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Save the Children Federation (USA)



## Community-Based Health and Rural Development Project

Gaza Province

### Final Evaluation Report

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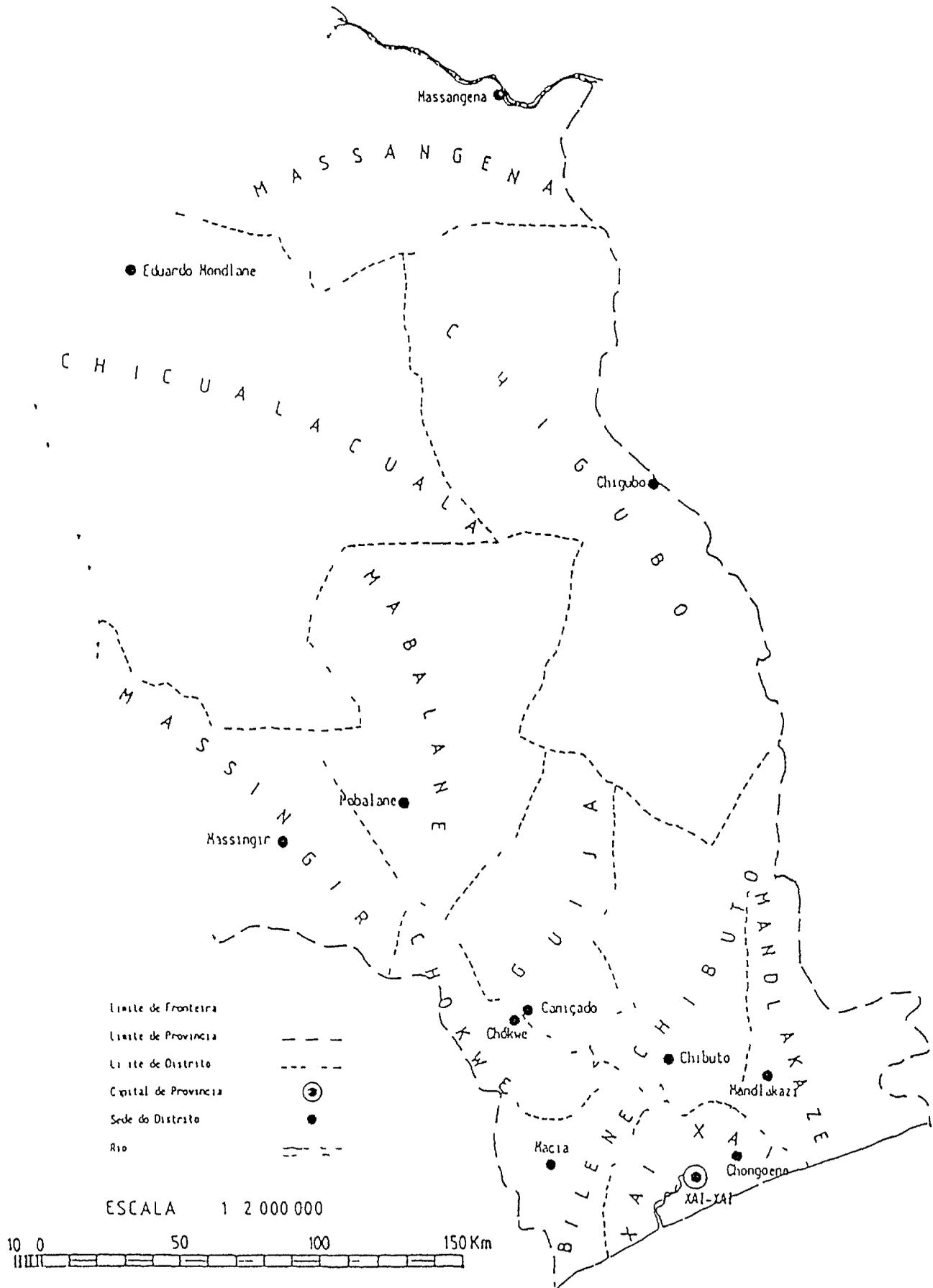
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## TABLE OF CONTENTS

	Map of Gaza Province	
	List of Acronyms	
I	Executive Summary	1
II	Project Background	2
III	Evaluation Methodology	4
IV	Achievement of Objectives	5
	A    Training	5
	B    Rehabilitation/Construction	11
	C    Linkages	13
V	Sustainability	17
VI	Review of Midterm Recommendations	19
VII	Recommendations	21
	A    Training	21
	B    Rehabilitation/Construction	22
	C    Linkages	23
VIII	Conclusion	25
	Annex A    Terms of Reference	
	Annex B    Contacts	
	Annex C    Field visit schedule	

# PROVÍNCIA DE GAZA



## LIST OF ACRONYMS

AMETRAMO	<i>Associação de Médicos Tradicionais Moçambicanos</i>
AP	Active Polio (vaccine)
APE	<i>Agente Polivalente Elementar</i>
BCG	Bacillus Calmette-Guerin (anti-tuberculosis vaccine)
CBHRD	Community-based Health and Rural Development (Project)
CHW	Community health workers
CMO	Chief Medical Officer
DDS	<i>Direcção Distrital de Saúde</i>
DPS	<i>Direcção Provincial de Saúde</i>
DPT	Diphtheria Pertussis Tetanus (vaccine)
EPI	Expanded Program for Immunization
GOM	Government of Mozambique
IE&C	Information, Education and Communication
KPC	Knowledge, Practices and Coverage (survey)
MCII	Maternal and Child Health
MOH	Ministry of Health
MSF	Médecins Sans Frontières
NGO	Non-Governmental Agency
PSI	Population Services, Incorporated
PVO	Private Voluntary Organization
SCF	Save the Children Federation
STD/HIV	Sexually transmitted diseases/Human Immunodeficiency Virus
TBA	Traditional birth attendant
TT	Tetanus Toxoid (anti-tetanus vaccine)
USAID	United States Agency for International Development

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## I EXECUTIVE SUMMARY

The final evaluation of the health component of the Save the Children Federation (SCF) Community-based Health and Rural Development (CBHRD) Project was conducted from 17-22 March 1997 by an external evaluator. The water, education and agriculture components were evaluated separately in October 1997.

Funded by USAID under Grant No. 656-0217-4017-00, the project focus area included 26 communities in Xai-Xai and Bilene Districts, in southern Gaza Province. SCF census data show that approximately 104,517 beneficiaries were served by this project.

The CBHRD health component comprised three principal activity areas:

- Training of community health workers,
- Rehabilitation/construction of health posts, maternities and health staff housing,
- Strengthening linkages between 26 rural communities and the formal health system.

