EUROPEAN COMMISSION

Evaluation of the Actions of Handicap International in Mozambique under the Financing of the European Commission

Final Report

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FINNCONSULT
MANAGEMENT CONSULTANTS AND CONSULTING ENGINEERS

”The author accepts sole responsibility for this report, drawn up on behalf of the Commission of the European Communities. The report does not necessarily reflect the views of the Commission”.

CONTENTS

ABBREVIATIONS

ABC	Ministry for Social Action Programme for Community Based Support for Disabled People
ADEMIMO	Association of Disabled Ex-soldiers of Mozambique
ADEMO	Association of Disabled of Mozambique
CBR	Community based rehabilitation
CND	National Demining Commission
CRIM	Children's Rehabilitation Centre of Malhangalene
CVM	Red Cross of Mozambique
DAG	Directorate for Administration and Management of the Ministry of Health
DPAS	Provincial Directorate of Social Action
DPS	Provincial Directorate of Health
EC	European Commission
ELAL	Ministry of Health Leprosy Program
HI	Handicap International
ICRC	The International Committee of the Red Cross
KEPA	Service Centre for Development Co-operation, Finland
MICAS	Ministry for Co-ordination of Social Action
MINED	Ministry of Education
MISAU/MoH	Ministry of Health
NAD	Norwegian Association of Disabled
NGO	Non Governmental Organisation
NORAD	Norwegian Development Agency
PAI	Ministry of Social Action, Programme of Institutional Support
PEPAM	National Co-ordination of Education Activities to Prevent Landmines and Other Explosive Devices Accidents
PNUD	United Nations Development Programme
POWER	Prosthesis and Orthotics World-wide Education Relief
SMFR	Ministry of Health, Service for Physical Medicine and Rehabilitation
UNDP	United Nations Development Programme
UNHCR	United Nations High Commission for Refugees
USAID	United States Agency for International Co-operation
UXO	Unexploded ordnance
WHO	World Health Organisation

EXECUTIVE SUMMARY

OVERVIEW

The European Commission has been supporting the activities of Handicap International in Mozambique since 1986 when the organisation began its work in the war-ridden country. The early projects aimed at the creation of workshops for the direct provision of orthopaedic appliances, extending later to the organisation of training courses for physiotherapy and orthopaedic technicians and the rehabilitation and expansion of the network of physiotherapy services. Social interventions and mine-awareness campaigns added new scope to the organisation's activities. A more institutional phase of working within the Ministries of Health and Social Action began in the mid-90s, whilst more recently the mine-awareness campaign evolved, in the province of Inhambane, into actual demining activities.

The activities have been implemented through individual projects, funded from different sources, including among others, the EC, the French Cooperation, the Swiss Cooperation, NORAD, USAID. In 1998, the European Commission commissioned the Finnish consultant company Finnconsult to undertake an evaluation of the actions of Handicap International in Mozambique under the financing of EC. This evaluation was the first one to be carried out of the already closed or still on-going projects of HI in Mozambique.

According to the Terms of Reference, the purpose of the evaluation was to carry out an overall analysis of the impact of the financed actions and the performance of Handicap International in Mozambique in order to assure better quality of similar actions for future beneficiaries with respect to identification, design, relevance, efficiency, effectiveness and sustainability of these actions. Close attention was to be paid to the evolution of the political and socio-economic context in Mozambique, as well as the evolution of the policies and approaches of various actors involved in the sector. Meeting with the direct beneficiaries was emphasised and the use of participatory methods strongly encouraged.

This Report presents the main findings, conclusions and recommendations of the evaluation team.

The evaluation is based on the study of the available documentation and project files; field visits to the on-going projects in Maputo, Nampula, Cabo Delgado and Inhambane provinces; interviews with the project personnel, counterparts and other relevant national, provincial and district authorities as well as with other donors and implementing agencies active in the sectors; and finally, on focus group discussions with beneficiaries of various projects; i.e. clients of orthopaedic centres, mothers of disabled children, villagers, community representatives.

The HI structures its various activities in three main areas, namely in paramedical activities, social interventions and mine programmes which include mine-risk education and proximity demining. This provided a useful interpretive division also for the evaluation team. Though principally evaluating the activities financed by the EC, the team has tried to situate them in the overall context of the actions carried out by Handicap International in Mozambique. However, some

important non-EC funded projects, such as the Programme of Institutional Support with the Ministry for Co-ordination of Social Action, have only marginally been mentioned and should be analyzed more in depth than has been possible here.

THE MAIN FINDINGS OF THE EVALUATION

Relevance

To assess the relevance of the projects, the evaluators were trying to find an answer to whether the projects implemented by Handicap International have made sense within the context of their environment and whether they are in line with the needs of the beneficiaries. While the evaluation highlights some weaknesses, in general terms the evidence gathered supports the view that the projects have been relevant in the rapidly changing political, economic and social situation in Mozambique.

In terms of paramedical activities HI has filled an important gap in the assistance to war injured and other physically impaired population. Over the years, HI opened a total of six orthopaedic workshops in five provinces. HI's intervention extended to supporting the rehabilitation, construction and equipment of physiotherapy units as well as training physiotherapeutic and orthopaedic technicians. More recently, the organisation engaged in the support to a new official structure in the Ministry of Health, the Sector of Physical Medicine and Rehabilitation (SMFR).

The activities of HI to support the freshly created national NGOs of disabled, ADEMO and ADEMIMO have their rationale not only in addressing the needs of disabled people but also in the changing policy environment of the early 90s when the "civil society" in the form of local non-governmental organisations entered the Mozambican scene.

The mine-awareness campaigns in Tete and Zambezia, in 1993 and 1994, were implemented immediately after the war when hundreds of thousands of refugees and displaced people were returning to their home districts. Awareness of mines was at its lowest at that point and thus information of mine-risks was of vital importance. However, one can ask whether technical and financial inputs could have been more efficiently channelled through existing bodies such as the Mozambican Red Cross, who were already working with mine-awareness programmes. The same applies to the initial phase of the National Co-ordination of Education Activities to prevent Mine and UXO accidents (PEPAM) which was commenced in 1995. As for PEPAM, its relevance must be assessed bearing in mind that though mines still exist in Mozambique, by now people are more informed and know relatively well which areas to avoid. In the present context knowing what to do in case one suspects to have found a landmine and to whom to pass the information seems to be the main needs of the direct beneficiaries at the community level. PEPAM has been able to respond fairly well to this need and the process of integrating mine-risk education in the national education system makes a lot of sense.

Project preparation and design

Project preparation and design is one of the weakest point of HI. None of the projects presented

for EC funding use a logical framework. Objectives, activities and beneficiaries are not clearly defined, nor are expected result or indicators. There is very little reference to government or sector policies. It is almost impossible to assess to what extent counterparts and beneficiaries were consulted. Analysis of factors affecting compatibility and sustainability is lacking as is any reference to possible feasibility studies carried out.

The poor quality of the project proposals does not signify that the projects themselves were poor, nor that only projects with measurable results are worth implementing and financing. But it means that evaluating the projects is extremely difficult not knowing where one wanted to go, with whom, by which means and, why. Secondly, some of the difficulties HI has had particularly in phasing out its projects might have been avoided if more attention had been given to the project design and to a clearer definition of various actors´ roles, and what is more important, this sould have been done in closer co-operation with counterparts and beneficiaries. Good project planning and design are among the crucial factors contributing to, or impeding, success of projects. Logical framework is at its best a very practical tool in the process of planning. It should however be remembered that no tool can replace participation of counterparts and beneficiaries in the process.What are their experiences, problems, suggestions? Only through understanding better how local social, political and cultural structures work can one respond to local needs with more sustainable solutions.

Efficiency

Evaluating the efficiency between various activities and projects results is made extremely difficult by the fact that most projects have funding from various other donors besides the EC. It is almost impossible to estimate the total costs of the projects. A clearly stated organisational set-up for the project implementation specifying the involvement of counterpart staff is also lacking. Thus almost the only base for assessing cost-effectiveness is to look at the way the projects have used technical assistance as a mean to achieve the expected results - which unfortunately are not clearly spelled out either. Expatriate costs in general have represented one of the major items in the budget.

The older projects in particalur have relayed on expatriate advisors, the number of whom seems in some projects quite out of proportion. For example in CRIM expatriate staff were working for the first five years without counterparts and even today the involvement of MoH staff consists of just one physiotherapist. The cost-effectiveness of technical assistance is in these circumstances very low when measured against the criteria of training and capacity building of local counterparts.

Only 4 of HI's 25 expatriate staff are currently working on paramedical projects. After the responsibility for the orthopaedic workshops was handed over to the MoH, technical assistance is not included anymore in the activities at provincial level. Since the creation, in the MoH, of the Sector of Physical Medicine and Rehabilitation (SMFR), which grew out of a proposition by HI itself and benefits of its technical and financial assistance, activities are carried out by the Mozambican technicians supervised by the Head of the provincial SMFR section and Head and Deputy of the SMFR at central level. There is still no technician trained at degree level in SMFR, although three people are currently continuing their studies in France

The first mine-awareness campaigns in Tete and Zambezia were staffed by expatriate advisers with few counterparts. The following programmes witnessed a closer co-operation with various national partners. Also by now, the great majority of staff working for PEPAM is Mozambican and, although they are paid by HI, the experience gained from the activities at least stays in the country after the project is finished.

Effectiveness

The evaluation team was quite at loss in trying to assess the relationship between initial project purpose and achieved results in order to evaluate the effectiveness of the projects. The project documents or reports do not make reference to expected results and the specific objectives are on a very general level. For example, what should one make out of the information that in the Malhangalene Rehabilitation Centre 78 children participated in social and sport activities and 99 home visits were paid during three months. Is this what was planned? More? Less? What is the relationship between these results and the purpose of the projects, i.e. the physical rehabilitation of disabled children and their better integration within the family, community and school?

Similar remarks can be made of the production of orthopaedic appliances, or of the number of people “sensitised” in mine-awareness campaigns. For instance, was the production of 3061 new appliances in HI’s workshops in 1995 high or low? Against which targets and standards? What to make of the fact that 55 per cent of this production is made up of crutches? Numbers often have a reassuring quality but what is their significance in relation to projects? And how do we know whether the production responded to the beneficiaries’ need? How and by whom were these needs defined? Only in the last years there begins to be a calculation of standard production and treatment of the data now collected by the SMFR.

The orthopaedic workshops and physiotherapy units are largely under-utilised. No feasibility studies were carried out of the need for the construction of orthopaedic centres nor have the reasons for the low utilisation of the units, particularly by women, or client satisfaction been studied.

Impacts

Results in relation to the orthopaedic workshops are positive, in as much as the six workshops created by HI are all functioning reasonably smoothly, and their transfer under MoH responsibility and management has been achieved. Combined with the more recent action of the SMFR and reflected in the sector's existence itself, HI's input can be acknowledged for achieving a higher 'visibility' of the workshops and physiotherapy units within the hospitals and provincial directorates of Health, already translated in some case into their inclusion in the allocation of the Health budget. A positive impact is also built up from training of basic and mid-level physiotherapy and prosthetic technicians.

It is still too early to gauge the long term effects of the much effort put into setting up the monitoring and recording system. However, a reliable use of forms is a complex issue requiring the co-ordinated functioning of different parts and is actually a long-standing issue in which the sector's workers had traditionally had little and inconsistent training. Thus trying to put an order into it and make it work for the whole country would be a momentous achievement.

On a more problematic side, the impact of a growing and increasingly vocal professional category attracting financial and technical inputs to their area of work may induce distortions in the current distributions of MoH resources. The use of relatively expensive and sophisticated equipment can reinforce a habit of dependency from imported foreign materials and induce the belief that 'therapy' only happens when using such instruments.

The positive impact of Malhangalene Centre are mainly to be found on the level of direct beneficiaries of the Centre's activities, disabled children and their mothers. The centre has been a place to come and have physiotherapeutic assistance to children and at least moral support from others in a similar life situation. The impacts on the capacity building of counterpart have been minimal. The possible foreseen negative impacts are also related to the direct beneficiaries. They are the ones to feel the consequences, if the pessimistic visions of the present staff on the sustainability of the activities after the withdrawal of HI should come true.

An important impact of the mine-awareness campaigns in Tete and Zambezia provinces was the lessons drawn for the future mine-awareness activities. An unforeseen impact has most likely been the importance that the mine-awareness and demining projects have gained both financially and in human resources within the HI-Mozambique. Capacity building of the national counterpart, the National Deminig Commission, as well as of officials from provincial governments and district administrations, has not been the strongest point of the project PEPAM. The positive impact can be witnessed on various other partners: local structures, communities, communities leaders, district level education structures, teachers who seem to be quite involved. Mine-risk education activities together with demining activities have raised people's expectation and demands for quick and immediate demining: an unavoidable impact that can have negative implications. HI's actual demining activities have been carried out for too short a time to have had much impacts for the surrounding communities.

