

**ADDED VALUE AND LONG TERM
VIABILITY OF COMMUNITY COUNCILS IN
ZAMBEZIA PROVINCE, MOZAMBIQUE**

**REPORT OF A CONSULTANCY MISSION
FOR UNICEF**

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EXECUTIVE SUMMARY

This report has been prepared by consultants who were contracted by UNICEF to examine the experience of Community Councils in Zambezia Province and similar health experiences in other parts of Mozambique. The purpose of the consultancy was to consider whether the experience of the Community Councils in Zambezia as developed by World Vision could be a potential sustainable community tool to be used in other projects. The consultants were asked to investigate whether community councils represent a realistic approach to CCD and a methodology in which UNICEF should invest more resources in the future.

UNICEF has supported from early 2001 to 2004 a malaria project in Zambezia implemented by World Vision. The focus has been community-level interventions through Community Councils. World Vision has also been implementing other community-level health projects in Zambezia through a total of 710 Community Councils. The other projects are HSDS (support to the health services in 8 Districts of Zambezia Province) and Ovata (a more recent health and food security project).

UNICEF was concerned about the high cost of the malaria intervention (measured by the cost per ITN distributed), about the lack of clarity about other benefits from the intervention, and about sustainability. The consultancy was carried out in June 2004 through visits to Gaza and Zambezia Province and through interviews in Maputo with UNICEF staff, and staff of other agencies and Mozambique Government officials. The draft report was circulated, and the comments received provided other important information that has been incorporated in this report.

Observations in the field showed that the model of Community Councils is similar in the three projects implemented by World Vision in Zambezia. There are two groups of people in each Council, members and volunteers. They are trained together. The role of the volunteers is to visit 10 houses in the village regularly to pass health information and to encourage treatment and prevention of health problems. The role of the members is to organise the work of the volunteers, prepare reports and maintain contact with the local health unit and local government. There are differences between the projects in the content of the training: those Councils that are only part of the malaria project have only a limited range of health activities while other Councils have a wider range of health, nutrition and agriculture activities. Participative educational methods have been used but the evidence was that this was used to transmit information, and that members and volunteers have not advanced significantly in assessment and analysis. However they do have a very good level of knowledge of the subjects in which they were trained and positive impacts were reported: the building of latrines, the use of ITNs, increases in level of pre-natal and post-natal and family planning consultations, the numbers of births taking place in the Health Units, the number of children whose weight is being controlled regularly and attending vaccination sessions, more rapid transmission to the health service about cases of AFP, measles, cholera and meningitis.

An assessment of the strength of the Community Councils visited suggests that the weakest are those that have been in existence for only a short time, and those that have been created for the malaria project that have not been included with the other projects (HSDS and Ovata). Community Councils created for the malaria project but which cannot be incorporated into other project are thus a cause for concern; the greatest number of these are in Districts where Ovata is not planned to function and where Ovata will not provide follow-up: Milanje, Mocuba, Namarroi and Quelimane Cidade.

The opinion of the consultants is that Community Councils are a potential sustainable community tool. They appear to represent a realistic approach to CCD and to be methodology in which UNICEF should invest more resources in the future. Assisting community leaders to form a cohesive group is an effective means for facilitating community-level interventions, for opening channels of communication between communities and authority and for developing the capacity of communities to assess, analyse and act to resolve the problems that they face. There is interest by the Government of Mozambique in developing community-level structures to do this. The evidence from the interventions in Zambezia Province is that there is a willingness by communities to take action to resolve the problems that they face, and an

ability at community-level to absorb quite complex information. Community Councils could be part of an effective strategy for reaching people who live at a distance from Health Units, which is one of the most important health challenges facing Mozambique. Health interventions may be a suitable entry point for the development of Community Councils that then go on to interventions in other sectors and in parallel develop as channels of communication between communities and authority and build up capacity in assessment, analyse and action.

However the malaria project in Zambezia has not, in the opinion of the consultants, realised this potential. It is unclear to the consultants why UNICEF highlights the Zambézia malaria project as a HRAP or CCD project as it lacks many of the features of HRAP and CCD (such as an analysis of duty-bearers and rights-holders, their capacities and capacity-building needs). The documents of the project define goals and purposes in terms of malaria control and prevention, and consider participative education as means to reach this end. In practice the project has focused on Community Councils as a means for facilitating community-level interventions and has not had a clear plan for opening channels of communication between communities and authority and for developing the capacity of communities to assess, analyse and act to resolve the problems that they face. Interviews with different participants in the project revealed very different perceptions about the original intentions of UNICEF for this project: either a malaria project with participative education as a means to reach malaria-related objectives, or as a CCD project for which malaria interventions were an entry point. These differences of perception may explain some of the difficulties that this project has faced.

The three different objectives of supporting Community Councils (facilitating community-level interventions, channels of communication between communities and authority, and developing capacity of communities to assess, analyse and act) can only be achieved in different time-scales. A sectoral project of limited duration is unlikely to provide enough time for the transformations that are implied by HRAP and CCD, and for the creation of the required capacities. The latter two objectives can only be achieved on a longer-time scale, and are difficult to achieve within the frame of the standard, sectoral two- or three-year project. HRAP and CCD are long-term transformatory approaches that cannot be used as means in a time-bound project with specific goals and purpose. It is challenging to combine specific goals and purposes with HRAP or CCD, which imply a long-term engagement to build community capacity in stages and in parallel to build the capacity (and attitudes) of other actors to effectively work with communities.

If UNICEF is committed to an HRAP or CCD approach, the Mozambique office should understand that this implies a long-term engagement to build community capacity in stages and in parallel to build the capacity (and attitudes) of other actors to effectively work with communities. It should understand that short-term, vertical programmes, on their own, are difficult to reconcile with an HRAP or CCD approach as the costs of a long-term engagement with community institutions (and with the State and private structures that interact with them) can be difficult to justify within the frame of a vertical programme. HRAP and CCD can most easily be operationalised by the UNICEF Mozambique office if it either:-

- develops a series of interventions over a number of years in different sectors but in the same geographical area
- develops a specific CCD project in a particular geographical area that runs for a number of years, into which sectoral interventions can fit
- coordinates its activities with other organisations so that it is part of a coordinated long-term programme of CCD in a particular place.

A further implication of this is that UNICEF should have a staff member (or team) specialised in HRAP and CCD, who can support the specialist sectoral staff in linking their sectors to HRAP and CCD, who can liaise with Ministries and Provincial Governments (an important part of the process of the development of Community Councils), and who can provide skills in the analyses of roles and capacities required by HRAP and CCD. It may also imply that UNICEF have staff in Provinces where they have a series of coordinated activities or have a CCD-oriented project, so as to improve coordination between the various actors involved in programmes (training centres, implementing agencies, government agencies, UNICEF), to

assist in monitoring inputs (quality quantity and timeliness), progress, outputs (immediate results), outcomes (changes in behaviour, knowledge and attitudes of the various duty-bearers) and impact, and to ensure that these new approaches are being implemented in the way that is intended.

If UNICEF is committed to HRAP and CCD, sectoral programmes should include a more complete analysis of the roles of duty-bearers and of the capacities that need to be built. Sustainable interventions require actors who are able and willing to carry out the expected roles. Low-cost interventions are not necessarily sustainable if they do not invest in the required capacities. The Mozambique office of UNICEF should invest in monitoring systems for CCD and HRAP programmes that cover, and distinguish between, inputs, progress, outputs, outcomes and impact. CCD programmes pay particular attention to **outcomes**, that is to the behaviour, knowledge and attitudes of the various parties (their willingness and ability to carry out their roles). The technique of **Outcome Mapping** has been designed for monitoring changes in behaviour, relationships, actions and activities by people, groups and organisations involved in programmes

As a UN agency with a mandate to work with the Government, but with also the possibility of working with donors and with other partners such as NGOs in the implementation of projects, the Mozambique office of UNICEF should work with various Ministries to support the transformation of the present Community Councils (that focus on health activities) into Community Councils or Community Leaders' Councils with a wider remit, through analysing the experience with Community Councils, and in developing and ratifying a government Community Strategy that goes beyond the health field.

ITNs have been shown to be an efficacious intervention against malaria. However the main lesson from other anti-malaria efforts is that identifying an efficacious control tool is only one step towards an effective, sustainable malaria control programme. Making the promise of malaria control through ITNs a reality requires operational research to test effective strategies for making ITNs available and ensuring their effective use (including re-treatment). Effective strategies have to be adapted to the context. Different approaches to the financing, distribution, periodic re-treatment and promotion of ITNs need to be explored. In this context "sustainable" does not necessarily mean fully self-financing. "Sustainable strategies" means strategies that can be implemented over a number of years attracting the support of the government, donors and local people. It is recommended that the Mozambique office of UNICEF should support the Government of Mozambique in developing effective strategies for making ITNs available and ensuring their effective use (including re-treatment). As a UN agency with a mandate to work with the Government, but with also the possibility of working with other partners such as NGOs in the implementation of projects, UNICEF is in a position to support policy-level work based on experience and operational research from project implementation.

In this the focus should be on operational-research component to identify how a community-based strategy can best be developed. Consensus should be reached beforehand before the various partners (such as UNICEF, commercial companies, NGOs and the DPS) about the fact that operational research is required. The systems for data collection should be devised before the start of the project. There should be regular meetings between the various partners to look at the monitoring data, and decide any changes required in order to meet the objectives. The various partners should agree to obtain and analyse as much information as possible about the experience to date in Zambezia. They should agree to work together to understand the real costs of the various components (transport, education, supervision, management etc) in different geographical areas and how these activities could be carried out in the most cost-effective manner.

INTRODUCTION

This report has been prepared by consultants who were contracted by UNICEF to examine the experience of Community Councils in Zambezia Province and similar health experiences in other parts of Mozambique.