Objectives and projected outputs in all three areas were achieved and, in many cases, exceeded. However, access shortfalls were noted in the area of new construction due to lack of qualified staff, weaknesses were noted in communications between SCF and GOM/MOH colleagues.

Community perceptions of the impact of SCF support through the CBHRD Project were consistently positive and knowledge levels about beneficial health practices appeared to be high. A rough comparison with non-SCF villages showed knowledge and practices regarding diarrhea management and STD/HIV prevention to be of significantly lower quality than in SCF impact areas.

Sustainability of CBHRD interventions will rely not only on community motivation levels, but on the re-allocation of GOM contributions to the health sector and a review of MOH training, supervision and service delivery priorities. Additionally, communities must be held to more rigorous standards of participation for volunteer community health providers and promoters.

Key recommendations for future health programming include,

- Encourage the DDS to schedule regular refresher and supplementary training events for CHWs, all training events should include a TOT component.
- Document all GOM commitments to staff newly constructed and rehabilitated facilities with properly qualified staff.
- Explore alternative pharmaceutical supply mechanisms.
- Require target communities to submit plans for participation in development activities as well as compensation for volunteer health promoters and providers.
- Promote donor dialogue with GOM regarding necessary increases in health spending.

## II PROJECT BACKGROUND

Save the Children Federation (USA) has been operating in three communities in Xai-Xai District of Gaza Province since 1988, providing relief and humanitarian assistance during a period of extreme violence and civil disorder. Prior to the cessation of hostilities in 1993, fighting accelerated in the countryside, particularly in Gaza Province, and many families fled to the relative security of the far side of the Limpopo River, hoping to go home when peace returned. SCF supported these and other displaced communities, providing the basic components: life, seeds, tools, health care and food assistance.

In 1994, a large portion of the displaced population of southern Gaza indicated that they wished to return to their land, fully recognizing that the infrastructure for health care, education and agriculture were virtually gone. It was time to rebuild their world.

In an effort to support these people in transition, who had few resources but the will to reclaim their land and their lives, SCF -- with its comparative advantage of having worked in the region for six years -- designed the Community-based Rural Health and Development Project. The purpose of the project was to re-establish basic infrastructure in the areas of health, water, education and agriculture, facilitating the return of displaced communities as well as demobilized soldiers and guaranteeing the viability of long-term resettlement processes.

CBHRD objectives and activities in all sectors took shape from three action strategies:

- **Empowerment** through training and capacity-building of community health workers (CHWs) and promotion of collective choice mechanisms,
- **Physical and functional rehabilitation** of service delivery infrastructure and networks,
- **Forging linkages** with government -- between government services, between traditional and formal sectors and between NGOs and government colleagues.

The common aim linking all these strategies is to create a situation in which the community, NGOs and government work in synergy to improve the quality of and access to social services for rural populations in the process of resettlement. None of the participants in this process can achieve progress in isolation.

CBHRD interventions have been carried out since April 1994. Scheduled to reach completion in September 1996, the project had not expended all funds and was granted a 9-month no-cost extension through June 1997. However, acceleration of construction activities in the last quarter of 1996 caused more rapid expenditure of the budget than anticipated, and health component activities were phased-out after September 1996.

The overall goal of the CBIIRD Project was to improve the health of rural families in the project focus area, with particular emphasis on children 0-5 years old and women of reproductive age (15-49 years old) through an array of interventions addressing issues of health, education, water and agriculture. The health component contributes directly to USAID's Strategic Objective 3, "Increased Use of Essential, Community-Based Maternal and Child Services in Focus Areas"

A KPC survey conducted in 1994 provided the baseline data which informed project activity design and implementation. An endline KPC, which would provide some indication of behavioral change and improvement in health status indicators was not conducted due to financial constraints and by recommendation of the midterm evaluator who felt that the sample size was too small and that the relatively short period of time between baseline and endline measurements would not allow for significant changes in behavioral and health status indicators to occur.

### III EVALUATION METHODOLOGY

The evaluation of the CBIIRD Project health component was initiated with a complete review of all project documentation including the original proposal, the KPC baseline survey conducted in May-June 1994, the Midterm Evaluation conducted in July 1995 Quarterly Reports and Project activity data Prior to departure for field work, a briefing was held with USAID-Maputo Grants Management and Health Section staff Upon arrival at the SCF-Gaza office, a briefing was held at which Sector Coordinators provided the evaluator with an overview of all CBIIRD components as well as other SCF program activities

Principal sources of information for this evaluation were

- Interviews with MOH provincial and district health staff,
- Discussions with SCF staff responsible for Project implementation and monitoring,
- Discussions with representatives of collaborating agencies,
- Community meetings in SCF impact areas, including leaders, CIW trainees and community residents,
- Community meetings in villages not supported by SCF,
- Site visits to newly constructed and rehabilitated health posts and staff housing units and interviews with the respective service providers,
- Exit interviews with service users,
- Focus groups with community beneficiaries,
- Personal observation and application of Public Health qualifications and experience in interpreting situations encountered and Project data

This report represents a largely qualitative assessment of the extent to which CBHRD health component objectives were achieved and the subsequent or projected benefits to the target population It examines the appropriateness and quality of project activities while commenting on SCF's collaborative relationships with government, NGO and community partners in carrying out those activities

Statistical data referred to in this report are drawn from the KPC baseline survey, SCF impact area data and MOH service record data

Significant related topics addressed in this report are constraints to project implementation, the degree to which midterm recommendations were satisfied and sustainability issues Finally, the evaluator makes recommendations for future interventions and strategies for each component area Recommendations include references to unmet needs which should be addressed in future programming

## IV ACHIEVEMENT OF OBJECTIVES

CBHRD Project health component activities fall into three distinct categories

- Training of community-based promoters and traditional health providers,
- Rehabilitation/Construction (physical and functional) of health units,
- Strengthening of linkages between 26 communities and the formal health system

Project interventions were wholly appropriate given the scarcity of financial and skilled human resources in the impact area. CBHRD Project implementation relied to an extensive degree on networks, including SCF's institutional presence, which were already in place -- community councils, motivated volunteers, and the traditional and formal health sectors. These networks facilitated all levels of the process -- planning, implementation, monitoring and follow-up -- and required only moderate financial inputs.

While the Rehabilitation/Construction component was highly capital-intensive and, therefore, beyond the current means of indigenous networks, structural rehabilitation was vital to serving the purpose of the CBHRD Project and necessary to guaranteeing the long-term resettlement of displaced communities.

