have been needed to be defined at the outset. Examples of hardcore indicators in this respect would be, e.g., mortality figures for infants, under-5s and pregnant mothers. Despite inherent difficulties in implementing such monitoring system, this should not be impossible considering the number of volunteers working in the involved communities.

To measure if the *Project's* general objectives have been achieved it is necessary to use other more soft process indicators.[53] The project has many such indicators to choose from:

- Number of trained CBHCs, TBAs and water and sanitation technicians in the area;
- Percentage of the population with access to simple treatment at the community level;
- Number of persons attended by the CBHC volunteers or the TBAs, divided by gender and appropriate age-groups;
- Number of new latrines installed in the area;
- Number of constructed shallow wells;
- Home visitation scheme for CBHCs and preventive messages on the use of latrines, water and nutrition at household level;
- Attendance figures in Hindane health centre and diagnostic profile according to registry;
- Number of women attending prenatal care at the health centre;
- Number of assisted births at the health centre as well as the number of referrals for delivery in Bela Vista; *and*
- Immunisation coverage of children in the area compared to other areas in the Province.

During *Project* implementation, community based health care activities with MRC volunteers, TBAs and water and sanitation technicians have been

[53] With a process indicator it is assumed the process under consideration will lead to improved health.

trained in the area and a new health centre constructed in Hindane, all in line with *Project* objectives.[54]

### 5.2.2 Institutional Capacity Building

The *Project* was expected to contribute to an on-going reform process within the MRC with capacity strengthening and self-reliance. In the *Project* area there is now a large group of MRC volunteers who have been trained by the *Project* and a structure of MRC committees has been established down to the village level.[55] At the same time the Provincial branch office has been strengthened and made more visible in the area.

The *Project* activities have not contributed to increased economic self-reliance of the MRC Provincial Branch office or the national organisation. Actually, the cost/benefit equation for the activities is high as the population involved is so small and dispersed and costs of implementation high. On the other hand, without the activity this population would be without any support. Through the training their self-esteem may have improved which in turn may result in more community self-reliance in the long run. The low income generation activity is however worrying as the Provincial Branch has no chance of being able to support the activities on their own without external support.

### 5.2.3 Hindane Health Centre

The formal construction of Hindane health centre was completed in November 2002; simple house for expectant mothers will however be constructed in 2003. In this respect the *Project* has reached its objective in contributing to the rehabilitation of the governmental health care system. What is needed is an effective strategy that gives the staff the needed competence and tools to appropriately support the CBHC volunteers, the TBAs and water and sanitation technicians in the field. At the same time they need support to deliver appropriate services, both at the health centre level and through out-reach activities.

### 5.2.4 Conclusion

The *Project* has been instrumental, and an important actor, for the implementation of health related activities that are expected—in the long run—to improve the health of the population in the *Project* area. This is in line with *Project* objectives.

Regarding institutional capacity building, the MRCs Provincial Branch office has benefited from *Project* activities which have improved its image, as

---

[54] One interviewee actually stated that one of the unexpected outcomes of the *Project* is that it achieved what it was intended to achieve.

[55] The weak district MRC structure is a national problem that needs a special consideration.

well as that of the national organisation. However, the weak income generation activity is a serious weakness that needs to be considered and acted upon. In this respect, the high associated cost of the activities, targeted at a small, poor population who lives in dispersed communities, is a reason for particular concern.

It can be argued that the *Project's* focus on the MRC Provincial Branch office and its lower organisational levels has contributed to—in many aspects—successful implementation. This moves the actors more closely to those the *Project* is intended to support, i.e., a poor and vulnerable rural population. Despite the MRC personnel, in particular the Programme Co-ordinator actively supported by the TA, has been an important and a necessary facilitator for the activities, without the participation of the community most of the objectives set out in the beginning would not have been reached.

## 5.3 Impact

*Other effects of the Project. Technological and socio-cultural factors affecting project implementation shall be considered. What are the positive and negative effects of the Project? What are their causes?*

### 5.3.1 Target population

It is frequently stated that the target population of the *Project* area is difficult and introvert in their attitudes and behaviour and rarely want intervention in the area. Effective promotion of hygiene and the use of latrine in such an environment is difficult, as cultural ideas may interfere with effective implementation. As an example, it can not be taken for granted that construction of a latrine results in its use, as latrines may be considered to be an unhealthy place the population should avoid. Discussion on issues related to sexuality and preventive measures is also sensitive and difficult, as elsewhere. The population is migrant to some extent, which in the long run, may turn out to be an obstacle. Further, it rarely speaks Portuguese. It is strength for the *Project* that the Programme Co-ordinator speaks the local language and is so well acquainted with the local conditions.