The purpose of the consultancy was to consider whether the experience of the Community Councils in Zambezia as developed by World Vision could be a potential sustainable community tool to be used in other projects. The consultants were asked to investigate whether community councils represent a realistic approach to CCD and a methodology in which UNICEF should invest more resources in the future.

UNICEF has supported from early 2001 to 2004 a malaria project in Zambezia implemented by World Vision. The focus of the malaria project has been community-level interventions through Community Councils, mainly the promotion of the use of ITNs. World Vision has also been implementing other community-level health projects in Zambezia through Community Councils. Furthermore UNICEF has begun, in 2004, to support a health project in Gaza Province (implemented by World Relief) that has some similarities in that it trains community volunteers to promote changed health behaviour.

Questions about the malaria project in Zambezia Province arose out a concern by UNICEF that the cost of the intervention appeared to be high, if measured by the cost per ITN distributed. There was concern by UNICEF that there were no clear indicators of any other benefits that the malaria project in Zambezia Province was bringing and whether these justified the additional cost. There was a concern by UNICEF about the sustainability of the intervention and about how it was incorporating a Community Capacity Development approach. The consultancy therefore aimed to see whether the support to Community Council was bringing any added value (ie other benefits beside the distribution of ITNs)

The consultancy was carried out in June 2004 through visits to Gaza and Zambezia Province and through interviews in Maputo with UNICEF staff, and staff of other agencies and Mozambique Government officials. The draft report was circulated, and the comments received provided other important information that has been incorporated in this report.

The full Terms of Reference are in Annex 1.

FIELD VISIT

The consultants visited Zambezia Province from 7th June 2004 to 18th June 2004 to observe the operation of Community Councils that are part of World Vision health projects. The projects are the malaria project, financed by UNICEF, and HSDS and Ovata, financed by USAID.

Three Districts of Zambezia were selected with different characteristics, namely Guruè, Mocuba and Morrumbala and a total of twelve Community Councils were visited in these Districts:-

Guruè	5
Mocuba	3
Morrumbala	4

The most important difference between the Districts is that Mocuba was part of the first phase of the malaria project, Morrumbala the second and Guruè the third phase. The Community Councils that were visited were the following:-

09 June: Macuarro, Intuba and Muximua, District of Guruè

10 June: Muahupo and Namiepe, District of Guruè

12 June: Sassamanja and Mbuma 1, District of Mocuba

13 June: Mpasso, District of Mocuba

14 June: Maço and Mecange, District of Morrumbala

15 June: Murda and Vungantinta, District of Morrumbala

In-depth group interviews were carried out with these Community Councils, each one lasting over two hours. Each Council consists of members and volunteers; the two were interviewed together. Notes on each interview are shown in Annex 2 and the main questions are shown in Annex 3.

Interviews were also carried out with personnel of the Ministry of Health and World Vision in Maputo, Quelimane and in each District visited. Personnel of Project Hope were also interviewed in Maputo and in Ile District (Zambezia). Notes on each interview are shown in Annex 4.

One of the consultants also visited, with UNICEF staff, the project implemented in Gaza Province by World Relief.

PROJECTS WITH COMMUNITY COUNCILS IN ZAMBEZIA

Data provided by World Vision indicates that there are (in total) 710 Community Councils in Zambezia Province that are part of World Vision health projects.¹

District	No of Community Health Councils
Alto Molocue	39
Gile	16
Guruè	39
Inhassunge	52
Lugela	21
Milanje	21
Mocuba	103
Mopeia	71
Morrumbala	87
Namacurra	76
Namarroi	14
Nicoadala	48
Quelimane	123
TOTAL	710

Some Community Councils were created under a USAID-funded rehabilitation project from 1995 to 2000. At present Community Councils are part of three World Vision projects: HSDS, Ovata and the malaria project.

	HSDS	Ovata	Malaria project		
			Ph 1	Ph 2	Ph 3
Alto Molocue		Yes			Yes
Chinde					
Gile		Yes			Yes
Guruè	WV	Yes			Yes
Ile	PH				
Inhassunge		Yes		Yes	
Lugela		Yes			Yes
Meganja da Costa					
Milanje	PH				Yes
Mocuba	WV		Yes		
Mopeia		Yes		Yes	
Morrumbala	WV	Yes		Yes	
Namacurra	WV	Yes		Yes	
Namarroi	PH				Yes
Nicoadala		Yes		Yes	
Pebane					
Quelimane	WV		Yes		

WV = World Vision

PH = Project Hope

¹ This information is taken from a data-base provided by World Vision of distribution of ITNs through Community Health Councils. Figures may vary slightly from those from other sources of information.

HSDS is a programme of support to the health services in eight Districts of Zambezia Province, running from 2001 to 2004. It is coordinated by the DPS and implemented in five Districts by World Vision and in three Districts by Project Hope.

Ovata is a more recent project. Wherever possible Ovata has used existing Community Councils created under HSDS and the malaria project. It has however created new ones in some areas where there were no existing Councils, such as in the north of Guruè District².

As noted in the previous section, the UNICEF-funded malaria project can be divided into three phases. In the first phase, there were activities in Quelimane and Mocuba Districts: as a response to experience that showed that ITNs were not reaching rural areas in those Districts, it was decided to create Community Councils in Quelimane and Mocuba; ITNs were distributed by World Vision to Councils for subsequent sale. In the second phase (2001 to 2003), the methodology used in Quelimane and Mocuba Districts (including the use of Community Councils) was extended to five other Districts (Inhassunge, Mopeia, Morrumbala, Namacurra, and Nioadala). In the third phase of the malaria project (2004) a different methodology has been used in 6 new Districts (Alto Molocue, Gile, Guruè, Lugela, Milanje and Namarro): no new Community Councils have been created and existing Community Councils have been used for education about malaria; ITNs are distributed by PSI to Health Units and Community Councils can obtain ITNs from the Health Units.³

It has not been possible to ascertain exactly how many Community Councils have been created under each of the three projects (malaria, HSDS, Ovata). However, it would seem from interviews that significant numbers of Community Councils were created by the malaria project in Inhassunge, Mocuba Mopeia, Morrumbala, Namacurra, Nioadala and Quelimane.

Of the Districts visited, it was possible to observe in Guruè District that Community Councils have been created by HSDS and Ovata projects. There have been malaria activities in Community Councils since the start of 2004. The distribution of ITNs has been through Health Units though some individual members of some of the CCs are involved in the sale of ITNs obtaining them from the Health Units. No new Councils have been created for the malaria project.

It was possible to observe in Mocuba District that at present the only project operating is HSDS. From 2001 to 2003, Councils had been created for the malaria project: some were formed only near the end of 2003 and received little training. The malaria project was active from 2001 to 2003 but has not been active since the end of 2003. Of the 103 Councils, only 40 are regarded as active because they are part of HSDS. The other 63 are inactive, or doing little, as they are regarded as belonging to a closed project (the malaria project) and there are no resources to supervise and motivate them. The sale of ITNs has now passed to the Health Units and mobile health brigades. No Councils reported being involved in the sale of ITNs since the start of 2004.

It was possible to observe in Morrumbala District that the projects operating at present are HSDS and Ovata. There are 85 Councils, created by HSDS and the malaria project. All of these 85 have a malaria component. Only 42 Councils are Councils created by HSDS. In addition, 29 Councils have a component of nutrition. Thus, 14 Councils only have a malaria component. These 14 Councils continue to be active, as staff of HSDS and Ovata manage to visit them occasionally to supervise and to encourage them to continue.

² There are few Health Units in the north of Guruè District as most existing Units in the District were built by the tea companies in the colonial era and there were no tea companies in the north of the District. HSDS created Community Health Councils close to Health Units, so did not cover the north of the District. It was felt that Ovata should include the north of the District as it is an important agricultural area, so new Community Health Councils were necessary.

³ As is discussed further later in this report, there are different perceptions about what has been agreed regarding the participation of Community Councils in the distribution of ITNs in the current phase of the project: which Councils can participate and how they can go about it. It was apparently felt by UNICEF that there had been wasteful duplication, because PSI was delivering ITNs to health units while World Vision was delivering ITNs to Councils in the same area. There were also apparently concerns by UNICEF about the creation of Community Councils that then carried out a limited range of activities. Apparently existing Community Councils should be able to arrange to collect ITNs from health units, but the evidence is that this has rarely been achieved.

In general, the malaria project has trained members and volunteers of Community Councils on malaria and diarrhoeal diseases. Project HSDS has trained members and volunteers of Community Councils in the following areas:

HIV/AIDS

Malaria

Diarrhoeal diseases

Sexual and reproductive health

(plus pre-natal and post-natal consultations and family planning)

Nutrition

Acute respiratory infections (ARIs)

Vaccination and its importance (EPI)

Acute Flaccid Paralysis (AFP)

The training is between 3 and 6 months, depending on the number of days per week in which there is training (once or twice per week). Training takes place in the village. Some HSDS Councils have members trained in IMCI (AIDI) (funded by USAID through John Snow Incorporated). Most Councils of HSDS have a bicycle-ambulance purchased from Malawi. Some of them have another bicycle.

Ovata means "ramified growth" and has the objective of promoting balanced and sustainable growth. It is in 10 of the 17 Districts of Zambezia Province. It is slowly extending through these Districts, but will not extend to other Districts. It is programmed to end in September 2007. It has agricultural and nutrition and HIV/AIDS components, plus some training in malaria and diarrhoeal diseases and a rural infrastructure component. The agricultural component aims to improve rural household food security, firstly by promoting food self-sufficiency then eventually help small farmers produce marketable crops. There is some emphasis on crops with a high Vitamin A content (certain types of orange sweet potato, carrots) mainly to help increase resistance to infections among HIV positive cases.