### A Training

#### 1 Objective #1

*Improved human resources and skill development among health providers through provision of refresher courses*

**Target** 10 district level MCH nurses (province-wide)

- Objective achieved and exceeded  
-1 additional MCH nurse trained

This was an appropriate intervention in that it reflected two of the three guiding strategies for this project. The capacity of district MCH nurses to conduct training and supervision of volunteer health promoters (*activistas*), traditional birth attendants (TBAs) and traditional healers (*curanderos*) was strengthened. Refresher courses also contribute to the quality of services delivered by these nurses as well as their potential to influence the practices of their colleagues. New linkages were forged and old ones strengthened between traditional and community-based networks and the formal health system.

Refresher training of MOH personnel contributes significantly to sustainability by ensuring retention of training capacity and curriculum development skills at district level.

## 2 Objective #2

*Improved access to community-based services through basic and refresher training in child survival and maternal care, primary and preventive health care safe birth practices and reproductive health and STD/HIV prevention for community-based and traditional health providers and promoters*

Target        50 TBAs (province-wide)  
                  360 *activistas*

- Objective achieved and exceeded
  - 79 additional TBAs trained
  - 4 *Agentes Polivalentes Elementares* (APEs) and 21 *activistas* trained, in cooperation with MSF-Switzerland, to carry out emergency community-based distribution of malaria and diarrhea therapy in flood affected areas in 1995
  - 16 additional *activistas* trained
  - 58 *curandeiros* trained in STD/HIV prevention and diarrhea case management
  - 50 *curandeiros* and TBAs given refresher courses in STD/HIV prevention and trained in social marketing of Jeito condoms in cooperation with PSI

Due to the CBHRD training intervention, considerable progress has been made in strengthening community support for basic health service delivery

- 96% of target communities have a functioning community health advisory group,
- 100% of fixed facilities in the catchment area support community outreach of PHC services,
- 100% of the communities in the catchment area have community-based groups supporting PHC activities

### 2 a *Activistas*

*Activistas* are community health promoters, trained to deliver basic health and hygiene messages as well as information about preventive and primary health care such as the importance of childhood and maternal immunization, the value of ante-natal care and infant growth monitoring and interim measures for diarrhea management. On a regular basis in many communities they participate in activities at their local health post assisting with baby weighing and conducting *palestras* (health education sessions) on a wide variety of topics including STD/HIV prevention and family planning. On a monthly basis they present reports of their activities and community morbidity and mortality to the nearest health post. They are volunteers, chosen by their own communities to serve on an indefinite basis. In the course of community visits, *activistas* demonstrated, with few exceptions,

a high degree of enthusiasm for and dedication to their work

During the last quarter of the project, SCF supported and facilitated five inter-village meetings for 132 *activistas* representing 12 communities in Xai-Xai District. Serving as an opportunity to share experiences and information among CHWs as well as district health staff, such meetings reinforce the sense of self-reliance engendered by CBIIRD training activities. Future meetings of this type will contribute to the long-term sustainability of the training intervention and reassure the participants of the continued value of their services to the community.

Immunization coverage, while difficult to track given fluctuating population figures (note BCG coverage rate of 113% for 1996 reflects immunization of infants outside SCF target area), -- this problem will be resolved with the completion of the national census in 1997 -- has improved significantly in the project impact area from 1994-1996. Coverage rates are roughly based on baseline and endline censuses, the KPC conducted by SCF in 1994 and service records from impact area facilities for 1996.

PROJECT IMPACT ARLA POPULATION Xai-Xai 71,744 Bilene 32,773 Total 104,517	1994 COVERAGE	1996 COVERAGE
BCG (children 0-11 mos)	77%	113%
DPT3/AP3 (children 0-11 mos)	66%	90%
Measles (children 0-11 mos)	56%	80%
TT2 (women 15-49 yrs) relative rate (#TT2/#TT1)	Not available	20%
TT2 (pregnant women) relative rate (#TT2/#TT1)	Not available	95%

The evaluator would like to emphasize the importance of using data from the upcoming baseline KPC for the PVO II grant to make more meaningful assumptions about the impact of CBHRD interventions on immunization coverage rates in Xai-Xai and Bilene Districts. The data will contribute a valuable addendum to this evaluation report.

Due largely to CBIIRD *activista* training activities, the community outreach indicator -- with specific regard to *activistas* -- (ratio of trained community-based health providers to catchment area population) is currently 1:201, a significant improvement over 1:1,322 at the outset of the project, and surpassing the project target of 1:50 families (approximately 1:250 people). All communities profess to far greater understanding of health and disease prevention issues as well as knowledge about how to "buy time" for their children through interim maintenance measures such as ORT preparation and use.

Through to increased community outreach, 61 129 individuals have participated in IE&C sessions although this figure likely represents some cases of double counting as some people have attended more than one session. Current gender breakdown of IEC participants is approximately 80% female and 20% male, SCF intends to encourage more male participation in the course of future interventions.

At present, *activistas* receive no compensation for the services they provide their communities apart from the symbolic contribution of T-shirts made by SCF when they assumed their responsibilities. In all communities visited *activistas* expressed the wish to receive some form of compensation for their work. The range of requests included more T-shirts, materials for their work such as notebooks and pens, a supply of soap which would serve a family need as well as lend credibility to their health promotion work, and cash compensation. At the same time, all *activistas* interviewed reaffirmed the commitment they had made to this work by simple virtue of having accepted the responsibility and received training, none, they claim, will cease working, even if they do not receive compensation.

## 2 b Traditional birth attendants

CBHRD support for TBA training has increased access to safer delivery services for rural women in SCF-supported communities. There is now greater confidence in and satisfaction with the services of trained TBAs. The rates for institutional (due to higher referral rates) and assisted births in the impact area increased between 1994 and 1996 from 55% to 73% for institutional births and from 17% to 23% for TBA-assisted births. Of equal significance, the percentage of home births in the impact area decreased during the same time period from 21% to 4%.

While the evaluator was unable to assess the impact of these coverage rates within the restricted scope and timeframe of this evaluation, it can be assumed that these data would have some positive impact on infant and maternal morbidity and mortality rates in Xai-Xai and Bilene Districts.

In one community, Emilia Dausse, a highly motivated TBA has served as a catalyst for SCF-supported improvements in the quality of the services she delivers as well as the hygiene practices of many families. In the absence of a maternity facility, but appreciating the importance of a location dedicated to safe assisted birth, the locally famous Dona Virginia requested that SCF assist her in building a birthing hut with a hygienic concrete floor. This request was honored. On another occasion, Dona Virginia collected money from 18 families (including her own) for the purchase of concrete slabs to be used in construction of improved pit latrines. SCF provided the transport for these slabs from Xai-Xai to her village. Such community role models can provoke significant changes in the health status of communities with few resources.

