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HEALTH RESEARCH FOR ACTION

WIWANANA Project
External Review

Cabo Delgado, Mozambique

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External Review of the Wiwanana Project

Cabo Delgado, Mozambique

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René Dubbeldam; Hélder Nhamaze
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List of abbreviations and acronyms

AKF	Aga Khan Foundation
ANC	Ante Natal Care
APE	Agente Polivalente Elementar (Village Health Worker)
ART	Anti-retroviral Treatment
ATS	Aconselhamento e Testagem da Saúde (VCT)
CBHC	Community Based Health Care
CBO	Community Based Organization
CC	Competence Centre
CD	Cuidados Domiciliários (Home Based Care)
CD	Cabo Delgado
CP	Collaborating Partner (= Development Partner; = donor)
CR	Centro de Reunião (Meeting Centre)
DAC	Development Assistance Committee
DDS	Direcção Distrital de Saúde (District Health Directorate)
DOT	Direct Observed Treatment (for TB)
DPS	Direcção Provincial de Saúde (Provincial Health Directorate)
EGPAF	Elizabeth Glaser Paediatric AIDS Foundation
EPI	Expanded Progamme of Immunization
FGD	Focus Group Discussion
FP	Family Planning
HMIS	Health Management Information System (SIS)
HR	Human Resources
HRD	Human Resource Development
HSDP	Health Service Delivery Program
IEC	Information, Education, Communication
IMR	Infant Mortality Rate
ITN	Insecticide impregnated Bed Nets
KAP	Knowledge, Attitude, Practice (survey)
LED	Liechtenstein Agency for Development Cooperation
MC	Meeting Centre (Centro de Reunião)
MCH	Mother and Child Health (= Saúde Materno Infantil SMI)
MDG	Millennium Development Goal
M&E	Monitoring and Evaluation
MICS	Multiple Indicator Cluster Survey
MISAU	Ministério de Saúde (MOH)
MM	Medicus Mundi
MMR	Maternal Mortality Ratio
MNH	Maternal and Neonatal Health
MOH	Ministry of Health
MSC	Most Significant Change Monitoring Method
NGO	Non Governmental Organization
NHS	National Health System
NSCIH	National Strategy for Community Involvement in Health
OECD	Organisation for Economic Cooperation and Development
OPD	Outpatients Department
ONG	Organização Não Governamental (= NGO)
PA	Posto Administrativo (Administrative Post)
PARPA	National Poverty Reduction Plan
PAV	Programa Alargado de Vacinação (Expanded Programme of Immunization)
PES	Plano Economico e Social
PESS	Plano Estratégico de Saúde (multi-annual health development plan)
PHC	Primary Health Care
PISCAD	Programa Intersectorial de Saúde de Cabo Delgado (Cabo Delgado Inter-Sectoral Health

	Program)
PPSS	Programa de Prestação de Serviços de Saúde (Health Service Delivery Program)
PR	Public Relations
PT	Parteira tradicional (Traditional Birth Attendant)
PTV	Prevention of Mother to Child HIV Transmission
RT	Review Team
SDC	Swiss Agency for Development and Cooperation
SIS	Sistéma de Informação de Saúde (Health Management Information System)
SM	SolidarMed
SMI	Saúde Materno Infantil (Mother and Child Health)
SNS	Sistema Nacional de Saúde (National Health System)
SO	Specific Objective
SWAP	Sector Wide Approach
TB	Tuberculosis
TBA	Traditional Birth Attendant (PT)
THP	Traditional Health Practitioner (curandeiro)
TOR	Terms of Reference
VCT	Voluntary Counselling and Testing (AST)
WB	World Bank
WEP	Wiwanana Office in Pemba
WHO	World Health Organization
WW	Wiwanana

Summary

English summary

Since the 90s, the Swiss organization SolidarMed (SM) has supported the health system in an extremely poor area in Cabo Delgado Province, in the Districts of Chiúre and Ancuabe. SM projects have been complementary, in that they have supported both supply and demand sides of the health system. One SM project is Wiwanana, which focuses on empowering communities in Chiúre and Ancuabe, through a range of community based health care interventions implemented by the Wiwanana team. This team includes animators/activists, local experts on health programmes ('temáticos'), managerial staff, and external technical assistance. Wiwanana is funded by the Swiss Agency for Development and Cooperation (SDC).

The specific objectives for the current phase are the following:

1) Community empowerment for health: communities make use of their knowledge and adapt practices to maintain health and prevent disease, they organize themselves to identify and address health problems at individual, household and community level with locally available resources and make use of the formal health system;
2) Institutional strengthening: Wiwanana as autonomous local entity makes use of its capacities and plans, implements, manages and monitors its activities professionally;
3) Competence centre and policy dialog: experience, knowledge and lessons learned are disseminated and shared with civil society organizations, decision makers and international bodies in order to contribute to advocacy and policy dialogue, and to increase impact of interventions.

SDC has indicated that it intends to phase out its financing of Wiwanana. Therefore, the transition of Wiwanana project into a new, independent CBO is a crucial activity during the current (2009-2011) phase.

From February 21 to March 7, 2011, an external review team (RT), including public health (1) and anthropological (1) expertise, visited the project and assessed relevance, effectiveness, efficiency and sustainability of the project, with regard to the three specific objectives mentioned above.

Overall, the RT is impressed by Wiwanana. In an extremely poor area in Cabo Delgado, the project has to some extent achieved to bridge the 'gap' between supply of health services and the demand and expectations of the communities. There is evidence of results in various areas. In particular, the project has been instrumental, together with other complementary projects of SolidarMed, to significantly improve maternal health. Also in other domains – HIV/AIDS, malaria, and hygiene – tangible results have been observed by the RT. The RT made recommendations on widening the scope of interventions, because some important public health problems have not sufficiently been addressed.

A major challenge is now to proceed with the process of change, towards an independent and viable organization. For various reasons, this process has been seriously delayed. The RT believes that concrete opportunities for Wiwanana becoming an independent Mozambican CBO do exist. Therefore, swift action must now be taken to make progress in the transition process. This action includes the development of a business plan, and recruitment of senior managerial expertise to strengthen acquisition, PR, advocacy, and public health leadership. Furthermore, the Wiwanana team needs to pursue the 'market' analysis, to further explore opportunities for Wiwanana to acquire new funding.

Capitalization of field experiences is another domain that needs more attention as of now. Wiwanana staff has documented many field experiences; however, a systematic description of all these – also most needed in advocacy of Wiwanana among stakeholders – is still lacking. Capitalization of the many interesting field experiences is an important instrument for PR, advocacy, and (contributions to) policy development, and will thus contribute to the viability of the new Wiwanana.

Portuguese summary - Sumário Português

Desde os anos 90 a organização Suiça SolidarMed (SM) tem vindo a apoiar o sistema de saúde em uma área extremamente pobre da província de Cabo Delgado, os distritos de Chiúre e Ancuabe. Os projectos da SM são complementares na medida em que apoiaram tanto o lado da procura como o da oferta dentro do sistema de saúde. Um dos projectos da SM é Wiwanana, que focaliza o empoderamento das comunidades daqueles distritos, através de um conjunto de intervenções de saúde baseadas na comunidade implementadas pela sua equipa. A mesma inclui animadores/activistas, peritos locais em programas de saúde (os chamados "temáticos"), pessoal gestor, e assistência técnica externa. O Wiwanana é financiado pela Agência Suiça para o Desenvolvimento e Cooperação (SDC).

Os objectivos específicos desta última fase eram os seguintes:

1) Empoderamento da comunidade para a saúde: onde as comunidades fazem uso dos seus conhecimentos e adaptam as suas práticas para manter a saúde e prevenir as doenças, elas organizam-se para identificar e lidar com problemas de saúde a nível individual, do agregado familiar e da comunidade usando recursos disponíveis localmente e o sistema formal de saúde;
2) Reforço institucional: o Wiwanana como uma entidade local autónoma que faz uso das suas capacidades e planifica, implementa, gere e monitora as suas actividades de uma forma profissional;
3) Centro de competências e diálogo de políticas: onde experiências, conhecimentos e lições aprendidas são disseminadas e partilhadas com outras organizações da sociedade civil, decisores políticos e organismos internacionais de modo a contribuir para advocacia, diálogo de políticas, e para aumentar o impacto de intervenções.

A SDC manifestou a sua intenção de terminar o financiamento do Wiwanana. Assim, a transformação do Wiwanana em uma nova e independente organização de base comunitária (CBO) é uma actividade crucial para a presente fase (2009-2011).

De 21 de Fevereiro a 7 de Março de 2011 uma equipa externa de avaliação (EA) integrando experiência em saúde pública (1) e antropologia (1) visitou o projecto e analisou a relevância, a eficácia, a eficiência e a sustentabilidade do mesmo, no respeitante aos três objectivos específicos mencionados acima.

No geral a EA ficou impressionada com o Wiwanana. Em uma área bastante pobre de Cabo Delgado o projecto conseguiu, em certa medida, preencher a lacuna entre a prestação de serviços de saúde e as necessidades e expectativas das comunidades. Existem evidências de resultados alcançados em várias áreas. De modo particular o projecto tem sido decisivo, juntamente com outras intervenções complementares da SolidarMed, em melhorar significativamente a saúde materna. Também em outros domínios - HIV/SIDA, malária, higiene – resultados tangíveis foram observados pela EA. A mesma fez recomendações em relação ao alargamento do âmbito das intervenções, porque alguns problemas de saúde pública igualmente importantes não foram devidamente abordados.

O maior desafio consiste agora em prosseguir com o processo de mudança em direcção a uma nova, independente e viável organização. Por diversas razões esse processo está bastante atrasado. A EA acredita que existem oportunidades concretas para o Wiwanana se tornar uma CBO Moçambicana independente. Assim medidas rápidas devem ser tomadas para se progredir no processo de

transição. Tais medidas incluem o desenvolvimento de um "plano de negócios", e recrutamento de gestores seniores para reforçar as relações públicas, aquisições e advocacia. Para além disso a equipa do Wiwanana devem realizar uma análise do "mercado", para explorar mais oportunidades potenciais de financiamento.

A capitalização das experiências no terreno é um outro domínio que precisa de uma urgente atenção. O pessoal do Wiwanana documentou várias experiências práticas; no entanto, uma descrição sistematizada de todas elas – bastante útil na advocacia perante outros parceiros – ainda não existe. A capitalização das muitas experiências interessantes é um instrumento preponderante para relações públicas, advocacia, e (contribuições para o) desenho de políticas; o que contribui sobremaneira para a viabilidade da nova Wiwanana.

Summary in Makuwa

Opadjera wa iyaka 90 mualano wa Osuiça SolidarMed – SM onvira okaliheryaka miteko sa ekumi mittette sa osikini soProvincia yo Cabo Delgdo, eDistrito yo Chiuri ni Ancuabe. Miteko sa SM tisokuehera variari va ophavela hata ovaha mikaliheryo sa ekumi ya attu.
Muteko kamosa kamosa wa SM onittaniwa Wiwanana, onkomaliha mittette sa idistrito seiyo, othocoreryaca okumi wattu variari va nikuru naya. Nikuru nenlo, akalamo maanimadore ni Maativista ansuwela ottocorerya miteko sa ekumi m'muttetteni (anittaniwa tematicos), alipa owuranela, ni okaliherya. Wiwanana onkaliheriwa ni musuruku wa Agencia ooSuiça, variari va othawali ni okaliheryana (SDC).
Saapavelexiwa mpantta ola wookiserya tiya:

1) Wakoomaliha ananmuttetteni variari va okumi aya: Vavo ananmuttetteni vanrumelaya osuwela waya wira akaliherye okumiaya ni asyake iretta. Awo, an'nittocattokihakonasuwela maxankiho a ekumi aya m'mansaya, ya amusi aya ni m'muttetteni muaya, arumelaka ittu sikanle mapuro anikalaya.
2) Okomaliha mapuro anvariwa miteko: Okala wira Wiwanana mualano wa m'mawani, onrumela ossuwela wawe, ni on'nittokiha, on'nivara hata wuranela miteko sawe ni makalelo ossuweleya.
3) Sinweryawe ovara ni ovanela variari va epolitica: Vavo vanleliheraniwaya ittu soxutta ni miyalano sikina sanan'mawani, alipa a epolitica vamosa ni miyalano sa ilapo sookopela, wira sikaliheryeke ovanela variari va rpolitica wira nave wundjerereye murarelo wa sohin'mua.

SDC osuweliha wira onorowa ohiya onvaha musuruku Wiwanana.Tivo vamphaveliwaya wira mpantte ola n'sya, (2009-2011) wiwanana okalihiwe mualano wa m'muttetteni.

Okuma mahiku miloko mili ni nimosa mweri wa Fevereiro mpaka mahiku mathanu ni manli meri wa Março, muaka wa 2011 , nikuru nimosa nattu oweha weha, wa mpantta wa ekumi ni sa ittu sa kalay, nahixecurya miteko sa Wiwanana, wira assuwele sorera sinvarawe supuweleliwaca ittu ttaru sihim'muale wopadjeryani.

Varokalaru siso,nikuru nenlo, nahisiveliwa ni meteko sinvariwa ni Wiwanana, mapuro yale anonaneya ossikini wa epronincia yo Cabo Delgado. Eprojeto yela yowerya wundjererya mavareliwo muteko wa ekumi sintoco vanttunaya anan'muttetteni. Sin'noneya ittu soorera sikumelenle iphantte sohiyana hiyana.

Wa mphantta mukina, eprojecto yela tiyowittokiha orattene vamosa ni mikaliheryo sikina sa SolidarMed, ererihaca vanxene okumi wa anamuyari, ni iphantte sikina ntoko HIV/SIDA, Malaria , wirattela, kunoneya wira EA ovara miteko soorera. Yowotho , ohiya miyumpereryo variari vookaleliwa mpantta nattu akina miteko seiyo, okala wira mixankiho sikina sa ekumi yanan'mawani kasilavuliwe orrattene.