Sustainability

Evaluating the financial sustainability of the projects is a somewhat absurd exercise in the present reality of Mozambique, where most of the donor projects have little chance of being financially sustainable, at least in the short term. An important question to ask is whether the positive effects of the projects can be sustained institutionally and whether they are socially and culturally sustainable. A related question is whether all activities need be sustained.

Currently the national health services depend about 80% from external aid. The whole system is facing great problems in terms of its planning and management capacity. The provincial representatives of SMRF were not trained in management and planning by the advisors while they were working in the provinces. Training is only taking place now.

There are plans for a gradual transfer on the MoH of financial burdens currently beared by the organisation, with support from its different donors. This includes essential items such as conservation and maintenance of buildings and equipment, regular supervision visits, training and placement of new trainees, and regular supply of materials. The question is whether the MoH and the SMFR would be able to obtain a similar level of support from donors without depending on the mediation of HI. A separate but related question is whether the SMFR has acquired the

technical competences for implementing those activities. This seems likely, considering that staff at central level has been receiving technical assistance for four years, although of course much specialised work still needs doing, particularly in relation to the integration of logistical activities in the general system of the Directorate for Administration and Management currently being restructured.

The sustainability of the activities in the case of the Malhangalene Children's Rehabilitation centre is not very promising . This is partly due to the insufficient involvement of the counterparts in the project planning and implementation, and partly to insufficient understanding of the real life situation of disabled children and their families. Alternative solutions in addressing the needs of beneficiaries could have been more sustainable in the long run.

As a whole, mine-risk education activities have good chances of being relatively sustainable if one succeeds in integrating them into the national education system as part of the curricula. Intensive mine-awareness campaigns will loose some of their dynamism once HI withdraws its human and material resources but it is not necessary to sustain them at present level for decades.

The demining programme in the province of Inhambane seems to have succeeded in training the local technical staff but capacity building of the provincial structures is not assured. The original objective of the project, to create provincial demining capacity without outside financing, is now being revised.

THE MAIN RECOMMENDATIONS

The main recommendations can be divided into those aiming at better project planning, design and monitoring; improved knowledge bases and their use; participatory approaches and integration of activities into the national structures.

Poor project preparation and design was identified as one of the major weaknesses of HI. This does not only have negative implications to the implementation and phasing out of the projects but also makes evaluation of them very difficult. It is therefore recommended that:

- *the European Commission should not continue to finance projects that are not reasonable well designed and prepared, regularly monitored and individually reported if it wants to be able to supervise and evaluate those projects*

By reasonably good design the evaluation team is referring to the use of logical framework and other guidelines in project preparation. A logical framework must not become a straightjacket but the documents should formulate the objectives and purpose of the project clearly; define the expected results and indicators to verify the results; plan the activities and means to achieve them. The project documents should include an analysis of the compatibility and sustainability of the proposed actions. It is recommended that:

- *Handicap International pays serious attention to improving its project preparation and design and arranges, if need be, training on these matters to its staff and counterparts. During the project preparation, compatibility of the proposed actions with the national*

systems as well as the need and qualifications of technical assistance should be carefully analysed and negotiated with the counterparts. The same should be done in relation to the phasing out plan including an assessment of counterparts´ ability to take over in the end of the project.

The possible continuation of the support to paramedical and mine-risk activities should be decided against the above recommendations. In the continuation of the support to SMRF one should be careful not to create hypertrophied parallel structures in relation to information systems and physical and human resources, including expatriates. In general, the process of strengthening one technical sector should be balanced and take into account the general strategy of development of the health sector.

It is the view of the evaluation team that participatory approaches, capacity building of counterparts and integration of HI activities into national structures have to be deepened. This can mean slower progress and less visibility for HI in the short term but the long term effects are more likely to be more sustainable. A more balanced use of sectoral expertise in relation to wider development needs and processes of counterpart, be they ministries, local associations or counterparts, is essential. Some projects are more advanced in these matters but in general weaknesses in this area have led to repeated extensions of the projects. It is therefore recommended that:

- *direct dialogue, consultation and feedback from the direct beneficiaries should be included in a systematic way into the projects and programmes in order to better meet the local needs. Particularly in those actions that involve community participation, for example, mine-risk education activities, a special care should be taken to avoid working methods and activities that can make people feel that they are helping HI to implement its programmes, and not the other way around.*

And that:

- *the capacity building of the counterparts is given more emphasis including more equitable decision making, resource management, policy choice and information available to all concerned in Portuguese. Since the onset of activities, training plan for resource planning, management and administration should be a part of any new project.*

HI, and NGOs in general, should critically reappraise their role within the Mozambican reality, which seems to become increasingly one of intermediaries for fund channelling even when counterparts have, or should have been trained to have, the relevant expertise to autonomously present and manage funding proposals. This deepens the dependency on individual donors and weakens the global planning and management capacity.

One of the conclusions of the evaluation has been that many activities were planned and implemented with insufficient knowledge of the existing reality, be that the real-life situation of disabled people, or how local social, political and cultural structures work, how decisions are made, how counterpart organisations work and what are their weaknesses and strengths. The evaluation team recommends that:

- *knowledge bases and their use is improved and strengthened. Adequate monitoring,*

feasibility studies and research should be included and financed in the projects and programmes. A study should be carried out of the reasons that prevent the effective use of orthopaedic centres and physiotherapy services. Plans for any new infrastructure to be created should be based on feasibility study that justifies the need and assesses the availability of human resources, material and sustainability of the recurrent costs.

However, the recommendation should not be interpreted as a call to only produce more data. One should also make sure that existing data is used.

Finally, in its work with disabled people and the local association of disabled people, HI should not lose sight of the fact that, for all its good intentions, it is not an organisation of disabled people, but rather an organisation of professionals with a specific area of expertise. "Professionals should be *on tap*, not *on top*" (David Werner).

1 INTRODUCTION

1.1 BACKGROUND OF THE EVALUATION

Handicap International began its activities in Mozambique in 1986, in the context of emergency interventions funded by the European Commission. In the twelve years of its presence in the country HI has extended its paramedical interventions in the establishment, management support and training for physiotherapy and orthopaedic services. Social interventions and mine-awareness campaigns were included in the programme in the early 90s. Actual demining activities in the province of Inhambane were more recently added into the programmes.

A total of 13 contracts have been signed between the European Commission and Handicap International for an amount of ECU 5 631 617 funded through different budgetary instruments including Emergency funds, Co-financing and Budget Lines. None of the projects has been financed solely by the EC but has also had funds from thre organisation itself and/or from other donors. However, only occasionally do project files report the value of those other contributions.

In 1998, solicitated by Handicap International itself, the European Commission commissioned an evaluation of the actions of the NGO in Mozambique under EC financing. The EC and HI considered to be useful "to evaluate the programme as a whole in order to draw lessons for the future# (TOR, annex 11). The evaluation was the first one to be carried out of the already closed or still on-going projects implemented during the years. With the exception of an internal evaluation of the course for basic-level physiotherapy technicians in Pemba. Apart from this, an exploratory mission effected by BARIC visited demining activities in the province of Inhambane. However, the mission document was reportedly not ransmitted to the organisation.

The evaluation team started its work in the end of September 1998, and this Report presents the main findings of the team. The leader of the evaluation team was Dr. Elva Tenorio Lopez, Public Health specialist, the other members were Ms Satu Ojanperä, sociologist and Ms Elena Medi, physiotherapist and expert in Orthopaedics and Physiotherapy.

1.2 OBJECTIVES OF THE EVALUATION

The broad purpose of the evaluation is outlined in the Terms of Reference thus:

the objective of the evaluation is to carry out an overall analysis of the impact of the financed actions and the performance of Handicap International in Mozambique in order to assure better quality of similar actions for the future beneficiaries in the future with respect to identification, design, relevance, efficiency, effectiveness and sustainability of these actions.

Furthermore it was specified that the evaluation will pay close attention to the evolution of the political and socio-economic context in Mozambique, as well as the evolution of the policies and approaches of various actors involved in the sector. The evaluation was to cover the period between 1986 – 1998, the main emphasis being on the period that began from the peace accord

in1992. In order to get a general vision of HI's actions and on-going projects, the team, following the propositions of HI staff visited and analysed a project not financed by the EC (PEPAM, MICAS).

The Terms of Reference are reproduced as Annex 11 of this Report.

1.3 METHODS AND APPROACHES OF THE EVALUATION

The TORs for the evaluation outlined some general approaches and methods. These comprised a briefing and a debriefing meeting at the Commission offices in Brussels; a visit to the headquarters of HI in France; and a field phase in Mozambique including a briefing and a debriefing meeting with the Delegation, HI and national authorities. During the fieldwork the evaluation team was expected to visit as many projects as possible; meet with the project personnel and national counterparts as well as all relevant national and local authorities, donors and implementing agencies active in the sector. Meeting with the direct beneficiaries was emphasised and the use of participatory methods strongly encouraged.

The evaluation work period was five weeks from the end of September until the end of October. The field work was carried out from 1 October to 28 October. Besides report writing, briefing and debriefing meetings, the evaluation consisted of:

- a study of the relevant documentation and archives available in the Delegation and Handicap International
- field visits to the on-going projects in Maputo, Nampula, Cabo Delgado and Inhambane provinces
- interviews with the project personnel, counterparts and other relevant national, provincial and district authorities, other donors and implementing agencies active in the sectors
- focus group discussions with beneficiaries of various projects; i.e. clients of orthopaedic centres, mothers of disabled children, villagers, community representatives

The HI structures its various activities in three main areas, namely in paramedical activities, social interventions and mine programmes which include mine-risk education and proximity demining. This provided a useful interpretative division which the evaluation team has used in the analysis of various activities. Though principally evaluating the activities financed by the EC, the team tried to situate them in the overall context of the actions carried out by Handicap International in Mozambique.

In the course of carrying out the evaluation, the team collected a great deal of information on various stakeholders expectations, experiences and viewpoints. That material was vital raw material for the main findings and conclusions of this Report. The team wishes to acknowledge a debt to all those who gave their time and shared their thoughts with the team, at time extensively and very thoughtfully. Special thanks go to the Delegation of EC and Handicap International in Maputo for the support provided all along.

Annex 9 lists the persons consulted during the evaluation mission.

2 MAIN FINDINGS

Handicap International's activities in Mozambique, described below, began with projects aimed at the creation of workshops for the direct provision of orthopaedic appliances. Following this first phase, the NGO identifies now in its history a second phase of extension and consolidation of the activities, which also includes the organisation of training courses for physiotherapy and orthopaedic technicians and the rehabilitation and expansion of the network of physiotherapy services. Social interventions and mine-awareness campaigns added new scope to the organisation's activities. A third and more institutional phase of working within the Ministries of Health and Social Action began in the mid 90s, whilst more recently the mine-awareness campaign evolved, in the province of Inhambane, into actual demining activities.

This work was implemented through individual projects, funded from different sources, including among others, the EC, the French Cooperation, the Swiss Cooperation, NORAD, USAID. Globally considered, they make up what the organisation calls its 'Mozambique Programme', which currently functions with 25 expatriates and 250-300 Mozambican personnel, with activities in the ten provinces of the country and a budget for 1998 of FF 28 million (about 4 180 000 ECU). The organisation, however, does not refer to a programmatic document, such as a 'master plan' or a 'country strategy paper' or the like, where its mission statement, overall aims, means, expected results and phasing-out plans would be laid out, and against which its progresses and future directions could be charted. The different projects did overlap frequently in their timing as well as in their targets (see the analysis of project files in Annex 8, Project Summary Forms), hence becoming interlocked and part of a wider picture, but this picture appears to be the result of an ex-post design which is not necessarily evident, and agreed upon, neither for donors nor for partners or counterparts.

2.1 PARAMEDICAL ACTIVITIES

2.1.1 Background and development of the activities

Orthoproshetic workshops

Paramedical activities, namely the production of prostheses and other orthopaedic appliances, were HI's original trademark and the object of its first interventions in Mozambique. They are still considered by the organisation itself as its core area of action, the backbone of their programme. HI had gained a reputation in the early 80s in South East Asia for producing simple, low cost artificial limbs, especially out of bamboo, according to what is known as appropriate technology. At a time when the war in Mozambique had become more intense, HI joined Medicines Sans Frontieres-Belgium in the province of Inhambane, in response to a request for support to populations affected by the war launched by the Mozambican government.