### 5.3.2 Project Organisation

It is not only on the level of the local population that cultural differences have influenced the outcome of the *Project*. Unexpectedly, two Icelandic organisations have at times experienced difficulties to effectively address in unison problems that have arisen during the *Project* implementation. Further, there has been tension in the relation among the *Contracting Parties* that has however been effectively addressed during the process. In particular, the transfer of money for *Project* activities has been a source of

irritation. To some extent this is grounded in cultural and organisational differences that for all parts have needed adjustment.

### 5.3.3 PROJECT IMPLEMENTATION

It has not been favourable for *Project* activities that the TA did not speak Portuguese to any useful extent in the beginning and had to rely on translation or speak only with people who understood English, and some with difficulty. This was compounded by the extra-ordinary emergency situation of floods and the following chaos.

As was to be expected, the use of transport vehicles has been a source of conflicts that partially are influenced by cultural attitudes and the generally low socio-economic situation in Mozambique.

The *Project* has experienced cultural differences regarding construction work, again with associated irritation and at times suspicion that the process was not financially sound and transparent.[56]

The *Project* has introduced technologies that are appropriate from a general point of view. However, there are many inherent problems associated with technologies so disparate as solar driven lightning, electric pump for water and running a car or bicycle, especially when it concerns future functionality. This has to be considered and be accepted that this investment may turn out not to be sustainable in the long run.

Staffing a health centre is a delicate task for health authorities that face constant constraints in terms of budget and qualified staff. A national law that defines seven years of school as minimum for a cleaner to be put on a public sector pay-roll is an obstacle to achieve the objectives of a project of this kind. It is not easy to change such laws, even not by-passing them if that would be an option. As a personal point of view, governments in countries like Mozambique are by international authorities, e.g. the World Bank, among other things required to cut down the size of the public sector to qualify for further loans on favourable terms. Thus, international macroeconomic culture among partners may influence outcome of a project of this kind.

### 5.3.4 CONCLUSION

During the *Project* period, cultural differences have influenced implementation of the activities. Felt differences have however continuously been dealt with and become a positive learning process for all those involved.

---

[56] It was frequently mentioned that construction costs in Mozambique are very high, and part of the reason might be so-called 'kick-backs' between key players, outside the control and knowledge of ICEIDA/IRC/MRC. It is worth noting that the formal audit used by PriceWaterhouseCooper in the *Project* does not address eventual fraud of financial statements or construction costs.

## 5.4 Relevance

*The direction and usefulness of the Project. Are the objectives worthwhile?*

### 5.4.1 MRC Health Strategy

At the beginning of the year 2000, the MRCs international collaboration was limited to a two-person IFRC delegation, focusing on institutional and finance development, a Norwegian Red Cross bilateral representative and the IRC delegate. Other national societies supported the MRC either bilaterally or through the Federation, but with no presence in the country. This situation dramatically changed in the aftermath of the floods when six participating national societies established new operational delegations in the country

A strategic review of the MRC activities, priorities and organisational structure was conducted in the aftermath of the floods. The review resulted in a clear operational focus on disaster preparedness and response, HIV/AIDS, and community based health care and an expansion of staff working in these so-called 'core areas.' Committed long-term financial and programme assistance from international partners to these 'core' areas was considered crucial if the strategy was to have any chance of success.

In CAS, the goal for the CBHC work is to reduce community vulnerability by promoting community based first aid activities in line with ARCHI 2010 principles, in 11 priority districts by the end 2004. More specifically, the work should concentrate on communicable diseases, health promotion and cholera while at the same time support institutional capacity building within the national society.

### 5.4.2 Design of the Project

The design of the *Project* is in principle based on training of MRC community workers who address different aspects of health care with main focus on pregnant women and children. At the same time, the *Project* addresses one of key objectives of the Ministry of Health, i.e., rehabilitation of the health care infra-structure.

In Mozambique, there is a long history of training so-called *Agente Polivalentes Elementares* (APE) in the communities. The training was part of an effort by the Ministry of Health to reach out with trained health personnel to populations living in small communities all over the country with difficult access to public health services. These community health workers worked together with TBAs. Both were trained in basic techniques and the community health worker had at his/her disposal drugs for treatment of common diseases, e.g., malaria and respiratory diseases.