Wiikanhanha ohanle vano ottikela muteko worukunuxa wira Wiwanana okale mualano n'sya wowiroromela ni wothocorereya orrattene. Muaha wa ittu soviricana,muteko yowo wopisa vandjene .N'nha,EA on'nicupali wira wokala okatti worerela wira Wiwanana onorowa okala mualano –CBO wa omoçambique otaphuwa.

Tivo vanrerelaya ovariwa muteko vowacuveya wira wupuwela n'no, orowe oholo. Muteko yowo otacaheya ni opakiwa wa epalano ya nagoso ni ophaveliwa alipa anrowa ovara vohanhiherya muteko aya, vowira okomalihiwe mukaliheryo wa advocacia. Ohiyatto vo nikuro na Wiwanana nihana ophavela osuwela yorera opadjerya ovara wira vaweryaneye wapwanha anamakaliherya ni musuruku aya. Woniherya sixuttiwe m'mawani ettu ekina enrerela wonela vattu vowakuveya.Attu Wiwanana ahoniheryasoxutta saya sottene,sotepaxa orera m'mancaloni mwa advocacia, oholo wa anamakaliherya akina.

Othukumanha wa soxutta ettu emosa yuluoale variyari va Wiwanana,advocacia ni mukaliheryo wa ipolitica. Ekanle tenrowa okaliherya vanxenexa mupuwelo wa mualano n'sya onrowa okumelela-Wiwanana.

1. Introduction

Since 1998 and with gradually increasing intensity, the Wiwanana project has been operational in Chiúre District, Cabo Delgado, and in neighbouring Ancuabe District as of 2005. The project is implemented by the Swiss organization SolidarMed (SM). Wiwanana (WW) is part of a broader programme of SM that focuses on strengthening comprehensive district health services. According to SM's medium-term strategic plan [42], its programme has three pillars:

- Governance and health care management;
- Improving health care delivery;
- Community Empowerment of Health.

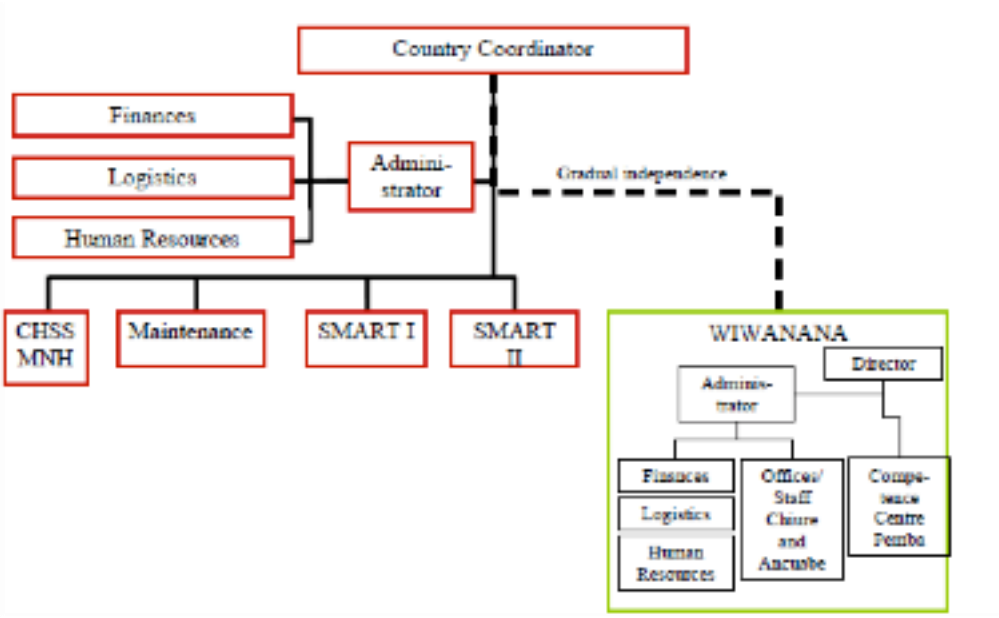
The Wiwanana project, which has been funded by the Swiss Development Cooperation (SDC), Liechtenstein Development Cooperation and SolidarMed, has developed a comprehensive approach for community empowerment of health, and is strongly demand-oriented. Wiwanana is complementary to other SM projects that focus more on the supply-side of health care. Currently, SM carries out the following projects:

- SMART Ancuabe (2008-2011) – promotion of prevention and treatment of HIV/AIDS (SM – ART);
- SMART Chiúre (2008-2010) – idem;
- Chiúre health system support (2008-2010; to be continued under 'Decentralized healthcare with a focus on maternal and neonatal health')
- Malaria – integrated in various projects.
- Wiwanana: Chiúre and Ancuabe.

SM is now preparing a new project, incorporating elements of the above projects: Decentralized healthcare with a focus on maternal and neonatal health.

Figure I shows the current functional set-up of SM[1].

Figure I. Functional set-up of Soldarmed



[1] CHSS and maintenance reflect the 2010 situation; MNH has started as new project; the green WW-case reflects current thinking by SM/WW management

The SM projects are located in the Districts of Chiúre and Ancuabe, Cabo Delgado, north Mozambique, where poverty is widespread and health indicators are well below the national averages (see also chapter 4 - relevance).

Wiwanana is now in its third phase (2009-2011). Initially, Wiwanana started as a small project, with few staff. Focus was on the development of specific approaches for community empowerment. Anthropological research, providing much insight in local beliefs and customs, laid the basis for the design of various interventions. Later, activities were expanded in Chiúre district and, as of 2005, also in Ancuabe District. Gradually, the number of staff (e.g. animators, temáticos) increased until approximately 80 around 2008. During the current phase, community health activities would be consolidated, the number of staff was reduced (50 now in total[2]) to improve efficiency of operations, and a transformation of Wiwanana into an independent, viable national Civil Society Organization (CBO) was to be carried out. One reason for the latter was that the SDC indicated that its financial support to Wiwanana would come to an end, possibly by the end of the current phase or somewhat later. SDC would however fully support the transition process.

The terms of reference (TOR) for this review are included in annex 1. The review team (RT) would not only assess the relevance, effectiveness, efficiency of the field activities, but would also focus on the transition process; therefore, the review has paid special attention to sustainability issues, including institutional-organizational sustainability and financial sustainability.

During a 2-weeks period in February/March 2011, the RT, consisting of public health and anthropological expertise, visited Chiúre, Ancuabe and Pemba, and had the opportunity to visit a large number of different field activities. Further, it discussed with the SM/WW team about achievements, challenges, and future scenarios. It also met with various stakeholders in the Province, and in Maputo (before going to the field). Briefing and debriefing sessions were organized with SDC. Annexes 2 and 3 provide information on persons met and the mission programme.

Chapter 2 and 3 focus on the methodology of the review and on Wiwanana's intervention logic. Chapter 4 describes the relevance of the project, by each of the three specific objectives of the project. Chapter 5 discussed the specific Wiwanana approach, and its relevance. In Chapter 6, the effectiveness of the project is discussed, while efficiency of operations – and budget details - are discussed in Chapter 7. Chapter 8 focuses on various aspects of sustainability. Finally, key recommendations are provided in Chapter 9.

[2]Chiúre: 21 animators/temáticos; 7 support staff. Ancuabe: 7 animators; 6 support staff; Pemba: 1 content manager; 6 support staff.

2. Methodology

2.1 Approach

The methodology for this External Review followed the general approach suggested by the Terms of Reference (see Annex 1). The review team (RT; one public health / health systems expert, and one anthropologist), conducted a review of the literature on the Wiwanana Project and held meetings before and during the field visit (see complete mission programme in Annex 3). The documents reviewed included annual reports, baseline studies, survey reports, minutes of meetings. The complete list of numbered references is in the Annexes, following the square brackets contained in the core text.

The mission started with a briefing of the RT by the Swiss Development Cooperation (SDC) health team. Then, the RT met with the Deputy Director for Public Health at the Ministry of Health, representatives of partner NGOs (*Medicus Mundi* and Elizabeth Glaser Paediatric AIDS Foundation - EGPAF) and World Health Organization's Country Representative. In Cabo Delgado, the RT met with members of the government namely the Cabo Delgado Province Governor, the Head of the Provincial Health Directorate as well as the officers for Planning and Cooperation and Community Health. Furthermore, meetings were held with other partners' representatives at provincial level: Medicus Mundi, EGPAF and Aga Khan Foundation (AKF). There was also contact with two influential health programs: the outgoing Cabo Delgado Health Inter-Sectoral Programme (PISCAD) and the recently launched World Bank led Health Service Delivery Programme (HSDP).

The RT stayed in Chiúre and Ancuabe districts during one week. It met with both districts' Administrators, health sector personnel and engaged in working sessions with the Wiwanana office team. The RT also directly observed field personnel activities. The team discussed various aspects of project management and implementation with Wiwanana management and with various staff; these aspects included: Monitoring and Evaluation; content of the 'modules' on the 4 Wiwanana themes (HIV/AIDS; maternal care; diarrhoea / hygiene; fever / malaria). Also, managerial and financial aspects of project management were discussed. The RT also participated in one radio broadcasting (on sexual health) financed by Wiwanana. Various village meetings were attended: e.g. 'balance' (Port. Assembleia Balanço)and 'reflection'(reflexão) meetings, 'follow-up sessions' (seguimento), theatre plays. Also, some health facilities (including mothers waiting homes) were visited. In one village, special attention was given to the expansion of water- and sanitation (latrine promotion) activities. The RT also undertook focus group discussions with the community, to learn about the communities' perception of Wiwanana.

Using existing data from the provincial/district health information system (SIS), the RT did an analysis of health service outputs, particularly on assisted deliveries in health facilities and outpatient data. As part of the methodology for this assignment there was a discussion of preliminary findings in Chiúre, a debriefing in Pemba and another final one in Maputo with the Swiss Development Cooperation team.

The RT analyzed the comments by SolidarMed and SDC on the draft report (draft report submitted in March, and comments received by the RT on March 31th, 2011) and used these while editing this final report.

2.2 Evaluation Criteria

The RT adopted the standardised OECD/DAC evaluation criteria: relevance (including perceived relevance by partners and beneficiaries), effectiveness, efficiency, sustainability. The intervention logic (Log Frame, with three specific objectives) was also commented upon. Information on project budgets and expenditure, as well as in-depth information of management tools and procedures, helped to assess efficiency of operations. Sustainability was assessed, by looking at socio-cultural, technical, financial and organizational-institutional dimensions of it.

3. Intervention Logic of the Wiwanana Project

According to project documentation [54], the formulation of Wiwanana was participative and bottom-up. The project document [54] includes a clear Logical Framework. Under the general objective are three 'outcomes' (= specific objectives - SO):

1) *Community empowerment for health: Communities make use of their knowledge and adapt practices to maintain health and prevent disease, they organize themselves to identify and address health problems at individual, household and community level with locally available resources and make use of the formal health system;*
2) *Institutional strengthening: Wiwanana as autonomous local entity makes use of its capacities and plans, implements, manages and monitors its activities professionally;*
3) *Competence centre and policy dialog: Experience, knowledge and lessons learned are disseminated and shared with civil society organizations, decision makers and international bodies in order to contribute to advocacy and policy dialogue, and to increase impact of interventions.*

Under each of these specific objectives, there are a number of 'expected results'. For each of these levels, a limited number of measurable SMART indicators were defined. At the SO level, these are related to health services outputs (e.g. % pregnant women using waiting homes; no children sleeping under bednets); managerial capacity of Wiwanana as a separate organization (from SM); Wiwanana as an active and recognized player in the health sector. At the level of expected results, the indicators are related to knowledge, voluntary HIV testing, satisfaction, managerial procedures and processes.

The RT finds the intervention logic straightforward and well-designed. Indicators are all useful and measurable.

The project document clearly describes the history of the project, and clearly explains the importance of the transition of Wiwanana towards an independent organization. The document also makes relevant suggestions on the type of activities related to the transition and possible milestones to consider. The RT feels that this project document is sufficiently clear to be used as a guide for project implementation. The only weakness, perhaps, is the paragraph on assumptions. The project document clearly considers the upcoming WB project as an important opportunity for Wiwanana to acquire external funding. As we will describe in the chapter on sustainability, this assumption may well be rejected. The project document does not include fall-back scenarios[3].

[3] For example, a fall-back scenario if the World Bank project would not materialize in time.

4. Relevance of the project – general aspects

4.1 Current situation

For several reasons, the relevance of the current Wiwanana project is high:

- Poor health status and poor availability of health services in the project area; low use of allopathic health services
- Wiwanana fits well in national and provincial health policy development;
- Also, perceived relevance among government officials, health planners and direct beneficiaries is high.

Poor health status and poor availability of health services in the project area

In Mozambique, infant mortality and maternal mortality are still very high. The infant mortality rate (IMR) oscillates around 100/1000 live births (sources: DHS 2003 [24a], MICS 2008 [55]), while the maternal mortality ratio (MMR) is still approx. 1000 per 100,000 live births (in 1990, the MMR was higher than 1400; 1995: 1000; 2000: still around 1000. Source: WHO country fact sheet [58]). The morbidity profile – certainly in more rural areas - is dominated by poverty related preventable contagious diseases, such as malaria, respiratory infections, and diarrhoea. Further, Mozambique is hit being by a severe HIV/AIDS endemic. Also, tuberculosis prevalence is high. In Cabo Delgado, many of the mortality and morbidity indicators are worse than the national average (e.g. under-5 mortality in 2008 was 180; only Zambezia Province showed a worse IMR of 205). In Cabo Delgado, stunting rates among children is the highest in the country (source: MOH [58]).