One of the constraints to increasing access to safe delivery services is MOH/DDS failure to keep trained TBAs supplied with adequate materials, including kerosene for sterilization of instruments.

## 2 c *Agentes Polivalentes Elementares*

In response to severe flooding in 1995, SCF collaborated with MSF-Switzerland in training 4 APEs and 21 *activistas* to carry out emergency community-based distribution of malaria and diarrhea therapy. The time-bound program met with considerable success in meeting the most critical health needs of the population in flood affected areas. There have since been many requests by communities and CIIWs to expand the program to cover non-emergency situations in isolated communities with low access to peripheral health posts.

Historically, APEs have served as non-paid collaborators with formal health sector personnel, usually working in a CIIW capacity. However, due to financial constraints and the slow pace of the nomination process, the MOH has trained some APEs to staff health posts in place of basic level nurses, when assigned to a facility, they receive some minimal compensation. They are authorized to dispense Kit C drugs, but they do not provide immunization services.

There is MOH resistance to giving APEs more extensive training or paying those not assigned to official facilities, however, they represent a potentially significant resource for filling gaps in the service delivery system which has yet to be tapped.

## 2 d *Curandeiros*

" we will never stop transmitting the information that we have learned we were lucky that we had our eyes and our ears opened "

Traditional healers in Mozambique were officially recognized by the GOM in 1982 with the establishment of the *Associação de Médicos Tradicionais Mocambicanos* (AMETRAMO). Although no attempts were made to create links between *curandeiros* and the formal health system, they feel that their work is valued by the community and appreciated by the MOH for the gaps it fills in the health service delivery network.

AMETRAMO's relationship with SCF began in 1996 when *curandeiro* groups operating in CBHRD impact areas began to receive training, primarily in STD/HIV prevention. Apart from the technical information gained through these training events, SCF support has provoked the creation of an unprecedented link between the traditional and formal health sectors. Participants in the training speak of a new-found confidence which allows them to realistically assess their capacities and limitations, *curandeiros* now refer their patients to MOH health facilities much earlier than they did in the past. For the first time, they recognize that referrals are not an admission of incompetence, nor are they regarded as such. On the contrary, a philosophy of interdependence and mutual respect has taken root, while *curandeiros* are more likely to refer patients to a health facility, there have also been cases of formal sector providers referring some patients to the traditional network. Several individuals pointed with considerable pride to the new overlap with modern medicine, with regard

to sterilization for example

In addition to the link forged between traditional and formal health delivery systems, an alliance is growing amongst a group of people who formerly worked independently and privately. *Curandeiros* who have participated in CBIIRD training events have been convoking groups of their colleagues to share both the knowledge they have acquired and the new perspective on their work. They are seeking advice from one another. One AMETRAMO leader noted that when the day comes for SCF to cease operating in the region, *curandeiros* themselves would assume responsibility for the training of new *curandeiros* in the prevention strategies promoted SCF and its MOH and NGO partners.

## 2 e Comparison with non-target communities

A superficial qualitative comparison of knowledge of diarrhea management and STD/HIV prevention between a project target community and a non-target community showed that exposure to trained *activistas* and *curandeiros* predicted better knowledge of ORT (how to prepare and when to use) and methods of STD/HIV prevention.

In Chipenhe (Xai-Xai District) where all six of the women interviewed had been exposed to *activistas* either in their homes or during IE&C presentations at the health post, 4 out of 6 knew that STDs could be treated at the health post, while HIV cannot be cured but can be prevented through monogamy or condom use. *Curandeiros* are not used extensively in this area, which may explain why no one was aware of the importance of providing a new blade for traditional cutting treatments or verifying that cutting instruments were sterilized. Five out of 6 respondents were aware of the importance of ORT as the key element of diarrhea management.

In contrast, in the non-target community of Bungane (Xai-Xai District), none of the five women interviewed had been exposed to *activistas*, and their health information was predictably incomplete. This community has been acutely affected by AIDS, with numerous men returning from jobs in South Africa, infected and dying. They are aware that condom use can prevent transmission of the virus, but acceptance of the method appears to be low. While this community relies on the services of *curandeiros* due to their distance from a health post, the women were startled to learn that use of cutting instruments on multiple patients can easily transmit the virus which causes AIDS. Only 1 out of 5 women had some knowledge of the home preparation of ORT, that one having learned from a friend. In this community, most women give birth at home, unassisted by TBAs -- trained or otherwise. Two of 5 women had sisters who had died in childbirth, while 4 out of 5 women had lost 2-3 children. In Chongoene (Xai-Xai District), another non-target community but one with good access to a health post and maternity, only 1 out of 7 respondents had a sister who had died in childbirth. 2 women had lost 1 child apiece, and one elderly woman had lost five. Women in both non-target communities expressed great enthusiasm at the idea of learning more about safeguarding the health of their families.

## B Rehabilitation/Construction

### 1 Objective #1

*Improved quality of facility-based services through rehabilitation of peripheral health posts and maternities attached to those health posts*

Target            2 health posts  
                      2 maternities

- Objective achieved in terms of number of units, but only partially in terms of completeness of work

It is clear that in the interest of completing structural renovations in a timely manner, technical supervision of this intervention lacked care and attention. The quality of the work was variable: windows were repaired but not consistently fitted with screens, in some cases, fresh coats of paint were applied to rotting or termite-infested wood. At the maternity in Chipenhe, a door jamb had recently fallen out, exposing the rotted wood and rusty nails beneath the fresh paint. Interior sink pipes were left in disrepair, prohibiting interior water disposal.

Only two of the four facilities visited had improved pit latrines. At Messano health post, the cement slab for an improved pit latrine had been sitting near the health post entrance for some time -- debris and sand having settled around it, weeds poking up through the hole. When asked about the situation, the nurse shrugged his shoulders, saying he didn't know anything about it.

In the course of evaluation site visits, there were many cases where it seemed that insufficient attention had been given to promoting a sense of community ownership of the health post and a recognition of its value to the community. At Zongoene health post, the nurse complained that SCF had not blocked up the eaves of the roof to prevent bats nesting there (bat feces stain the interior walls). When it was suggested to him that it was a simple matter of getting some assistance from the community to block up the openings, perhaps with mud bricks, he seemed genuinely disinterested in that alternative.