The policy of APE within the Ministry of Health has collapsed, partly as it was difficult for the authorities to supervise these health workers and they were also interested to become public servants in the long run. Thus, the

Ministry of Health has opted for a policy that allows NGOs working in the field to train such community health workers in the hope these organisations might be better equipped to support and train the workers. In turn, the policy of the Ministry of Health is that its staff in the health centres shall supervise and give support to these volunteers. Currently, it is discussed if the volunteers should be given priority when they or their families come to seek help at the health centres in case of need.[57]

The MRC has worked for more than two decades within the health sector, training volunteers and TBAs. The difference is that these volunteers are working more with prevention than curative services. Nevertheless, they have access to basic drugs like chloroquine and aspirine. Consequently, many of former APEs have later become Red Cross volunteers. Currently, the Red Cross has 4,400 volunteers working in 75 districts of Mozambique, of whom about 2,700 are trained for CBHC work and assistance to pregnant women. These volunteer health workers form the backbone of the MRC. Other categories of Red Cross volunteers are, e.g., those who work with disaster preparedness and response, social issues, water and sanitation and in heavily mined areas. Further, the MRC is increasingly interested in questions related to poverty and advocacy on that issue.

The design of the *Project* has taken all the above aspects into consideration.

### 5.4.3 Governmental Structures

In Matutuíne District, the MRC has collaborated with governmental structures in Bela Vista. Teachers and other public servants are either active members of the organisation or helpful in informing the local population about pending meetings or other MRC activities.

Regarding the health sector, the MRCs activities are planned in collaboration with the District Health Authorities. Thus, for training of the CBHC workers and TBAs several governmental organisations are involved. The District Health authorities participate in the planning of the training course, health workers are recruited to become trainers/teachers and the training sessions are conducted within the hospital premises. For accommodation, hospital staff cleans the hospital ground for tents, contributed from the district governmental administration and used for accommodation of participants. For the construction of health posts governmental Ministry of Public Work is involved and consulted.

---

[57] A request from MRC representatives for such preferential treatment was positively taken by Provincial health authorities, and said to be practised elsewhere.

### 5.4.4 International Organisations

The Maputo Province MRC branch collaborates with the Spanish Red Cross on HIV/AIDS and in water and sanitation, including Matutuíne. This relationship has been elaborated still further through the extended collaboration with IRC to construct 30 shallow water wells in the district.

In Matutuíne district there are not many organisations that have been working with local communities as does the IRC. In Dajbula, the Swiss Cooperation has supported volunteer work with the construction of a Health Post and a school and reintroduction of live-stock in the area. They have also supported the Bamako Initiative in the village, still functioning with regular delivery of essential drugs from Bela Vista.[58]

The activities of the MRC in Matutuíne are in line with its other activities elsewhere. The *Project* is similar to one in Inhambane Province, financed by the Danish Red Cross. This project is going to expand to other localities in the area to include more than 50,000 inhabitants.[59] This project, as does the Icelandic one, includes the construction of a health centre and First Aid Posts and the training of volunteers. In the pipeline is an extension of the project to Sofala Province, also financed by the Danish Red Cross.

In Manhica Province, The Netherlands and Belgium support a similar project to the Hindane health project, with the exception that it includes the rehabilitation of health centres rather than new constructions. Further, there are other projects in all of the provinces with training of volunteers and TBAs and the construction of health posts but without the construction of a health centre.

### 5.4.5 Conclusion

The *Project* activities are in line with those spelled out in the MRCs Country Assistance Strategy plan for 2001-04, its health strategy and programme. Further, strengthening the health related work of the volunteers fits well in with over-all national policies as well as that of the MRC. Thus, the design and implementation of the *Project* is in line with over-all national strategies within the health sector as well as that of MRC. Its set-up is also similar to other MRC donor-funded projects in other provinces. To achieve its objectives the *Project* has, as appropriate, collaborated with other relevant organisations and governmental institutions, to the benefit of all.

---

[58] Bamako Initiative is a programme executed in many African communities, aimed to guarantee the population access to drugs. Thus, after initially receiving a fixed amount of essential drugs, the health posts sell the drugs with their curative services and consequently a fund is created, under the control of the communities. In turn, this fund is used to replenish the medical stocks as needed.

[59] It was pointed out that the Hindane project is a sister project to the one in Inhambane.