For plausible reasons, SolidarMed decided to develop its field activities in Chiúre District (and more recently also in neighbouring Ancuabe District). The population living in these districts is extremely poor; economic activities are very limited and the local economy mainly consists of subsistence agriculture. The population sizes of these rural Districts in Cabo Delgado Province are relatively large (In 2007: Chiúre: 217,487; Ancuabe: 107,238; 3rd Census data, National Statistics Institute). After Pemba City, Chiúre is the highest populated District in Cabo Delgado and is also among the largest. The availability of health facilities is particularly low. Currently, Chiúre has two 'tipo-I' health centres (health centres with inpatient facilities, OPD, maternity), seven 'tipo-II' facilities (OPD; maternity) and one health post (limited OPD only). Ancuabe has two tipo-I health centres and 4 tipo-2 health centres. In Chiúre, the average population size per health facility is as high as 23,250 (projected population of 2010), and is approx 19,000 for Ancuabe (idem). These health facility/population ratios are among the highest in Cabo Delgado. Neither Chiúre, nor Ancuabe have facilities for basic surgery (currently, the health centre in Chiúre town is being upgraded to a 160 bed rural hospital, including surgery facilities; no surgery os planned for Ancuabe in the near future).

When Wiwanana took off in 1998, utilization of health services in Chiúre District was low (see section 6.1.2 on trends of health services outputs), for various reasons. First, accessibility of basic health services has been very low (limited availability of health facilities in a large District; limited scope of health services). Furthermore, demand for formal health services has been low, also due to complex socio-cultural reasons (e.g. traditional beliefs; mistrust in formal health services); this has been well documented by SolidarMed in anthropological studies ([26, 29, 34, 35], and by others [2].

Health policies

Wiwanana fits well in existing national policies and strategies on health care development, including community health. The multi-annual national health plan PESS [22, 23] recognizes the importance of community health activities, so as to bridge the gap between perceived needs of communities and supply of allopathic health services. Recognizing slow progress towards achieving MDGs (e.g. 4, 5 and 6), and stagnating use of health services, MISAU has recently put community health care higher

on the policy agenda [20, 24, 16-18]. In 2009/2010, the Provincial Directorate of Cabo Delgado(DPS) has developed a manual for community involvement in health care [6a], which provides a comprehensive picture of community health activities to be implemented by health services, local government, NGOs, CBOs and other stakeholders in the sector. The activities of Wiwanana fit well in this vision.

Although Wiwanana's project approach is not the preferred aid modality according to national policies on aid architecture, it certainly has potential added value in the Mozambican sector-wide approach. Since many years, Mozambique has been trying to develop sector-wide approaches (SWAP), by promoting the use of common management arrangements and joint financing mechanisms, and by harmonizing approaches for health systems development [24a]. Although SWAP mechanisms have been developed and applied by various CPs, including the SDC that has been a pioneer on SWAP in the past, the sector is still highly fragmented, through the existence of vertical programmes and of many parallel projects implemented by NGOs. This fragmentation has led to high transaction costs and inequities, while overall expenditure for health in Mozambique is very low. What might however justify Wiwanana's parallel project approach is that the project certainly has potential for policy development at a wider and higher level (see various WHO publications on SWAP, e.g. by A.Cassels and K.Janovski).

Perceived relevance.
From all interviews by the review team with key stakeholders, and from focus group discussions with the community itself, it appears to the review team that the perceived relevance of Wiwana is very high. Health policy makers at the DPS and at District level recognize Wiwanana as an organization that has developed relevant approaches for community health. Also, the clear focus on empowering the communities to proactively improve their health status – rather than only focusing on the supply side of health services provision - is perceived as most relevant, not only by communities themselves, but also by health policy makers and other stakeholders. Further, local government has highly appreciated its 'mediator' role at the interface between the formal health services and communities (e.g. during cholera epidemics, Wiwanana played a crucial role in explaining to the community the causes of it, and controlling public unrest by taking away important misperceptions).
In general, there has been little criticism to externally funded community interventions, mainly because they fulfil people's needs and support local governments with actions that would not at all be possible otherwise (e.g. community outreach).

4.2 Looking forward

Also for the next years, it remains relevant for Wiwinana to keep focused on Chiúre and Ancuabe Districts (although the organization may also expand some activities beyond these Districts – see chapter 9, recommendations). Although health services utilization has increased over recent years, and some progress has been made in expanding health services, the problems as described above (gap between supply and demand; low use; low density of services; precarious health status) still persist and the two Districts are relatively worse-off in compared to many other Districts in Cabo Delgado (e.g. in terms of density of health facilities). To achieve the higher level objective of the community empowerment for health project Wiwanana – '*People in the Districts of Chiúre and Ancuabe are less vulnerable and have improved their health status, especially the rural poor'* - will, obviously, take much time and effort; an immediate exit of Wiwanana from its project area would seriously jeopardize some of the results already achieved (see chapter 6). A simplistic scenario of another organization 'taking over' the project activities does currently not exist.

As can be seen from the mapping of key stakeholders (annex 4), there are various organizations already active in other Districts. Therefore, there is no clear request by national health planners to expand is reduces the need for Wiwanana to immediately engage in other districts.

In chapter 5, the relevance of Wiwanana's approach is discussed in more detail (Wiwanana as part of district health care development; focus on important morbidity).

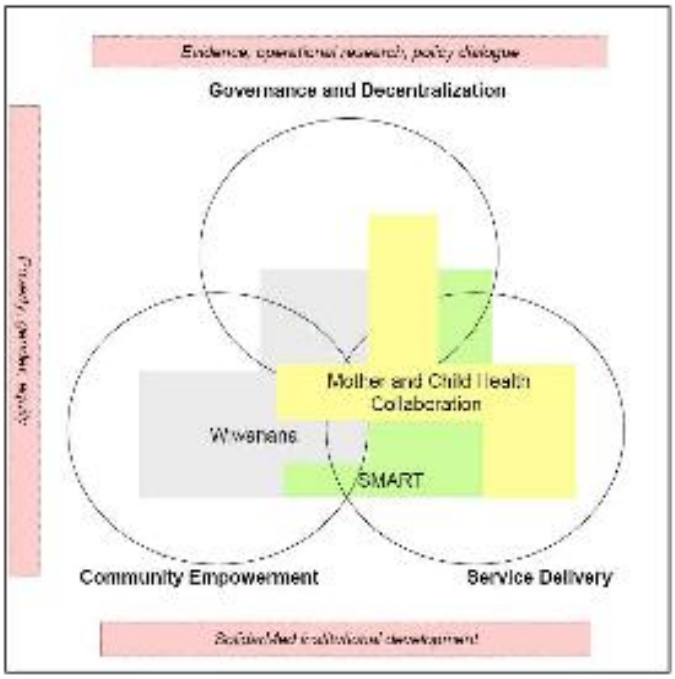
5. Wiwanana approach

Strong features of the Wiwanana approach are:
Synergy between Wiwanana and other projects carried out by SM, to maintain a clear focus on improving district health systems;

-
- Design of interventions based on relevant prior knowledge;
- Multiple communication channels;
- Community at the centre of interventions
- Group approach; checks and balances; close, frequent contact between Wiwanana teams and communities

Synergy between SM projects
Wiwanana project is not operating in isolation. SolidarMed has tried to keep focus on broad district health strengthening, through various projects (see introduction). The projects have addressed both supply and demand aspects of the district health system, and there is clear synergy between them, so as to maximize results. For example, while Wiwanana is promoting the use of health facilities for assistance to deliveries by qualified staff in a bottom-up manner (e.g. sensitization of TBAs; introduction of 'bicicleta-ambulância' to facilitate referrals to the nearest health centre), other SM projects have addressed and will continue to address (i.e. through the future Mother and Child project) this important issue from the supply side perspective, e.g. by promoting the creation of waiting homes for pregnant women, and by providing bednets and 'pacote bébé'. Vice-versa, the SMART projects (promotion of VCT; improvement of HIV/AIDS treatment) have benefitted from Wiwanana, in that demand has clearly increased (e.g. for voluntary testing). This complementary approach has certainly led to tangible results (see chapter 6). The figure below shows the set-up of the strategic framework of SM in Mozambique, including its elements, synergies and complementarity.

Figure II. Conceptual framework of the Solidarmed programme



(from: SolidarMed. STRATEGIC PLAN [REF] .

Prior knowledge basis for Wiwanana interventions

The content of health promotion messages, and the way how these are being handled, are based on prior knowledge. Socio-cultural determinants of health status and health seeking behaviour have been well described in various anthropological studies [2, 26, 29, 34, 35]; observations from these studies have been the basis for a number of health messages contained in the 4 'modules' of Wiwanana.

Multiple communication channels

Wiwanana makes use of multiple channels for communication. Animators ('animadores'; 2-3 for each administrative sub-district – postos administrativos) keep close contact with health groups trained by Wiwanana and with other community institutions (e.g. régulos – community leaders; traditional village chiefs; village health workers [APE], village health committees). The members of the health groups play an important role in sensitizing communities on health messages. Further, Wiwanana uses traditional theatre groups (contracted by the project on an ad-hoc basis) to convey the same messages, in other manner. Regularly, Wiwanana staff ('temáticos) hold meetings with the health groups in the villages to jointly analyze the results of activities and use these contacts to infor the communities on health issues. Furthermore, Wiwanana uses the rural radio station in Chiúre to broadcast health programmes in Makua and in Portuguese for IEC purposes. The evaluation team observed these various IEC techniques during the mission and appreciated the quality of these (complementary) communication techniques.

Community at the centre

By investing in the very intensive contact with the communities – animators/activists are expected to remain for 15 consecutive days 'in the field' (this was 21 days earlier on) – Wiwanana ensures a very high level of identification of the intervention by the beneficiaries. In doing so the project increases the chances of messages being understood and applied by the communities and, above all, places the community at the centre of the whole intervention. Many similar initiatives strive to accomplish this.

Gender: crosscutting

Wiwanana is gender-sensitive in all its actions. In all themes, the role of men and women is discussed. In theatre sessions, this is very visible. The project complies also with most of the requirements set by the SDC (e.g. Checklist on Gender Equality Mainstreaming: Governance, water/sanitation Programme). Furthermore, SolidarMed and Wiwanana focus a lot on maternal and child health, to improve MDGs 4 and 5.

The Wiwanana approach also includes some elements that raised questions throughout the evaluation:

- Limited managerial ownership, dependency on external expertise;
- Restriction of project activities to four themes;
- Expected results of 'Empowerment', and observed results;
- Limited involvement of DDS teams;
- Limited health systems knowledge in Wiwanana teams

Ownership and dependence on external TA

Not only in strategic decision-making, but also to some extent in daily management, Wiwanana still depends quite much on the inputs by the external assistance (i.e. the SolidarMed country coordinator; the external Manager/Coordinator of Wiwanana). Although the idea is to gradually hand over responsibilities to local managers[4], the recently appointed (Mozambican) Director of Wiwanana still reports to the (external) Manager/Coordinator of Wiwanana (this hierarchy is also described in the task-description of the Director). At the operational level, certain responsibilities have effectively been handed over to local staff: logistics; HR management, general admin, day-to-day planning of operations. Also, all reports and plans have been translated from English to Portuguese. However, the evaluation team feels that during the current phase of the project more could be done to transfer knowledge, skills and managerial responsibilities to Mozambican project staff, especially at the higher managerial level.

Selective PHC?

Well before the current project phase, it was decided to focus activities on four 'themes': maternal health; HIV/AIDS; Diarrhoea and hygiene; and, fever and malaria. Apparently, these themes were once selected by involving the community [54]. This 'selective PHC' approach has advantages but also limitations. For many years already, this has been subject to 'hot' discussions among health experts (REF Walsh and Warren). Given that the general objective of Wiwanana is to empower communities to improve their general health status, the evaluation team feels that the scope of interventions may need to be broadened. Some other important public health problems could relatively easily be addressed without much additional resources. One example is tuberculosis, which has a very high incidence (500-600 new cases per 100,000) in Mozambique, due to poverty and to the rampant HIV/AIDS situation in the country. In Cabo Delgado, current detection and cure rates are much lower[5] than the global targets of 70% and 80% respectively [6]. Using the available Wiwanana 'infrastructure' in the villages and districts, Wiwanana could play an important role in the detection of new cases and in case-holding through DOTs, by involving all health groups and other community based health workers. By doing so, Wiwanana could play an exemplary role in showing that community health care also contributes to the control of TB. Certainly, there are more examples of diseases that could be addressed at the community level.

[4] The external Manager/Coordinator of WW would then become 'Technical Advisor'.

[5] In Ancuabe health centre, the RT reviewed health statistics with the Solidarmed team and the medical doctor. From the data, it appeared that detection and cure rates (for Ancuabe district as a whole) were lower than 20% (!!).

Empowerment

It is not entirely clear from the Project Document what is exactly meant by 'community empowerment for health' in terms of activities on the ground, and what the expectations were. But one can assume that it entails a process that gives more power to the communities in order to interact in a critical and constructive way with the formal health systems. The ProDoc indicates that communities were supposed to 'use their knowledge and adapt practices to maintain health'. However, what has happened is that formal IEC messages are deployed in a somewhat mechanic fashion, while local knowledge and/or practices were not always taken into consideration. So it remains a little unclear to what extent communities have been 'empowered'. Certainly, the backstopping reports of L. Ruedin have addressed this complex matter. If the expectations on empowerment were made more explicit, an assessment on the degree of it would have been more meaningful.

Involvement of DDS and health staff in health facilities

The District health management teams of Chiúre and Ancuabe have not been intensively involved in the implementation of the project activities. This is mainly due to two reasons: i) the capacity of the DDS's in terms of human resources is very limited[6]; and, ii) Wiwanana is a parallel project, with own management procedures and own staff. The DDS considers itself more of a beneficiary, rather than 'owner' of the project. Although the DDS's are involved in planning activities of Wiwanana, decision making on type and scope of activities remains with Wiwanana management.