Mozambique had, in colonial times, just one orthopaedic centre, in Maputo, which had become inoperational. After independence (1975) and originally to provide appliances for Zimbabwean guerrillas injured in the course of their fight for independence (achieved in 1980), the International Committe of the Red Cross (ICRC) had set up a modern orthopaedic workshop in the Maputo Central Hospital. This remained the only orthopaedic facility in the country well into the worst years of the last Mozambican war, with the easily imaginable consequences of

congestion and long delays in the provision of appliances (i.e. prostheses and wheelchairs, for double amputees), compounded by the difficulties of flying in people from the different provinces according to some sort of rota system, and by the even more difficult task of getting them back again after their appliances were made.

It is in this context that Handicap International set up its two first orthopaedic workshops in Inhambane Province, one in the northern district of Vilanculos (1986) and one in the provincial capital, Inhambane (1987). This intervention responded to a specific government request and to the clear need of making a service locally available, thereby avoiding travelling and further risks to the affected population.

Soon after the construction of the two workshops, two 'Transit Centres' were also built to host the workshops' users. This drained quite a lot of energies and time, particularly the Vilanculos centre (see Annex 10, HI's 1991 Annual Report), but by 1992 the two centres were completed and functioning. Although attached to the hospitals, both workshops and Transit Centres were separately funded and administered by HI, managed by expatriate technicians and staffed by a number of local workers trained and employed by the organisation - some of whom, according to HI's practice in other countries, were disabled themselves.

The institutions were to be placed under responsibility of the Ministry of Health (MISAU), but this soon proved to be a difficult issue. For a start, the transfer of the workers onto MISAU payroll became contentious, since several of the lacked MISAU entry requirements, and their number didn't tally with existing staffing plans of the province. A compromise was finally reached and some of the workers later admitted, but the organisation complained about the ministry's alleged irresponsiveness for many years (see Annex 10, in particular 1991 and 1992 Annual Reports). Consequently, due to this first experience, the workers who were reqruited in the centres were already part of the hospital staff or were a result of the training courses held between 1991 and 1994.

As for the transit centres, they remained under HI's administration until 1995, when their integration into the provincial structure of MICAS was achieved. Partial financial support to the centres, from the projects funded by the French cooperation is provided up to (see Annex 10, April-June 1998 Report).

The organisation extended its activities in 1990 and 1991, building a new workshop in Nampula and coordinating the opening of the Tete orthopaedic centre (a joint action UNICEF/MISAU). The Nampula workshop was only to produce orthoses, as a prosthetic centre was already operational, set up sometime earlier by the ICRC. Finally, two more workshops were built by HI in Lichinga and Pemba, the former in 1993, the latter eventually completed in November 1996 after a long history of mishaps with MISAU, requests for project extensions and requests for new funds (see Annex 8, Files N. 6 and N.9).

At that point, in 1996, a total of 6 expatriate personnel and 17 local staff (out of 92 local staff paid by HI in all the projects) were involved in paramedical activities, including training (see further). All orthoprosthetic workers were already employed byMISAU, with the exception of just four workers employed by HI. The financial support to these workers ended at the end of 1996. On the other hand, all material supplies, administration costs and maintenance of the

workshops continued to be provided directly by the organisation.

At that stage, the orthopaedic availability in the country had substantially progressed from one workshop in the early 80s to ten workshops by the mid 90s. Of these, four had been set up by the ICRC:

- in the Central Hospital of Maputo, the first and oldest,
- in the Central Hospital of Beira,
- attached to the Central Hospital of Nampula,
- and a smaller workshop in the Provincial Hospital of Quelimane.

Handicap International had been setting up the remaining six:

- in the Central Hospital of Nampula, orthotics only,
- in the Provincial Hospital of Inhambane,
- in the Provincial Hospital of Tete,
- in the Provincial Hospital of Lichinga
- in the Provincial Hospital of Pemba,
- and in the District Hospital of Vilanculos.

With the consolidation of peace after 1994, the ICRC withdrew from the country and its activities were taken over by the British NGO POWER, with funding from USAID, whilst HI stayed on, continuing the long announced process of transferring the responsibility for its workshops onto the Ministry of Health. This process was only completed in 1997. As for POWER, its contract expires at the end of 1998, when all the workshops will be managed directly by the ministry through the SMFR.

Currently, there is now one orthopaedic workshop in each province except Gaza and Manica. The two complementary workshops in Nampula are already in the process of being unified (a new building is under construction attached to the former HI workshop), and the district workshop in Vilanculos should , according to plans, be dismantelled. The Sector of Physical Medicine and Rehabilitation (SMFR) of MISAU, to which HI is adviser, has drawn up plans which include the opening of one new workshop in the provinces of Gaza and Manica as well, thus having one orthoprosthetic facility in each province. This is reflected in a new important project proposal submitted by HI to the EC.

Training and physiotherapy sector

In 1990 HI became involved in the organisation and technical orientation of two courses, for mid-level Physiotherapy Technicians and basic level Orthoprosthetic Technicians, to be run within the training facilities and according to the criteria established by the training department of MISAU. The courses, funded by USAID, began in 1991 and enrolled 25 and 20 students respectively. However, the ministry incurred in some difficulties in placing the newly graduated orthoprosthetic technicians, and was forced to accept HI's offer to anticipate their salaries (see Annex 10, 1994 Annual Report). For these and other reasons, a new course for basic level Physiotherapy Technicians, initially planned for 1994, could only start in 1996 in the Centre for Health Studies in

Pemba. This course, funded by the French Cooperation and British High Commission, ended in 1998, graduating 27 of the 34 students initially matriculated.

Almost in parallel with the training and the development of the orthopaedic network, but especially during 1995-96, HI also provided technical advisers and/or material support for equipment and buildings of 16 physiotherapy services, with funds from the EC and other sources. These services are:

- a unit in the Nampula Central Hospital (attached to the workshop),
- units in the Provincial Hospitals of Inhambane, Tete, Xai-Xai, Lichinga, Pemba (attached to the workshop),
- units in the Rural/District Hospitals of Vilanculos, Massinga, Chicuque, Angoche, Monapo, Nacala, Namapa, Montepuez, Moeda, Mocimboa da Praia.

Another unit, in the Rural Hospital of Cuamba, was funded by the Canadian Cooperation with no participation of the EC.

Advisory role to the Ministry of Health and Creation of the Sector of Physical Medicine and Rehabilitation

By the end of 1996, all these actions had given the organisation a large influence over the orthoprosthetic and physiotherapy activities in the country and created the opportunity for scaling up its intervention. Indeed, within an interpretive timeframe suggested by HI's managers themselves (meeting at HI headquarters, 5/10/98), the organisation's work can be structured in three distinct periods:

6 orthop.centres 10 physio units	integration orthop.centres, 7 new physio units at district level	advisory role for policy, systems, management
1986---------->	1994---------->	1996----------->2001

Thus, the first period, from 1986 up to 1994, saw the organisation directly engaged in technical paramedical activities and the setting up of orthopaedic workshops. In the second period, untill 1996, HI's main concern was that of placing the workshops under MISAU management, and expanding the network of physiotherapy units at district level. A more careful approach is recognisable here: although the units were built/repaired and equipped by the organisation, they never became 'HI's units' in the way the workshops had been. Then, in the third period, after initial approaches already in 1993 and within a project initially funded by USAID, HI's technicians 'entered' the ministry itself, as advisors to a newly established central level structure that the organisation had contributed to shape. This structure, the Sector of Physical Medicine and Rehabilitation (SMFR), became operational as an official ministerial body, with provincial representation, in 1995. Since then, through an agreement with MISAU ratified in 1997, HI's role has become more that of a policy and systems adviser, working on the identification and definition of management procedures, information and monitoring systems, supplies and stock control, staffing and equipment levels, production standards, economic sustainability and cost recovery options for prosthetic and physioterapy activities. To complete this role and implement a wide range of other activities including the construction of the workshops in Gaza and Manica,

HI is submitting for EC funding the new project mentioned earlier (see Annex 10,, Projecto de Medicina Fisica e Reabilitacao. Autonomizacao do Sistema da Saude), with an end date by 2001.

The Malhangalene Children's Rehabilitation Centre and the Transit Centres

Two more interventions must be mentioned, borderline with the paramedical area. One is the Malhangalene Child Rehabilitation Centre (CRIM), which HI undertook to to build in 1991 reworking on previous plans of MISAU and introducing the aim of setting up a community-based rehabilitation (CBR) pilot project for disabled children in a populous *bairro* of Maputo. The project, funded at different stages by several donors including the EC, involved up to about 80-100 children at a time, with physiotherapy exercises carried out at the centre, home visits and other activities (see further Social Interventions, and File N.11 in Annex 8 for a more detailed analysis). It is debatable whether CBR is to be considered a medical, social, or even political activity, or indeed an intersection of all these. What is certain is that a CBR project not only must include community participation, and therefore a careful analysis of what is exactly a community, but it must respond to its felt needs in a way which is culturally acceptable, affordable and which will promote the community's *ownership* of the project. Unless these conditions are met, the project, from a paramedical perspective, will not differ substantially from a more or less well delivered out-reach activity - important as it may be. Whilst the main problem with the CRIM can be epitomized perhaps by saying that no local institution or organisation has been identified which would accept taking responsibility for it after HI's withdrawal later this year, in terms of rehabilitation activities it has responded, to a certain degree, to the need for more accessible rehabilitation services for children, which are otherwise only available at the Maputo Central Hospital. This opportunity is now lessened, however, by the changing social structure of the bairro. The project is mentioned here because HI, as well as the centre's director, are adamant in placing it within the health domain; however, the evaluation team has considered it essentially from the point of view of a social intervention.

The other activity which needs mentioning is that of the Transit Centres. This is not considered by HI as a paramedical issue, although obviously related to the effective functioning of the orthopaedic workshops. Indeed, with funds from the French Cooperation, the organisation itself has now embarked on a Programme of Institutional Support to the Ministry of Coordination of Social Action (MICAS), which has the institutional responsibility for the six Transit Centres in the country. Beside the ones set up by HI, three more were made on purpose in Maputo, Beira and Nampula with funds from different donors. Adding to these, the Old People's Home in Quelimane has long since acted as a Transit Centre and is now included as such in the Programme of Institutional Support.

As it has been said above, HI built, managed and financially sustained the Transit Centres in Inhambane and Vilanculos, slowly withdrawing according to the administrative capacities of the Provincial Directorate of Social Action. This process is still to be concluded (see Annex 10, April-June 1998 Report), mainly because of MICAS's lack of funds to run the centres. However, according to a plan drawn up by SMFR and retained in the new HI project proposal to the EC, the Vilanculos workshop should be closed and its assets transferred to the neighbouring Province of Gaza, currently without orthopaedic workshop. Consequently, the Transit Centre would be discontinued as well.

Finally, it may be interesting to note that there are no Transit Centres in Pemba, Tete and Lichinga: the users of those workshops are currently simply hosted in separate wards within the hospital compound under the general hospital management, without the need of any hard-to-manage separate institution. In the past, long delays in the production of prostheses justified, to a certain degree, the creation of a space separate from the hospital for non-sick long term patients. But in 1998, with workshops now far from overcrowded, and where an above-the-knee prosthesis can be made in a time which varies between 10 and 48 hours (according to SMFR itself, see Annex 10 Normas de producao nos Centros Ortopedicos, March 1998), things may look quite different.

2.1.2 Discussion against the criteria of the evaluation

Orthoproshetic workshops

It is undisputable that the creation of workshops has responded to a specific need of the country, offering the opportunity to create a national orthoprosthetic network . It is openly acknowledged, however, and it was plain during the visits, that the workshops are currently largely underutilised. Different explainations were given which go from lack of raw material (e.g. the Pemba workshop stopped production from June to September 1998), to lack of transport for clients from the districts, to low attendance rates for reasons which, indeed, do not seem to have been properly analysed. The current explaination given by the Health personnel at the workshops and at central level (SMFR), is that the institution responsible for the transfer of these clients to the workshops, the Ministry for Cooperation of Social Action (MICAS), can only provide a limited performance, due to its own limitations in terms of funds, transport, and personnel trained to the effect. For these reasons, HI established an agreement with MICAS for a Programme of Institutional Support (PAI), with funds for 5 million FF over three years provided by the French Cooperation (see Annex 10, HI's Quarterly Report April-June 1996). The programme began in June 1996 and is expected to better train MICAS staff and mobilise community resources in order to find alternatives to the lack of own vehicles that cronically affects MICAS's activities. The programme should also establish a better coordination between Health and Social Action workers involved in the identification, referral and follow-up of people needing the workshops' services, so that joint visits could be carried out and the use of transportation means rationalised.