### 2 Objective #2

*Increased access to facility-based services through construction of new health posts and maternities*

Target            3 health posts  
                      3 maternity units

- Structural objective achieved, functional objective achieved at 1 out of 3 sites

A new construction site visit was carried out at Mangol in Bilenc. While the quality of the design and construction work appeared to be quite high, the health post was found to be barely operational,

the situation was said by SCF staff to be similar at another of the new construction sites in Tuane. Reasons for this shortfall in meeting a stated objective are complex and for the most part not due to deficiencies in CBIIRD implementation.

Neither Mangol nor Tuane health posts have been staffed by appropriately qualified personnel, the level of the staff allows use of only the most basic of Essential Drug Kits, Kit C. At the moment, even those are in critically short supply. The kerosene refrigeration units at both locations have remained in their shipping carton as current staff (APEs) are not qualified to deliver EPI services, the gap in immunization coverage has not yet been filled by a mobile immunization brigade visit. The majority of the population continue to travel to the health center in Macia (approximately 15-25 km away for area residents) for care and services. In short, functional access to primary health care services has not been increased at these locations and SCF intervention has produced few results.

SCF had confidence that MOH -- who had participated, along with the GOM Planning Commission, in selection of new health post sites -- had made a commitment to assigning properly qualified staff to new health posts upon completion of construction. However, documentation of this commitment which could serve as a leverage to compliance with staffing commitments was not on hand. It is widely recognized that the MOH nomination process is lengthy and carries costs which GOM is not currently prepared to assume. However, it would not be unreasonable to assume that GOM, having full knowledge of health sector construction plans -- approved in 1994 -- to build new health posts, would have initiated the nomination process and made the necessary financial arrangements with appropriate ministries and offices well in advance of the October-December 1996 completion of construction.

MOH, in general, is not meeting its responsibilities for supporting health service delivery structures. Supplies of essential drugs (MOH/Medimoc responsibility) are at critically low levels at all health units visited, and according to reports, throughout the country. In particular, no chloroquine has been available since January, at the height of the malaria season. Supplies of kerosene (DDS responsibility) arrive irregularly at most health posts, causing discontinuity in the EPI program as well as disrupting sterilization procedures. All health units visited are operating with critical shortages of basic medico-surgical supplies and equipment (MOH/DDS/DPS responsibility). While SCF holds no responsibility for pharmaceutical stock ruptures and inadequate fuel and service supplies, access to services and impact of SCF interventions are limited by these GOM-controlled deficits and undependable delivery mechanisms.

### 3 Objective #3

*Increase access to facility-based health providers through construction and renovation of residences for health post staff*

**Target**            **10 residences for health post staff**

- Objective achieved and exceeded  
- 3 additional residences rehabilitated

The DDS-Bilene made a special request to SCF to forego originally-planned rehabilitation of two health posts in exchange for rehabilitation of the residence of the District Chief Medical Officer who was finding it difficult to assume responsibilities at the health center without adequate housing nearby. SCF agreed to this modification, the CMO reported that the work was very satisfactory.

One new residence at Zongoene had been constructed of local materials. Poor construction, particularly of the roof, has had a negative impact on the outlook and energy of the MCH nurse-midwife posted there. She notes that on rainy nights the roof leaks profusely, interrupting her sleep and ruining her possessions. Residents who benefit from her services have offered no assistance in repairing the roof or the now-ruined wall of her house, she is extremely discouraged. This community has very few TBAs to serve their obstetric needs, so this MCH nurse carries a particularly heavy burden.

Residents of 8 other houses built or rehabilitated by SCF expressed general satisfaction with the quality of the work and their improved living conditions, although not all have had improved pit latrines installed.

## C Linkages

CBHRD interventions forged a number of valuable linkages for improved delivery of community-based services in Xai-Xai and Bilene Districts. Those linkages are found at a variety of different levels: between the community and the formal health system, between neighboring communities, between CHWs and their communities, and between CHWs themselves. However, some areas of weakness in communications were noted, and the evaluator has formulated appropriate recommendations to address those weaknesses (See Section VII).

### 1 Linkages forged through training activities

- Through the training of cadres of community-based health promoters and providers in modern primary and preventive health practices, SCF has instigated a synergy between the traditional and modern approaches to health care, thereby increasing the overall impact.

of both systems

- Noted during a meeting with the national association of traditional healers, AMETRAMO the significant impact of training on *curandeiros'* sense of their power to promote positive health practices among their clients and their colleagues, the group expressed a new-found confidence to accept the limits of their curative capacity, and their willingness to refer individuals to modern health providers sooner in the treatment process than they used to, resulting in fewer deaths and complications (their observations)
- By virtue of regular exposure to trained *activistas*, rural inhabitants are learning to "buy time" for their children, preventing many common illnesses and learning interim therapeutic strategies to ensure survival en route to distant health facilities
- *Activistas* are spurring increases in facility-based utilization rates and immunization coverage rates through dissemination of appropriate IE&C messages
- In the course of a visit to the Julius Nyerere health post in January (for work unrelated to this evaluation), the evaluator noted complaints from staff there about *activistas'* perceptions of themselves and their work as "belonging" to SCF rather than to the formal health structure. During the field visits for this evaluation, neither health post staff nor *activistas* gave evidence of this perception, on the contrary, they all demonstrated great enthusiasm about the role of *activistas* in supporting the work of the MOH network

## 2 Linkages forged through construction and rehabilitation activities

- Through construction of new health posts and maternities, SCF increased access to facility-based services where none had previously existed. Some target area populations had always relied on the traditional health network of *curandeiros* and TBAs to serve most of their health needs, with predictably mixed results. Those people have now been offered alternative connections to the formal health system
- Rehabilitation of existing but seriously degraded health facilities has contributed towards access to improved quality of care for rural inhabitants, apart from the availability of services, people are more inclined to seek services at a facility which is reasonably clean and sound

## 3 Linkages forged with the formal health service delivery network

- Logistical support for DDS/EPI programs have contributed significantly to increases in coverage rates between 1994 and 1996. The value of this support however is somewhat

diluted by the ongoing dependence it has created on NGO transport mechanisms. As SCF has phased-out its logistical support for the EPI program in Xai-Xai District, the debate continues as to how the MOH will obtain financial and material resources to continue fielding mobile immunization brigades.

- SCF support for district supervision activities has contributed to the maintenance of standards of service at peripheral health units. SCF plans to continue its support for supervision in the impact area throughout the anticipated PVO II-funded project.
- At both the DPS and DDS-Xai-Xai, some dissatisfaction was expressed with a perceived lack of collaboration between SCF and provincial and district health officials. Specifically, it was reported that SCF had at times neglected to inform the DPS about its activities in the province, nor had the DPS been included in the process of original target area selection for the CBHRD project.