Knowledge and skills on district health care among Wiwanana staff

The strength of Wiwanana is that it contributes to strengthening district health systems, by focusing on the 'demand side'. However, knowledge and skills on public health in general, and on district health systems in particular, is rather limited among Wiwanana managers (Director; coordinator) and staff (animators). Two 'temáticos' have a health background; however, their experience is limited to specific programmes related to the four Wiwanana themes (HIV/AIDS; diarrhoea; malaria; mother- and child health); specific experience on the organization of district health care systems is lacking. The RT recommends therefore that the future WW organization includes expertise on district health care', to ensure that WW community health activities remain complementary to activities implemented by the formal health services and 'fit' in Provincial and District health plans[7].

6. Effectiveness

6.1 SO-1: community empowerment; maintaining health and preventing disease

6.1.1 Morbidity

From available data collected through the provincial/district health information system (SIS) and analyzed by the SM national coordinator, there are no clear trends in (decrease of) malaria and diarrhoea, or other diseases related to the project interventions. Community-based information on prevalence/incidence of these diseases is not available for the project area. The RT notes that

[6]Within the DDS/district health management teams, there is only one person responsible for 'community health'. In collaboration with programme managers (EPI; TB; MCH; etcetera), this person has to coordinate a wide range of activities at community level, including EPI and MCH outreach sessions; TB/DOTS; training of APEs and traditional midwives.

[7] Currently, WW activities fit perfectly well in existing health plans.

morbidity data is difficult to interpret anyway; to attribute any trends (or: absence of trends) to Wiwanana is haphazard, since many other factors are also influencing morbidity.

6.1.2 Trends in health services utilization

To assess impact of the project, it is therefore more appropriate to look at intermediate indicators, such as trends in health services utilization ('service outputs' and service coverage). There is plausible evidence that the Wiwanana interventions have led to a significant increase in uptake of basic health care, in particular for assisted deliveries by health staff in health facilities. Figure II shows trends in coverage of assisted deliveries (by trained personnel in health centres). The first graph shows the trends in absolute numbers of assisted deliveries, by district, during 2006-2010. It appears that Chiúre district shows the fastest increase in assisted deliveries among all Districts in Cabo Delgado. Further, Ancuabe district is also among the fast growers, but the increase is mainly due to a sharp increase during 2010, and the overall trend is perhaps less convincing.

Figure III. Trends in numbers of assisted deliveries, by district; 2006-2010

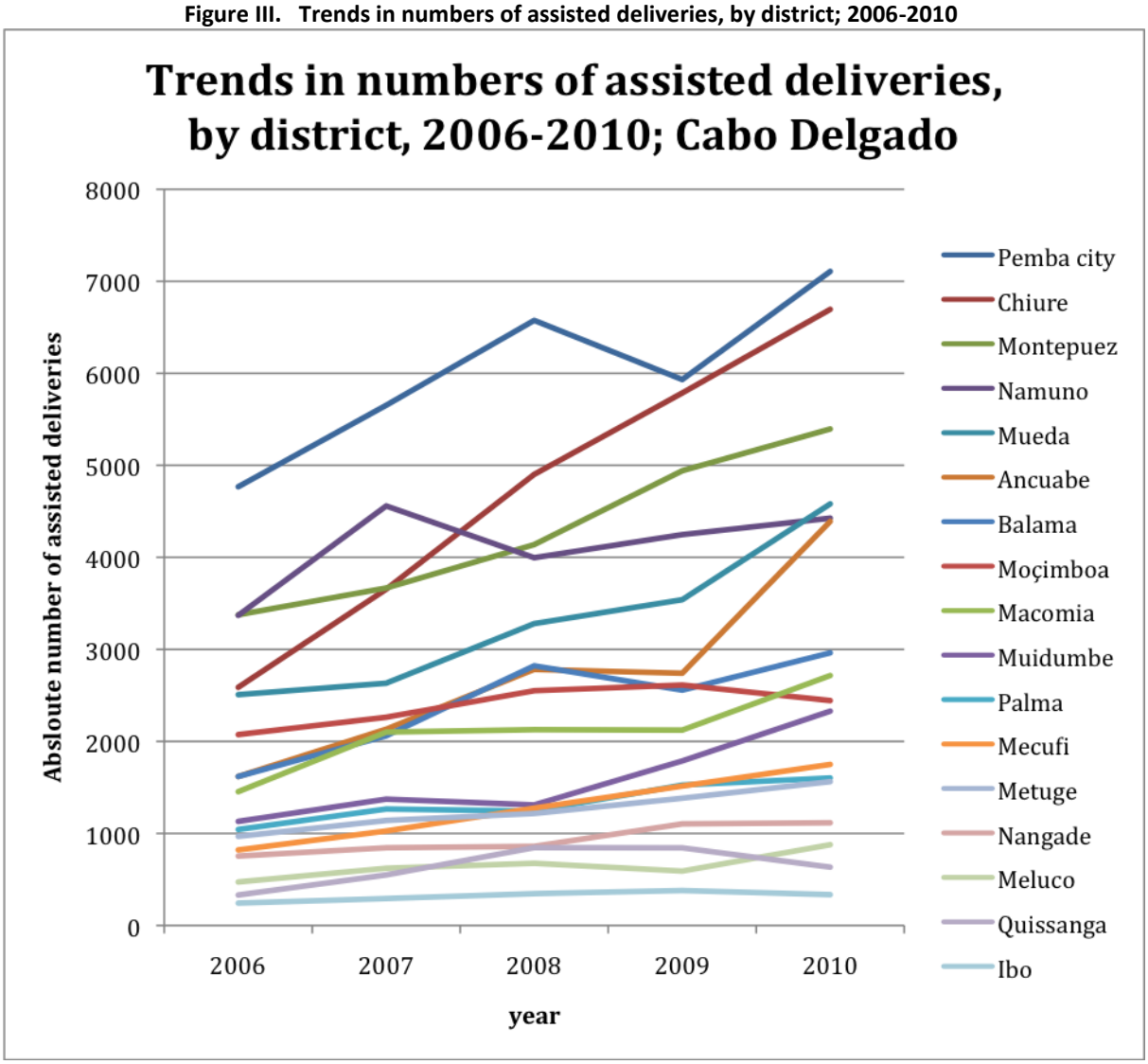


Figure III shows the coverage (i.e. % of expected number of deliveries actually assisted in health institutions by trained staff) of assisted deliveries in health facilities[8]. This graph shows that in the

[8]Population data were derived from the National Institute of Statistics, Pemba; the official population data of 2007 reflect the latest census. Using these figures for the population size in 2007, the official population

whole Province the coverage went up during the last 5 years. Further, it shows again that in Chiure and Ancuabe the coverage growth was particularly fast. The fact that Chiúre finds itself in the middle of all Districts is not surprising: delivery coverage depends much on the density of health facilities with maternity. This density is particularly low, when compared with most other Districts. Ancuabe is already among the front runners, which appears to be a remarkable achievement.

This data shows that both Wiwanana Districts have done remarkably (!) well, certainly also for African standards. The sharp increase in the coverage of assisted deliveries in Chiúre and – perhaps also – in Ancuabe is probably due to a high effectiveness of the sensitization of the communities to deliver in health centres, rather than at home. Accompanying measures, such as the introduction of bicycle-ambulances, and incentives for traditional midwives (if targets on referring / accompanying pregnant women to health centres are realized), have undoubtedly contributed to this development. In the Districts, Wiwanana is collaborating with approx. 50 traditional midwives. In one visited peripheral health centre (Katapua), the number of deliveries per day was between 2 and 3[9], and the existing casa de espera was used by at least 5-6 women awaiting delivery. In some visited villages, the evaluation team observed a quite radical change in health seeking behaviour: the great majority of women are now going to health centres to deliver, and make use of 'casas de espera' and the bicycle-ambulance. The Wiwanana team analyzed data on the utilization of waiting homes (now 5 in Chiúre[10]) and the bicycle ambulance (now 27 in Chiúre and 8 in Ancuabe; 13 out of 35 have technical problems). This first analysis included waiting time, distances to the health centre, bed occupancy, reasons for use (availability of risk factors), and the outcome of deliveries. Analyses showed an increase of pregnant women using waiting homes. The RT recommends continuing with these interesting analyses, to provide more evidence for the relevance and for the positive impact of these interventions, and to inform health planners in Cabo Delgado and beyond.

Figure IV shows OPD attendance, expressed as number of contacts per capita per year, among Districts in Cabo Delgado. Again, there is a positive trend in most Districts. However, the interpretation of this increase is more complex. The SIS does not register 'first cases'; therefore, it is not clear if the numerator (number of contacts) reflects a real increase in utilization of service, or perhaps a high number of contacts among a limited population only (e.g. due to treatment failure?). However, the evaluation team feels that there is at least a plausible relation between the massive sensitization efforts by Wiwanana and increased use of OPD services. To better interpret OPD data, additional analysis – e.g. health seeking behaviour surveys at the community level – would be required.

growth rate, and the official figure for the proportion of the population reflecting the expected number of deliveries, we calculated the expected number of deliveries during 2006-2010. For the numerator (actuals for assisted deliveries in health institutions), we used data from the health information system SIS.

[9] In many African countries, underutilization of peripheral health centres is the rule rather than the exception. For example, this was observed during a recent review by one member of the RT of the MOH capital investment programme in Ghana (January-February 2011). This, however, is not the case in the Wiwanana project area.

[10] Annual report 2009.

Figure IV. Coverage of assisted deliveries in health facilities 2006-2010, by District, Cabo Delgado.

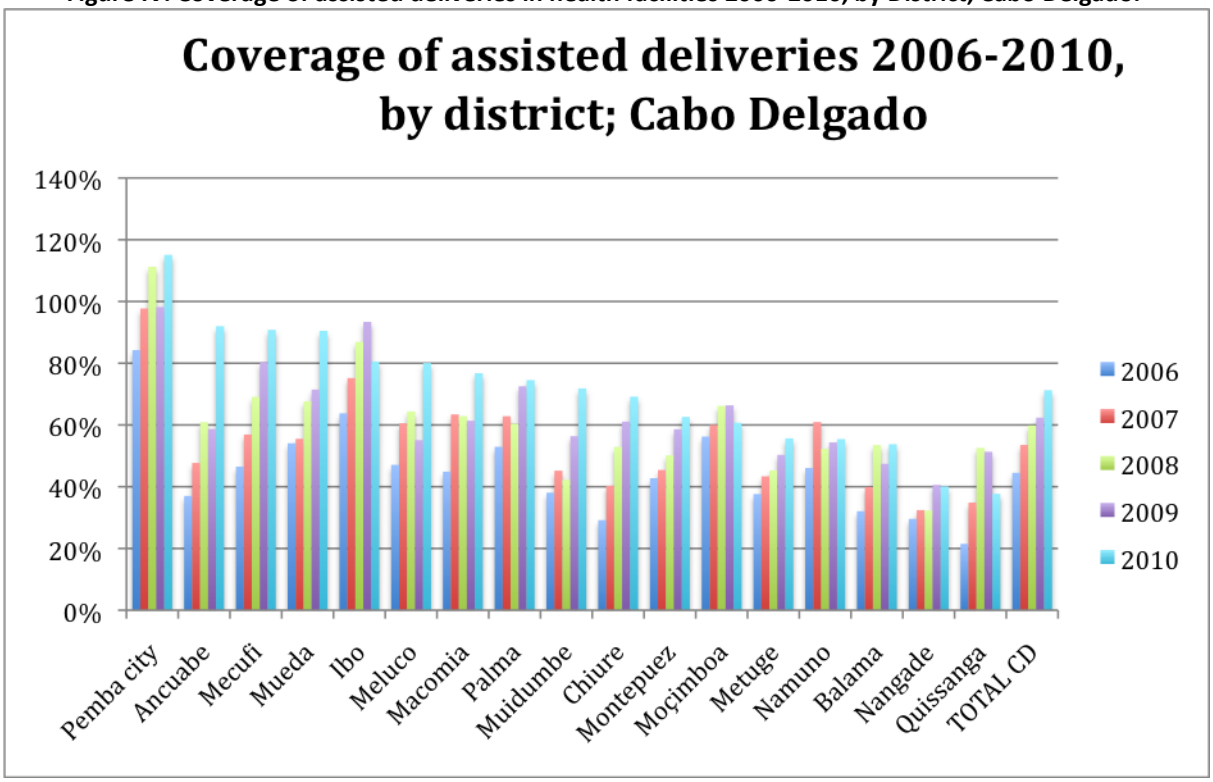
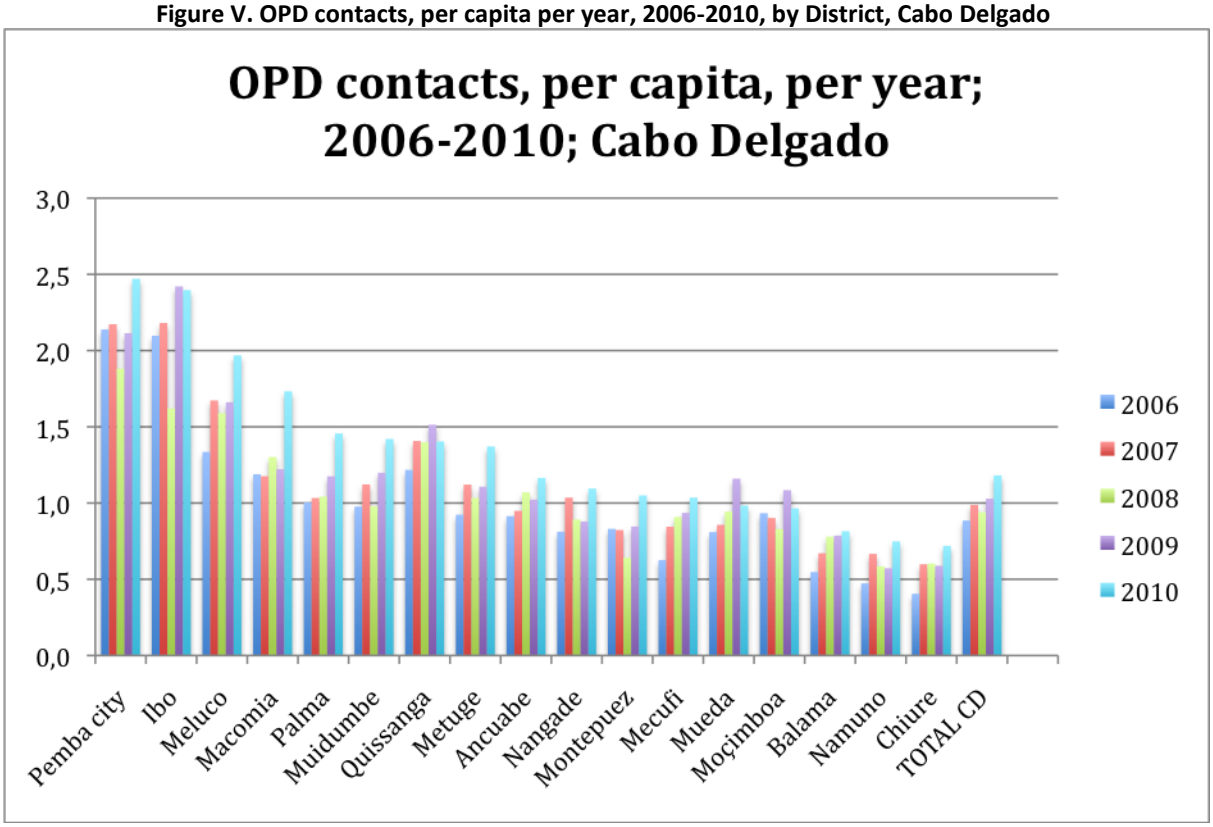