However, there is no specific research on the needs for prostheses and other appliances, nor on the need for an orthoprosthetic workshop in each province. HI's project proposals only refer to global statistics published by WHO years ago, giving estimates of a prevalence of disability at around 7 % in Af rican populations, and a percentage of 0.5 for loss of limb, limb deformities and other debilitating conditions relevant to orthoprosthetics. Far from suggesting that yet another count of disabled people be conducted, perhaps the time has come to pull together the data available to make a better map of prosthetic needs. At the moment, information gathered at the Ministry of Health and the surgical services of the Central Hospital of Maputo mentions an average of 150 people with amputations per year in the hospitals of the country.

On the other hand, only now, with the development of SMFR, are the whokshops beginning to compare the *expected* production, that is the optimum average production capacity, with the *real* production. The average production capacity is calculated as being

- 10 prostheses/month/technician for the POWER workshops, and

- 4-6 prostheses/month/technician for the HI workshops

(see Annex 10, POWER Mozambique Quarterly Report, Sept.-Dec.1997, and Normas de Produção nos Centros Ortopédicos.) But this capacity is in any case severely underattained: POWER, which claims to be producing around 85 % of prostheses in the country, reports that its workshops produced in 1997 only 50 % of the optimum average appliances expected (same document).

However, this is still not yet an analysis of coverage. The central question is whether the workshops' capacity tallies with the existing needs? Six years into a new era of peace, it is legitimate to question whether, given the situation described, it is still relevant to stick to a plan which previewed a workshop in every province, and whether alternative solutions could not be more efficiently explored, without jeopardising anybody's entitlement to the use of the services of the workshops. The low level of attendance is a multifaceted phenomenon which is in need of a profound analysis. The reduction of the problem solely to geographical accessibility only augments the ineeffectiveness and inefficiency of the entire established system.

At the moment, the total number of technicians in the orthopaedic workshops is of 92 workers, of whom 23 are mid-level technicians, 29 basic-level technicians, and 40 are specialised workmen (orthopaedic shoemakers, carpenters etc.). What is this workforce producing? From a document by SMFR (see Annex 10, Estatisticas da Seccao de Medicina Fisica e Reabilitacao para o ano de 1997), in 1997 the total production of the ten orthopaedic workshops was of 5 626 items, of which 868 prostheses (16.2 per cent) and 187 wheelchairs (3.3 per cent). The workshops also repaired 1 812 items in the same year, of which 650 prostheses and 318 wheelchairs. In Nampula, for instance, whilst in one of the two workshops (ex-HI, with a technical staff of 11) several wheelchairs were awaiting repairs, the other (POWER, 7 staff) was producing prostheses - just for five people. In Pemba (8 staff) again there were only five amputees, recently arrived from the district of Montepuez. The bulk of the production, however, is made up of crutches and other walking aids (62 per cent of the total in 1997) - some for disabled people, some for those currently in hospital, and a larger number as a reserve for hospital wards and district physiotherapy units. All these numbers tell us little to assess the workshops' efficiency, as no initial targets had been stated. But again, the question stands out of whether the specialised production capacity of the workshops is best put to use.

A separate, but related issue, is that of the technology used in the workshops. One of the traditional tenets of Handicap International is the adoption of 'appropriate technology'. This includes the use of locally available material, usually cheaper and more 'cultural-friendly' than imported material. In relation to prostheses, commitment to appropriate technology initially implied the development of an artificial limb made of local wood and leather, and only needing simple tools to be crafted - rather different from the prosthesis made in the ICRC workshops, which involved wood too, but also resins, centrally made components and complex and expensive machinery. HI's prosthesis became commonly known as 'traditional', whilst ICRC's as 'definitive' - with reference to a promise made during the war years to injured soldiers that they would eventually be given that kind of prosthesis even if they had to be temporarily fitted with a simpler one.

Over the years, HI has improved the design of its prostheses, which have now a lighter vulcanised

foot and a cosmetic shaft. On the other hand, POWER has more recently introduced the use of polypropylene (PP), which needs to be imported but is much simpler and quicker to use. Thus, according to documents produced by SMFR (see Annex 10 Análise de uma Metodologia Tarifária ao nivel dos Serviços de Medicina Física e Reabilitação, Oct. 1997, and Normas de Produção nos Centros Ortopédicos, March 1998), if in terms of materials an 'appropriate technology' prosthesis is about 50 per cent cheaper than a PP one, in terms of time it takes more than 4 times longer to produce. In terms of costs, SMFR considers a streamlined cost per prosthesis between a range of 32 to 96 USD according to the complexity of the make.

Ultimately, however, the appropriateness of an artificial limb is decided by its users: people decided with their feet about the 'traditional' prosthesis, going great distances to try and get a 'definitive' one. In Pemba, we were told that people would effectively prefer to travel to Nampula to get the prosthesis of their choice. Similarly for the wheelchairs, people in Nampula remembered when the wooden model produced by HI was finally discontinued in favour of a metal one. Aware of this, but not wanting to displease any of their donors, and also to maintain the know-how of different prosthesis making, the SMFR, in one of its first resolutions, decided that all MISAU worskshops would offer both technologies, and a mixture of the two as appropriate: this choice has been termed "technical polyvalence", and technicians are currently undergoing (re)training in the different technologies.

Physiotherapy units

Similar considerations can be made for the physiotherapy services. Although, on the one hand, improvements to the physiotherapy units in the central and provincial hospitals and the extension of the rural network are generally considered an undisputable acquisition, on the other hand, again, the question of their use stands out. Who uses the physio units - and who doesn't? In all the units visited by the team (in Nampula, Pemba, Inhambane, Nacala, Namapa, Montepuez) activities were already over by 10-10.30 a.m., or even earlier in the districts (although occasionally, as one district director observed, some may turn up later 'to keep the body fit'). An old study reported on the 1983 issue of "Cadernos de Saude" (a magazine published by MISAU) revealed a prevalence of 'young-male-town dweller-with sport injuries' users of physiotherapy services: how much has this pattern really been changed by the interventions?

In 1991 HI identified a cause of the limited use of physiotherapy services in 'the lack of knowledge about the role of physiotherapy in the treatment of long-term bed-ridden patients... On the other hand, doctors often have just a vague idea of which conditions can benefit from rehabilitation' (see Annex 10 Relatório de Missão exploratória – Lichinga – 1991). In the visits made, this situation didn't seem to have changed much. Some of our respondents mentioned also the lack of rapid results, or the long duration of treatments, as reasons for discarding physiotherapy as an elective form of therapy, except for those living near the hospital. This is probably reflected in the disproportion between first visits and number of subsequent sessions, which shows that in the majority of the units people only go for the first visit (see Annex 10 Estatísticas da Secção de Medicina Física e Reabilitação para o ano de 1997).

Some discrepancies and imprecisions have been observed in the way different services keep their records, and particularly in the definition of 'treatment' as opposed to 'session'. There are, however, indications that standards are being sought in this area, such as the definition of the

(ideal) average number of 12 clients/ technician per day, with sessions of 30 minutes on average and about 15 sessions (three weeks) per client: currently the national average is 8 clients/technician for 9.4 sessions per client, clearly showing a low use of services.

Workers in the units are in total 122 (67 basic-level technicians, 54 mid-level and 1 with a higher qualification). Their integration within the hospital structure (participation to clinical sessions, coordination with the nursing department) is uneven. The technicians' activities are not clinically supervised by the hospital's doctors, although they are by the provincial Head of SMFR. On the other hand, the services visited had obvious advantages in comparison with other much busier services in the same hospitals, e.g. in term of personnel, infrastructure, equipment, and often co-exist somewhat incongruously with situations where services as essential as a laundry department are inoperational.

Training

Apart from the initial skill-training initiatives undertaken without coordination with MISAU, subsequent training activities are another area where HI's contribution can be deemed as being relevant. The organisation provided the necessary expertise and the opportunity for the ministry to run new courses for physiotherapy and orthoprostetic technicians, which would have been difficult for MISAU to organise, at a time when a new demand for this personnel had been created. However, as in many other professional sectors, the actual posting of trainees was not exempt from difficulties, related to the ministry's overall staffing plan and capability: temporary contracting was often required and, in some cases, the ministry was even obliged to borrow from the organisation itself in order to pay for the new workers' salaries (see Annex 10, 1994 Annual Report).

There is a clear need for further training and close supervision, particularly for those technicians who were on the very first courses run in the country soon after independence and are working on their own in more isolated localities.

The experience and enhanced confidence that the Director of the Pemba course for basic-level physiotherapy technicians has acquired from the HI advisor coordinating the course, seemed a successful example of capacity building. However, a touch of 'verticalism' can be inferred again from one respondent's comment that the students on that course were 'the Handicap students', and enjoyed better learning conditions and materials than other students on different courses.

Support to SMFR

Also this more recent facet of HI's activities can be deemed as highly relevant, given the previous lack of official structure to manage and supervise orthopaedic and physiotherapy activities. The introduction of new forms (for production, stock control, treatments, etc.) to match the creation of a regular monitoring and information system, the new work on production standards and statistical and economic analysis, and the support to supervisory activities, respond to a current need in MISAU and in the sector itself.

The impulse to the creation of SMFR and the orientation and support to its programmes are perhaps, among HI's paramedical activities, those with the biggest impact. Frequent visits,

contacts kept up, circulation of training material, organisation of meetings and seminars, even the (unofficial) support to the creation of a professional association, are helping to shape the outline of a professional body which had no previous representation, and little self-awareness and consideration. The fact that their views can now be heard, although far from regularly, in once exclusive clinical meetings does represent at least the beginning of a change. However, this very development can entail an excessive shift towards a self-centered growth, in a vertical advancement of the category which can induce distortions in the current distribution of MISAU resources.

The SMFR has currently 'only' 4 of HI's 25 expatriate staff (two directly working in the sector's office in MISAU, one for the introduction of the new PP technology, and one as a continuing support to the Northern region), plus one Mozambican staff to carry out technical research. Activities in the workshops and physiotherapy units are carried out by regular MISAU personnel no longer assisted by HI staff. But the national Head and Deputy Head of the sector, respectively orthopaedic and physiotherapy mid-level technicians, still have a daunting task in organising and running the sector, and although both have sharpened their skills considerably, it is likely that they would still need support from experts with higher training, particularly in the field of management, supervision, logistics and sector policy. This is the main purpose of the new three-year project proposal submitted by HI to the EC, 'to support the sustainable development of the sector of physical medicine and rehabilitation, within the scope of the global support to disabled people in Mozambique' (see Annex 10, Projecto de Medicina Física e Reabilitção. Autonomização do Sistema da Saúde). It seems rather surprising, however, that in a project which should mark the smooth withdrawal of the organisation, five or six expatriates would still be deemed necessary, even if not all full time and to be reduced over the three years. The value of the project is 2 312 193 ECU, of which 327 220 ECU should be provided by MISAU, 80 000 ECU by HI itself, and the balance of 1 904 973 ECU by the EC.

Currently HI provides about 74% of the funds needed by the SMFR at central level (about 70 000 USD). SMFR's calculations of the funds needed to run the whole sector's activities (orthopaedic workshops and physiotherapy units) amount to about 372 000 USD, which the ministry can provide only partially. The preoccupation is to secure a long-term form of financial autonomy, such as bilateral cooperation or equivalent, so as to avoid dependency on short-term funds channeled though NGOs (see Annex 10, Planificação Financeira da Secção de Medicina Física e Reabilitação e dos Servicos de Medicina Física e Reabilitação para o ano 1999, SMFR May 1998). Swiss Cooperation has recently launched the proposal of creating a pool of donors for the Health sector, supporting decentralisation and integrated planning at provincial level (SWAP initiative) via a long-term non-conditional fund. SMFR and HI hope that the sector's budget be included in the one presented by the National Directorate of Management and Administration as one of the priorities for funding by the pool.

2.2 SOCIAL INTERVENTIONS

2.2.1 The Malhangalene Children´s Rehabilitation Centre

The purpose of the Malhangalene Children´s Rehabilitation Centre (CRIM) is rehabilitation of disabled children and their better integration within the family, community and school. Integration

of the centre into the national health system, participation of disabled children´s parents and involvement of the surrounding community in the centre´s activities were defined to be the objectives of the second phase which started in 1994 with co-financing from the EC.

Originally the activities started in 1990 with plans to rehabilitate a building belonging to the Ministry of Health in the Malhangalene suburb which at that time was a poor neighbourhood housing an increasing number of low-income families and refugees. The first phase included construction activities, identification of disabled children, contacts with various local partners and rehabilitation services for children coming from Malhangalene and Maxaquene suburbs.

How the project was initially justified, why the needs of disabled children and their mothers were best seen to be met by opening a rehabilitation centre and to what extent the counterparts and beneficiaries were involved in the process is impossible to say now almost ten years later. The same applies to the project proposal of the second phase. There is no reference to government and sectoral policies or analysis of compatibility and sustainability. Lack of the analysis of the economic and financial feasibility and institutional capacity of the counterparts is particularly worrying considering that the second phase, originally planned to cover the years 1994 –1996, was to be the consolidation phase during which the centre would be integrated into the national health system. Why the activities aimed to support the physical rehabilitation of disabled children were not already at the outset integrated in the national health system is not clear.