In Guruè District, Ovata is only active in the Locality of Lioma where it created some new Councils, and in other cases integrated with older Councils. This is because HSDS had not operated in all of the Locality of Lioma, and it was felt that this locality should be included, especially because it is an agriculturally productive, but more remote, Locality. Ovata does not function in Mocuba District. In Morrumbala District, Ovata activities have been carried out with Councils previously created by the malaria project and HSDS. This is why there are few (14) Councils in Morrumbala District with only a malaria components. The training for Ovata lasts 3 months, twice per week. Ovata incorporates agricultural staff (of the DDA)

RITA is a very new project, beginning at the end of 2004, about HIV/AIDS (home-base care and assistance to affected and infected children). Its activities are being incorporated in some Councils where there are Ovata activities. At present, the staff has been recruited and received some training but no field activities have taken place.

FUNCTIONING OF COMMUNITY COUNCILS IN ZAMBEZIA

Members and volunteers. There are two groups of people involved with all the Community Councils that were visited: the members of the Council and the Volunteers. There are usually between 5 and 10 members and between 10 and 20 volunteers in each Council. The members of the Council are leaders of the community, usually a traditional leader, an administrative leader, representatives of various religious groups and political parties, traditional healers and traditional birth attendants. The initial contact with the village was made by World Vision through a traditional leader. The volunteers are usually women and a few young men. Some Community Councils also have a Mother's Group, created more recently, with the objective of demonstrating to other women enriched foods for malnourished children.

The members of the Council and the volunteers were trained together. The role of the volunteers is to visit 10 houses in the village regularly to pass on what they have learnt, to look for signs of illness and to encourage people to seek treatment or to take actions that prevent sickness. The role of the members of the Council is to organise the work of the volunteers, prepare reports and maintain contact with the local health unit and local government. In practice the role of the members of the Council has also been to support the volunteers when they have difficulty in carrying out their work: in the early stages of the work of a Council there is often resistance to the advice given to households by the volunteers and back up by members of the community with a leadership role is important.

Training. The evidence from the visits to Community Councils and interviews with members and volunteers indicates that the members of the Councils and the volunteers were trained using similar methods by each project, involving series of posters. The members and volunteers did not receive copies of the posters for their use when they are speaking to people in their villages. There are some cases where Councils received material such as bags and plastic covers, others where they have not received. In some Councils, maps of the village and seasonal calendars have been made. The evidence from the visits to Community Councils and interviews was that participative educational methods have not been used in a very participative manner: members and volunteers said that their trainers spoke using the posters rather than using them to provoke participation. There was not much evidence that the members and volunteers have advanced significantly in assessment and analysis⁴.

Knowledge. The members and volunteers of the Community Councils were observed by the consultants to have a good level of knowledge in the subjects in which they were trained. In some cases it was impressive how much the members and volunteers had learnt and retained. They are able to repeat the information clearly, and to transform into songs and dances and theatre. Councils that had received training on HIV/AIDS had a good knowledge of the symptoms and of preventive measures. They had difficulty in saying whether their activities in transmitting this information had any impact, because of difficulties in identifying exactly cases of HIV/AIDS.

Sale of ITNs. Most of the Councils have been involved in the sale of ITNs during the period 2001 to 2003⁵. The average number of ITNs sold by each Council is about 100. There is a lot of variation in the quantity of insecticide for re-treatment sold by the Councils. Most Councils said that the supply of nets and insecticide had been erratic and that it had been difficult to build up a constant rhythm of re-treatment.

⁴ As is noted elsewhere in this report, the perception of some interviewees who were involved at the beginning of the project was that participatory training processes were initiated that were intended to create capacity at community level for assessment, analysis and action, not just for the transmission of information about malaria and other diseases. However the evidence from interviews with Community Councils and those directly involved with them points to the use of training only for the transmission of information about malaria and other diseases.

⁵ Some of those in Guruè District have only sold very small quantities: it was said that it was not intended that these should sell ITNs but in late 2003 there were ITNs that needed to be sold quickly so these Councils were included.

There were some significant changes in the way in which ITNs are supposed to be distributed from the beginning of 2004. In the Districts in which the malaria project had been operating from 2001 to 2003, World Vision ceased to have an active role in the malaria project. ITNs are supposed to be delivered by PSI to the DDS of each District, which in turn distributes to Health Units. Health Units can sell ITNs to the target group (children under-5 and pregnant women). Community Councils that are some distance from Health Units can negotiate locally to collect ITNs from Health Units for sale to the target group in their area, and NGOs can make their own arrangements to deliver ITNs to Community Councils. Observations suggest that this revised system for sale of ITNs is not functioning smoothly. Most Community Councils are unaware that they can negotiate to collect ITNs from Health Units for sale in their area: they are under the impression that they have been completely excluded from the sale of ITNs. NGO staff appear to be unaware that they can arrange to deliver ITNs to particular communities in liaison with the local DDS.

In some areas, individual members of the Community Councils have been asked by the staff of Health Units to sell ITNs. The Councils report that under the new system they do not know who has bought ITNs through the Health Units so cannot monitor their use, and cannot monitor whether there are fewer cases of fever among those who have ITNs.

There are some conflicts between staff of Health Units and Councils about the new responsibilities and access to the profit margin. There are doubts about the price and the new recommendation for re-treatment periods. The personnel of the DPS and DDS and World Vision are aware of the shortcomings of the methodology of Phase 2 of the malaria project but are unconvinced about the methodology of Phase 3 or see it as something experimental that needs to be monitored and adjusted. Their concern appears to be that the new methodology is based on a test in Ile District during 2003 in collaboration with Project Hope (an NGO that works with the DDS of Ile District), and that this test may not be replicable because Project Hope was able to absorb transport costs and at the same time make regular and reliable deliveries. The DPS and World Vision are still unconvinced that the case of Project Hope represents a model that can be extended to other Districts.

Another particularly problematic point is that the new system requires nurses at Unidades Sanitárias to cooperate with CCs though there was very little time to prepare them to do so; furthermore nurses and CCs are potentially in competition for the profit margin on ITN sales while also being expected to collaborate. There are areas where there is now a lack of involvement of the CCs in the sale of nets and insecticide. The level of re-treatment, which was always incomplete, seems to have fallen further where insecticide is only available at the Unidade Sanitária.

Many people in rural areas of Mozambique live in areas that are distant from Unidades Sanitárias and from stable commercial networks. (Commercial networks consist of temporary marketing of cash crops in the dry season and mobile traders whose stock can fit on a bicycle or in a rucksack.) CCs have thus played a key role in making ITNs and insecticide available in these areas. Transport costs for a dependable delivery of ITNs are probably high. Relying on the transport of other projects and entities may be unreliable: added to the other sources of unreliability in the ITN and insecticide delivery system (funding, availability from the factory, import, transport to the provinces) may make delivery of ITNs in rural areas highly unreliable.

Members of Community Councils commented that people in rural areas do not necessarily have money readily available. To raise money, even a small amount, they need to produce and sell something and this takes time. They need notice of when ITNs will be available. Irregular availability may discourage them from purchasing.

If UNICEF is interested in sustainable delivery of ITNs, it would be useful for UNICEF to study more deeply the question of transport costs and the factors that influence them, and the storage capacity for ITNs at various levels. UNICEF will need to monitor closely how it develops, and what is the trade-off between coverage and costs. They will need to be supportive of the other stakeholders who are trying to make it work. World Vision is collecting data about how ITNs are in practice being delivered, and this could be useful for understanding transport costs. Costs are likely to be higher where people are dispersed and

distant from towns, where they are expected to pay (so have to have money ready at a certain agreed date) where there are infrequent vehicle movements and where the aim is a long-term and sustainable delivery system. The difference in costs between the distribution of ITNs in Gaza after the floods and distribution in Zambézia may in part be due to some of these factors.

Impact. The activities that are carried out in the community are well organised. It was also observed that there were some positive results, such as the building of latrines and the use of ITNs. It was reported to the consultants that there had been an increase in level of pre-natal and post-natal and family planning consultations in nearby Health Units, and an increase in the numbers of births taking place in the Health Units (although there are still cases of late arrival of complicated births at the Health Units). It was reported that there was an increase in the number of children whose weight is being controlled regularly and attending vaccination sessions, and that information was being transmitted more rapidly to the health service about outbreaks of measles, cholera and meningitis. It was also reported that there is more rapid identification of cases of AFP, a reduction in the number of cases of malaria and diarrhoeal diseases, and better identification of suspected cases of malaria and their transfer to the Health Units). In those places where there is a nutrition component, it was reported that there has been recuperation of the nutrition profile in the community; that there is better knowledge about balanced diets, and improved agricultural productivity.

The Councils have simple forms on which to register their activities. The forms also allow registration of the number of cases of certain diseases detected and people who were advised to go to the Health Unit. The Councils also have simple forms that people can take with them to the Health Unit to explain why they have been transferred. The data from the compilation of these forms are used by the Council to produce a monthly report that is sent to the Health Unit and forms the basis for the monthly meeting between Councils at the Health Unit. Somebody from each Council goes to a meeting at the nearest Health Unit each month. Somebody from a group of Councils goes to a meeting with the DDS once every three months.

The HSDS project will carry out in the near future an inquiry with a community KAP component as part of its final evaluation. This will be in the same format as a base-line study at the start of the project in 2001. This should provide firmer information about changes in knowledge and practices among the population in the areas where HSDS is working.

Evaluation of Councils. The following table summarises information about those Community Councils that the consultants visited: the date of creation and the projects in which each one is involved. It also shows an evaluation by the consultants of the strength of each Council.

The table indicates that the weakest Community Councils are those that have been in existence for only a short time. This suggests that it takes some time for a Council to gain confidence in itself and gain the confidence of the local community. Often people distrust information from the outside. It takes time for people to get used to volunteers and to get used to the idea there are not going to be any handouts. There is also a tendency for those Community Councils that are only linked to one project to be weak or very weak. This may be because they were created more recently, or it may be that the support from more than one project helps to strengthen the Council⁶.

None of the Councils linked to HSDS were judged to be weak; this may be due to the quality of the training or support from this project, the fact that HSDS has a number of components or may be due to the fact that all Councils visited with an HSDS component are also part of another project.