The *Project* aims at reaching the poorest sector of the Mozambican society with activities that are intended to alleviate some of the health burdens in the communities, in particular that of pregnant women and children. It engages also many people in the communities. Thus, the conclusion is that the *Project* is relevant and appropriate for the fulfilment of its objectives.

## 5.5 Sustainability

*The long-term viability of the* Project. *Which benefits of the* Project *continue beyond donor involvement?*

### 5.5.1 MRC Volunteers

The criteria applied by the MRC for recruitment of the volunteers have the potential to select the most able individuals in their respective communities. After recruitment they receive special training by the organisation and they are supported in their work. Consequently, after this human resource development, the volunteers become attractive for recruitment by other organisations that are willing to pay better than the MRC.[60]

Through *Project* activities, the MRC has become visible in the Hindane area and they throw light on the organisation. It is an honour and an attraction by itself to belong to such an organisation and be visible and instrumental in community development. This could be one important pillar to retain the volunteers within the ranks of the MRC.

### 5.5.2 Local MRC Committees

If appropriately trained, the local MRC committee in Hindane and the sub-committees at the village level have a potential for survival after withdrawal of support. However, their current financial resources are small or non-existent, and the prospects for a large and paying membership base are dim. Nevertheless, even with small contributions from community members, these committees could develop income generative activity that would be supportive for development in the area. Further still, crucial for the CBHC workers and the TBAs are national policies to support such community structures with appropriate material and supervision. Introduction of cost-recovery schemes, e.g. the Bamako Initiative, have the potential to generate income to fund activities that are to the benefit of all community members.

### 5.5.3 Provincial MRC Branch Office

At the Provincial level, most recurrent costs of the office are funded by ICEIDA and IRC. Without a clear policy and firm implementation of income

---

[60] The difficulties experienced in Kwache to construct the First Aid post are illustrative, i.e., the policy of food-for-work.

generation for the Branch, there is no way the office can continue to support the community activities to the extent as currently is the case, i.e., if the MRC Headquarters are not to support those activities with their own funds.

There have been discussions on income generation within the Branch office but it has been weak in implementation of such activities. The management of the income generated from the hiring of the truck is also a constant source of suspicion and irritation within the Branch office. Thus, to secure sustainability, transparent accounting of all income and expenses should be implemented. The MRC financial department has a key role to play, and its current reform work in this respect is to be supported and strengthened.

### 5.5.4 Technical Assistance

The presence of a TA has taken on different forms within other MRC projects. Initially, the Danish Red Cross was not going to have one in the Inhambane Health Project, but later sent one to improve implementation. The Dutch Red Cross has come to another conclusion, i.e., not to have one in the CBHC project in Manica Province. Nevertheless, this is a cross-border project with Zimbabwe with a TA who resides in Zimbabwe. To facilitate the collaboration, the MRC sends, as appropriate, their workers to Zimbabwe for discussion or the TA comes to Mozambique on a regular basis.

During the evaluation it was claimed that implementing new projects that were supported with a TA improved the contact with the donors. The TA pushes things ahead and creates a lot of 'noise' around him/her, to the benefit of the project. The TA lives the realities of the country and is able to channel such information more convincingly back to the donors than the nationals may do. For them as well as the nationals the collaboration becomes a learning process that, in the best of worlds, benefits both. These individuals bring often with them knowledge that is not existent in the country or within the collaborating organisation. This knowledge is however to skilfully balance with knowledge of national realities and culture, and the balance is sometimes not always perfect.

For the implementation of this *Project*, the good collaboration of the TA and her official counterpart has been crucial for many of the achievements this report illustrates. The Provincial Branch office has also benefited and local MRC structures have been established.

### 5.5.5 Consolidation Phase

As evidenced in this report, the *Project* has been a key player to implement community based health care activities in the Hindane area, supplemented with the construction of a health centre. It has also supported the institutional development of the MRC. The *Project* has in many aspects been

successful in fulfilling its objectives despite encountering difficulties during implementation.

To secure sustainability of *Project* activities, consolidation of what has been done so far is crucial and it will take time. First, the construction of First Aid Posts is not completed in the involved communities, the training of volunteers has to continue and the work with the introduction of shallow water wells strengthened. Second, the capacity for local supervision of the MRC health activity in the area has to be improved. Towards this ends, the best of the volunteers may need extra training. Third, the local committee and the sub-committees need more training and support, in particular regarding income generation and management. This is already in the pipeline for the current year.