Figure V. OPD contacts, per capita per year, 2006-2010, by District, Cabo Delgado



It appears that Chiúre – and to a lesser extent Ancuabe – has a relatively low OPD per capita rate. This is most likely due to the low density of health facilities. During recent years, no expansion of health facilities has taken place. However, during field visits to some health facilities in Chiúre and

Ancuabe districts, the team observed that the workload for health staff has indeed increased substantially. In Katapua health centre, the small health team (one agente de medecina; one nurse-midwife) is now attending 90-100 outpatients per day, and is assisting 2-4 deliveries per day (!). The 'casa de espera' appears to be very well used. In Chiúre District, the number of women using these facilities increased substantially (2008: 239, 2009: 275, and 2010: 514) and in Ancuabe District 125 women used the first facility in 2010.

To verify as to whether this situation is representative for the entire project area, more analysis needs to be done on health seeking behaviour (community based surveys; exit interviews).

Whereas the number of persons that went for voluntary testing for HIV remained stable (2006: 419, 2007: 755, 2008: 694, 2009: 783, 2010: 640,) the total number of HIV tests have increased substantially, especially in Ancuabe (see Table). Likely, Wiwanana has contributed to this through IEC activities in this domain.

Table 1. Total number of persons for HIV testing, Wiwanana project area, 2008-2010

year	No. persons for HIV testing	
	Chiúre	Ancuabe
2008	8784	…
2009	11476	3868
2010	14135	18896

(Source: M&E database; SolidarMed, 2011).

Although Wiwanana has positively impacted on health services utilization as shown above, the consequences of higher demand and use have not been addressed by WW and by SM. For example, in the District of Ancuabe where there are no facilities for basic surgery, the number of referrals (to Pemba) of women requiring a caesarean section has increased considerably (to more than one case per day). The RT feels that SM should consider the establishment of basic surgery conditions in Ancuabe (in Chiúre, the health centre is currently upgraded to a district hospital with basic surgery). This was discussed with the DPS during the mission. Although Ancuabe is not the first priority for expansion of basic surgery, the DPS was strongly in favour to create conditions there, given that SM and Wiwanana are strongly impacting on service utilization and are likely to stay in the area.

Due to the 'selected PHC' approach of Wiwanana, some public health problems are not adequately addressed. One of these concerns tuberculosis. As was mentioned above, detection and cure rates of tuberculosis in Cabo Delgado are well below the global WHO standards of 70% and 80% respectively. Yet, Wiwanana has not proactively used its available 'infrastructure' (e.g. animators; health groups) to improve the detection of suspect cases, and/or improve continuity of care (through DOTS) of patients in treatment.
The same can be said about other public health priorities, such as malnutrition (in Cabo Delgado, stunting rates among under-fives are high, of over 50%), blindness among the elderly (backlog of operable cataract; blindness had high socio-economic repercussions), family planning (quite often, FP products are out of stock; SM/WW could perhaps play an advocacy role to improve the supply of FP products by MISAU) and/or sexually transmitted diseases (syphilis prevalence rate among adults > 13% ! [source: information by SM

6.1.3 Water and sanitation

Wiwanana has invested much effort in promoting hygiene, by promoting the construction and use of traditional and/or improved latrines (SolidarMed has developed a method to produce convenient slabs), and by ensuring drinking water supply, in collaboration with local government and Helvetas,

an organization that provides deep bore holes and water pumps. From the field visits, the RT has the impression that latrine availability and use are high, and that many villages dispose of one or more deep bore holes. During the mission, the RT asked for quantitative data to verify the availability of latrines and functional bore holes. This data could not readily be made available. Wiwanana also introduced three public toilets, along main roads. Committees now manage these clean and well-built toilets, and their costs are recovered through user fees. It appears that their use is high, and that they are financially viable.

6.1.4 Knowledge, attitudes, practices (KAP)

To assess impact of Wiwanana, it is important to 'measure' changes in knowledge, attitudes and practices, at least with regard to the four themes selected by Wiwanana (fever/malaria; hygiene'diarrhoea; HIV/AIDS; maternal care). Although planned, a recent KAP has not been carried out. Therefore, the RT was not able to make statements on KAP changes.
Apparently, according to minutes of the Steering Committee meeting of December 2010, SDC and the project did not attach high priority to a KAP survey in 2011, given that many KAPs have already been carried out in the Province. The RT has a different view. There is potential to undertake a KAP survey, by making use of available baseline studies for Wiwanana, and of other KAP surveys carried out in Cabo Delgado. Relevant studies include:

- 2000. Laurent Rüdin. CAP ; quantitative study[11] [29].
- 2003. Laurent Rüdin. Qualitative, descriptive, anthropological study [34][12].
- 2004. Medicus Mundi. KAP on malaria in Cabo Delgado : urban MontePuez, rural Montepuez, Ancuabe, Namuno [15a].
- 2006. KAP Study by M. Le Fur, Namuno, Montepuez and Chiúre, for the PISCAD project [13].
- 2010. Repetition of the Le Fur study, in Namuno, Montepuez and Chiúre. The final report will become available in March / April 2011. (the RT received interesting preliminary results, indicating variation among a number of relevant indicators over time). The report will also include results by District, including Chiúre.

The RT suggests that a meta-analysis be carried out of these KAP surveys, to summarize observations and to design a KAP study in 2011 or 2012 to assess and interpret any changes in the project area.

6.1.5 Empowerment

The RT did not get a clear impression about progress made in 'community empowerment'. Clearly, the adherence of community members to some NHS services has been strengthened, due to a very intensive presence of the project activists in the field. The repetition of messages and incentives provided in some of the project's interventions led to people's reaction. Pregnant women were entitled to a mosquito bed net in case of an institutional delivery, access to bicycle ambulances took more people to the health facilities, traditional birth attendants were better motivated to refer pregnant mothers to the health units. However, the RT does not consider these (important!) achievements as part of community empowerment *per sé.*

According to the Project Document [54], empowering the community was considered crucial to address a situation in which State-citizen relationships were characterized by pervasive power relations, upward accountability only and mandatory use of the public services. Although the Document also specifies the need to establish village health groups as an instrument for change and empowerment, in practice their role appears more limited to channelling health messages towards

[11] Detailed study, addressing many concrete questions. Useful input for KAP meta-analysis and for design of repeated KAP.
[12] This study was instrumental for the design of the content of various Wiwanana 'modulos'.

the community members. Although NHS sensitization messages where competently delivered by the activists, the RT could not see much evidence for systematic knowledge exchange (including local practices, coping strategies, etc.) between communities and Wiwanana (referred to in the ProDoc). Considering the great potential of Wiwanana, the RT recommends that this area be given more focus.

6.2 SO-2: Wiwanana transformation into an autonomous local entity

During the current project phase, some steps have been taken to adapt managerial procedures, and a plan exists to further pursue that. The day-to-day management (accounting; logistics; human resource management) of Wiwanana has been separated from that of SolidarMed. Wiwanana also has a specific bank account, which is fed by SolidarMed. Furthermore, a detailed plan has been developed to further strengthen Wiwanana's managerial, financial and administrative autonomy.
The RT also understood that important progress was made after 2008 to introduce a more business-like management culture, by streamlining planning and management procedures, including transparent M&E procedures (target setting; introduction of performance-based incentives; etc.). Also, Wiwanana became involved in consultancy activities (i.e. training health staff on community involvement in health, for Medicus Mundi; these services were highly appreciated by MM).

However, there have been important delays in the transformation process. Partly, this was due to some difficulties with respect to hiring staff. For example, Wiwanana contracted a M&E officer, so as to enable the Coordinator to focus on more strategic issues. However, this officer left the project a few months later.
Another reason for the observed delays was that among SDC, SM and Wiwanana no clear consensus has yet been reached about how Wiwanana should exactly be structured in the future. While SDC has followed the vision described in the project document (i.e. transforming Wiwanana in an independent organization, including an office in Pemba [for PR, policy development and capitalization of experiences] and two field teams in Chiúre and Ancuabe, SM proposed to establish a network organization, whereby SM would 'keep' Chiúre as a project, financed through own funds and SDC, and Pemba-office and Ancuabe would become an independent entity with temporary SDC support). These options were discussed between the stakeholders in December 2010, during the latest Steering Committee meeting [37]. This lack of *strategic c*onsensus perhaps explains why, so far the focus was on transforming procedural and managerial issues, rather then on the core issue: defining Wiwanana's 'unique selling point', exploring Wiwanana's future position on the 'market', and – as a result of strategic choices made – defining Wiwanana's future needs in terms of manpower (e.g. for public relations, acquisition, internal management), legislation (registration of Wiwanana as a CBO), and management.

6.3 SO-3: Capitalization; policy dialogue; advocacy

The RT feels that the Project Document includes a clear and logical vision establishing the WIWANANA Competence Center (later renamed Wiwanana Escritório Pemba - WEP), and on the way to make it operational. However, during the current phase, there has been much debate between SDC and SM about the role of 'Pemba'. Due to the hesitations (see section 6.2) among the SM/WW team about Wiwanana's independence, and to doubts about the importance of a strong representation of Wiwanana in Pemba, the Wiwanana team has not made much progress regarding SO-III.

Certainly, the project team produced a fair amount of interesting documentation on practices and lessons learned, often in draft form. This information offers possibilities for more specific pieces of research. Also, Wiwanana's inputs in the policy dialogue on community health are significant; for

example, its input in shaping the Cabo Delgado's Operations Manual for Community Involvement [6a] is certainly worth mentioning.

However, the RT feels that more could have been done with regard to SO-III: i.e. capitalization of lessons learnt from the field; 'knowledge management'; advocacy to replicate Wiwanana experiences elsewhere. Establishing linkages between micro, meso and macro levels - whereby knowledge generated at the grassroots is available and influences policies – has not been very successful. So far, the role of Pemba office was restricted to representing Wiwanana at the provincial level and to participating in meetings. However, the WEP has not yet been acting as a competence centre, thereby proactively advocating Wiwanana's importance and potential in community health among all stakeholders.

7. Efficiency and project management

The RT observed that the Wiwanana team has developed transparent planning and management procedures. Much effort has been put on developing task descriptions for all staff, and on describing procedures for planning, managing resources, acquisition and purchasing of goods and services. Each year, external audits take place; the auditors have not observed major irregularities [12a].

In line with the project document, the project has significantly reduced the number of staff to approximately half of the staffing in the previous project phase. For example, the number of 'animadores' was brought down: now, 2 animators are available for each sub-district – 'posto administrative'; formerly, this number was 3-4. This reduction has apparently not jeopardized the effectiveness of operations, and was thus an important measure to ensure sustainability at the longer term.

In general, it appears that the project has provided good value for money. With the available resources, many activities have been carried out, often with modest inputs. Sometimes, the project could be more stringent on bringing down costs. For example, Wiwanana has ordered a number of 'bicicletas-ambulâncias' from a manufacturer in Pemba, for a unit cost of approx. US$600. This appears a lot of money for relatively simple equipment, and the RT feels that in this case Wiwanana should have negotiated a better price. However, this is an exception; overall, the value for money is rather convincing.

There has been a strong budget discipline. Expenditure remained well below the budget ceilings [50-53]. In 2009, the budget execution for expenditure in Mozambique was approx. 77%; this was 64% in 2010 (source: WW provided the evaluation team two excel files with expenditure against budget: budget execution field WW 2009 MV.xls, budget 31 dec 2010.xls). During the mission, there were no comprehensive overviews available of expenditure against budget, for all budget items as mentioned in annex 5 of the project document. The annual report 2009 does not include this overview; during the mission, the annual report 2010 was net yet finalized. Some savings on the budget seem not entirely justified. For example, the project has spent very little on external technical short-term support. Considering the difficulties the project has with specific objectives 2 and 3 (see above), the project team could have requested for technical support.