⁶ However some World Vision staff commented that sometimes the demands of donors make integration of projects difficult and that it is not always possible to obtain resources so that a sequence of activities can be carried out with the same community organisations over a reasonable period of time. World Vision staff gave examples of difficulties with donors because of integrating activities funded by different donors.

District	Comm. Health Council	When created	Project malaria	Project HSDS	Project Ovata	No. of Projects	Evaluation
Guruè	Macuarro	1999	Yes	Yes	No	2	Good
	Intuba	2002	Yes	Yes	No	2	Good
	Muxima	Mar-99	Yes	Yes	No	2	Very good
	Muahupo	Nov-02	No	No	Yes	1	Weak
	Napiepe	1997	No	Yes	Yes	2	Very good
Mocuba	Sassamanja	1998	Yes	Yes	No	2	Very good
	Mbuma	2003	Yes	No	No	1	Very weak
	Mpasso	Jul-01	Yes	No	No	1	Weak
Morrumbala	Maço	2001	Yes	Yes	Yes	3	Good
	Macange	2001	Yes	No	Yes	2	Good
	Murda	Oct-03	Yes	No	No	1	Weak
	Vungantinta	Jan-99	Yes	Yes	Yes	3	Good

Some of the Councils created for the malaria project that have not been included with other projects are weak or very weak. They consider that, to some extent, their activities have ended since the malaria project ended in their Districts. Some Councils created for the malaria project reported that they were formed in 2003 and have had an effective life of less than a year⁷. The strategy adopted in practice by the malaria project is thus a cause for concern. The original project documents seen by the consultants do not specify how many Councils were to be created by the malaria project, how many ITNs were to be sold in total and thus how many ITNs were to be distributed by each Council. In practice, each Council has sold about 100 ITNs, and has carried out educational work about malaria and diarrhoea: this seems to be a very limited activity in relation to the investment in setting up these Councils⁸. In some Districts Ovata project has taken on the support of these Councils but Ovata is only operating in certain Districts and cannot take on the support of all the Councils in the Districts where it is operating. There are thus Councils created as part of the malaria project that face an uncertain future.

Coverage. Even though there are large numbers of Councils in some Districts (and the sustainability of such a large number of Councils is questionable), they do not provide a complete coverage of the population of the District. For example, the population of the District of Mocuba is 290,000 but the population covered by the 103 Councils is 70,000.

The differences between the Community Councils can create some difficulties. Somebody from each Council goes to a meeting at the nearest Health Unit, but those from Councils that have received less training can feel excluded when topics that have not learnt are not discussed. The meetings disillusion those who cannot follow the meeting and the information, and particularly those Councils that feel that they have an uncertain future with little future support while there are others that have already received significant support.

⁷ There is however some discrepancy between the dates reported by Councils and written reports. Apparently Councils were not supposed to be created as part of the malaria project during 2003, though this appears to have happened.

⁸ Community Councils were also originally supposed to be involved in community-based malaria treatment. This was never achieved because, apparently, the Ministry of Health did not clear the import of chloroquine for this purpose. If there had been community-based malaria treatment, Councils would have had a slightly larger activity base.

Money. ITNs have been bought by Councils for 25,000 meticaïs and sold for 30,000 Meticaïs to the target group of pregnant women and those with children under five. Insecticide has been bought by Councils for 3,000 Meticaïs and sold for 5,000 Meticaïs. This has created a fund of the Council. Councils have little previous experience of managing common funds and have received little guidance: managing money and managing a collective project can be difficult for rural people. The income to these funds is low and unpredictable, as the supply of insecticide has been irregular and most Councils have sold only about 100 ITNs.

Most Councils have a bicycle and those linked to HSDS have a bicycle – ambulance. The Councils are responsible for their repair and maintenance (except for some large breakages that require welding, for which the DDS take responsibility, as this cannot be done in rural areas). Without a regular supply of ITNs to sell, it is likely that the funds of many Councils will be exhausted with the repair and maintenance of bicycles.

Although the value of the local currency has been stable recently, it has been known to suffer periods of rapid devaluation, and in these situations, the funds of the Councils would rapidly lose their value. It seems that some Councils have been advised to begin an income-generating activity so as to maintain and increase the value of their funds. Only one Council that was visited has done this. The others are very reluctant to do so: income-generating projects can be very challenging and Councils see the need for outside support to be involved in income-generating projects. Project staff are not trained to manage income-generating projects and it is not advisable for them to be involved in this area unless they are properly trained.

Supervision. From 2001 to 2003, Community Councils were usually supervised and supported by World Vision staff. The objective of HSDS has always been that Community Councils should be supervised and supported by staff from the nearest Health Unit, and for this reason the Councils created as part of HSDS were close to existing Health Units. Although this meant that there would be incomplete geographical coverage, there would be a better chance of sustainability after the end of donor financing.

The project documents for the malaria project do not say how Councils will be supervised and supported after the end of donor financing. This has led to a situation where a number of Councils created as part of the malaria project are unsure how to continue.

However, in the case of all Councils, it would seem that the Health Units have difficulty in making regular visits to the Councils; there appear to be very few of such visits. The impression of the consultants is that the supervision of Councils by Health Unit staff has been inadequately prepared and the staff, who have a curative training, and unsure how to supervise a preventive programme.

There seems to be as yet no uniform method of accompaniment of the Councils by the Health Units, and there seems to be no manual or guide for how they should do it. There are Mobile Brigades of the Ministry of Health that visit rural areas and also interact with the Councils, though Councils commented that the Mobile Brigades⁹ did not come to their areas as frequently as planned especially in areas distant from the Health Units. There were some reports of poor relations between health staff and the Councils: nurses have not been trained in a “partnership for health” approach and sometimes speak to patients in a critical way. Some Councils reported that nurses criticise patients who arrive late at Health Units in an advanced stage of an illness and also criticise the Councils for letting this happen. There were also reports of poor relations between Councils on the one hand and staff of the Health Units and Mobile Brigades on the other because of the system of sale of ITNs in the third phase of the malaria project: this puts nurses and Councils in competition for each other over the sale of ITNs, and nurses seem reluctant to encourage Councils to sell ITNs because they would lose the 5,000 meticaïs that they earn from each sale.

⁹ The main objective of Mobile Brigades is to increase vaccination coverage, though they also carry out growth monitoring of young children and other health activities.

Sustainability and value-added. Community Councils are potentially valuable. They link people to the health services, especially in areas that are remote from health facilities. They are active in four of the six activities that were priorities for action at community and family levels in the last UNICEF/GoM country programme so potentially play an important role in these activities.¹⁰ For the foreseeable future there will continue to be large numbers of rural people in Mozambique who are at some distance from health facilities. Funding of Councils through the malaria project potentially could have had an added-value. But in practice it may not have added value: Councils created by the malaria project have facilitated the distribution of ITNs but now have difficulty in monitoring who has and uses an ITN (because the main source of ITNs is now the Health Unit). Councils created by the malaria project have not been integrated into a wider range of activities (though they potentially could do so) and the large number of such Councils has made it difficult to integrate them all into other programmes. (It is likely that there are Councils in this situation in all Districts where the malaria project created Councils, though the greatest number is likely to be in Districts where Ovata is not planned to function and where Ovata will not provide follow-up: these Districts are Milanje, Mocuba, Namarroi and Quelimane Cidade.)

There are two aspects to the sustainability of Community Councils. One is the running-costs of the Council itself, of which the most important aspect appears to be the maintenance of the bicycle and (in some cases) the bicycle-ambulance. As noted above, it would seem that the expectation has been that the Councils themselves would pay for this maintenance, possibly from the fund derived from the profit on sale of nets.¹¹ It is unclear whether, in the long term, these profits are enough to support the costs of bicycle maintenance. Income-generating projects have been mentioned as a source of funds, but such projects imply a high cost for support staff to help Councils develop such project.

The other aspect of sustainability is motivation, which potentially comes through Councils seeing their work as being valued, through seeing the value of what they are doing (to individuals, families and the community as a whole), through continued support and through being linked into a wider system of health and other activities.¹² The cost of this is the cost of staff to maintain links, supervise and motivate the Community Councils. At present this work is being transferred from World Vision staff to government health service staff and presumably it is hoped to reduce costs and improve financial sustainability by having this work carried out by health staff as part of their normal duties. It has not been yet demonstrated, however, that health service staff are fully prepared for this. It is likely that there is a need for continuing support to staff of Unidades Sanitárias and mobile brigades to develop their skills in working with Councils. This problem is most acute for Councils developed through the malaria project and not integrated into Ovata, as there has been least preparation for how they will continue to be supervised and motivated.

Other activities in communities should be encouraged to work with existing Councils, as better use can be made of existing capacity in this way. Other projects should take into account where there are already activities and should try to integrate with them.

The assessment of value-added of Community Councils requires a consensus among the various participants in the project about the potential roles of the Community Councils, how these roles can be achieved, what investment is required and subsequently whether this investment has achieved its intended objective. The different perceptions of the project, held by different participants, appears to lead to different assessments of whether it was worth investing in Community Councils. In practice some Community Councils may not have added much value to the project as their role has been limited to participating in the distribution of a

¹⁰ They are not active in the area "getting and keeping children in school (especially girls)". Further study would be needed to assess their potential in this respect, though many are distant from schools. Project RITA will soon begin to work with some in the other area where they are not active, namely "caring for orphans and children affected by HIV/AIDS"

¹¹ Some former have said that the original intention was for Councils to be able to choose how they spend the profit from sale of nets. However in practice the need to pay for bicycle maintenance leaves them with little discretion about how to use funds. Some staff commented that the funds raised from sale of ITNs and insecticide was hardly worth the effort of setting up systems to manage it.

¹² More use could be made of the data on morbidity that Councils are collecting to show them that their work is having an impact and thus to maintain motivation.

limited number of ITNs. Potentially, with a small amount of further investment, they could have had much more impact through a wider range of activities.