The project has relied heavily on technical assistance. Since the beginning of the project until its originally expected phasing out in 1996 the centre had at least one, during some years two expatriates advisors working without counterparts. Only in 1995 a Mozambican director was employed by HI to work together with the advisor. Today the centre is still managed by HI personnel, though since last year she is finally Mozambican. The involvement of the Ministry of Health staff consists of one physiotherapist. ADEMO has provided 6 assistants of whom 5 are remaining. However, they can be integrated into the health personnel only as aides because of their educational qualifications. This probably means that most of them will leave the centre once it is handed over to the Directorate of Health of the City of Maputo in a few months time.

The project proposal prepared in 1994 for the second phase defines on a very general level the objectives and activities. No expected results or indicators are presented which makes measuring the achievements against objectives rather difficult.

From the actual beginning of the project in 1992 until now physiotherapeutic assistance has been provided altogether to 412 children. The number of children receiving assistance in the centre has varied yearly between around 80 to 100 children. Today the number of children assisted in the centre is 103 besides which 37 children are visited at home. In the first quarter of 1998 twenty families were supported financially to pay the school fees, funerals or medicines. At the same time 10 straw chairs and 3 wheelchairs were given to children. However, it is not possible to assess whether these figures correspond to what was planned nor how they relate to the purpose of CRIM, i.e. physical rehabilitation of disabled children and their better integration within the family, community and school.

Of the other objectives specified in the project proposal only the rehabilitation of the multipurpose room has been achieved. A reference and information centre has not been created

and the workshop for prosthesis fabrication was closed down. Integration of the centre in the national health system, originally planned to be achieved by the end of 1996, then by the end of 1997, is still pending.

Community involvement was defined as one of the objectives but "community"- however it was conceived - does not seem to have been involved in any substantial way in the centre´s activities during the years. At least it is not so today. Community participation has not increased beyond children from nearby coming to play in the centre´s playground or football field.

Women as mothers of disabled children are by definition the direct beneficiaries but to what extent the project has been sensitive to their specific situations and whether their participation in the planning of centre´s activities has been a reality is difficult to say. During the discussions with the mothers they seemed generally satisfied of the assistance offered to their children. Many come from quite far, some even from Costa de Sol or Matola, which for them is quite a sacrifice in transport costs, and also in time. Only 4 mothers who visit the centre live anymore in Malhangalene.

For the women the main preoccupation is the lack of money to support their families, to buy food, medicine, daily necessities. Some were quite frustrated with the experiences they had had with the income-generating micro projects implemented by ADEMO/HI. Women had registered and participated in workshops. After that nothing had happened, only money was wasted to phone and inquire about what is happening. One woman was quite angry: she is alone taking care of eight children and has to struggle really hard to make means and ends meet. Then one spends time and money only to find out that nothing comes out of the income-generating micro projects that one has hoped so much from. Others agreed and spoke about the difficulty of working outside the home due to the lack of nurseries for disabled children.

It seems that the early years of the centre were characterised to some extent by charity functions. Some of the mothers who had visited the centre already in 1994 said that at that time they received milk and sugar, sometimes other things. That has now changed.

Probably the main positive impact of the centre´s activities has been the mental support it has provided for mothers most of whom live in a very difficult social and economic situation. Most of them are single, separated or abandoned heads of households burdened with daily struggle to maintain several children with very meagre economic means. On top of it they are faced with problems of taking care of a disabled child. Meeting other mothers with similar life situation in the centre can help them not only to feel less isolated socially but also to get support from each other and find solutions together. According to the present director of the centre, the physiotherapeutic assistance offered at the centre to the children has increased their mobility thus making it easier for mothers to take care of them and with better care disabled children have lived longer. Home visits have made it possible to offer help to those mothers and disabled children that cannot come to the centre.

However, for an outsider the story of Malhangalene Rehabilitation centre seems quite a sad one of good intentions leading up to an artificial creation. There is a beautiful well equipped building, assistance offered to disabled children and finally a relatively regular use of the centre. And yet nobody seems to want to manage it. Attempts to integrate the centre in the national health system

has taken years but, as the director of the centre put it, it is like putting an add to a newspaper: Wanted! HI is looking for somebody to take over the centre, possibly one of the local associations working with children. In her opinion it would have been wiser to work from the beginning within the national health system and perhaps with alternative solutions like, for example, creating modest mini-centres in different neighbourhoods where those already working within the health system could have also addressed the needs of disabled children..

The centre will be handed over to the Directorate of Health of the City of Maputo in a few months time. The present staff is rather pessimistic about the future. Home visits will most likely end and most of the present staff cannot be integrated in the ministry´s health personnel. Even the location of the building itself is today far from optimal. Malhangalene suburb has witnessed a rapid change from what it was when the project started to what it is now: a rather affluent neighbourhood with better-off families, new infrastructure and an enormous shopping centre. Consequently few of the families with disabled children visiting the centre live in Malhangalene anymore.

2.2.2 Structural support to ADEMO and ADEMIMO

ADEMO (Mozambican Disabled People Association) and ADEMIMO (Mozambican Disabled Militaries Association) are young national non-governmental organisations. ADEMO was created in the end of 1989 and ADEMIMO few years later, in 1992. For HI they were natural local partners and consequently both of them were supported in their initial stage. Co-operation with ADEMO has continued through the years in spite of rather strained relations which at times have characterised the relationship between the two organisations. With ADEMIMO the co-operation came to an end only few years after it was initiated. ADEMO counts that it has today around 60 000 members and ADEMIMO 10 000 members.

HI´s structural support to ADEMO has been financed by various donors, EC among them. There has not been any specific support project to ADEMO but some of the project proposals to EC have included a component aiming at supporting the organisation. For example the proposal "Assistance to Displaced Persons in Mozambique" (see Annex 8, File N. 3) financed since 1989 and extended until 1993 includes institutional and organisational support to ADEMO as does the continuation of the project with a new name "Assistance Towards the Return and Reintegration of Handicapped Persons to their District of Origin" financed in the years 1993 and 1994 (see Annex 8, File N. 7).

Views of what activities have been supported by EC via Handicap differ totally depending on whom one is speaking with. According to the representatives of ADEMO, financing the construction of the new headquarters is the only support they have received from EC. They did get technical assistance, organisational and material support to strengthen both the national headquarters and provincial offices but that was financed by NAD (Norwegian Association of Disabled). According to representatives of HI the construction of the new headquarters has never been even partially financed by EC. Perhaps who has been financing what is not all that important in practice but it is confusing if one tries to evaluate the structural support to ADEMO. One is also quite at loss in trying to figure out what activities have been implemented by HI in its support to ADEMO and what are the activities ADEMO itself has been implementing with HI acting only as a financial intermediary.

The picture becomes even more confusing when in the discussions with the representatives of ADEMO it turns out that the main problem in the relations with HI is the lack of information and transparency. Representatives of ADEMO feel that they do not have copies of project proposals, budgets, reports etc and cannot thus know what has been agreed between the donors and HI nor what the reports presented in their name contain. There should be more transparency in co-operation from both sides according to the representatives of ADEMO. They also would like to have projects financed directly by a donor without northern NGOs as intermediaries. Unfortunately donors do not trust local NGOs but how do we develop our capacities and become adults if we are always dependent on others to manage our affairs, the representatives of ADEMO ask.

The representatives of HI, on their side, consider the lack of trained people in ADEMO as the main problem. The association is thought to be somewhat introspective with difficulties of accepting professionals – accountants for example – or other new people from outside the organisation to work with them. On the positive side it is seen that ADEMO is functioning more independently as an organisation and has been able to build its capacities as a result of the co-operation. That is also seen as one of the positive results by ADEMO itself. Another positive result has been the co-operation in the Mozambican campaign to ban landmines which according to the representatives of ADEMO was rather successful and made Mozambique known outside its borders.

Structural support to ADEMIMO was a component of the project "Assistance Towards the Return and Reintegration of Handicapped Persons to Their District of Origin" financed partly by EC during the years 1993-1994. The support included help in dealing with the legal requirements to register the association, administrative costs for the national and provincial offices, training of the staff in accountancy and management, technical assistance and a car.

Co-operation between the two organisations seems to have been difficult from the beginning. According to the chairman of ADEMIMO they were very inexperienced and felt that criterions for co-operation were missing, or at least were not clearly spelt out. Staff of the provincial offices was even more inexperienced and untrained. There were problems with money sent to provincial offices either due to financial misuses or simply because the staff did not know how to keep accounts and manage finances. Lack of experience also prevented ADEMIMO from benefiting from the technical assistance the way they could have nor did the advisor grasp how inexperienced people he was working with. Both sides were disillusioned and co-operation came to an end.

Training of the new staff, help in the creation of the provincial branches and installation of the organisation are recognised as the positive results of the co-operation with HI.

2.3 MINE-RISK EDUCATION AND DEMINING ACTIVITIES

2.3.1 Mine-awareness campaigns and mine-risk education activities

HI`s involvement with mine-awareness campaigns dates back to 1993 when awareness raising

activities were initiated in the provinces of Tete and Inhambane. A separate project proposal was submitted to EC in 1994 for "Mine-awareness Campaign, Tete and Zambezia Provinces". Originally the project was to last one year 1994 – 1995. It was however extended several times until June 1996. The campaigns of Tete and Zambezia provinces were merged into the firsts phase of the Programme of National Co-ordination of Education Activities to Prevent Landmines and Other Explosive Devices Accidents (PEPAM) which covered the period between June 1995 - June 1996. Although the second and the present, third phase of PEPAM are not financed by the EC even partially, they are part of the process that started with the Tete and Zambesia mine-awareness campaigns. Thus looking at the present activities of PEPAM one has an opportunity to see what was learnt from the Tete and Zambezia campaigns. Lessons learnt have probably been their main impact although in all likelihood the campaigns also had achieved results in preventing mine accidents.

The purpose of the Tete and Zambezia campaigns was to raise the level of awareness of the existence and problems caused by the mines among rural and returning populations. The estimates for the provinces of Tete and Zambezia centred around 800 000 refugees and around 900 000 displaced people which were expected to return to their home districts. Together that represented about a half of the rural populations in the provinces. The mine-risk awareness was probably at its lowest at that point and thus there really was a need for information. People were not aware of what had happened while they were away and consequently did not know what areas to suspect to be mined.

Community involvement in mine-awareness activities was one of the objectives of the Tete and Zambezia campaigns. It is very difficult to evaluate to what extent the communities actually were involved at that time. The final report of the project does not make any reference to community participation in Tete. In Zambezia initial steps to work through the local structures and communities seem to have been taken. Committees were created in the communities and the co-operation was deemed very positive at least by HI itself. Co-operation with the counterparts does not seem to have been close. The projects were staffed by expatriate advisers and local awareness agents employed by HI. Involvement of the counterpart staff from the provincial governments appears to have been rather minimal.

The campaigns included training of the awareness agents, production of campaign material, awareness meetings and collection of information of suspected mine areas. Radio programmes in local language in Tete and theatre groups in Zambezia were used on a limited scale to transmit the messages.

According to the final report during the one and half a year campaign in Tete 98 853 people were "sensitised" in 716 different places in 9 districts. 129 mined areas or areas that were suspected to be mined were identified. During the project in Zambezia province which lasted from June 1994 to July 1995 almost half a million (450 820) people were calculated to be "sensitised", 3 300 meetings were held and 708 places visited in 15 districts of the province. The number of areas identified with mines or suspected to be mined was 516. No statistics of mine accidents are available. Unfortunately these very exact numbers tell very little of the way they were put together or how "sensitised" was defined. The only conclusion one can draw is that the figures for Tete campaign are low compared to the number of "sensitised" people in Zambezia although the NGO claims that data gathered have allowed a better understanding of how accidents happen,

hence improving the content of their message.

What were then the lessons learnt from the Tete and Zambezia mine-awareness campaigns? Today PEPAM is a wide programme implemented in all of the provinces of Mozambique. Besides the more traditional awareness type of activities it encompasses several interlinked activities under the mine-risk education. Most of the activities as such are not new and were already included at least in the plans of Tete and Zambezia campaigns. However, the activities are designed better and what is more important, the way the activities are carried out has undergone significant changes. This has also implications to the sustainability of the activities.

One of the main lessons learnt appears to be the importance of working with and through local structures and partners. Instead of HI implementing a massive campaign in a short period of time, the strategy now is to involve, and to offer support, to existing local structures to include preventive work in the activities they already carry out. The most important among them are provincial and district staff of Education, Social Welfare, Health and Police as well as Mozambican Red Cross. Committees have been created at district and community level to co-ordinate the mine-risk education activities. Besides representatives of the Education, Health etc, the committees often include religious and community leaders.