While the evaluator does not wish to doubt the accuracy of the DPS's concern, it is useful to note the chaotic background against which CBHRD interventions were launched. The cessation of hostilities in 1993 had given way to a period of severe drought, exacerbating the conditions of people's lives at that time. A large portion of the population was displaced and receiving SCF support in food and emergency medical assistance. When people began to move back to their communities, SCF was there to provide the support necessary to a new beginning: revitalization of health infrastructure and systems, seed and tool distribution, water and schools. SCF chose primarily to support communities whose people had been beneficiaries while living in exile. Furthermore, the CBHRD project comprised components outside the health sector -- water, agriculture and education all received CBHRD inputs. Therefore, communities were, of necessity, selected according to criteria for integrated rural development and not according to health criteria in isolation.

Lack of communication may be perceived due to the transience of DPS and DDS staff, many individuals currently assigned to the DPS and DDS-Xai-Xai arrived after CBHRD staff, all of whom express a willingness to communicate with the DPS and DDS officials about their activities. It was not clarified to the evaluator why DPS/DDS concerns, complaints and comments were not brought to SCF's attention for earlier resolution.

- Another source of DPS/DDS dissatisfaction has been what is seen as insufficient fulfillment of commitments made to provide logistical support to the EPI program. DPS and DDS officials noted that failure to meet pre-arranged schedules can result in discouragement for the population and deterioration of the motivation to get their children immunized. SCF-Gaza staff confirmed that, because of competing transport pressures, decisions were taken by the SCF-Gaza Representative to place heavier emphasis on completing construction work than on providing transport for mobile immunization and supervision brigades, particularly during the last two quarters of the project. SCF-Gaza staff also noted that there were

occasions when the SCF vehicle would arrive to pick up the mobile brigades, they would not be ready to go causing delays and modifications in SCF-staff's field schedule as well

- Finally, the evaluator noted considerable chagrin at the DPS caused by the perception that SCF failed to consult with the DPS in elaborating the proposal for the PVO II grant. With regard to this concern, the evaluator was informed by SCF-Gaza staff that the concept paper for the PVO II grant, Synergy for Improved Health, was developed in early 1996 and supported by the Provincial Director of Health assigned to the DPS-Gaza at that time. There have since been changes in his as well as in other DPS and DDS staff positions. The final proposal was not submitted in May 1996, as originally intended due to the USAID's request that it be submitted in February 1997, during the second review phase. These clarifications may resolve some of the confusion at the DPS regarding this issue.

## V SUSTAINABILITY

*In the course of many community meetings when asked about how they would continue to support activities initiated by SCF, community leaders and health promoters and providers would respond with the analogy to a child whose father has died -- although that child has lost his original provider, teacher and nurturer, he will continue to grow, learn and thrive even if it is a bit difficult at first*

Sustainability of development projects is a goal constantly strived for yet rarely attained. It assumes that beneficiaries have the capacity -- including the financial means -- to continue producing, to some degree, the results of a project intervention after the implementing agency has ceased its operations. That assumption is flawed in many respects.

It is unrealistic to expect most interventions to be sustainable at the community level in isolation, particularly in an environment where there is no cash-based economy (so minimal purchasing power), low-skilled workers and a minimally educated population. The growth rate in Mozambique for the previous fiscal year was 7%, 85% of the national budget comes from external contributions, and per capita spending on health care amounts to less than US\$2.00. The government of a such a nation must be obliged to contribute more to the long-term sustainability of current development assistance. By increasing its budget allocation for health and restricting health expenditures to a small number of component areas -- e.g. EPI, training support for CHW network and salaries -- rather than diluting the effect of an increased contribution by spreading it over all areas, GOM could contribute in relatively low-cost ways to the sustainability of development initiatives and demonstrate more tangible support for the currently marginalized rural population of Mozambique.

MOH district health officials must encourage community leaders themselves to request support (e.g. for refresher training for *activistas*) from the national health system as well as from NGOs working in their regions. Continual follow-up at the community level will ensure that people are familiar with the channels to be followed in making requests. At the same time, health officials must be prepared to receive community representatives and respond in a timely manner to reasonable requests or offer indications of when more complex needs can be met. Government is responsible for creating a relationship of trust and confidence with its own people. It is an aberration for the population to be dependant on non-nationals to respond to their needs.

Another way in which sustainability of the community health network could be strengthened would be to provide ID cards for volunteer *activistas* and TBAs which would give them some sort of benefit such as free health care in Xai-Xai or Maputo. It is a simple fact of human nature that people need recognition to be able to take pride in their work and preserve the enthusiasm necessary to continuing to provide a volunteer effort. It is unrealistic to assume otherwise.

By the same token, the community itself must be held to stricter standards with respect to

participation in project activities and support for volunteer service providers. There is a wide variety of ways in which a community can ensure the sustainability of time-limited project interventions. Compensation in cash, food or domestic supplies must be provided for CIWs currently working on a volunteer basis. Communities must contribute labor or time to basic repair or construction activities such as health post latrines. Collection of water fees should occur prior to installation of water points so that down time is minimized when pumps require maintenance or repair. More elaborate community support mechanisms and strategies may evolve over time as the collective ethic is adopted. One unmet need referred to on numerous occasions during the field visits was transport for medical evacuations. Community med-evac credit funds might be created, or standing arrangements made with local vehicle owners. When a community fails to submit a plan for participation and support prior to initiation of project activities, development agencies should consider postponing or cancelling interventions in that community.

Sustainability is also affected by the availability of technical resources to refer to at times of uncertainty. For example, *activistas*, TBAs, APEs and *curandeiros* would all benefit from having access to complete but easily understandable health manuals. UNICEF publishes (in partnership with numerous international organizations including SCT) an excellent family health manual entitled *Facts for Life*. The manual provides thorough but basic information on a variety of key primary health topics including Timing births, Safe motherhood, Breastfeeding, Child growth, Immunization, Diarrhea, Coughs and colds, Hygiene, Malaria, AIDS, and Child development. In some countries, the manual has been adapted to recognize region-specific characteristics and issues. For example, a cholera epidemic in Zambia in 1993 led to the inclusion of a Cholera section in the Zambian version of *Facts for Life* which was produced in 1994.

The manual is usually acquired free of charge, it would be a worthwhile resource to make available to all health providers, but especially to those working at the community level.