In general, salary levels of staff are modest, especially if compared to other NGOs in the region. The RT feels that this is justified, considering the low profile of most of the staff (most have completed 10 or 12 classes of secondary education, and only some 'temáticos' have professional mid-level training, e.g. MCH nursery. However, the salary levels seem not adequate for high-profile managerial

staff that might be contracted in the future, to strengthen Wiwanana's ability to position itself on the 'market'.

The share of total budget/expenditure for overhead (expenditure at SM / HQ level) plus costs of external TA is approximately one third.

8. Sustainability

Sustainability has various dimensions. SM/Wiwanana perceives sustainability as a process, rather than a result, and considers four levels of sustainability: a) outcome and impact level, b) community level, c) policy level and d) individual level. For this assignment the Review Team (RT) has differentiated between political sustainability; socio-cultural (and also technical) sustainability; institutional and organizational sustainability and financial sustainability.
One important goal for the current phase was to make progress in transforming Wiwanana into a viable, independent organization. Therefore, during the evaluation, the RT intensively discussed various aspects of sustainability with SM/WW and with SDC.

8.1 Socio-cultural sustainability

The Wiwanana project made a considerable investment in training of and skills transfer to community members as a means of adapting local costumes and cultural values. The extensive stay of the animators/activists in the communities has helped in this process (as did also the provision of material incentives, e.g. bednets for pregnant women, incentives for TBAs promoting institutional deliveries, etc.). The RT noted in several villages that some changes in attitudes and practices are taking place (although these changes have not been confirmed by a KAP survey – see above). An interesting example is the introduction and use of mother waiting homes' ('casas de mãe espera'); these are relatively new to the Mozambican context in general and even newer to the two districts were Wiwanana is operating. It was possible to visit a waiting home for mothers fully booked and with a good record on attendance. Another example concerns sanitation. The construction of latrines was also not a current habit among the communities within the project area. In one village visited by the RT almost every house had a latrine, and activists/animators explained that this was not exceptional in the Districts. Reasons for not having a latrine would be: poverty and lack of affordability among elderly and disabled people, rather than mere refusal or resistance. According to a participant of a FGD in Mugipala community: "When you have a latrine, your guest doesn't have a hard time at your house".

The formation and use of theatre groups is an important means of communication. The dramaturgical representation of reality is, in itself, a new phenomenon for the populations of Chiúre and Ancuabe. One respondent explained that Wiwanana is equivalent to theatre, so when kids say 'let's play Wiwanana' everybody is aware of is s/he talking about.

An important question is to what extent any changes in knowledge, attitudes and practices will remain after the project ends. We refer to changes regarding the habit of washing hands, utilization of personal razors, keep the waste away, village cleaning campaigns, and many others. Based on its field observations, the RT feels that sustainability of these aspects is quite likely. In the report on backstopping in 2009 by Laurent Ruedin [31], a number of other examples of permanent change are described.

8.2 Institutional and organizational sustainability

After its transformation into a new, independent Community Based Organization (CBO), Wiwanana will certainly have opportunities to remain viable. Currently, there are very few CBOs in Cabo Delgado. Furthermore several Collaborating Partners (CP) have indicated to be willing to support such a new organization that can play an important role in implementing community-based health care. Having interests in bringing the transformation process to a good end, the SDC is also most likely to technically and financially support the transformation process.

When aiming at reaching cultural and institutional change, the target population - 'owning' culture - is not the only potential subject of change. There is a wider range of organizational/institutional cultural factors - involving the Wiwanana organization itself - that need to be addressed. In particular, this refers to strengthening local ownership among Mozambican WW staff. The RT recommends that due attention be given to progressively involve WW staff in major strategic decision making and to rapidly shift decisive power in operational issues from external TA to local managers [13] . The RT is aware of WW's intentions to do so during 2011.

8.3 Financial sustainability

Wiwanana is fully dependent on external financing. The RT discussed with local government (Governor of Cabo Delgado; 2 District administrators of Chiúre and Ancuabe) possibilities for co-financing of Wiwanana activities. However, these are extremely limited to nil.
Although Wiwanana certainly provides value for money (see above), the costs of the interventions are considerable. On an annual per capita basis, these are approx 2.7 US$/capita/year. It must be noted that in this figure costs for SM/overhead and external TA are included. Considering the total resource envelope for health care, per capita, per year in Cabo Delgado of approximately US$ 18 (for 2007; mentioned in the appraisal report of HSDP; a recent presentation by DPS-Cabo Delgado on the PESS 2009-2015 mentions even a much lower per capita envelope of approx. US$ 7[14]). When SM overhead and TA are excluded (constituting approx one third of total budget), the remaining US$ 2 per capita per year are still a high cost, amidst a resource-deprived health sector. Therefore, the future Wiwanana will need to convince future financers on the added value of the intervention package. Again, this requires a strong profile of Wiwanana management.

The position of some key CPs in Cabo Delgado in financing future community health activities is not very clear, so far. Although the RT made an effort to 'map' key players in the Province (see annex 4) and to describe 'market' opportunities for Wiwanana, a more detailed analysis is needed to get a clear picture of the current and future context.
To avoid missed market opportunities, the pace of transforming Wiwanana would need to increase (see 'recommendations').

[13]The Wiwanana bank account has two signatories: the SolidarMed coordinator and the Wiwanana Manager/Coordinator. Mozambican staff does not yet sign (the evaluation team understands that measures are taken to include the Director's signature on banking transactions in due time). This shows that Wiwanana is not yet fully 'owned' by the staff. Another example concerns the translation of documents (plans; annual reports; etc) from English in Portuguese. The expat staff considered this as a sign of more involvement of Mozambican staff in project management. The RT is of the opinion that the alternative option of preparing reports in Portuguese by Mozambican staff, assisted by expat staff, and having these reports translated into English (e.g. for SDC-Maputo) would perhaps make more sense.

[14]DPS. Análise da Despesa e Financiamento. PESS-CD 2009-2015. 28 April 2009.

The project document includes a - rather optimistic, according to the RT's views - hypothesis that the Health Service Delivery Programme (HSDP), financed by World Bank/IDA (concessional loan), SDC, Russia and CIDA would become a major 'client' of the future Wiwanana. The implementation of this Project is, however, delayed; only in December 2010, the HSDP was launched in Pemba. Implementation has not started yet. Furthermore, the RT reviewed the Project document of HSDP [57]. This Project appears to include a rather classic support package to strengthen the supply – rather than demand – of health services in the Province of Cabo Delgado (and in Nampula and Niassa, the remaining two northern Provinces): infrastructure; training of health staff; strengthening planning and management. The project document does not include a clear community health component. The Provincial representative of HSDP explained that Wiwanana was seen as complementary to HSDP, rather than an NGO to be contracted for community work. The RT feels that these first observations must carefully be checked by SM/WW, and discussed with SDC. Perhaps, SDC and other consortium partners of HSDP may want to modify the HSDP package towards giving more emphasis on the demand side, including community health, of health care. This would open up possibilities for Wiwanana to be contracted for community based health care.

Another opportunity for Wiwanana might be the future financial support by SDC to DPS[15]. During this evaluation mission, the formulation of this support project – 'Support to the Cabo Delgado health plan' - was not yet concluded. From minutes of the latest Steering Committee [37], the RT understood that this project would include a community health component, where Wiwanana might be able to play a role

The Aga Khan foundation informed the RT that USAID is particularly interested to support new CBOs. This is another obvious thread to be followed up.

Elisabeth Glaser Foundation might offer concrete opportunities for Wiwanana to establish a viable relationship (although available funding for sub-contracting is currently not high). The Elisabeth Glaser Paediatric AIDS Foundation (EGPAF) works on Paediatric TARV, training on Mother and Child Health (MCH), HIV/AIDS and bio-security. Until December 2010 the organization was working in 10 out of the 17 districts of Cabo Delgado province. In the beginning of 2011 it expanded activities to the remaining seven districts. EGPAF's main approach to collaborate with partners is the establishment of annual sub-contracts, including specific targets, expected results, activities and budget. It has already granted sub-contracts to two Community Based Organizations (CBO): one in Mocímboa da Praia ('Desafio Jovem') and another in Pemba City ('Karibu').

Furthermore, there are concrete possibilities for Wiwanana to continue with 'consultancy' (see above: Wiwanana has already been contracted by Medicus Mundi to train health workers in other districts, on a consultancy basis.

Clearly, the importance of conducting a robust market analysis, to further explore opportunities for Wiwanana in the future cannot be ignored. Equally, it is crucial paramount to clearly define Wiwanana's unique selling point – Wiwanana's 'products' - in the future. These elements will further determine the 'shaping' of the new organization, in terms of staffing (numbers; profile). In chapter 9, specific recommendations are given with regard to these crucial issues.
Sofar, SM and Wiwanana have not undertaken a more in-depth analysis of the market opportunities. This is an essential activity during the transformation process and needs to be carried out as a matter of urgency (see recommendations in section 9.2.2).

[15]Support to community involvement. Budget: US$ 3.7 m. for 6 years period. Formulation done. DPS still to produce prodoc.

9. Main conclusions and recommendations

9.1 Conclusions

Overall, the RT is impressed by Wiwanana. In an extremely poor area in Cabo Delgado, the project has really been working very hard to bridge the 'gap' between supply of health services and the demand and expectations of the communities. Working at this interface between formal health services and community based health care is not at all easy, and Wiwanana has built up very relevant experience. There is evidence of results in various areas. In particular, the project has been instrumental, together with other complementary projects of SolidarMed, to significantly improve maternal health. Also in other domains – HIV/AIDS, malaria, and hygiene – tangible results have been observed by the RT.

A major challenge is now to proceed with the process of change, towards a new, independent and viable organization. For various reasons, this process has been delayed. The RT believes that concrete opportunities for Wiwanana becoming an independent Mozambican CBO do exist; therefore, action must be taken now to take crucial next steps (see section 9.2). During the limited time available, the RT did a first analysis on the role of the various stakeholders, so as to get a 'feel' for future market opportunities. This - rather superficial - analysis showed that market opportunities exist. At the same time, it was concluded that some hypotheses in the project document (i.e. opportunities for sub-contracting by the HSDP project by WB, CIDA, SDC, Russia) were not well justified. Support by SDC during the transformation remains a crucial success factor. SolidarMed's position to 'stay' in Chiúre is also vital for the future organization, given that SM also co-finances with own funds (the amount of which is not known by the RT).

Capitalization of field experiences is another domain that needs much attention as of now. Wiwanana staff has documented many field experiences; these can be further documented in a systematic manner. That would be an asset in the process of advocacy of Wiwanana among stakeholders.

9.2 Recommendations

This section includes the main recommendations in bullet form. The recommendations are sorted by specific objective of Wiwanana.

9.2.1 SO-1: community empowerment; maintaining health and preventing disease

- SolidarMed should further strengthen comprehensive PHC, and district health, at all levels of the health pyramid. SM should play an advocacy role to organize basic surgery in Ancuabe, to cope with the increased utilization of health services, including emergency obstetric care.

- Wiwanana should make better use of the existing 'infrastructure', by addressing other public health priorities than the four selected themes only. For example, the organization could play an important role in improving detection and cure rates of TB, by involving health groups in DOTS.

- Wiwanana should use existing KAP surveys in Cabo Delgado to carry out a meta-analysis. Based on this, a KAP survey should be designed and carried out, in 2011 (or 2012).

- Monitoring of services outputs and coverage of health programmes could be strengthened. Examples of these are given in this mission report. Inter-district analyses are a useful tool to trigger policy debate on the importance of community health interventions. Obviously, this activity would require sufficient capacity among the WW team – this could be given further thought.

- Interesting information from the field could be better used to adjust the content of Wiwanana messages to the communities, through various channels, and to better communicate with health facilities, DDS and DPS.

9.2.2 SO-2: Wiwanana transformation into an autonomous local entity

- Wiwanana should speed-up the transformation process by avoiding lengthy procedural steps and processes. Suggested next steps:

    - First (March-May 2011), develop a comprehensive business plan, which includes: Wiwanana's core business and Unique Selling Point; SWOT analysis; detailed analysis of the 'market' (assessing the position of the key players in Cabo Delgado – this also requires meetings in Maputo and Pemba by senior management of Wiwanana and SM); robust risk analysis;

    - Seek consensus on the draft business plan, among SM, Wiwanana and SDC (mid-May?); organize a workshop to allow for sufficient brainstorming among the stakeholders; to facilitate this process, and to finalize the business plan, the services of external consultancy may be solicited[16]; (the senior expert should be familiar with the Mozambican health system, should have relevant experience with major donor agencies, and should have relevant experience with the establishment of business plans (for NGOs; consultancy firms);

    - Based on the business plan, define requirements in staffing, especially with regard to acquisition, PR, Wiwanana advocacy, and public health knowledge (see the RT's suggestion to have sufficient knowledge and expertise on 'district health' in chapter 5, last sentence);

    - Recruit one additional Mozambican manager (*start identification as of now*) responsible for acquisition, advocacy, PR. Together with the current Wiwanana Director; this manager would form the Wiwanana management team. Design a contract with a competitive salary, and include bonus/malus arrangements related to sharp (acquisition) targets;

    - While the current Director would be mainly responsible for internal affairs (i.e. HRD, M&E, supervision of field operations), the other manager would, for example, have a focus on external relations, acquisition, PR. The description of the Pemba office in the project document is still most valid.

[16]During the latest backstopping by Laurent … it was suggested to have a backstopping to support managerial aspects of the transition process. This suggestion might be valid; the RT does not know to what extent SM could provide these services to WW.

- *Then*, *after consensus on the business plan*, fill key positions and vigorously pursue PR activities, and continue the market analysis; intensify dialogue / negotiation with key CPs, including SDC.