CCD and HRAP Councils have received and absorbed a great deal of useful information about health. They appear to have passed this on to other members of the communities where they live, and it appears that this has had some impact on individual and family behaviour and attitudes. This is impressive, and a particular capacity of the community has been developed. By integrating community leaders and getting them to agree about the need for action on key problems, their authority has been used to increase the effectiveness of the information being transmitted.¹³ The training provided under the malaria project, HSDS and Ovata has used participative education methods (such as discussions around drawings) and this may be why transmission of information has been successful. However it seems that these methods were used as teaching tools and there is little sign that they have been used to develop assessment and analysis skills in the Councils¹⁴.

There is a potential for developing assessment and analysis skills. Data about their activities and its impact could be used as the basis of discussions, which could reveal where and why their activities have yet to have an impact: this could potentially lead on to identifying new messages and activities that respond to the new needs identified by the communities (such as deeply-embedded traditional practices that are more difficult to change).

This could be challenging for the organisations involved, and have resource implications. The organisations involved would probably need to retrain the trainers so that they move away from transmitting information to helping communities analyse. The organisations might themselves need to look for possible solutions to the new problems revealed. This is in addition to the time spent with Councils discussing the data. Developing community assessment and analysis skills is inevitably time-consuming.

The malaria project has thus contributed to the greater use of participative education methods. However it is risky to say that this, by itself, is CCD or a HRAP. CCD and HRAP require a longer-term and more integrated approach. They require identification of a series of different community capacities that may need to be built, as well as capacities of other actors that need to be developed so as to complement the community capacities.¹⁵ They require the development of a strategy to assist in the development of these various capacities through a planned sequence of capacity-building activities.

Particular questions in the Terms of Reference. Traditional community structures existed in the areas visited before these projects started, but do not appear to have been active on many of the issues currently faced by these communities. More recent existing community structures do not appear to have been in place before these projects started. Community Councils are new community structures that bring together those individuals who have some status and influence in the community. They may include the “traditional” leadership but it was observed that in some cases the “traditional” leadership had an honorary role or was not participating in the Community Councils as the individuals had difficulty in assuming leadership roles with respect to contemporary questions. There does not seem to have been any weakening of existing community structures by creating Community Councils.

Representatives of Community Councils are taking part in meetings with the DDS, and sometimes there is contact with the District Administration through this mechanism. However there is not yet effective and regular contact between Community Councils and local

¹³ It would seem, from observation, that in most communities there is now various types of leadership (“traditional”, various churches, various political parties, those linked to the state administrative system). The positive aspect of CCs is to unify these different types of leadership and potentially competing leaderships around a community objective. Care needs to be taken to maintain this unity. Leadership could usefully be studied in more depth, as HAI did in Manica Province.

¹⁴ During their training, Councils involved in the malaria project were asked to prioritise their health problems. Almost always they prioritised malaria and diarrhoeal diseases. This was the package that the trainers had prepared, as it is usually what affects communities most in these circumstances. This is hardly an example of communities choosing what they want to learn about.

¹⁵ For the delivery of ITNs this could involve a series of actors, from peripheral health staff to importers and various Ministries.

authorities as a whole. Community Councils have, up to now, been seen as bodies working on health issues, and have not taken on a wider range of issues.

World Vision has been creating Community Councils since the mid-1990s. Where they have worked with the same communities for different projects, there has been continuity between the different projects. Between projects, Community Councils have usually lain dormant because there have not been other structures for them to interact with. Where there are dynamic individual community leaders, or where a Community Council has been supported for some time, they appear to continue to carry out some activities on their own.

HSDS and Ovata aim to make Community Councils sustainable entities once World Vision pulls out of a particular area, by linking them in with the staff of Health Units and with regular DDS meetings. However it is as yet unclear this will happen, and in particular whether the government staff have been adequately prepared to carry out the expected roles.

The potential advantages of Community Councils as a means to Community Capacity Development is that it brings together existing individuals who are, apparently, respected in the community and tries to create a cohesive entity focused on resolving community problems. It also attempts to link these to government bodies and create channels of dialogue. The health volunteers are closely linked to the Councils, whose members clearly know what is expected of the volunteers. Potentially this improves linkages and accountability within the communities, and provides support from community leaders to those involved in particular projects. This is probably an advantage compared to the model of the World Relief Project in Gaza where health volunteers are distant from the community leaders.

In theory, projects could work with different individuals in a community depending on the project, and could avoid working with those community members who are seen as leaders or influential. However in practice it is advantageous to ensure that leaders are informed of what is happening, and are persuaded to be supportive of projects. It is also advantageous to bring leaders together and handle any potential rivalries by focusing their attention on the resolution of community problems. UNICEF can best support such community structures by supporting the long-term programmes necessary to build their AAA skills and create mechanisms of dialogue between them and authority.

HIV/AIDS is a part of the work of Community Councils that are part of HSDS and Ovata.

WORLD RELIEF IN GAZA PROVINCE

World Relief is implementing a Community Health Project in Gaza Province since 1995, initially in Guija and Mabalane Districts. As it was believed to have a positive impact on the health profile in those Districts, the DPS requested World Relief to implement a similar project in Chokwe District, where the project began in 1999. Subsequently a similar programme has begun in Massingir District. UNICEF has lately become involved in funding this programme.

The aim in all four Districts is to strengthen the District health system, build the capacity of families to make informed health decisions, and to build the capacity of communities to improve their health status.

Volunteer mothers are trained in village groups (or sub-village groups) by animators. Each volunteer mother then passes on what they have learnt to 10 households. The animators are women who live in or near the communities. They are in turn supervised by World Relief supervisors. There are, for example, four World Relief supervisors for Massingir District and 24 animators. Ten volunteers should form a care group. A care group should correspond to approximately 100 households. Training of the volunteers takes place in care-groups, and covers malaria, diarrhoea, nutrition, immunisation, maternal care family planning and HIV/AIDS. Training material is available for the training of volunteers, and for the volunteers to use when speaking to the families in their area. The aim is to build the capacity of families to make informed health decisions.

In parallel, the project trains village health workers and helps to build health posts in each community. In the two original Districts, this had led to almost all the population being within 5 kms of a health facility compared to 50% previously. Follow-up training of village health workers takes place regularly when they come to the Health Centre to collect new materials. Village health workers liaise with mobile vaccination teams about the visits of the teams to each area.

Village health committees have been formed in each village. A number of different care-groups may relate to one village health committee. The committee involves a number of different influential people from the village, and they meet monthly.

The health education programme implemented by World Relief in Gaza Province thus has a number of similarities to the approach of World Vision in Zambézia Province. Changes in health prevention and treatment are being sought by better information to households, though volunteers (with each volunteer having ten households). There are some differences however.

In the World Relief programme, village leaders are not trained in health issues. Volunteers are trained first, and Village Health Committees are formed later. There appears to be less emphasis on the development of the capacity of the Committees and the link between the volunteers and community leaders appears to be weaker. This may lead to less support from community leaders when volunteers are in difficulties. It is also less clear whether the aim is to create a cohesive group of community leaders who can go on to lead processes of analysis and action in their communities.

Another difference is that the World Relief Programme involves village health workers. The DPS of Gaza apparently has been more supportive of village health workers than the DPS of Zambézia and has interpreted national policy to support them.

A further difference is that data that are collected by the village health workers, animators and volunteers (for example on vaccinations, use of ORS, treatment seeking) are used more systematically in the project reports and in village health committee meetings. Analysis of these data is more systematic at the local level in the World Relief programme than in the World Vision programme.

CONCLUSIONS

1 Developing an effective ITN distribution and re-treatment system.

ITNs have been shown to be an efficacious intervention against malaria¹⁶. They are probably the most important tool for controlling malaria, given the lack of a vaccine, resistance to chloroquine and the complexities of other vector-control mechanisms.

However the main lesson from earlier anti-malaria efforts is that identifying an efficacious control tool is only one step towards an effective, sustainable malaria control programme. Making the promise of malaria control through ITNs a reality requires operational research to test effective strategies for making ITNs available and ensuring their effective use (including re-treatment). Effective strategies have to be adapted to the context: the population distribution, their knowledge and poverty levels, the distribution of commercial and health service networks. Sustainable ITN programmes on a large-scale in routine health-intervention programming require operational research, adaptive programming and careful monitoring, to better inform managers and policy-makers on how to create such effective and sustainable programmes. Different approaches to the financing, distribution, periodic re-treatment and promotion of ITNs need to be explored¹⁷.

Achievement of the goal of the Zambézia malaria project (reduced burden of malaria in pregnant women and children under 5 in Zambézia) and its purpose (effective community based strategies for malaria and treatment adopted) requires an effort to find effective sustainable¹⁸ strategies to make ITNs accessible to the population of Zambézia Province (many of whom live some distance from health units and normal commercial networks) and promoting their effective use. It will require an operational-research approach: the systematic study (by observation or intervention) of the workings of the system with a view to improvement. This implies continuous monitoring of how the ITN distribution systems are working, uptake rates in different locations and through different distributions systems, as well as monitoring of real costs of distribution and comparing them with similar situations in other countries.

The project documents of the Zambézia malaria project that are available to the consultants do not state clearly how a sustainable effective distribution strategy is to be developed through the project. They do not indicate how the experience should be used to develop a national policy on ITN distribution, nor who should take the lead in studying how the distributions systems are operating and how they could be improved. The documents do not state clearly how it is intended to use the money raised from the sale of ITNs and kits, and whether it will serve as a rolling fund for further purchases of ITNs and kits (which is the normal pre-condition for a sustainable system); they do not state how such a fund will be monitored and whether UNICEF (which has contributed to the initial funding) will be able to monitor the status and use of this fund; they do not state how the fund will be recapitalised if there are losses due to subsidies, transport costs or devaluation of the local currency.