### 5.5.6 Extension of Activities

Concurrent to the consolidation phase the extension of *Project* activities in neighbouring areas is a natural continuation. There is already discussion within MRC to include the community Tinonganine. Without external funding this will not be realised.

In the year 2003, the MRCs HIV/AIDS department will with funding from IRC initiate work in the area. They will need to train the same volunteers in aspects related to HIV/AIDS and this work needs integration with their other on-going health related activities in the area.

At the provincial level, it is important to improve management and administration of the finances and how to run large cadre of community based health workers. In particular, income generation will be an important issue to address and much work has to be done to increase economic sustainability. This was not explicitly stated in the *Programme Document* but is in line with over-all MRC strategy. Lastly, the district level within the Provincial Branch needs to be supported if it is to have any chance to actively engage in district MRC activity.

### 5.5.7 Conclusion

The Project activities have contributed to increase the institutional capacity of the MRC in Maputo Province, from the Provincial Branch office to the local level. Without external support and income generation, the *Project* activity has nevertheless no chance of survival in the long run. Yet, training that supports community self-reliance and engages the community in health related work is by itself sustainable as it contributes to over-all community development.

Currently, it is no difficulty to recruit volunteers while retaining them may in the future be problematic. However, an individual trained in preventive health activities may bring this knowledge onwards with him, irrespective if he or she may leave. In that respect, their training is

sustainable to some extent. To retain volunteers, the MRC has few if any solutions except to continue to be supportive to a general socio-economic development in the country.

The Hindane health project has positively benefited from the work of one TA since the year 2000 whose contract terminates at the end of the year 2003. After termination of the current contract, it is concluded that the *Project* activities do not need a resident TA in the country.

## 6. CONCLUDING REMARKS

It is the over-all conclusion of the Evaluation Team that the IRC and MRC should, after termination of the current *Contract*, continue its collaboration on health related activity in Maputo Province, in particular the District of Matutuíne. It would be beneficial for the collaboration, and to recommend, that a short-term IRC delegate to be assigned to the *Project* to come on regular visits to supervise the activities and support it as found appropriate.

To implement the *Project*, ICEIDA and the IRC initiated collaboration that was new for both. In general terms it can be concluded that this collaboration has been beneficial to both parts. Yet, in principle, the *Project* is a collaboration of two NGOs and continued practical involvement of ICEIDA can be questioned, at least engagement to the same extent as hitherto has been the case. The collaboration has not, e.g., alleviated ICEIDA of many of the burdens of running a project on its own terms. The same can be concluded regarding the involvement of IRC. Consequently, it is the conclusion of this evaluation that the IRC should now take on the responsibility to support MRC in the above future work with health related activity in Matutuíne district. The current share of *Project* costs of the IRC should suffice for the necessary financial support, complemented with short-term delegate visits after the termination of the current *Contract*. The programme and Plan of Action for the period 2004-05/06 should be prepared as early as possible and during implementation, regularly followed up during short-term visits. It would be beneficial to assign at least one person to continuously monitor the progress of the *Project* during the whole period. With an exit strategy in line with the above, ICEIDA formally terminates its involvement in the *Project* activities a the end of the current *Contract* while the IRC continues and develops further its collaboration with the MRC.

If ICEIDA and IRC want to continue their co-operation in the *Project*, there are several options. The ICEIDA office in Maputo could, e.g., continue to offer practical assistance in the transfer of IRC funds to MRC and even monitor activities as found appropriate. Another possibility, if judged compatible with Icelandic laws, would be for ICEIDA to fund through IRC

clearly defined *Project* activities, supported with guidelines on appropriate reporting to the Agency on the expenditure. Here, IRC would transfer the ICEIDA contribution to the MRC bank account with appropriate monitoring mechanisms in place that fulfil the needs of all *Contracting Parties*. To withdraw all support to the activities in the *Project* area is not an option.

## LIST OF KEY REFERENCES

Einarsdóttir J. (2001). Mósambik. ICEIDAs Country Profile Report, nr. 3. ICEIDA: Reykjavík.

Gunnlaugsson G. (2001). Health Services in Maputo Province, Mozambique: Appraisal for Collaboration between the Ministry of Health and ICEIDA. Reykjavík: ICEIDA.

ICEIDA (2000). Langtímaáætlun Þróunarsamvinnustofnunar Íslands fyrir árin 2000-2004 [Long-Term Plans of ICEIDA in the Years 2000-2004]. Rekjavík: The Agency.