The final evaluator does concur with the judgement of the midterm evaluator that discontinuation of SCF support must be carefully timed so as not to jeopardize the effective adoption and sustainability of project interventions. However, a shifting of responsibility must take place over the life of any project so that indigenous systems are in place for continued support and follow-up.

Finally, the concept of sustainability must be promoted by SCT staff themselves. They should continually generate ideas and suggestions for ensuring the sustainability of most project interventions. They should view themselves as temporary facilitators, animating the initial phases of development initiatives, but instilling the confidence in community members and government colleagues to be able to carry on without SCT.

## VI REVIEW OF MIDTERM RECOMMENDATIONS

### A "Ensuring sustainability through empowerment"

The midterm evaluator suggested that meetings should be held with *activistas* to reinforce the sense of having increased control over their lives. These meetings could provide a forum for *activistas* to develop a variety of ways to apply the knowledge and skills they have learned through CBHRD-supported training and to discuss their experiences and lessons learned.

*Activista* meetings are being held in all communities and have been held between communities on several occasions. They serve as an opportunity to share experiences, obtain advice and reinforce knowledge. The evolution of the *activista* dynamic is, however, still in its early stages. The promoters themselves are in the process establishing their role in the communities, consolidating their experience, refining their methods of approaching individuals and strengthening their presentation of health messages. It appears to be too early in the process to expect innovation and new initiatives. Time is being well-spent on simply "institutionalizing" the *activista* network. New applications of knowledge will likely begin to appear when *activistas* have established themselves in their communities and have demonstrated their capacity to sustain the network.

### B "Reinforce healthy community knowledge"

It was suggested that *activistas* investigate traditional methods of treating common illnesses, reinforcing methods found to be valid, this could increase the community's sense of self-worth.

This specific recommendation has not been carried out as it would require additional inputs (monitoring by a health professional) which were outside the scope and budget of the CBHRD Project. It would also divert attention from current efforts to strengthen the role and performance of the *activista* as originally planned. It would be a valuable extension of current *activista* responsibilities to be included in future programming.

Such work is being done in the context of *curandeiro* training. This is a more appropriate target group at present as they have first-hand knowledge and experience in traditional/herbal treatments.

### C "Ensuring stability of *activistas* - income generation"

The recommendation that *activistas* be trained and supplied to dispense basic preventive and curative drugs, promoting income generation for *activistas* has not yet been approved by MOH.

Other suggestions for income generation through micro-projects such as marketing crafts and dairy products have not yet been adopted.

A "token of appreciation from SCF" has been extended in the form of T-shirts and *capulanas*.

D *"Ensuring sustainability - making sure activistas and TBAs are effective, the need for identification"*

See reference to "token of appreciation" above

E *"Ensuring sustainability by increasing a sense of autonomous problem-solving and new innovation development"*

The recommendation of facilitating inter-village meetings was initiated in the last quarter of the project as an opportunity for exchange of information, experiences and common problems. The events were assessed as having had very positive results, this evaluator recommends that they be continued in the course of future programming.

F *"Consolidation of ORT knowledge"*

The midterm evaluator recommended the dissemination of more precise information regarding the quantity of ORS to be given to infants, children and adults. In the SCF impact area, most respondents knew that 1 litre of the solution should be given to a child in the course of a day. However, knowledge of subtle differences in quantity across different age groups was not apparent. Furthermore, the measurements of salt and sugar for the home preparation were not consistent. Attention is due this issue during training events and in monitoring activities.

G *"Prevent activistas from taking a victim-blaming approach"*

This evaluator did not gather information which would substantiate the observation of the midterm evaluator. However, this could be due to the recommendation having been met or the fact that different communities were visited in the course of the two evaluations.

H *"Ensure that mattresses are plastic covered"*

Mattresses provided by SCF for rehabilitated health posts and maternities have been covered in plastic, following the recommendation of the midterm evaluator.

I *"Pilot community-based distribution of oral contraceptives"*

This recommendation has not yet been addressed.

J *"Community-based distribution of condoms"*

Activistas and TBAs have been supplied with condoms, resistance to this method remains strong and actual distribution of the supplies is minimal to non-existent. See Recommendation VII A.10

## VII RECOMMENDATIONS

### A Training

- 1 Assist DDSs in setting up long-range refresher training for trainers in order to identify -- well in advance of the events -- cost and logistic implications advance planning of this nature may facilitate more effective allocation of resources and ensure the sustainability of community-based health networks which rely on regular refresher training and supervision
- 2 Encourage non-cash, MOHI-supported incentive system for performance of such training duties, e.g. compensation time or special community recognition
- 3 Work with the DDS in scheduling regular refresher and supplementary training events for community-based promoters and providers, include a TOT component in these training agenda to ensure that the possibility for training new promoters and providers exists at the community level
- 4 Encourage diversification of IE&C presentations For example, messages regarding the importance of clean water and water point hygiene could be conducted at the water point itself Theatre presentations regarding STD/HIV prevention could be accompanied by *palestras* on the same topic In this way, *activistas* can minimize the dynamic of "preaching to the converted" when they conduct most health education presentations at the health post
- 4 Assist in promoting community support and compensation (cash or non-cash) for *activista*, TBA and APE services, where communities are not willing to provide this support, it may be advisable to consider discontinuing project support There is the operational phenomenon that a felt need is more readily satisfied than a need that has yet to be identified
- 5 Encourage trained promoters and providers to convoke colleagues for skills and information-sharing opportunities, particularly in the case of TBAs and *cui andeiros* This activity extends the impact of the original training in terms of improved health behavior, and it strengthens the sustainability of the intervention
- 6 Support more contiguous communities in order to increase the opportunities for exchanging information and experience
- 7 Explore with MOHI the possibility of assigning some form of identification to *activistas* to allow them access to some free health services or other benefits in recognition of their voluntary efforts at the community level to increase utilization of PHC services and to improve health behavior The MOH/DPS/DDS insist that *activistas* identify themselves with the formal health system in their capacity as collaborators, MOH, logically, must

acknowledge their contribution to the promotion of primary health care services

- 8 Provide logistical support for supervision for an additional year in order to solidify recognition of the value of maintaining a skilled community-based promoter/provider network, will build MOH willingness and capacity to continue supervision once this support from SCF is phased-out
- 9 Explore with MOH the possibility of conferring upon *activistas* basic therapeutic and curative capacity through supplies of ORT packets, chloroquine and aspirin (e.g. through the establishment of village pharmacies). The impact due to increased access to interim measures could be substantial. Cost recovery schemes -- where the revenue generated compensates the *activista* --, using this basic supply of preventive and curative drugs could provide an increased measure of sustainability to the *activista* network. The system would have to be carefully monitored to ensure that drugs were not being dispensed indiscriminately.
- 10 More extensive education on condom use is indicated to increase acceptance of this approach to STD/HIV prevention, acceptance levels -- despite community-based distribution mechanisms -- appear to be extraordinarily low at this time.
- 11 Procure copies of *Facts for Life* for all target district health facilities and community representatives of the CHW network to serve as a valuable resource for basic preventive health information.