The documents do not state what information will be collected, and by which partners: they do not make explicit how such data will be used. In practice there seem to be gaps in information: it is unclear what data have been collected about far the geographical distribution of sales through PSI (which make up the majority of sales of ITNs), the real costs of distribution through various systems, and how that varies between different parts of the Province, nor about the costs of the different components (such as transport costs, storage, education, advertising, shopkeepers' margins).

¹⁶ Hill, 1996

¹⁷ Lengelee, Cattani and Savigny, 1996

¹⁸ In this context "sustainable" does not necessarily mean fully self-financing. Given the levels of poverty of some of the target populations in Mozambique (and the fact that some of the poorer people live in areas where transport costs are likely to be higher), some kind of subsidy or cross-subsidy may be required. "Sustainable strategies" in this context means strategies that can be implemented over a number of years attracting the support of the government, donors and local people.

2 Community Councils as part of an effective ITN distribution and re-treatment system.

Community Councils are a potential way of improving access to ITNs and insecticide kits in areas that are distant from Health Units and normal commercial networks. They can potentially improve geographical coverage, and the sale of ITNs and kits fits in well with their other activities and their role in raising awareness of health and other development issues.

The malaria project in Zambezia could have had benefits in addition to the distribution of ITNs, if its work with Community Councils had been planned in an integrated way with the long-term plan by the DPS and World Vision for development of Community Councils in the Province. In practice there has been little added value as many Councils developed by this programme will now be difficult to integrate into a plan of supervision of Councils by health staff or World Vision. Those Councils formed as part of HSDS and Ovata have made greater progress in consolidating their activities. If World Vision continues to accompany their activities and to link them in to other projects and State institutions, there is some chance that they will be sustainable. Those that were created for the malaria project (and not linked in to other projects) have a lower probability of being sustainable, as they tend to be weaker and there has been no strategy for the continuation and consolidation and linkage to other institutions.

It should be noted that in the present model of Community Council, each Council covers an average population of less than 750. Even in Mocuba District, where more than 100 Councils were created, Councils serve 70,000 people out of the total population of the District of about 300,000. It was not possible to map fully the areas covered by commercial sales, Health Units and Community Councils, but respondents believed that there were still areas of the District unserved by any of these outlets.

Creating Councils for a limited number of activities implies poor cost-effectiveness, and creates frustration among members and volunteers when they have completed these few activities. In some Districts the Zambézia malaria project has created large numbers of Councils mainly for malaria activities, and their future is now very uncertain: most have sold only about 100 ITNs. However other World Vision projects have created limited numbers of Councils that may only cover a small part of each District, and the tendency of HSDS project has been to create Councils close to Health Units (so that there should be a strong link between the Council and the Unit): thus use of existing Councils as one of the ITN distribution channels may leave extensive areas of a District unserved.

3 Health challenges in Mozambique.

It was apparent from interviews with the Ministry of Health and the DPS that the network of Health Units in rural Mozambique is unlikely to be extended in the foreseeable future. This will leave many areas at a considerable distance from the nearest Health Unit. At the same time, there are considerable and growing health challenges in these areas: as well as the long-standing diseases (malaria, cholera, measles, tuberculosis etc) there is now AIDS. People need to be informed about these diseases, how to recognise them, how to avoid them and when to seek treatment. People need to be reminded about how to avoid them and when to seek treatment. Treatments for Tuberculosis and, in future, AIDS will require that people are reminded to continue to take their treatment. This requires a strategy for reaching people who live at a distance from Health Units. Donors cannot continue to think in terms of vertical programmes delivering services to communities without considering the development of the system at the community level for delivery of a variety of services.

There is an awareness in the Ministry of Health of the need for such a strategy. There is interest by the Ministry of Health in Community Councils as part of this strategy, along with Mobile Brigades, First Aid Posts, Traditional Birth Attendants and links with the nearest Health Unit. However this requires operational research to test effective strategies for using these elements to the best effect, to develop their capacity and link them together. Effective strategies will depend on the context: for example the population distribution, and their knowledge and poverty levels.

4 Community Capacity Development and the Human Rights' Approach to Programming.

It is unclear why the Zambézia malaria project is highlighted as a HRAP or CCD project. The Zambézia malaria project does not have many of the features of HRAP and CCD projects (see box on UNICEF's Human Rights' Approach to Development). It has not, for example, developed an analysis of the duty-bearers and rights-holders for a sustainable ITN distribution system and what capacities they require. It has focused on a limited number of objectives and actions in a specific period: the documents of the project define goals and purposes in terms of malaria and HRAP and CCD would seem to be envisaged as means to reach this end.

HRAP and CCD are long-term transformatory approaches that cannot be used as means in a time-bound project with specific goals and purpose. It is challenging to combine specific goals and purposes with an HRAP or CCD, which imply a long-term engagement to build community capacity in stages and in parallel to build the capacity (and attitudes) of other actors to effectively work with communities. The Zambézia malaria project has used participative educational tools, which are undoubtedly effective, but in themselves these do not make it a CCD project. There is a tendency, in any project, for the aspects of such tools that should create analytical capacity in communities to be neglected and for the emphasis to be on transfer of information.

Many of those involved in the implementation of this project said that they were puzzled by the fact that UNICEF was highlighting this project as a HRAP or CCD project. They were in favour of transformational development, but were of the opinion of that it had not been clear at the outset that this was UNICEF's intention. Their impression was that most donors were only interested in tangible outputs (such as numbers of ITNs distributed) and that this project was no exception: their perception was that the main objective had always been ITN distribution to reduce malaria prevalence and that the provision of information to communities had been intended to support this objective. They were also of the opinion that the implementation design did not provide opportunities for such an HRAP or CCD approach.

On the other hand, some of those involved in the original design of the project (but no longer directly involved) expressed the opinion that this project initially had been intended primarily as a project of Community Capacity Development: malaria activities had been intended to be only an entry point for a longer-term process of strengthening of community's capacity for analysis, assessment and action, and the role of the volunteers had been to introduce community to introduce community to CCD processes and participatory communication (rather than passing on information or giving advice). There would thus seem to be different perceptions about the original aims and the history of this project¹⁹. The authors of this report are not in a position to make a judgement about which of these perceptions is correct. However it would appear to the authors of this report that UNICEF is making claims about the malaria project as a HRAP or CCD project that are based on some possible original aims of the project and not on the present reality of the project²⁰.

¹⁹ For example: the UNICEF internal discussion document "Zambezia malaria project: situation August 2002" states that the initiative was started in April 2000 to offer sustainable malaria interventions to vulnerable groups. It also states that distribution of ITNs through community councils began when it became apparent that the previous strategy of social marketing of ITNs through commercial markets did not improve access to ITNs in rural areas. Some of those involved in the original design of the project disputed this: their perception was that the main objective had been community capacity development, that malaria interventions were an entry point to this, and that it was not the lack of penetration to rural areas that had prompted ITN distribution through Community Councils.

²⁰ Documents such as the UNICEF internal discussion document "Zambezia malaria project: situation August 2002" and published documents about the project are unsatisfactory, in the opinion of the authors of this report, as they do not make it clear about how HRAP and CCD will in practice be reconciled with the specific aim of a malaria project. It is possible that HRAP and CCD are being confused with participative education methods.

UNICEF's Human Rights' Approach to Development. From UNICEF (2002), UNICEF (2003) and UNICEF (2004)

UNICEF's Human Rights' Approach to Development considers children as rights-holders, who have a claim against individuals or institutions with a duty to meet or fulfil those claims. These duty-bearers have a relationship among each other, they can be held accountable, and the reasons for not meeting children's rights are explained in a causality analysis. This analysis points at capacity gaps among those duty-bearers. Programme interventions will help to identify the problem, support the claims and help to identify accountabilities, and will eventually aim to close the capacity gaps of duty-bearers.

There is a principle of accountability that suggests that if people have rights – that is, that they are rights-holders or claim-holders – there must be others to whom they can make a claim to ensure that their rights are fulfilled. Therefore there are also duty-bearers, such as the state, institutions or individuals, which have the duty to respect, protect, promote and fulfil human rights. Adopting a human rights-based approach obliges UNICEF Country Programmes to help governments, civil society, communities, families, guardians, caregivers and other duty-bearers to meet their obligations to children and women. It is also essential for Country Programmes to ensure that rights-holders are aware of their rights and to assist them in claiming those rights.

HRAP implies a robust empowerment strategy to promote accountability and democratic governance. It implies that participation is not just participation in community projects and in what is defined by others: it implies participation in influencing state policy and budget formulation. It implies more information about decisions made at national and local gov levels, and feed-back on activities of political representatives. It implies the monitoring of activities of government workers and guarding against corruption

This implies contributing to the capacity-building of the State's institutions so that it can more effectively deliver services. It also implies empowering communities so that they can demand the quality services to which they have a right, and so that they can hold state agents accountable for poorly delivered services. It implies a problem analysis and then the design of rights-based social programmes in the public sector: demand creation on the one hand and ensuring the capacity of duty-bearers on the other hand (including government at all levels, communities and families) to effectively respond to that demand.

For UNICEF, child survival, development and participation in the ultimate goal and the analysis is that these depend on human, economic and organisation resources. HRAP and CCD address these resources: what resources a community has, what outside support is needed and what is needed to provide this outside support (usually with a focus on the duties of the State).

Communities in rural Mozambique are marginalised, though not isolated. They live at some distance from sources of reliable information and from commercial networks. They have difficulty in making their views heard and recognised. Nevertheless, they produce crops for the world market and their livelihoods depends on the price on the world market²¹. Some people go to Malawi and other distant places to work. They are not isolated from AIDS though they are marginalised from the information and means to fight it. Communities in rural Mozambique need ways to decrease their marginalisation.

Community Capacity Development is thus highly relevant for Mozambique. It could improve the access to reliable information by these marginalised communities, help them to make their views known to policy-makers, help them to plan their own development and help to provide better access to a range of services.

²¹ People in Marrumbala, for example, produce cotton but were unaware of the Oxfam-sponsored conference in Maputo in June 2004 about the world market for cotton.