International Federation of Red Cross and Red Crescent Societies. ARCHI 2010. URL: http//www.ifrc.org/WHAT/health/archi/strategy/backgrnd.htm (downloaded on December 10, 2002).

IRC, ICEIDA (1999). Samstarfssamningur milli Rauðda kross Íslands og Þróunarsamvinnustofnunar Íslands um þróunaraðstoð við heilsugæsluverkefni Rauða kross Mósambík í Hindane í Maputo hérðaði í Mósambík, 2000-2003. Reykjavík: The Agencies.

Kaseje DCO, Nauclér A. (2001). The Mozambique Red Cross Society Community Based Health Care Programme (CBHCP). Annual Programme Review Report 2001. Mozambique Red Cross Society and Danish Red Cross: Maputo and Copenhagen.

Ministry of Health (April 2001). Plano Estratégio do Sector Saúde (PESS) 2001-2005-(2010). Maputo: The Ministry.

Mozambique Red Cross Society (2002). Strategic Plan 2003-2005. Maputo: MRC.

MRC (2000). Country Assistance Strategy (CAS) 2001-2004. Maputo: MRC.

MRC, IRC, ICEIDA (1999). Development Contract between the Mozambique Red Cross Society and Icelandic Red Cross and Icelandic International Development Agency concerning Health Sector Support: Community Based Health Care Programme 2000-2003. Reykjavík/Maputo: The Agencies.

MRC, IRC, ICEIDA (1999). Programme Document: Community Based Health Care, Maputo Province. Reykjavík/Maputo: The Agencies.

Victor, BW (2001). Introduction to PIMES – A Planning, Implementation, Monitoring and Evaluation System developed by the Danish Red Cross in Collaboration with Vietnam Red Cross 1993-2000. Copenhagen: Danish Red Cross.

Besides the above, other appropriate Contracts for the *Project*, Plan of activities, Activity reports, Agreed minutes and Travel documents, among others.

# TERMS OF REFERENCE: SCOPE, FOCUS AND ISSUES

## Scope and Focus of the Evaluation

The evaluation will focus on providing information for decision-makers, both in Mozambique and Iceland, but will also be a learning exercise for the stakeholders and especially MRC at HQ in Maputo and at branch and district level in Maputo province.

In general, the evaluation shall:

- ✓ consider the goal and purpose of the project, as well as inputs and outputs and financial management;
- ✓ consider unintended outcomes of the project;
- ✓ assess the programme implementation and progress of programme activities in relation to the plans;
- ✓ evaluate the impact for the beneficiaries or how it can be measured in the future if not obvious yet;
- ✓ provide a description of major constraints and risk factors for programme implementation and sustainability;
- ✓ assess the degree of programme sustainability;
- ✓ assess the relevance and appropriateness of the programme components, hereunder;
- ✓ assess whether any changes in programme context should lead to changes in programme set-up;
- ✓ provide a description of lessons learned in relation to future programme implementation;
- ✓ give recommendations on future modifications and improvements in light of the above listed objectives.

The final draft is to be submitted to the MRC, ICR, ICEIDA and the health authorities in question.

## ISSUES TO BE COVERED IN THE EVALUATION

Special attention shall be given to but not necessarily limited to, the following issues:

### Efficiency

Results achieved (inputs -outputs).
*Have resources been effectively used in the project? What problems have arisen? Could they be avoided in similar projects?*

- ✓ review of the programme organisation on all levels (including management, reporting and monitoring, human resources and technical backup);
- ✓ assessment of financial management including disbursement of funds at the different levels and financial reporting;
- ✓ assessment of staff development and needs for further capacity building at HQ level, provincial and district level;
- ✓ assessment of the infrastructure facilities, equipment etc. provided through the programme;
- ✓ assessment of needs for eventual additional equipment and other capital investment;

- ✓ assessment of the programme capacity for monitoring and evaluation;

**Effectiveness**
Achievement of objectives.
*Has the project achieved its objectives? What has facilitated or prevented the effectiveness of the project?*

- ✓ the potential of the programme to reach the stated objectives;
- ✓ to which extent the programme is progressing towards producing the anticipated outputs;
- ✓ assessment of the focus on community based activities, including an assessment of to which extent the community is involved in planning and implementation.

**Impact**
Other effects of the project. Technological and socio-cultural factors affecting project implementation shall be considered.
*What are the positive and negative effects of the project? What are their causes?*

- ✓ assessment of the impact of involvement of local communities and project activities;
- ✓ assessment of the impact of the training of the volunteers and TBAs.