The evaluation team discussed with the committee members, provincial and district representatives of the most important partners, teachers, district administrators and beneficiaries, children and community representatives. As a gross generalisation it can be said that the district administrators were least involved and more critical, teachers and school authorities were most involved and very enthusiastic. Mine-risk education was considered important by the school authorities and easy to include in the teaching. Also the teaching material PEPAM has provided was greatly appreciated in the situation where schools lack everything. The Committees and community leaders were also rather involved though for example in Nacala Velha one could not but wonder how long the initial enthusiasm would last. The Committee – the Handicap Committee, as they themselves called it - was formed few months before. Its members had participated in the 2 days course offered by PEPAM, liked it very much and wanted more and longer courses. If not salaries then at least some per diems and help with transport was considered rather necessary to carry out the mine-risk education activities.

It is almost inevitable that any outside organisation faces these expectations. The crux of the matter is to succeed in getting people to participate not because they gain some material benefits but because it is their programme. "Ownership" is a difficult issue but unless there is local commitment the sustainability of the activities is questionable. People participate when they feel the problem to be theirs but want also to influence and have control over the activities. Mines are part of people´s daily reality and people seem to be quite worried about the mines. The role of PEPAM should be to help local communities to find solutions to the mine problems, not the other way around: local communities should not feel they are helping HI to implement its programme.

Another major lessons learnt from the Tete and Zambezia campaigns appears to be that education is not something anybody can do. One needs professionals both in mass communication and in work with the schools. In practice this has meant that PEPAM has recruited pedagogical technicians to work with the integration of mine-risk education in the national system of education. The Teachers Guide was prepared together with the staff of National Directorate of

Basic Education, the radio programmes "Danger –Landmines!" are done by professionals of Consorcio-Radio, professional theatrical groups are used to train local groups, specialist are used in designing communication tools and so on.

A third lessons learnt seems to have been that follow-up, self-reflection and evaluation of the activities needs to be given serious attention. As a result strengths and weaknesses of various activities in the programme have been analysed and used as bases for future planning. This seems to have improved the definition of the key partners, their roles and needs of technical support. Awareness tools and their use in different settings have been diversified and pre-tested. Differentiated strategies per province have been elaborated. A good sign of the learning capacity of the organisation is the way it uses feed-back: weaknesses were identified in knowing what actually have been impacts on beneficiaries and in understanding the socio-cultural context of the programmes. Consequently PEPAM has been planning, and also succeeded in getting financing, for a proper impact evaluation of this nature to be carried out in the near future. This can only be deemed as very positive, not only because of the conclusion that can be drawn from the study but it should also help to develop more refined indicators to measure the achievement of the programme´s objectives.

The capacity building of the counterparts to take over the responsibility of the activities after the phasing out of HI is problematic in most of the HI implemented projects, and that is also the case with PEPAM. The conclusion of the inability of the National Demining Commission (CND) to substitute HI in its role in supporting education activities to prevent mine accidents was reached in the end of the second phase. What the bases of this conviction were is not clear but as a consequence "privileged partners" were to be chosen to carry out in the future the activities regarding the danger of landmines.

During the discussions with various partners and staff of PEPAM one was faced with almost as many different "exits" as there were discussions. For many the Mozambican Red Cross for mine-awareness education and National System of Education for integrating education regarding the danger of landmines were the answer. Some thought that Social Action should carry out the work of PEPAM, others that it should be CND, alone or together with provincial governments. Considering the difficulties HI has had in phasing out its projects and that PEPAM has only one more year to go, the situation seems rather blurred.

On the other hand, how long does one need to carry out the more traditional type of awareness campaigns, radio programmes, theatre performances? Should one succeed in integrating mine-risk education into national education system as a part of curricula, much of the future mine-risk education needs will be at least minimally taken care of. Unfortunately, irrespective of the positive steps taken into this direction, there still seems to be a long way to go. The representatives of the National Directorate of Primary Education, for example, considered that in spite of working with HI during the last year and a half, the co-operation was still in a very initial and ad hoc level. Criterions for co-operation were seen to need a clearer definition so that the MINED would have a say in matters concerning primary education and revision of curricula. Few examples were given: the staff had participated in the preparation of the Guide for Teachers – Awareness Regarding the Danger of Landmines and other Explosive Ordnance but had no say in deciding how many copies would need to be printed to satisfy the needs of teachers. The actual number of impressions, 10 000, was considered totally insufficient. Another example was the advisor

planned to start working with them: what would be his/her job description, expertise, qualifications?

2.3.2 Demining in Inhambane province

The project was requested by the Provincial Governor, who was interesed in demining on a small scale, decentralised, with independent teams and increased mobility. In 1994 HI decided to get involved in proximity demining activities and establishes a link with its mine-awareness programme. In 1995 the programme's objectives were defined as follows: “to provide means, training and equipment to implement a demining of proximity through a structure managed by the province. The 3 years program will work in 4 districts: Vilanculos, Massinga, Morrumbene and Inharrime.” However, actual demining activities did not begin until January 1998, 19th (see Annex 8, File N. 13). The NGO's approach to the Inhambane project is concerned with the implemention of a concept of humanitarian proximity demining aimed at 'giving back' access to safe paths to small communities, and involves a high component of communication with them.

It is far too early to assess the socio-economic impacts of the demining activities carried out by HI in the Inhambane province. First demining operations started only in January 1998 in the area of Nhaduga. Operations in the area of the Catholic mission in the Mocoduene district and in the area of Mazoonda School and dip tank were initiated even later this year. Consequently only small parts have been cleaned and implications of these operations are yet to be felt.

The team visited the Catholic mission which before the war had a school and a hospital run by the mission. The small town close by was an active centre of the economically important area. Vegetables were cultivated in the fertile soils and sold to markets of Inhambane. Irrigation systems were functioning and yields were high in normal years. Another important source of income for the neighbouring communities were coconut and cashew trees which are abundant. The war changed all this.

In the end of 80s RENAMO burnt the small town down and took over the mission. People fled. The Catholic mission was a battleground and was at some point taken over by FRELIMO. Today the small town and the mission is almost totally destroyed. People have built traditional thatched mud houses in the town and reparation works have started in the mission. Fields are cultivated again though people are worried about the mines. After the war when people started to return, the Catholic mission witnessed three mine accidents in four months.

The demining operations of HI were considered very positive by the representatives of district administration and education authorities as well as by the representatives of communities, traditional and religious leaders were met during the visit. They were however somewhat perplexed about the slowness of the operations and expressed great concern of having the demining teams as soon as possible also in their villages and fields. Especially the community leaders seemed committed and active in mine-risk education activities but either the message that all mined areas would never be cleared had not been understood or then the visit was seen as an opportunity to propagate the importance of demining the areas close to their communities.

When asked how the mines affected their daily lives, the answers varied. Obviously life was freer before: one could go where ever one wanted without being afraid, on that everybody agreed.

Some said that the risk of mines had made people afraid to cultivate certain fields, others that the mines represented danger for small animal husbandry. Others thought that there was enough land to cultivate even if one avoided the areas suspected to be mined. The scarcity of good land was felt only in times of drought like the one now when the rains were late. Nobody considered that mines prevented people from fetching firewood from the forest or water from the water sources. The demining teams were agreed to have behaved correctly; there were no problems in their relations with the nearby population.

3 CONCLUSIONS

3.1 RELEVANCE

To assess the projects' relevance, the evaluators were trying to find an answer to the question whether the projects implemented by Handicap International have made sense within the context of their environment and whether they are in line with the needs of the beneficiaries. As it can be expected, the role of various groups of beneficiaries and partners, their needs and the policy environment vary from project to project. The beneficiary groups have also undergone significant changes over the years. Mozambique witnessed rapid and profound economic, political and social upheavals in the period during which Handicap International has been implementing its projects in the country. Particularly the war years, and those immediately following the peace agreement in 1992, were difficult for any organisation working in the country, especially outside the capital. Handicap International deserves recognition for being one of them, its staff probably working at times in extreme situations, in ever changing social and political environment. Furthermore HI has worked in an area, that of provisions for disabled people, which nowhere in the world is the top priority of governments or societies at large. This is the case in Mozambique as well, despite the adoption of a health system based on the principles of Primary Health Care, of which rehabilitation is indeed one of the essential components (see WHO, Report of the International Conference on Primary Health Care, Alma-Ata 1978).

3.1.1 Paramedical activities

Paramedical activities undertaken by HI are relevant to the needs of people needing orthopaedic and physiotherapy attention. Beginning its activities in 1986 in a war context, at a time in which only one prosthetic workshop run by the International Committee of the Red Cross existed in the country, HI filled an important gap in the assistance to war injured and other physically impaired population. Over the years, HI opened a total of six orthopaedic workshops in five of the ten provinces of Mozambique, extending its support to the rehabilitation, construction and equipment of sixteen physiotherapy units. The organisation also run training courses for physiotherapy and orthoprosthetic technicians. More recently, HI began transferring management responsibilities for its orthopaedic workshops to the respective Provincial Hospitals and Provincial Directorates of Health. At the same time, the organisation engaged in the support to a new official structure in the Ministry of Health, the Sector of Physical Medicine and Rehabilitation (SMFR). This was created in 1996 out of a proposition from HI itself and currently benefits from its technical and financial assistance. The SMFR technically supervises and coordinates the work of the physiotherapy units and orthopaedic workshops nation-wide.

3.1.2 Social Interventions

The activities of Handicap International in support of the recently created national NGO's of disabled people, ADEMO and ADEMIMO, have their rationale not only in the purpose of the organisation of addressing the needs of disabled people, but also in the new opportunities for intervention opened by the changing policy environment of the early 90s, when the "civil society" in the form of local non-governmental organisations entered the Mozambican scene. It would not

have made sense not to support them, considering that disabled people were the target population of Handicap International's projects. Support to the Malhangalene Children's Rehabilitation Centre is a more complex question. From the viewpoint of beneficiaries, the disabled children and their mothers using the services of the centre, the project has probably been able to address at least some of their needs. Whether it was, or it has been, in line with accepted policies of health intervention, or represented instead a new strategy not thoroughly elaborated and agreed with the health authorities, is a bigger question. Whether the needs of beneficiaries would have been better met with alternative solutions is also open to speculation.

3.1.3 Mine-risk education and demining activities

It is difficult to say so many years after the implementation of the mine-awareness campaigns in Tete and Zambezia, in 1993 and 1994, how well they met the "mine-awareness needs" of the intended beneficiaries, the rural communities, returning refugees and displaced people. It is certain, however, that the projects did make sense in the political and social context of the moment. If ever there is a need for a mine-awareness campaign, it is in circumstances such as these, where almost half of the rural population have been dispersed and have little experience of mines, and do not know what happened in the area while they were away. However, one can ask whether technical and financial inputs could have been more efficiently and appropriately channelled through existing national bodies such as the Mozambican Red Cross, who were already working with mine-awareness programmes. The same applies to the initial phase of the National Programme of Co-ordination of Education Activities to Prevent Mine and UXO accidents (PEPAM), which started in 1995.

The relevance of PEPAM's third and final phase must be assessed in a different context. In spite of years of demining activities, mines still exist in Mozambique and will continue to exist for several decades. They still kill and cause accidents. What has changed, is the level of awareness of mines, partly due to the campaigns, partly due to the fact that people have settled and know better, or at least suspect, certain areas to be mined and consequently avoid them. In this context, the information of what to do in case one suspects to have found a landmine, whom to pass the information to and what happens then, does seem to be an important need of the direct beneficiaries, people themselves and their representatives at the community level. That PEPAM has been able to answer to this need can be assessed as positive and relevant. The same applies to a specific group of direct beneficiaries, children. Attempts to integrate mine-awareness themes in the national educational system can only be deemed to make a lot of sense.

3.2 PROJECT PREPARATION AND DESIGN

This is one of the weakest points of Handicap International. The poor quality of project proposals is not related to only one project but it is a general characteristic of all of them. Even the projects prepared in mid-1990s define very vaguely objectives, activities and beneficiaries. None of the project documents of the projects financed by European Commission use logical framework or other existing methodological tool, nor describe expected results nor indicators to verify whether results or objectives have been achieved. There is very little reference to government or sectoral policies. Analysis of factors affecting compatibility and sustainability is lacking, as is any reference to possible feasibility studies carried out. Evaluating the projects has thus been extremely difficult.

Furthermore, the projects had not been evaluated before, except for in the course of an exploratory mission effected by BARIC whose consultants visited demining activities in Inhambane province , and an internal evaluation of the Pemba course by Maryvonne De Backer, from HI central staff.