## B Rehabilitation/Construction

- 1 A complete inventory of rehabilitations, including existence of improved pit latrines, should be conducted by a qualified construction specialist in the company of a health provider in order to determine basic weaknesses or deficiencies in the completed work. That team should then provide its recommendations to SCF for follow-up action.
- 2 Resources should be obtained from other sources to complete the work in the interest of increasing access to a high quality facility offering high quality services. As a rule, quality affects a range of health service delivery components including impact on health status indicators, client satisfaction and utilization rates, as well as health staff motivation. Of substantial importance, too, is the reflection of good or poor work, especially of something as visible as physical structures, on SCF's institutional reputation in the province.
- 3 Community mobilization and participation commitments need to be strengthened prior to initiation of project activities, where there is lack of community support, rehabilitation and construction plans should be modified or cancelled.

# ANNEX A

## Schedule A

### TERMS OF REFERENCE

#### Final Evaluation of CBHRD Health Sector

#### I PURPOSE

To carry out a final evaluation of the health component of Save the Children Federation's (SCF) USAID funded Community Based Health and Rural Development (CBHRD) Project in Xai Xai and Bilene Districts, Gaza Province

#### II AREAS OF EVALUATION

- Assess SCF's relationship with collaborating organizations including MOH other PVOs/NGOs and community structures through discussions interviews with key informants and review of documentation
- Assess appropriateness timeliness and quality of project activities progress and inputs
- Assess achievement of project objectives (outputs)
- Assess whether recommendations of mid-term evaluation have been met
- Evaluate project impact including
  - 1) benefits provided by grant-funded training of community-based providers to the target population
  - 2) benefits provided by grant-funded support of MOH activities (e.g. EPI supervision training) at the sub-district and district levels
  - 3) sustainability potential of community-based health activities without continued international assistance and/or funding
  - 4) extent to which activities have resulted in improved health status for targeted populations
  - 5) met and unmet needs of the total population of Xai Xai and Bilene Districts
  - 6) benefits to children under five and women of reproductive age

- Make recommendations for directions for future work in health and child survival in Southern Gaza Province particularly in the areas of reproductive health (e.g. child spacing, family planning) and child survival

### III SCOPE OF WORK

The evaluator will carry out the field portion of the CBHRD health sector during the six day period March 17-22, 1997. De-briefing with USAID will be scheduled for March 31, 1997. The balance of the time will be for preliminary write-up, final write-up and any subsequent interviews that need to be conducted with SCF staff prior to April 30.

The evaluator will receive essential background materials on the project prior to the beginning of the final evaluation and will have the opportunity for further background briefing in Maputo and Xai Xai. In addition, she/he will have access to all project documents, reports and files including baseline KPC and midterm evaluations.

Following briefings and visits with SCF and USAID officials and other key informants in Maputo on March 17, the evaluator will travel to Gaza Province to meet with health sector staff, conduct field visits, interview beneficiaries and meet with relevant MOH officials and other key representatives of collaborating organizations.

The evaluator will return to Maputo on Sunday morning, 23 March. The evaluator will write-up preliminary findings and will present a preliminary draft report and oral de-briefing to SCF and USAID officials on Monday, March 31. Comments, questions, suggestions, and feedback from these briefings will be incorporated into the final written report, which will be due to Save the Children no later than Wednesday, April 30, 1997.

### IV DURATION

Fifteen days including six days of field work, March 17 - 22.

### V REMUNERATION

The consultant will be paid a fee of \$200 per day, not to exceed a total sum of \$3,000. Payment will be paid upon submission of the final evaluation report and an invoice stating the number of days worked.

### VI TRAVEL EXPENSES

Save the Children will provide lodging during the consultants stay in Xai Xai. Meal expenses in Gaza will be reimbursed upon presentation of receipts.

## ANNEX B

### CONTACTS

- 1 SCF-Maputo staff
- 2 Health Office staff, USAID-Maputo
- 3 Mr Tiago Macuacua, Provincial Director of Health
- 4 Mr Manuel Ernesto Muianga, Provincial Director of Community Health
- 5 Mr Francisco Samuel, District Director of Health, Xai-Xai District
- 6 Mr Auguste Alice, District Director of Health, Bilene District
- 7 Mr Roque Silva Samuel, District Administrator, Xai-Xai District
- 8 SCF- Gaza staff Representative, all Sector Coordinators health technical staff
- 9 SCF- Bilene staff
- 10 Chief Nurse, Xai-Xai District
- 11 Mr Crstovão Tovela, Preventive Medicine Technician, Xai-Xai District
- 12 Chief Nurses and Nurse-Midwives at all health posts visited (See Annex C)
- 13 Leaders of AMETRAMO, Bilene District
- 14 Administrative Post Chief, Zongoen
- 15 Community leaders, *activistas*, TBAs, *curandeiros*, representatives of *casas agrarias* and water point maintenance groups, community members
- 16 Dr Federico Rocuts, Provincial Advisor, University Research Corporation/USAID

## ANNEX C

### FIELD VISITS

17 March 1997

- Briefing with USAID Health Office staff and SCF-Maputo staff
- Briefing with SCF-Gaza staff

18 March 1997

- Meetings with DPS-Gaza and DDS-Xai-Xai officials
- Meeting with District Administrator, Xai-Xai
- Field visit Nhancutse community, Nhancutse health post and maternity

19 March 1997

- Field visit Nhabanga community
- Meeting with Administrative Post Chief, Zongoene
- Field visit Zongoene health post and maternity
- Field visit 24 de Julho community
- Field visit Voz de Frelimo community

20 March 1997

- Field visit Mangol community, Mangol health post and maternity
- Meeting with AMETRAMO - Bilene
- Field visit Incoluane community
- Field visit Messano community, Messano health post and maternity
- Meeting with DDS Director, Bilene

21 March 1997

- Field visit Chipenhe community, Chipenhe health post and maternity
- Field visit Bungane community (non-SCF village)
- Field visit Chongoene community (non-SCF village)

22 March 1997

- Field visit Emilia Dausse community, TBA Dona Virginia
- De-briefing with SCF-Gaza staff