**Relevance**
The direction and usefulness of the project.
*Are the objectives worthwhile? Does the design of the project support the objectives?*

- ✓ assessment of the degrees and need for collaboration with other organisations in the health sector, including the role of government institutions;
- ✓ assessment of programme relevance in relation to MRC´s Country Assistance Strategy (CAS), health strategy and other overall planning strategies for programme work;
- ✓ assessment of programme relevance in relation to other MRC´s community health programmes implemented in co-operation with other partners.

**Sustainability**
The long-term viability of the project.
*Which benefits of the project continue beyond donor involvement?*

- ✓ assessment of the programme potential to survive after donor financial and technical support
- ✓ assessment of the programme potential and ability to recruit and retain Red Cross volunteers;
- ✓ if found necessary, recommend measures to improvements or re-direction on the above in light of stated objectives and relevant strategies.
- ✓ assessment of the need for external technical assistant after end of year 2003 (short term or long term)
- ✓ assessment of what kind of follow-up/exit strategy would be needed to secure the sustainability of the programme

The evaluation will be sensitive to unintended outcomes of the project.

# PROGRAMME OF THE VISIT

**TUESDAY, DECEMBER 10, 2002**

20:30 Arrival Maputo Airport

**WEDNESDAY, DECEMBER 11**

08:00 Hjördís Guðbjörnsdóttir, TA, IRC
10:00 Co-ordinating meeting of the Evaluation Team
11:00 Respeito V. Chirrinze, Department of Institutional and Resource Development, MRC HQ
12:00 Eunice Mucache, Programme Manager, MRC HQ
13:15 Lunch
14:30 Ernestina Jorge, Health Co-ordinator and Pedro Caleleiano, Health Technician, MRC HQ
15:30 Samuel Asamoah, Finance Development Delegate, IFRC, and Armindo Lopes Adelino, Project Accountant, MRC HQ
17:00 End of work

17:30 Dinner: Invitation of Björn Dagbjartsson, Ambassador of Iceland

**THURSDAY, DECEMBER 12**

08:00 Elín Sigurdardóttir, Country Director, ICEIDA, Maputo
10:00 Abdul Hamid Mussa, Provincial Director of Health, Matola, Maputo Province w. Evaluation Team and Mr. Leonardo Manhique, Provincial Secretary, Matola
12:00 Leonardo Manhique, Provincial Secretary, MRC Matola
13:00 Carlos Mabote, Finance Administrator, MRC Matola
14:00 Ilda João Cuna, Programme Co-coordintor, MRC Matola
15:30 Departure to Maputo

19:00 Dinner: Invitation of Hjördís Guðbjörnsdóttir and Robin Bovey with Head of Department Jim Robertsson, IFRC

**FRIDAY, DECEMBER 13**

08:00 Departure to Bela Vista, District of Matutuíne, Maputo Province
10:30 Yasmin Cassam, District Director of Health in Matutuine, Bela Vista, Maputo Province
12:00 Jaime Machamiu Malate, President, Matutuíne District Branch, Bela Vista
14:00 Internal Meeting of the Evaluation Team
16:00 Departure to Maputo

**Saturday and Sunday, December 14-15**
Report writing

**MONDAY, DECEMBER 16**

08:00 Departure to Hindane, District of Matutuíne, Maputo Province
10:00 Inspection of the Hindane Health Centre with the midwife Juana Lopes
11:30 Open community meeting and group discussions with leaders, community based health care volunteers, traditional birth attendants, water and sanitation volunteers, committee local and population from the seven communities involved in project activities.
15:30 Departure to Maputo

**TUESDAY, DECEMBER 17**

08:00 Departure to Kwache, District of Matutuíne, Maputo Province
10:30 First Aid Post and latrine inspected
11:30 Meeting with leaders, CBHC volunteers, TBAs, water and sanitation volunteers and population of Kwache
15:00 Internal meeting of the Evaluation Team
17:00 Departure to Maputo

**WEDNESDAY, DECEMBER 18**

08:00 Meeting with Simão Nhassengo, Co-ordinator of Water and Sanitation, and Carlos Macande, Community Education Technician, MRC HQ
09:00 Meeting with Balbina Santos, Co-ordinator of HIV/AIDS, MRC HQ
10:30 Meeting with Marcos Diaz, Water and Sanitation Technician, Spanish Red Cross.
11:45 Lunch
14:00 Internal meeting of the Evaluation Team
15:30 End of meeting