3.2.1 Paramedical activities

Projects developed in this area are often overlapping, but their 'tails' or interrelations are difficult to trace from available documentation, making it difficult to grasp the global scope of HI's actions. Since the initial agreement with the Mozambican authorities in 1986 and up to the mid-1990s, activities have been adding to one another, building up a design which is revealed *ex-post* in the organisation's own reports, but which is not traceable in an overall document (such as a 'master plan' or a 'strategy paper') to be submitted to partners and counterparts and agreed upon in its components, long-term responsibilities and implications. Thus, it is difficult to chart the organisation's progresses and future directions, or make an informed decision on whether to become partners and for what.

Project justification is usually resolved by quoting general WHO estimates of disability prevalence, or merely by listing HI's previous activities, or in some instances simply by annexing declarations obtained from health or administration authorities. Prosthetic needs are regularly taken for granted: they do not appear to be questioned or analysed anywhere. Beneficiaries are generically indicated (e.g. "the handicapped of the province") and there is a persistent confusion between people in need of an orthopaedic intervention (for instance, hospital patients) and disabled people (not all of whom may need or want an orthopaedic intervention).

On the implementation side, project timeframes needed to be extended almost constantly. The financial structure, the way in which funds have organised, is difficult to understand because there are usually several donors. In reading the files one easily got lost trying to figure out money fluxes (see further, Efficiency). Although it was definitely not included in the team's tasks to carry out any type of auditing (which had been carried out satisfactorily on a few occasions), it seemed hard just simply to try and match specific financial inputs with specific results achieved.

3.2.2 Social interventions

The poor quality of project proposals does not necessarily mean that the projects themselves were poor. However, some of the great difficulties that Handicap International seems to have had in phasing out its projects, Malhangalene Children's Rehabilitation Centre can serve as an example, might have been avoided if more attention had been given to the project preparation and design. It is almost impossible, some ten years after the project was originally designed, to assess to what extent counterparts and beneficiaries were consulted at the time, or to what extent alternative interventions were considered. It is always easy to have *ex-post* wisdom, but with better planning, clearer definition of the various actors' roles and integration in the health system sought since the very beginning, the future of the Malhangalene Children's Rehabilitation Centre after HI withdrawal would probably look brighter.

3.3 EFFICIENCY

Evaluation of the efficiency between various activities and projects results is made difficult by the fact that most projects have funding from various other donors besides the EC. Firstly, it is almost impossible to estimate the total costs of the projects. Secondly, evaluating the projects' efficiency is difficult due to the lack of clearly stated organisational set-up for the project implementation, specifying the involvement of counterpart staff. Thus almost the only base for assessing cost-effectiveness is to look at the way projects have used technical assistance as a mean to achieve the expected results - which unfortunately are not clearly spelt out either. In general, projects have relayed on expatriate advisors, the number of whom in some projects seems quite out of proportion.

3.3.1 Paramedical activities

Project costs higher than initially calculated resulted from lack of proper consultation with relevant ministerial departments, and from poor set-up definition. This appears to have been the case in the construction or rehabilitation of buildings for workshops, physiotherapeutic units and transit centres. A case in point is Pemba, where the costs for building the workshop went well beyond the original previsions, spanned over different projects and used up much of the organisation's and ministerial counterpart's energies. Independent training of personnel, irrespective of ministerial requirements or human resources plans, was another reason for low efficiency, since their integration in the official structure needed intensive efforts from both sides. However, this problem seems to have been lessened since the creation of the Sector of Physical Medicine and Rehabilitation (SMFR).

3.3.2 Social interventions

Only expatriate staff have been working at the Malhangalene Centre for the first five years, not taking into account the aides and guards who were also paid by HI. Today the Centre is still managed by HI personnel, though since last year the director is finally Mozambican. The involvement of Ministry of Health staff consists of one physiotherapist. The cost-effectiveness of technical assistance is in these circumstances very low when measured against the criteria of training and capacity building of local counterparts.

When evaluating how efficient the support to ADEMO has been, one is faced with difficulties of knowing what that support actually consists of. Opinions of what activities EC has financed via HI differ completely depending on whether one is discussing with representatives of ADEMO or HI. Project files do not help much and once again the conclusion is that the project preparation, involvement of counterparts, organisational set-up of the projects and project monitoring leave much to wish for. And again, this does not mean that the support has not been efficient, effective and produced positive effects in the circumstances. There just is not sufficient information to assess the efficiency.

ADEMIMO, created in 1992, received support in the form of equipment, training of its staff both at central and provincial level, and technical assistance. The relations seem to have been rather strained and after few years the co-operation came to an end. According to ADEMIMO, the organisation was too inexperienced to benefit from the technical assistance, and the advisor did not grasp how inexperienced were the people he was working with. Both sides were disillusioned

and criterions for co-operation were felt to be missing.

3.3.3 Mine-risk education and demining activities

The first mine-awareness campaigns in Tete and Zambezia provinces were staffed by expatriate advisers, apparently with little counterpart staff from the provincial governments. The following campaigns witnessed, however, a closer co-operation with various national partners. Particularly in the present phase impressive steps have been taken to integrate a great variety of local partners at community, district and provincial level for the implementation of activities. Also by now, the great majority of staff working for PEPAM is Mozambican. Though HI pays them, the experience gained from the activities at least will stay in the country after the project is finished.

3.4 EFFECTIVENESS

Assessing the relationship between initial project purpose and achieved results in order to evaluate the effectiveness of the projects is difficult for the reasons already mentioned. The project documents or reports do not make reference to expected results and their specific objectives are on a very general level. For example, what should one make out of the information in the quarterly report stating that in the Malhangalene Rehabilitation Centre 78 children participated in social and sport activities and 99 home visits were paid during three months. Is this what was planned? More? Less? What is the relationship between these results and the purpose of the projects, i.e. the physical rehabilitation of disabled children and their better integration within the family, community and school?

3.4.1 Paramedical activities

Same remarks can be made for statistics about the production of orthopaedic appliances, usually attached to HI's own global annual or biannual reports and specified by type of appliance and workshop. For instance, was the production of 3061 new appliances in HI's workshops in 1995 high or low? Against which targets and standards? What to make of the fact that 55% of this production is made up of crutches? These were 57% of the production in the first semester 1996, and 62% in 1997. Numbers often have a reassuring quality but what is their significance in relation to projects? And how do we know whether the production responded to the beneficiaries' needs? How and by whom were these needs defined? It is repeatedly asserted that the workshop are underutilised: how have factors such as cultural accessibility, quality of reception in the workshops and transit centres, type of technology used, length of time away from home (particularly for women) etc. been taken into consideration? Similar questions are relevant for the physiotherapy units. Only in the last years there begins to be a calculation of standard production and treatment of the data, both for the workshops and the physiotherapy units. However, current production, data collection and its analysis are now of course under SMFR's responsibility, i.e. this is no longer a HI project although the sector still enjoys the organisation's technical assistance.

3.4.2 Social interventions

Reasons why some objectives of the Malhangalene Centre, namely participation of the community

and parents, development of reference and information centre and workshop for prosthesis fabrication, were not achieved are not clear. Were they no longer relevant? That cannot have been the reason for failing to integrate the Centre in the national health system. For HI, the whole process of attempting to integrate the Centre has been a painstaking effort full of drawbacks. If the reason for the difficulties is that the Directorate of Health of the City of Maputo, the future "owner" of the Centre, was not originally consulted during the project preparation nor was it actively involved in the implementation, then the lesson for the future should be clear.

3.4.3 Mine-risk education and demining activities

Mine-awareness campaigns and mine-risk eduation activities

The results from the Mine-awareness campaigns in Tete and Zambezia are presented in the Final report as follows: in Tete 98 853 people were "sensitised" in 716 different places in 9 districts. In Zambezia the corresponding figures are 450 820 people "sensitised", 3 300 meetings held, 708 places visited in 15 districts. Can one conclude that particularly the Zambezia campaign was effective - indeed: in one year a quarter of the population in the province appears to have been "sensitised"? The bare separate numbers unfortunately tell very little of the way they were compiled, or how "sensitised" was defined.

Demining activities in Inhambane province

It has not been possible for the team to evaluate technical aspects of the demining activities in Inhambane Province, as this would have entaild the analysis of how effectively inputs are transformed in results. This must be done by specialists in this field. What makes things difficult is to gauge the problem of landmines in its right terms, taking into account its political implications, levels of inputs and economic interests involved, as well as its moral, ethical and public opinion implications. It is also difficult to establish indicators of progress: should these be the number of mines found, the square meters cleared, activities which the community has regained as a consequence of demining? Measuring the cost of the intervention implies measuring indirect and opportunity costs. The gains of demining could then become quite difficult to quantify.

Once the criteria, priorities and objectives are clearly stated, it would be easier to define technical strategies and resources appropriate to the carachteristics of the areas prioritised. Surely criteria should be based on the knowledge of the location of the mines, made available through a centralised and trustworthy database. Such a database is being put together by the National Demining Commission with technical assistance from UNDP. There are also plans for the creation of a National Institute for Demining, which should be more autonomous than NDC. What is certain is that priority areas should be defined by a competent, neutral and objective technical body, able to act towards general interest, to establish standards of quality and performance, to evaluate demining programmes and their results, so that their faisibility and criteria for control could be established. Without such a body, deminig activities could well be influenced by donors, implementing agencies, ideological or economical groups trying to put forward their particular interests.

The main problem with the current technique used for proximity demining is that the process is extremely slow (2.65 square meters/hour/deminer). This cannot bring back to use large areas. It

can, however, open safe paths, and clearly signal dangerous areas. HI project demined 44 004 square meters, destroyed two AP/AG mines and 8 uxos (NDC official communication, 5/8/98) from January to October 1998.

3.5 IMPACT

3.5.1 Paramedical activities

Results in relation to the orthopaedic workshops are positive, in as much as the six workshops created by HI are all functioning reasonably smoothly, and their transfer under MoH responsibility and management has been achieved. Combined with the more recent action of the SMFR and reflected in the sector's existence itself, HI's input can be acknowledged for achieving a higher 'visibility' of the workshops and physiotherapy units within the hospitals and provincial directorates of Health, already translated in some case into their inclusion in the allocation of the Health budget. This in turn has vigorously boosted the morale of the sector's workers who are beginning to make their professional voice heard in clinical settings, although much still needs to be done to penetrate the regrettably common medical profession's lack of information about this area.

A positive impact is also built up from HI's training activities (training of basic and mid-level physiotherapy and prosthetic technicians, only some of that was funded, among other donors, by the EC). Particularly in the course for basic level physiotherapy technicians recently concluded in Pemba, the training and nurturing of students was deemed good, and the involvement and enhanced confidence of the course director was apparent. This can be considered a capital gain for the country.

It is still too early to gauge the long-term effects of the many efforts put into setting up the monitoring and recording system. In the visits made to the physiotherapy and orthopaedic units of provincial and district hospitals it appears that not all the services are following quite the same practices. However, a reliable use of forms is a complex issue: unlike other sectors in the MoH (e.g. MCH clinics, Nutrition, ELAL/ELAT etc.), in the orthopaedic workshops and physio units this is actually a long-standing issue in which the sector's workers had traditionally had little and inconsistent training. Thus trying to put an order into it and make it work for the whole country would be a momentous achievement.

On a more problematic side, the impact of a growing and increasingly vocal professional category attracting financial ant technical inputs to their area of work may induce distortions in the current distributions of MoH resources. Although this is minimised by the health authorities as "a reality we need to live with", the misbalance between an overcrowded MCH clinic and the relative spaciousness of a (semi-empty) physiotherapy unit remains outstanding. The use of relatively expensive and sophisticated equipment, which includes cyclettes and nautical wheels, can reinforce a habit of dependency from imported foreign materials and induce the belief that 'therapy' only happens when using such instruments.

3.5.2 Social interventions

The positive impacts of Malhangalene Centre are mainly to be found among the direct beneficiaries of the Centre's activities, that is the disabled children and particularly their mothers, most of who live in very difficult social and economic circumstances. The Centre has been a place to come to, and where to have assistance for their children. Meeting at the centre other women with similar life situation has helped mothers not only to feel less socially isolated but also to get support from each other. The impacts on the capacity building of counterpart structures have been minimal.

The negative impacts, which are possible to foresee, are also related to the direct beneficiaries, disabled children and their mothers. They are the ones to feel the consequences, if the pessimistic visions of the present staff on the sustainability of the activities after the withdrawal of Handicap International should come true.

The positive impact that HI's structural support have had on ADEMO and ADEMIMO is mainly in the opportunity for the associations to establish links between national offices and provincial delegations or branches, which otherwise would have been harder to achieve, and to create physical places where members could meet, and the association be seen and located.