9.2.3 SO-3: Capitalization; policy dialogue; advocacy

- As part of the business plan, revisit the role of the WEP in PR / acquisition, policy development, capitalization / documentation of field experiences; define staffing requirements accordingly.

- Start capitalizing on knowledge already 'in-house' (see notions collected by the RT under 6.3) and identify best ways for dissemination and action planning

- Accelerate informing policy makers and general public, by compiling existing, interesting documentation already available.

ANNEXES

Annex 1. Terms of Reference

External Review of the Wiwanana Project

1. Background

In its Wiwanana project, realized in two districts of the province of Cabo Delgado, Solidarmed has since 1999 successfully implemented a community participation project. Facilitators work together with the community to identify and address health problems together. The objective is to improve the health status of the population in the communities by adopting healthier behaviours and thereby sensibly reduce the burden of disease. The expected result is (1) a community involved around health issues that is increasingly undertaking activities on its own; (2) a generally reduced burden of disease; (3) a steadily increasing rate of institutional births; (4) and improved hygienic conditions.

The Programme has identified three outcome objectives to be reached during the phase 01.01.2009 - 31.12.2011:

1) Community empowerment for health: Communities make use of their knowledge and adapt practices to maintain health and prevent disease, they organize themselves to identify and address health problems at individual, household and community level with locally available resources and make use of the formal health system;
2) Institutional strengthening: Wiwanana as autonomous local entity makes use of its capacities and plans, implements, manages and monitors its activities professionally;
3) Competence centre and policy dialog: Experience, knowledge and lessons learned are disseminated and shared with civil society organizations, decision makers and international bodies in order to contribute to advocacy and policy dialogue, and to increase impact of interventions.

The last external review was done in 2004 for the period 1994-2004. In 2000, a baseline study was carried out (*Análise de Situação : Conhecimentos e Praticas de Saúde, Levantamento quantitativo).* In December 2006, a study named Analise dos resultados e efeitos da Wiwanana (*Inquérito sobre os conhecimentos, os recursos e as práticas de saúde no Distrito de Chiúre)* was done.
Since then, no external review or study has taken place.

2. Purpose of the external review

Phase 2 of the Wiwanana Project will be coming to an end in December 2011. An external review has been foreseen for end 2010/early 2011 in order to assess the results achieved and provide an input to the decision making process on the future in particular on the way forward with the NGO Wiwanana and with the integration of community involvement in the health sector. The review is intended to:

1) assess how far Wiwanana achieved the expected results of the current Phase .
2) assess to what extend Wiwanana contributed to the intended outcomes
3) discuss the factors which have influenced the level of achievements
4) get the perceptions of the different stakeholders on the project in terms of its relevance, added value, sustainability and project management
5) make recommendations for the way forward on the future of the NGO Wiwanana

3. Scope of the Work

The review team will assess the level of achievement of the project objectives and expected outcomes and the validity of earlier assumptions using the project document and log frame, operational plans, budget, progress reports and other relevant project documents and documents on the health situation in Chiúre, Ancuabe and Cabo Delgado province in general as well as interviews of key and resource persons and field visits,.
The review team will also have to assess the likelihood of financial and operational sustainability of the new NGO Wiwanana and recommend options for strategies on how to best survive.

The review is expected to answer the following questions:

1. To assess thei**r relevance** of Wiwanana in the present context, identify/validate whether Wiwanana still fills a gap in the implementation of the government strategy and determine whether it can make a difference and how.

Specific issues

- Do the experiences and lessons learnt collected at project level feed the thematic and policy dialogue at district, provincial and central level?
- What is the relationship between Wiwanana and other existing projects in the region?
- How is the link between Wiwanana and the formal health prevention and promotion workers? Is there a scope for closer relation?
- Is there need for another phase and if yes what type of support and on what level?
- What should be considered in a future phase in order to enhance Wiwananas relevance?
- Is the geographical focus still relevant?
- Is Wiwanana reinforcing existing Community Based Groups?
- Which strata of poverty quintiles of the population is Wiwanana reaching?

2. To assess the **Performance** (effectiveness and efficiency) of Wiwanana

Effectiveness:

- Has Wiwanana achieved the expected outcomes objectives?
- How far has Wiwanana managed to implement the three action lines?
- How does Wiwanana integrate gender in health promotion and which are the results?
- How is knowledge shared with district and provincial level?
- What important lessons have been learned from interventions supported by Wiwanana?
- What can we learn about effectiveness in view of scaling up a Wiwanana approach?

Efficiency:

- Have the project achievements been done in a cost efficient way?
- Are the costs justified in relation to the project achievements?
- What can we learn about cost efficiency in view of scaling up a Wiwanana approach?

3. Outcome

- What changes has Wiwanana brought to the communities that it has worked with in the districts where the project is being implemented?
- Has Wiwanana brought any change in the perception of the population towards the National Health System?
- Has the Wiwanana approach of working with communities influenced the districts in their overall planning and implementation process?

4. Sustainability

- Is the project approach contributing to sustainable changes? What kind of changes?
- Are the project outcomes sustainable?
- What capacity is being developed at beneficiaries and at local government level?
- What more should the project focus on to ensure that sustainability is enhanced?

5. Project management

- What is the assessment of all stakeholders of the current project organisational arrangement?
- Is the current institutional arrangement in the implementation of the project cost effective?
- What are the lessons learnt from the current institutional arrangement?
- What are some of the proposed project management options for the future of the project? The consultants should propose at least 2 options on the way forward of the institutional arrangement including pro and cons.

6. Perception of the project

- Is the project and its various activities and achievements known to the district and provincial authority?

- What are the perceptions of the district and provincial authorities on the project? Does this area of work correspond to a priority as seen from their perspective? Do they identify possible different priorities that should be addressed?
- What potential is there for Wiwanana to play a different role in contributing to the MISAU strategic plans and district development plans?
- What are the challenges in taking this role?

7. Conclusions and Recommendations

The review team should draw conclusions about the relevance, role, performance, impact and sustainability of Wiwanana. They should make specific recommendations and propose options for the immediate future as well as for the medium term.

The review team should also draw conclusions and recommend about the best options for legal status, project management and strategic orientation for a financial and operational sustainable new organisation Wiwanana.

4. Methodology

The external review exercise will involve a review team of 3 people – one international consultant, one local consultant with community participation orientation plus an additional peer review[17] team member from SDC. The team will review the literature on the Wiwanana Project and conduct field visits. Semi-structured interviews and focus-group discussions with the different stakeholders from the district and provincial level, SDC and community groups who are the beneficiaries will be carried out. The review team will visit some of the initiatives being implemented by community groups. Additionally it is expected that the report shows the trend of some relevant health indicators for Chiúre, Ancuabe and Cabo Delgado Province.

5. Deliverables

1. A presentation (Power Point Presentation (PPP)) for the debriefing session and discussion of the preliminary draft including results, major conclusions and recommendations (logistics to be arranged by SDC Programme Officer responsible for the project).
2. Within 2 weeks after the debriefing, a draft report submitted to SDC and Wiwanana for comments
3. A final report (max. 15 pages plus annexes and a summary) is to be sent to SDC (date will be specified in the contract)

The annexes should include a list of documents consulted and persons interviewed, as well as the PowerPoint presentation used for the debriefing; material from the Wiwanana project should not be attached. The report should be delivered in 2 paper copies and an electronic (email, CD) version.

Language (Portuguese or English) will be defined once the consultant team is defined. However, an extensive summary in the language not used for the report will have to be provided.

6. Time frame and human resources

The assessment is to take place over a period of 20 days, and shall be completed not later than March 30th 2011. The breakdown for the time period is as follows:

- 3 days preparation and reading of documents, questionnaires preparation, methodology and plan of action
- 1 day meeting with SDC for discussion in Maputo
- 12 days in Cabo Delgado (including travel)
- 1 day preparation of PPP presentation and debriefing (at least 2-3 hours)
- 3 days report writing

Qualifications

Two consultants will be required including at least one Mozambican in a preferably gender balanced team.

The following experiences and competences are expected to be provided in the team:

- Project evaluation
- Senior Programme management experience in public health or related development field;
- At least one consultant to have 5+ years experience with development assistance;
- At least one consultant to have 5+ years experience in the area of community participation, mobilization and development.
- Familiarity/experience with CBOs

- Knowledge of the Mozambican health and government context (policy and strategies, reform processes….)
- Methodological competences (in the areas of Focus Group Discussion), technical writing expertise;
- Social science, finance, business, health or related training at Masters level or above;
- Fluent in English and Portuguese.

7. Documents for the review

WW Project document phase 2
WW Annual reports 2008/09/10
Baseline study 2000 (L. Ruedin)
Evaluation 2004
Study 2006 (Carine Pin- Diener)
Malaria surveys (2006/7/8)
Steering committees Minutes (2009-2010)
Solidarmed Programme 2010
Consolidated DRAFT of 'the future of Wiwanana', SolidarMed-SDC (January 2011) – if available
Provincial and districts health reports

Annex 2. List of people met

Name	Organization, Position
AUGUSTO, Sousa	Health Component Coordinator, Aga Khan Foundation
BENZANE, Julieta	Cabo Delgado Provincial Health Directorate Focal Point, Health Service Delivery Program
BENZERROUG, El Hadi	Country Representative, World Health Organization
BILANA, Júlia	Community Health Officer, Chiúre District Health Directorate
CAMBA, Tunísio	Health Programme Officer and HIV-AIDS Focal Point, Swiss Development Cooperation
CELESTINO, Eusébia	Ancuabe District Administrator
CHAVANE, Leonardo	Public Health Deputy Director, Ministry of Health
DUERST, Markus	SDC Maputo / Head Development Cooperation
FAQUIHE, Rosário	Head of Community Health Sub-department, Cabo Delgado Provincial Health Directorate
FERNANDEZ, Jordi	Coordinator of the Programme Management Unit, Cabo Delgado Inter-Sectoral Health Program
FREIBURGHAUS, Franziska	Head of Health Domain, Swiss Development Cooperation
GODINHO, Celestina	Wiwanana Director
HAGY, Mussá	Cabo Delgado Provincial Health Director
HOBBINS, Michael	SolidarMed Country Coordinator
KARAJEANES, Esmeralda	Programme Director, Elizabeth Glaser Pediatric AIDS Foundation
MACHAVA, Eliseu	Cabo Delgado Province Governor
MUNAMI, Victor	Wiwanana Manager
MUTAOLIMA, Américo	Head of Planning and Cooperation Department, Cabo Delgado Provincial Health Directorate
NAMPAVA, Carlos	Chiúre District Administrator
NAPIPI, Márcia	Mother and Child Health Officer, Chiúre District Health Directorate
OSSMAN, Zakir	Ancuabe District Chief Doctor
PERACAULA, Neus	Medicus Mundi Project Coordinator, Southern Cabo Delgado
PESTILI, Sabrina	Project Manager, SMART II
PIPREK, Alexandra	Project Manager, SMART I
PUCHE, Nacho	Medicus Mundi Sanitary, Northern Cabo Delgado Project
RUIZ, Ivan	Country Representative, Medicus Mundi
SAMUEL, José Carlos	Wiwanana Strategic Manager
SUEGE, Cesário	Cabo Delgado Province Chief Doctor
TAVARES, Gregório	Elizabeth Glaser Pediatric AIDS Foundation Cabo Delgado Province Coordinator
VILLARET, Marianne	Wiwanana Coordinator

Annex 3. Programme of the mission

Date	Activities
20 Feb	Departure RD to Johannesburg
21 Feb	Arrival RD in Maputo; Meeting with SDC: first briefing on WW project; collection of project documents; Team meeting RD HN
22 Feb	Meetings in Maputo: EGPAF (Programs Director) *Medicus Mundi* (Country Coordinator) MISAU (Deputy Director for Public Health) WHO (Country Representative)
23 Feb	Departure to Cabo Delgado; arrival; Meetings: SM/WW team (SM Country Coordinator, Wiwanana Director, Wiwanana Coordinator, Wiwanana Strategic Manager) DPS (Head of Planning and Cooperation Department, Head of the Community Health Sub-department) Departure to Chiúre District; arrival
24 Feb	Meetings: District Administrator Briefing with Wiwanana Chiúre team (Theme: Overview)Chiúre Visit to the new rural hospital
25 Feb	Briefing with Wiwanana Chiúre team (Theme: M&E)Chiúre – Visit to Chiúre Health Center Follow up of a community HIV group (Muhurunga) Visit to informal sex workers and traditional drinks sellers (HIV peer educators) Visit to sex workers in the Corridor (peer educators)
26 Feb (sat)	Reflection meeting with Leaders on Diahorrea (Katapua) Visit to Katapua Health Center and 'Mother Waiting House' Briefing with Wiwanana Chiúre team (Theme: HIV/AIDS)
27 Feb (sun)	Follow up meeting on a Bicycle Aumbulance Committe (Majasse) Visit to the Metoro Public Sanitary
28 Feb	Visit to Ancuabe Hospital (SMART I Program) Balance meeting in the Community of Nacussa (Ancuabe)
1 Mar	Visit to latrine activist (Mahipa) Meeting with the Ancuabe Administrator Balance meeting on Fever/Malaria (Mugipala) Visit to the Chiúre Community Radio (Wiwanana Program)
2Mar	Balance meeting with TBA (Chiúre Sede) Briefing with WW Chiúre team (Theme: Management) Meeting Community Health Officer in Chiúre DDS Discussion of preliminary findings with SM/WW staff Departure to Pemba
3 Mar	Meetings: Aga Khan Foundation (Health Coordinator) Provincial Health Directorate (Director, Chief Doctor, Planning and Cooperation Head) *Medicus Mundi* (Southern Area Coordinator, 'Sanitary' of Northern Area)