**THURSDAY, DECEMBER 19**

08:15 Meeting with Dr. Martino D´Gege, National Director of Community Health, Ministry of Health
10:00 Meeting with Boaventura, MRC Property Officer and José Manuel Rocha de Sousa, MRC Construction Supervisor
11:00 Meeting with Boaventura and Rocha de Sousa and representatives of Tavel Empreendimentos Ltd., Orlando Vieira and Mr. Jorge Buene.
12:15 Meeting with Fernanda Teixeira Secretary General, and Eunice Mucache, Programme Manager, MRC HQ

13:00 Internal meeting of the Evaluation Team
15:30 End of meeting

**Friday, December 20**

08:15 Internal meeting of the Evaluation Team
12:00 Lunch with the Evaluation Team at the invitation of Elín Sigurdardóttir, Country Manager, ICEIDA Maputo
14:00 Formal evaluation terminated

**Saturday and Sunday, December 20-21**

Report writing

**Monday, December 22**

09:00 Visit to the Department of Paediatrics, Central Hospital, Maputo
13:00 Report writing

**Tuesday, December 23**

Departure from Maputo City

# List of People Met

## Icelandic Red Cross

Ms. Hjördís Gubjörnsdóttir, Delegate, Maputo
Ms. Helga Þórólfsdóttir, Director, International Department, Reykjavík
Ms. Nína Helgadóttir, Programme Co-ordinator, International Department Reykjavík

## ICEIDA

Mr. Sighvatur Björgvinsson, Director, Reykjavík
Ms. Margrét Einarsdóttir, Programme Manager, Reykjavík
Ms. Elín Sigurðardóttir, Country Manager, Maputo
Mr. João, driver, Maputo
Ms. Gilda Lopes, Project Officer
Ms. Sara Titosse, Office Assistent

## Icelandic Embassy

Mr. Björn Dagbjartsson, Ambassador, Maputo

## Mozambique Red Cross

**National Headquarters, Maputo**

Mr. Mariamo Jasso, HIV/SIDA
Ms. Eunice Mucache, Programme Manager
Mr. Respeito V. Chirrinze, Department of Institutional and Resource Development,
Ms. Ernestina Jorge, Health Co-ordinator,
Mr. Pedro Caleleiano, Health Technician
Mr. Jacinto Moiane, Administration and Finance Manager
Mr. José Manuel Rocha de Sousa, Supervisor of Construction
Mr. Samuel Asamoah, Finance Development Delegate, IFRC, Maputo Headquarters
Mr. Armindo Lopes Adelino, Project Accountant, Maputo Headquarters
Mr. Marcos Diaz, Water and Sanitation Technician, Spanish Red Cross
Ms. Balbina Santos, Co-ordinator of HIV/AIDS
Mr. Simão Nhassengo, Co-ordinator of Water and Sanitation
Mr. Carlos Macande, Community Education Technician
Ms. Fernanda Teixeira, General Secretary
Mr. Boaventura, Construction Supervisor

**Maputo Province Branch**

Mr. Jaime Machamiu Malate, President, Matutuíne District Branch, Bela Vista
Ms. Ilda João Cuna, Project Co-ordinator, Matola
Mr. Leonardo Manhique, Provincial Secretary, Matola
Mr. Carlos Mabote, Finance Administrator, Matola

## TAVEL EMPREENDIMENTOS LDS.

Mr. Orlando Vieira, Administrative Director and Financier
Mr. Jorge Buene, Technical and Production Director

## MINISTRY OF HEALTH

Mr. Abdul Hamid Mussa, MD, Provincial Director of Health, Matola, Maputo Province
Ms. Yasmin Cassam, District Director of Health in Matutuine, Bela Vista, Maputo Province
Mr. Martino D´Gege, Director of Community Health Services, Maputo
Ms. Lopes, Midwife, Hindane Health Centre

## OTHERS

Ms. Birgit Westphal Victor, HIV/AIDS Coordinator, DANIDA, Maputo
Ms. Lena Granqvist, paediatrician, Central Hospital, Maputo
Mr. Robin Bovey, formerly IFRC delegate, Maputo
Mr. Jim Robertson, Head of Department, IFRC, Maputo

Community Members in two community meetings, one in Hindane and the other in Kwache, in total about 130-150 persons.

## MAP OF HINDANE PROJECT AREA