3.5.3 Mine-risk education and demining activities

Mine-awareness campaigns and mine-risk education activities

The purpose of the mine-awareness campaigns in Tete and Zambezia provinces was to prevent mine accidents through raising the level of awareness of the existence of mines and problems caused by them among rural and returning populations. In all likelihood the projects contributed towards this end, especially because of the timely action, and mine accidents were prevented as a consequence of the project.

An important impact of these campaigns was the lessons drawn from them for the future mine-awareness activities implemented by Handicap International. An unforeseen impact has most likely been the importance that the mine-awareness and demining projects have gained both financially and in human resources within the projects of Handicap International Mozambique. Today around 80% of the HI staff and half of the total budget is linked to mine-risk education and demining activities. The number of mine accidents has dropped quickly during the last years – 10 times less in 1998 than in 1995. This is partly a consequence of mine education activities, though certainly other factors have been crucial. The most important among them are the fact that people have now settled, and obviously the demining activities themselves.

Since their onset, the campaigns in Tete and Zambezia had set community involvement as one of their objectives, and apparently in Zambezia initial steps towards this direction were effectively taken. In the present PEPAM, the overall objective is to strengthen the capacity of the National Demining Commission and to create a network of organisations and institutions involved in mine-risk education activities in order to prevent new mine accidents. However, capacity building of the national counterpart, the National Demining Commission, has not been the strongest point of the project. The same applies to provincial government and district administration. Far more positive impacts of PEPAM's interventions can be witnessed among various other partners. Rather impressive work is carried out in integrating local authorities and communities in mine-risk

education activities. As a consequence, particularly the district education authorities, teachers themselves and many community leaders seem to feel quite involved. This can have long-term impacts on the overall level of mine-risk awareness should the process be sustained.

Mine-risk education together with demining activities has raised people's expectations and demands for quick and immediate demining. Perhaps this is an unavoidable impact, but it can have negative implications. Ordinary people seldom understand how time consuming and expensive demining is. The radio programmes and awareness agents may have explained about different aspects of demining and about priority areas, and may have said that all mines will never be cleared. That does not seem to have much influence on people's expectations in getting rid of the mines by tomorrow. When nothing happens, people's original enthusiasm and involvement in mine-risk education may turn into indifference and bitterness towards the government, perceived as uncaring. Also, paranoia could be an unintended impact of mine-risk education, particularly if the messages were transmitted in a wrong way. However, this does not seem to have happened. On the contrary, people seemed to feel more secure by now knowing better what to do.

Demining activities in Inhambane province

The demining activities of HI have been carried out for too short a time to have had economic impacts in the areas where they have taken place. In general it seems that in a country like Mozambique with abundant agricultural land, demining activities do not have great impact on agricultural production. The situation is quite different in countries where land is scarce and every inch of it is carefully used. Pressure on land in Mozambique is felt mainly during droughts or other calamities. Mines can however affect the yearly rotation of cultivated lands which in the long term can decrease land productivity and cause negative environmental consequences.

Economic impacts can also be a result of demining a place that is important socially and culturally for the surrounding communities. It is still too early to say how the demining of the Catholic mission in Mocoduene, for example, will boost the economic and social life of the surrounding areas but at best the reopening of the hospital and the school as well as the installation of a generator to pump water can have very positive impacts to the local economy.

People seem to know quite well which areas to avoid because of mines and consequently the impacts on daily life are not very great. Fields are cultivated, firewood is collected and water fetched. Children go to school. People do worry because of the mines; they still kill and injure causing incalculable losses and difficulties for the victims and their families. But so do many other accidents, diseases and crisis that people in the present Mozambican reality face. As one of the persons met during the evaluation put it: demining is a necessary but not a sufficient condition for development. Parents may refrain from sending their children to school, for example, because they are afraid of landmines, but they may also do so just because they cannot afford to.

3.6 SUSTAINABILITY

Evaluating the financial sustainability of the projects is a somewhat absurd exercise in the present reality of Mozambique where most of the donors' projects have little chance of being financially sustainable at least in the short term. This is particularly true for projects in which the majority of

beneficiaries are very poor, as it is the case with the paramedical and social activities supported by HI. Currently it is said that the whole of the health services in the country depend for about 80 per cent from external aid. A more interesting question to ask is whether the positive effects of the projects can be sustained institutionally and whether they are socially and culturally sustainable. A related question is whether all activities need to be sustained.

3.6.1 Paramedical activities

Currently the MoH bears the costs of national personnel, some capital and recurrent costs and part of the costs for material needed for the workshops. Specific plans have been made for a gradual transfer on the MoH of financial onuses currently covered by the projects implemented by HI with funding from its different donors. This includes essential items such as conservation and maintenance of buildings and equipment, regular supervision visits, training and placement of new trainees, and regular supply of materials. The issue of cost recovery for health services is currently being debated and studies are under way also in relation to orthopaedic appliances and physiotherapy services, both by SMFR/HI and POWER. The latter supports USAID's suggestion that a non-governamental body be created (perhaps a non-profit foundation) which would globally take care of the orthoprosthetic sector. However, Health authorities have no doubt that external funds are necessary for the running of this service, and that alternative sources would need to be identified in the unlikely event that HI become no longer available. The question is whether the MoH and the SMFR would succeed in obtaining the required level of support from donors without depending on the mediation of HI.

A separate but related question is whether the SMFR has acquired the technical competences for implementing those activities, not only at central level but also in the provinces and particularly in relation to the integration of logistical activities in the general system of the Directorate for Administration and Managemeng (DAG) currently being restructured. Training of provincial counterparts in management and planning was not achieved when the workshops were run by Handicap International. Only now Heads of SMFR services are being trained, and at central level the counterpart to the logistics and health economics adviser has not been appointed yet. Moreover, although the sector does require a certain level of specialised logistical knowledge, it is questionable whether a high powered technical assistance should be applied over a long period of time especially to the area of orthopaedics and physiotherapy rather than to the overall area of DAG.

3.6.2 Social interventions

The sustainability of the activities in the case of the Malhangalene Children's Rehabilitation Centre does not seem very promising. Partly this is due to the insufficient involvement of the counterparts in the project planning and implementation. The Directorate of Health of the City of Maputo has not been involved in the project at any stage, nor were the beneficiaries consulted when it was decided that the needs of disabled children are best met by creating a centre. Nor were workers of a community-based programme for disabled people run by Social Action. A better understanding of the real-life situation of disabled children and their families would probably have suggested alternative solutions more adapted to the urban reality of Maputo.

3.6.3 Mine-risk education and demining activities

Mine-awareness campaigns and mine-risk education activities

The question here is, do the more traditional type of awareness campaigns maintain their rationale for years to come? Probably not, and if one succeeds in integrating mine-risk education into the national education system as part of the curricula, much of the future mine-risk education needs will be at least minimally taken care of. As a whole, mine-risk education activities have good chances of being relatively sustainable: mines are part of Mozambican history and people's daily reality, just as the means used – radio, cultural groups, meetings – are of traditional cultural fabric. The issue touches people: who would not wish to prevent accidents, given the chance?

Demining activities in Inhambane province

The project seems to have successfully trained local personnel in the technical competence required for demining activities. On the other hand, management and financial capacity building have been weak both in relation to personnel and to the government representative attached to the operation. At any rate, a problem is seen in maintaining current salaries paid to demining workers. Provincial authorities allegedly are not informed of the amount of funds currently involved in the operation.

The creation of a local NGO to carry on demining activities, or in alternative the creation of a public service company, are now being considered as a solution to the phasing out of HI. This is rather different from the prevision given in HI's Annual Report 1995 "At the end of the program, the provincial authorities must be able to manage the functioning of this programme and, from the second year, the staff will be contracted by the provincial government. The program's costs will be so low that the government of the province can assume it almost without outside financing" (see Annex 10, HI Annual Report 1995).

4 RECOMMENDATIONS

1. Handicap International should pay serious attention to improving its project design and preparation, and arrange, if need be, training for its staff and counterparts in the use of the logical framework and other guidelines for project preparation.

2. Better project design is also a prerequisite for more effective project monitoring and (participatory) appraisals. These should form an integral part of HI's project implementation and would benefit particularly the paramedical and social projects.

3. Any new project proposal should include a phasing-out plan including an assessment of counterparts' ability to take over the project once HI withdraws. This plan should be prepared together with the counterpart. Since the onset of activities, training in resource planning, management and administration should be part of any new project proposal in order to ensure the counterparts' capacity to continue the project.

4. Capacity building of the counterparts should be given more emphasis if HI wants to advance towards more equitable partnership. A central factor in capacity building is shared decision making, resource management, policy choice and information that are available to all concerned - in Portuguese.

5. The need for and qualifications of technical assistance should be carefully analysed and negotiated with the counterparts. National and regional capacity also exists, and should be systematically sought out. Sometimes it is not expertise that is needed but resources.

6. HI, and NGO's in general, should critically reappraise their role within the Mozambican reality, which seems to become increasingly one of intermediaries for fund channelling and gate-keeping even when counterparts have the relevant expertise to autonomously present funding propositions. This deepens the ministries' dependency on individual donors and weakens their global planning and management capacity.

7. A more balanced use of sectoral expertise in relation to wider development needs and processes of counterparts (be they ministries, local associations or communities) is essential if HI wants to promote an equitable growth and avoid creating hypertrophic areas of intervention. Any new infrastructure should be based on studies done beforehand, proving the need for the creation of the new service as well as the availability of human and material resources and the sustainability of recurrent costs within the government's capabilities.

8. The EC should not finance projects that are not reasonably well designed and prepared, regularly monitored and individually reported if it wants to be able to supervise and evaluate those projects.

9. Finally, in its work with disabled people and the local associations of disabled people, HI should not lose sight of the fact that, for all its good intentions, it is not an organisation of disabled people, but rather an organisation of professionals with a specific area of expertise. "Professionals should be *on tap*, not *on top*" (David Werner).

5 LESSONS LEARNT

Three main lessons can be drawn from the above discussion. Firstly, the repeatedly stated great difficulty in evaluating the various aspects of the projects due to lack of information, indicators or facts, as well as due to poor quality of project documents and monitoring, does not signify that the projects were poor, nor that only projects with measurable results are worth implementing and financing. Not everything is measurable nor needs to be. But good project planning and design are among the crucial factors contributing to, or impeding, success of projects. A logical framework is at its best a very practical tool in the process of planning. It should however be remembered, that no tool can replace participation of counterparts in the process. That, according to the accumulated experience of some decades of development co-operation, is even a more crucial factor contributing to the success of a project. The findings of the present evaluation tend to confirm this.

Secondly most of HI's activities would have benefited from dialogue with the beneficiaries, be they clients of the orthopaedic centres, mothers of disabled children, villagers, community representatives. What are their experiences, problems, and suggestions? Only through a better understanding of how local social, political and cultural structure work can one expect to respond to local needs with more sustainable solutions.

Thirdly, there is room for both improving the counterpart relations and strengthening capacity building of the counterpart organisations. Capacity building is rather an obscure concept that lacks an agreed definition, even though one can hardly find a project – the ones presently under evaluation making no exception - that does not include capacity building as one of the main objectives. Maybe the following quotation helps: “An organisation that reflects good capacity is somewhat like a festive curry meal. Making the meal requires skills, dedication, fresh ingredients, and good timing. There are staple ingredients that are understood as being essential – transparent management systems, clear communication, participatory work approaches – but there are also specific ingredients and spices that can only be selected by the people of that place. And, in the end, it is only they who will be able to put all the ingredients together in a recipe, select just the right cooking utensils, and make a curry that will truly reflect what they and their communities enjoy most.“ (Postma, W, 1998, 54).

ANNEX 1

HANDICAP INTERNATIONAL EM MOÇAMBIQUE – PROGRAMAS 1998-

ANNEX 2

CONTRATS ENTRE L'UNION EUROPÉENNE ET HANDICAP INTERNATIONAL AU MOÇAMBIQUE

ANNEX 3

ORGANIGRAMME MINISTÈRE DE LA SANTÉ

ANNEX 4

ORGANOGRAMA DO DEPARTAMENTO DE ASSISTÊNCIA MÉDICA

ANNEX 5

ORGANIGRAMME HI MOZAMBIQUE

ANNEX 6

MINEFIELD LOCATIONS MAP – INHAMBANE

ANNEX 7

PRODUCTION OF ORTHOPAEDIC WORKSHOPS (94-95)

ANNEX 8

PROJECT SUMMARY FORMS

ANNEX 9

LIST OF PERSONS CONSULTED

ANNEX 10

DOCUMENTS CONSULTED

ANNEX 11

SPECIFIC TERMS OF REFERENCE

ANNEX 12

BRIEF CURRICULA VITAE OF THE EVALUATORS