Community Capacity Development is also likely to receive some support from Government. The Ministry of Health is supportive of the health activities carried out through Community Councils. Other Ministries are interested in the model of Community Councils that would permit the activities of various Ministries to reach communities through a grouping of community leaders, who would then support other groups of local people in carrying out various activities. Community leaders would be aware of the activities of those trained to maintain a hand-pump or helping to manage a school, and be able to support them.

The current activities of Community Councils, such as provision of health information, are a useful first step in the development of such Community Councils. They are a good entry point into communities and communities undoubtedly value this information. However the provision of information to communities tends to perpetuate the idea that communities know nothing and that professionals from outside already have the information and can simply transmit it to communities who do not know. It usually becomes clear after some time that it is necessary to listen to local people to understand why they do not fully adopt recommendations from outside. There are often local constraints that people from outside cannot see. There is a need to join local and outside knowledge to find workable solutions to local problems²².

Moving beyond "information giving" to "information exchange to create partnerships for change"²³ can be a difficult step. Professionals are accustomed to a situation where they have and transmit relevant information. They are not trained to exchange information. However it is an important part of developing the capacity of communities, helping them to assess and analyse. Assisting the development of Community Councils would be a CCD process, though it would be a challenging, long-term programme.

In the opinion of the consultants, it is possible, though challenging, to reconcile HRAP and CCD with a project focused on a limited number of objectives and actions in a specific period. In this case, for example, developing sustainable malaria interventions requires the analysis of the existing capacity of a number of different actors (in communities and various parts of the health service), comparing that with the capacities necessary to sustain malaria interventions and developing a plan of activities to provide the capacities that are lacking. This is at the same time a central part of HRAP and CCD. All of the six specific threats to the realisation of children's rights identified by UNICEF and the Government of Mozambique and adopted as priorities for action²⁴ imply something similar: identifying problems, and thus goals, identifying actors and their potential roles, identifying their capabilities and the resources available, and thus identifying a plan of action for ensuring the availability of the required capabilities and the resources.

A sectoral project of limited duration is unlikely to provide enough time for the transformations that are implied by HRAP and CCD, and for the creation of the required capacities. Implicit in the work with Community Councils in Zambezia is the expectation that they will:-

- be a mechanism for certain specific interventions, and in particular act as channels of information into the community to facilitate such interventions
- be part of a process of developing the capacity of communities to analyse, assess and act (involving improved confidence and experience by the community and its leaders, improved accountability and cohesion within communities)
- be part of two-way communications channels with authority, make the views of communities of communities known to authority, and hold authority to account (involving changes in attitude towards communities by those outside them, a recognition by local authorities of the potential capacities of communities).

²² While rural people in Africa may know little about the workings of the human body they often know a great deal about climate and soil and crops. They often do not need to be told how and when to sow traditional crops. Sometimes agricultural extension messages are of little relevance to them.

²³ "Partnerships for change" and communication: guidelines for malaria control. WHO and the Malaria consortium.

²⁴ Prevention and management of common illnesses (especially malaria, diarrhoea, ART, immunisable diseases), promotion of good growth and nutrition, promotion of safe motherhood, getting and keeping children (especially girls) in school, preventing HIV infection among young people, caring for orphans and children affected by HIV/AIDS

These different aspects involve different time-scales. In practice in this project, the first aspect has been given priority, probably because it is easier to understand and implement by field-workers, does not involve significant changes in attitudes and practice by fieldworkers and those in authority, and fits more easily with the time-scale of a two- or three-year project. In project management terms, it may be difficult to deal with the different expectations mentioned above within the same project. There is a strong case for having separating project management (though with strong coordination mechanisms), with one project focusing on a specific intervention and another on the long-term development of the Community Councils in a particular area²⁵.

The capacities implied by HRAP and CCD imply a longer-term process. This in turn has one of the following implications for UNICEF

- that it develops a series of interventions in the same place over a number of years²⁶
- that it develops a specific CCD project in an area that runs for a number of years²⁷
- that it coordinates its activities with other organisations so that it is part of a coordinated long-term programme of CCD.

Another implication is that UNICEF has a staff member (or team) specialised in HRAP and CCD, who can support the specialist sectoral staff in linking their sectors to HRAP and CCD.²⁸ It may also imply that UNICEF have staff in Provinces where they have a series of coordinated activities or have a CCD-oriented project: these approaches require high levels of liaison with local levels of government and with other implementing agencies, and require monitoring of project implementation to ensure that these new approaches are being implemented in the way that is intended²⁹.

²⁵ The points in the previous two paragraphs are similar to points made by Tim Freeman in his internal paper of 28 September 2002 "Human rights' approach to malaria programming"

²⁶ Intersectoral, integrated programming is considered to be linked to HRAP and CCD in the UNICEF document "Application of the Human Rights-based Approach to Programming in UNICEF Country Programmes of Cooperation: Assessment 2000 – 2001".

²⁷ The SUSTEM report of April 2000 makes the point that "a key weakness in current CCD approaches in Mocuba (ie the Zambezia malaria activities at that time) and Manica is that there are no generalist CCD oriented projects to provide communities with the institutional basis and relationship with local government which support community development activities according to mutually agreed agendas". One of the recommendations of the SUSTEM report is as follows: "UNICEF will have to make a decision concerning its level of commitment to implementing CCD. That is, rather than supporting funded projects in the short term, it would be more supportive of CCD to fund longer-term programmes that can support UNICEF's projects as they appear." It is unclear how UNICEF responded to this report. However it could be that the lack of a clear response has led to the difficulties of a sectoral project attempting to incorporate wider and longer-term HRAP and CCD aspirations.

²⁸ Many UNICEF sectoral staff expressed their concerns about their lack of experience of implementing their sectoral programmes with HRAP and CCD approaches.

²⁹ It is unclear to the consultants why UNICEF has field staff in certain Provinces but not in Zambezia given that it appears from the SUSTEM report that Zambezia was to be geographical focus of activities. As the SUSTEM report makes clear, all the potential partners in CCD programmes will require strong supervision and monitoring, otherwise there is "a risk that CCD and Triple A will turn into a purely theoretical strategy". Potential partners are interested in CCD and have some capacity but it cannot be assumed that they will implement CCD without continual support (page 17, final summary).

Implications of HRAP and CCD. From UNICEF (2002), UNICEF (2003) and UNICEF (2004)

HRAP and CCD involve an analysis of duty bearers at various levels:

- individual
- household
- community
- institutional
- local government
- national government

They involve a role analysis of what each of these should be doing, and then a capacity analysis of each of these in the following ways:

- 1 Responsibility: does the duty-bearer feel an obligation that they should perform this role? (should they?)
- 2 Authority: does the duty-bearer have the authority to perform this role? (may they?)
- 3 Resources: does the duty-bearer have the resources (human, organisational and financial) to perform the role, and what is missing? (can they?)

HRAP requires advocacy, training, information, education as well as service delivery.

Indicators are required at various levels for CCD and HRAP: -

- Input indicators (quality and quantity of inputs, their timeliness)
- Process indicators (progress of activities, when carried out)
- Output indicators (immediate results)
- Outcomes indicators (changes in behaviour, knowledge and attitudes of the various parties)
- Impact indicators

RECOMMENDATIONS

1 Community Councils as part of an effective ITN distribution and re-treatment system.

Community Councils should be one of the channels of sale of ITNs and insecticide kits. However Community Councils should not be created just for a limited range of activities: sale of ITNs and kits should be done through Councils that have already been created or that have a good prospect of long-term continued support and supervision and inputs for a wide range of activities.

This may mean that it is difficult to have satisfactory geographical coverage of a Province in the short-term. This in turn may mean that the extension of access to ITNs has to be gradual, through the gradual geographical extension of commercial sales and of Councils and identification of other channels (such other NGO projects, agricultural extension workers, churches).

2 Developing an effective ITN distribution and re-treatment system.

The Mozambique office of UNICEF should decide how it could best support the Government of Mozambique in developing effective strategies for making ITNs available and ensuring their effective use (including re-treatment). As a UN agency with a mandate to work with the Government, but with also the possibility of working with other partners such as NGOs in the implementation of projects, UNICEF is in a position to support policy-level work based on experience and operational research from project implementation.

If the Mozambique office of UNICEF decides to take this approach, UNICEF malaria projects (in Zambezia or other Provinces) should have objectives that explicitly mention a **sustained** reduction in malaria burden, the **sustained** adoption of community based strategies and a **sustained** improvement in access to affordable ITNs and insecticide kits (and their use). UNICEF malaria projects should clearly state the challenges in doing this, such as the remoteness of many people from commercial networks and Health Units, and that the projects will have an operational-research component to identify how a community-based strategy can best be developed. Consensus should be reached beforehand before the various partners (such as UNICEF, commercial companies, NGOs and the DPS) about the fact that operational research is required.

If UNICEF is to provide a start-up fund for an initial order of ITNs and insecticide, and if this fund is then to be used for future purchases of ITNs and insecticide, UNICEF should be in a position to monitor the state of this fund and its use. The project documents should state clearly how any losses through devaluation of the local currency will be made up, how transport costs will be absorbed and how losses due to subsidies will be absorbed.

The systems for data collection should be devised before the start of the project, which will indicate quickly how many ITNs and kits are being sold, where and to whom, how they are used. It should indicate any difficulties in distribution and costs of distribution. There should be regular meetings between the various partners to look at the monitoring data, and decide any changes required in order to meet the objectives.

The various partners should agree to obtain and analyse as much information as possible about the experience to date in Zambezia. They should agree to work together to understand the real costs of the various components (transport, education, supervision, management etc) in different geographical areas and how these activities could be carried out in the most cost-effective manner.

3 Health challenges in Mozambique.

The Mozambique office of UNICEF should decide how it could best support the Government of Mozambique in developing effective strategies for reaching people who live at a distance from Health Units. As a UN agency with a mandate to work with the Government, but with also the possibility of working with donors and with other partners such as NGOs in the implementation of projects, UNICEF is in a position to support policy-level work based on experience and operational research from project implementation.