4 Mar	Meetings: Cabo Delgado Province Governor HSDP (Focal Point) PISCAD (Management Unit Coordinator) EGPAF (Province Coordinator)
5 Mar (Sat)	Debriefing with SM/WW staff
6 Mar (Sun)	Departure for Maputo LAM 13.50 hrs Preparation debriefing
7 Mar	Debriefing with SDC; Departure RD for Netherlands

Annex 4. Mapping of health partners in Cabo Delgado

Table 2. Mapping of health partners in Cabo Delgado

Organization	Type of activities/domains	District coverage	Duration
Engenheria Sem Frontaires	Water and sanitation; district planning/SIS; support to management	Ancuabe, Balama, Montepuez, Namuno	
GVC?	Mother- and child health; school health; HIV/AIDS; capacity building of health staff	Cidade de Pemba	
Medicos del Mundo	SRH; MCH; HIV/AIDS; strengthening planning and management of health services; HRD; infra (new programme – other districts)	Mueda	
Conselho Interhospitalario de Cooperacion	SRH; MCH; prevention; Malaria; rational prescription of medicines; planning and management; HRD;	Ibo, Mocimboa	
Fundação Contra Fome	Nutrition/ nutrition habits; SRH/SMI; hygiene; planning and management; governance/decentralization;	Mocimboa, Palma	
Fundação Aga Khan	malaria project (USAID): bednets through community. Subcontract with Progresso. Nutrition (local theatre; TBAs) / UNICEF; Philantropic US organization. SMI (CIDA): bicycleta-ambu; casas de espera; PF Support to peripherical health units.	Malaria: Pemba Mecuse, Quisanga, Ibu, Meluco, Macomia, Ancuabe, Mueda, Muidunge, Nacalde. 5 distritos (not in Chiúre/Ancuabe) 5 distritos + Mocimboa	New proposal
Pathfinder	FP (US)		Launch in March 2011
Banco Mundial / Health	Broad health support in 3 Northern Provinces of Mozambique; strong community health component	Support to DPS	Was launched in December 2010; not yet operational
PISCAD	Support to DPS: management, SIS, maintenance, infrastructure, limited community health (cholera)	Province; all 17 districts	Until March 2011

EGPAF (E. Glazer)	HIV/AIDS; SMI; community health with CBOs	Balama, Cidade de Pemba, Macomia, Mueda, Mocimboa, Monte Puez, Muidumbe, Namuno, Nangade, Palma Joint planning (EPI) with all districts	2006 – today …
SolidarMed	Wiwanana; SMART (HIV/AIDS); Mama (SRH)	Chiúre, Ancuabe	
Medicus Mundi	HRD of health staff (broad); primary health care (no hospital involvement); home based care (in 3 districts in Northern part of CD); infrastructure (health centres)	Monte Puez, Balama, Namuno, Macomia, Meluco, Ancuabe	
PEPFAR	HIV/AIDS; general health	Province (TA team; financial support to DPS)	…

Annex 5. Glossary on community health in Mozambique (Portuguese)

Envolvimento Comunitário para a Saúde - significa envolvimento activo de pessoas de todos os extractos sociais, (homens, mulheres, jovens, crianças e velhos) que vivem juntas, de forma organizada e coesa, na planificação e implementação dos Cuidados de Saúde Primários, usando recursos locais, nacionais ou outros.

Mobilização Comunitária- é uma expressão que implica um processo activo, por parte das autoridades de Saúde e outras para suscitar o «Envolvimento Comunitário» e criar um ambiente que lhe seja favorável à Saúde.

Comunidade - é um conjunto de pessoas vivendo numa área geográfica limitada, de forma organizada e coesa, mantendo vínculos sociais entre elas.

Autoridades comunitárias- Segundo o Decreto n° 15/2000, são autoridades comunitárias os chefes tradicionais, os sectretários de bairros e de aldeias e outros líderes legitimados como tais pelas respectivas comunidades locais e recnhecidas pelo competente representante do Estado.

Estruturas de base comunitária -Designam-se os conselhos de lideres comunitários ou comités de saúde comunitário, composta por homens e mulheres, membros influentes de uma comunidade, os quais foram escolhidos ou eleitos por essa comunidade.

Conselho de lideres comunitários (CLC´s) -O Conselho de Líderes Comunitários é uma estrutura sócio-comunitária composta por homens e mulheres, membros de uma comunidade, os quais são escolhidos ou eleitos por essa comunidade, para a 'representar' em todas as ocasiões em que é preciso tomar decisões como uma comunidade. Essas pessoas tem a particularidade de serem na comunidade líderes formais ou informais, podendo ser: líderes religiosos, régulos, professores, secretários de bairros, comerciantes, representantes de grupos de mulheres, de jovens, de profissionais, Agentes Comunitários de Saúde e outros.

Rede Comunitária de Saúde-Refere-se ao sector comunitário de prestação de cuidados de saúde, com infrastruturas comunitárias, que se pretende auto-sustentável, envolvendo todos os intervenientes comunitários como Agentes Comunitários de Saúde (ACS), Estruturas de Base Comunitária (CLC´s) e Autoridades Comunitárias .

Agente Comunitário de Saúde - São designados Agentes Comunitarios de Saúde (ACS)todos os indivíduos, escolhidos na comunidade e pela comunidade, formados pela Saúde ou pelas ONGs e instituições religiosas para realizar actividades promotivas, preventivas e/ou curativas a nível das comunidades. Dentro do grupo dos Agentes Comunitários de Saúde (ACS) encontram-se os Agentes Polivalentes Elementares (APEs), Parteiras Tradicionaiss (PTs) e os Activistas.

Agente Polivalente Elementar (APE) – é um elemento da comunidade, por esta seleccionado, treinado pelo SNS ou pelas ONGs para prestar cuidados preventivos, curativos e promocionais a essa mesma comunidade.

Activista comunitários da Saúde - é um voluntário membro da comunidade, por esta seleccionado, treinado por uma ONG e/ou por uma instituição da Saúde, trabalhando sob a orientação a apoio metodológico de uma ONG ou de instituições do Estado, ao conselho de líderes comunitários (CLC).

Parteira Tradicional (PT)- é a mulher que faz partos na comunidade e reconhecida pela comunidade

Medicina Tradicional- segundo a OMS, é a combinação total de conhecimentos e práticas, sejam ou não aplicáveis, usados no diagnóstico, prevenção ou eliminação de doenças físicas, mentais ou sociais e podem assentar exclusivamente em experiências passadas passadas e na observação transmitida de geração, oralmente ou por escrito.

Praticante de Medicina Tradicional (PMT)- Segundo a OMS, é a pessoa reconhecida pela comunidade na qual vive, como sendo competente para fornecer saúde usando plantas, animais, minerais e outros métodos baseados em conhecimentos anteriores, religiosos, sociais e culturais, bem como atitudes e crenças que são prevalescentes na comunidade tendo em vista o bem estar físico, mental e social.

Annex 6. Slides of debriefing

External Evaluation – Wiwanana

Cabo Delgado, Mozambique

Debriefing, March 7, 2011
February – March 2011

Methods

- Desk review
- Interviews: MISAU, SDC, WHO, national and provincial NGO partners, DPS, DDS, Prov. / District Government, WB/CD, PISCAD
- Field visits Chiure / Ancuabe: village assemblies, 'balanços', rural radio; focus groups
- Meetings / working sessions with WW teams
- Data analysis on services outputs
- Discussion preliminary findings Chiure/Pemba
- Debriefing SDC/Maputo

Evaluation criteria

- Relevance (technical; perceived)
- Effectiveness / intermediary results / 'outcome'
- Efficiency / project management
- Sustainability: technical, socio-cultural, institutional, financial

Intervention logic of WW

ProDoc / LogFrame:

- 3 clear and rational specific objectives (SO)
- Rational vision on phased WW development
- Clear link between key activities /expected results and baseline knowledge
- Clear, concrete vision on transition phase towards independent WW institution, with proposed milestones and key activities
- Risks described; however, fall-back scenarios not sufficiently described

WW approach (1)

Strong features:

- Synergy between WW and other SM projects – focus on 'district health'
- Design of interventions based on prior knowledge
- Multiple, synergic IEC techniques
- Community at the center of interventions
- Group approach; checks and balances; close, frequent contact between WW teams and communities

Approach (2)

but:

- 4 themes: selective PHC? Rationale? Flexibility?
- 'Empowerment': expected results clear? sufficiently addressed with standard IEC messages?
- Limited involvement DDS teams in operations, due to project approach and limited capacity
- Limited health systems knowledge in WW teams
- Large managerial dependency on SM / ext TA; local ownership among WW team growing, but still limited
- Imbalance in attention: SO-1++; SO-2+-, SO-3+-

Relevance

- Health status: SM/WW important contribution in poor area with poor health status
- WW bridges large gap between demand and supply
- WW fits well in provincial PESS
- Large potential for contribution to policy devt
- High perceived relevance: policy makers, local government, NGO partners, community
- But: WW also adds to fragmented sector development, due to project approach

Effectiveness (0)

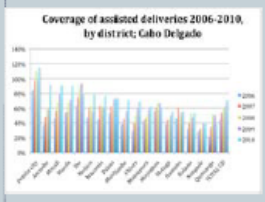
1. SO-1: community empowerment; maintaining health and preventing disease
2. SO-2: WW transformation into autonomous local entity
3. SO-3: Capitalization; policy dialogue; advocacy

Effectiveness / SO-1 (1)

- Positive effect on health services utilization / demand
- Impressive maternal care interventions
- Convincing results water / sanitation
- Perceived results +++
- Voluntary VCT ++

but:

- OPD trends less convincing
- Trends morbidity unclear.



Effectiveness / SO-1 (2)

and, :

- Increased service utilization not sufficiently adressed (e.g. C-sections in Ancuabe?)
- Selected PHC: some health problems not adequately addressed (e.g. TB!)
- Insufficient data on CAP, but: possibilities for meta-analysis of past CAPS, and for appropriate design of CAP-2011/12
- 'Empowerment': do we see what was intended?

Effectiveness / SO-2

- Some managerial / procedural steps taken towards autonomy
- After 2008: change towards business-like environment; start with consultancy services

but:

- Transition process seriously delayed
- Important *first* steps not yet taken: 'unique selling point', vision, future market position
- Lack of consensus on way forward (SDC; SM; WW)
- Implementation of project activities (SO-1) gets more attention than development of full-fledged WW business plan and PR (SO-2/3).

Effectiveness / SO-3

- Interesting (draft) documentation exists on practices and lessons learned
- Much potential for more scientific papers

but:

- Purpose of 'WEP' not clear among SDC, SM, WW, despite clear prodoc
- Opportunities for capitalization of field experiences not fully explored
- Policy dialogue (provincial; national) insufficient

Efficiency & Project Management (1)

- Clear planning and management procedures
- Strong budget discipline
- Impression: value for money
- Stringent control of financial transactions

Efficiency & Project Management (2)

but:

- Doubts about competitiveness of salaries for required managerial key position(s)
- Current profile of managerial staff not entirely adequate for future tasks (PR; acquisition; advocacy) of independent WW
- Some savings / low budget execution rates difficult to justify? (e.g. missions)

Sustainability (0)

- Political
- Socio-cultural & technical
- Institutional
- Financial

Political sustainability

- WW fits in PESS, DPS approach for community involvement, and in national policies
- Willingness by government to co-finance, despite lack of resources

but:

- Not clear if the complex WW concept will hold against trends to mainstream 'slimmer' approaches and strategies
- Project approach contradicts SWAP principles; fragmentation and high transaction costs

Socio-cultural (and technical) sustainability

- Change in habits likely (anecdotal evidence; no confirmation by CAP)
- Increased skills and knowledge among community members constitute important asset

but:

- Duration of change in habits unknown

Institutional / organizational sustainability

- Opportunity for new WW: in Cabo D., lack of CBOs
- SDC likely to support organizational change process
- Other CPs at least supportive to new WW

but:

- Future position key CPs in Cabo D. unclear (incl WB)
- Slow pace of transformation and lack of pro-active PR and marketing of WW concept at provincial level may lead to missed (market) opportunities

Financial sustainability

- WW fully dependent on external funding (CPs; SM)
- WW:value-for-money, but expensive due to massive inputs for community health only (2.7 US$ / cap / yr., versus total health exp. 18 US$ in 2007 – source: HSDP appraisal 2009)
- Market situation: still important unknowns (HSDP – mainly supply oriented?; SDC in HSDP?; SM – own funds?; USAID – support to national NGOs?), and also some clear opportunities (Glazer; SDC support to DPS)
- Future financial scenarios for new WW insufficiently explored (SO-2)

Recommendations (SO-1)

- Further promote comprehensive PHC / district health: identify funding for basic surgery in Ancuabe (SM? SDC/WW?); involvement in TB/DOTS; malnutrition
- Use information from field to adjust content of messages and to improve dialogue
- Carry out meta-analysis of past CAPS and design methods for CAP to measure results and to establish baseline for new WW (2011?)
- Improve M&E on health services outputs and coverage

Recommendations (SO-2) – (1)

- Move faster to autonomy of WW; avoid lengthy procedural processes
- *First*, define core business and USP; brainstorm on SWOT; refine market analysis; based on these building blocks, develop concrete business plan, including robust risk analysis; define urgent next steps
- Seek concensus on businessplan asap.

Recommendations (SO-2) – (2)

- Also: Revisit WEP's role (PR / acquisition, policy devt, capitalization / documentation) and define managerial positions accordingly
- *Then*, after concensus, fill key positions and vigorously, pursue PR, market analysis; intensify dialogue / negotiation with key CPs, including SDC
- And: contract senior Mozambican additional senior manager (to lead PR, acquisition, ext dialogue), and apply targets and bonus/malus arrangements

Recommendations (SO-3)

- For WEP / institutional development: see SO-2
- Redress balance between implementation (SO-1) and capitalization (SO-3)
- Accelerate informing policy makers and general public, by compiling existing, interesting documentation already available.

Maputo, 7 Março 2011

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