If UNICEF decides to take this approach, UNICEF should advocate with donors to help develop a system at the community level for delivery of a variety of health services, rather than continue to think in terms of vertical programmes delivering services to communities.

UNICEF should work with the Ministry of Health in analysing the experience with Community Councils in the areas where they have been introduced to understand better what they have achieved and any constraints.

Where UNICEF has the opportunity to be involved with projects that include Community Councils, UNICEF should advocate for objectives that include the development of a sustainable strategy for reaching people who live at a distance from Health Units. This would involve taking an operational-research approach, so as to identify how a community-based strategy can best be developed. Consensus should be reached beforehand before the various partners (such as UNICEF, commercial companies, NGOs and the DPS) about the fact that operational research is required.

An operational-research approach would need to explore how Community Councils (and other community health workers), Mobile Brigades and Health Units can share responsibilities and work together effectively. It would need to explore how much they cost to function effectively and any other constraints, in different contexts.

4 Community Capacity Development and the Human Rights' Approach to Programming.

UNICEF should further invest in Community Councils as an approach to community development. However, if UNICEF is committed to an HRAP or CCD approach, the Mozambique office should understand that this implies a long-term engagement to build community capacity in stages and in parallel to build the capacity (and attitudes) of other actors to effectively work with communities. It should understand that short-term, vertical programmes, on their own, are difficult to reconcile with an HRAP or CCD approach as the costs of a long-term engagement with community institutions (and with the State and private structures that interact with them) can be difficult to justify within the frame of a vertical programme. The sustainability of Community Councils will require investing in them and in the government structures that will interact with them and support them.

It should understand that specialist technical staff of vertical programmes will have difficulty in implementing an HRAP or CCD approach unless they have the full-time support of staff with an HRAP or CCD background. The Mozambique office of UNICEF should consider more integrated inter-sectoral programming in particular areas in which different sectors can together support capacity-building of communities and service-providers³⁰. It should alternatively consider general CCD programmes in particular areas into which sectoral programmes fit. It should consider having specialist staff in CCD and HRAP who can design

³⁰ Some of the HRAP and CCD literature suggests that communities should be given complete freedom to choose what activities they want to carry out, after they have assessed and analysed their current situation through CCD activities. This is very difficult to achieve, except in the very long term. In the short and medium term, the choice of activities is constrained by the capacities and resources of the community and of the supporting agencies. It is also constrained by the agenda of the supporting agency: UNICEF is only likely to be willing or able to support activities that are part of its priority actions, and it would be unwise for UNICEF to support activities in which it does not have the skills. However UNICEF should avoid imposing on communities activities that they clearly do not want or need, and should be willing to incorporate the opinions of communities into the design of programmes.

and manage CCD programmes and support sectoral staff ensuring, for example, that the role and capacity analysis of the various duty bearers is adequately carried out and capacity-building plans devised. It should also consider having a presence of staff at a Provincial level in areas with CCD programmes, to improve coordination between the various actors involved in programmes (training centres, implementing agencies, government agencies, UNICEF) and to assist in monitoring inputs (quality quantity and timeliness), progress, outputs (immediate results), outcomes (changes in behaviour, knowledge and attitudes of the various duty-bearers) and impact.

The Mozambique office of UNICEF should invest in monitoring systems for CCD and HRAP programmes that cover, and distinguish between, inputs, progress, outputs, outcomes and impact. CCD programmes pay particular attention to **outcomes**, that is to the behaviour, knowledge and attitudes of the various parties (their willingness and ability to carry out their roles). The technique of **Outcome Mapping** has been designed for monitoring changes in behaviour, relationships, actions and activities by people, groups and organisations involved in programmes³¹.

If UNICEF is committed to an HRAP or CCD approach, Community Councils are a possible entry point to a long-term programme. Community Councils do represent a realistic approach to CCD and a methodology in which UNICEF should invest more resources in the future, though little of the potential has been realised as yet.

As a UN agency with a mandate to work with the Government, but with also the possibility of working with donors and with other partners such as NGOs in the implementation of projects, UNICEF is in a position to support policy-level work based on experience and operational research from project implementation. UNICEF could work with various Ministries to support the transformation of the present Community Councils (that focus on health activities) into Community Councils or Community Leaders' Councils with a wider remit. It could help in analysing the experience with Community Councils to understand better what they have achieved and any constraints, and in developing and ratifying a government Community Strategy that goes beyond the health field.

In particular, the Mozambique office of UNICEF should be able to provide assistance to the various Ministries in developing a "partnership for change" approach, in which Ministry staff work in cooperation with community organisations rather than an "information giving" approach³². This should tackle the natural tendency of government institutions to see their links with community institutions as being a one-way "conveyor-belt" of information (and sometimes instructions) from government to communities. It should assist in the development of an understanding of the mutual rights and responsibilities of communities and those working with them.

There are many tools available that can support this change in attitude, such as the REFLECT literacy method developed by the NGO "Action Aid"³³, the SARAR methodology³⁴ and various tools for participative health education³⁵. However tools on their do not guarantee the change in attitudes by those working with communities, and there will always be a risk that the tools will be used to support "information giving" rather than "partnership for change". UNICEF will need to accompany programmes closely so as to monitor how far, in practice, they help to develop relations of mutual respect, rights and responsibilities between communities and the various institutions working with them. This implies some change in the way in which UNICEF works in practice. Partnerships will be required with Ministries and NGOs and training institutions that, while being codified in contracts, will go beyond the "contract culture" and will involve a high level of interaction during the planning, implementation and evaluation of programmes.

³¹ Earl, Carden and Smutylo, 2001

³² WHO and malaria consortium". No date

³³ Action Aid, 1996, which combines Freirian literacy with practical planning and action to develop assessment and analysis skills

³⁴ Srinivasan, 1990; Srinivasan, 1992

³⁵ WHO and malaria consortium". No date; UNICEF Mozambique, 1991; UNICEF Mozambique, no date.

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GLOSSARY

AAA	Assessment, analysis and action
AFP	Acute Flaccid Paralysis
ARI	Acute respiratory infections
CC	Community Councils
CCD	Community Capacity Development
DDA	District Agriculture Department
DDS	District Health Department
DPS	Provincial Health Department
EPI	Extended Programme of Immunisation
ESARO	Eastern and southern Africa regional office
GoM	Government of Mozambique
HAI	Health Action International
HSDS	Health Services Development Support
HRAP	Human Rights' Approach to Development
IDRC	International Development Research Centre
IMCI	Integrated management of childhood illnesses
ITN	Insecticide-treated nets
KAP	Knowledge, attitudes and practices
ORS	Oral Rehydration Solution
PMPT	Participatory malaria prevention and treatment
PSI	Population Services International
SARAR	Self-esteem, associative strength, resourcefulness, action planning, responsibility.
UNDP	United Nations Development Programme
WHO	World Health Organisation

ANNEX 1: TERMS OF REFERENCE

ADDED VALUE AND LONG TERM VIABILITY OF COMMUNITY COUNCILS IN ZAMBÉZIA PROVINCE MOZAMBIQUE

I Background

World Vision in Zambézia Province in Mozambique, since 1997, have developed community structures known as Community Councils (CC) through which most of their project activities occur. CCs, as the name suggests, are community committees are supposed to be made up of village leaders and other influential members of the community. These committees are envisaged as being long term sustainable entities whose activities should continue once formal project activities cease. The CCs are expected to be the central focus for Community Capacity Development through which all community problems are analysed and dealt with in a logical manner. Also importantly, the CCs are being seen as an important communication link between authorities and communities whereby authorities can communicate information to communities, and also, in turn, communities can convey issues to local authorities.

At present, World Vision has three separate projects employing a similar model. In Zambézia, the three projects are HSDS (Health Sector Development Support), OVATA (An abbreviation in a local language) for an HIV/AIDS project, and lastly, the UNICEF supported malaria. In these projects, issues of sanitation, HIV/AIDS, nutrition and malaria are being dealt with in the different projects.

The overall aims of the malaria project to which the community councils are involved are:

- Community capacity development for the use of malaria preventative measures, particularly demand created for the use of ITNs, early recognition of malaria symptoms, and prompt and correct treatment-seeking practices.
- Community-based distribution system for the First Line Drug (FLD) for malaria treatment (chloroquine)

In the malaria project, CCs are typically made up of about ten village elders who co-ordinate the activities of about ten volunteers who in turn are responsible for ten families each. In this way, each CC looks after the welfare of about 100 families. Participatory education techniques are employed to educate the CCs and volunteers who in turn use a similar approach to educate the families whom they coordinate.

In the malaria programme, these activities are restricted to sanitation and malaria, after which, Insecticide Treated Nets (ITNs) are sold to pregnant women and children under five. The CCs under the malaria programme are also expected to be involved in the treatment at a community level through the distribution of chloroquine by trained community volunteers to people who are identified as having malaria.

II Purpose

The purpose of this consultancy is to consider the experience of the CCs in Zambézia as developed by World Vision as a potential sustainable community tool to be used in other projects. In order to do this, the consultancy needs to investigate the malaria project as well as other experiences of similar community structures.

The overall question that needs to be asked is whether community councils represent a realistic approach to Community Capacity Development and a methodology that UNICEF should invest more resources into in the future, particularly in relationship to programmes such as malaria. For example, Insecticide Treated Nets (ITNs) distributed in Gaza in 2000 together with participatory communication

techniques cost US\$2 per net distributed. In Zambia, through the CCs, ITNs have cost US\$16 per ITN distributed. In this context, what added value does the CCs have in relation to the malaria project or to the overall CCD framework?

In carrying out this consultancy, the consultants need to look closely at the operations of the World Vision projects in Zambia and compare the results found, to similar systems used elsewhere in Mozambique and through a literature review in other parts of the region.

III Overall Objective

To assess the added value and long term viability/sustainability of the CC in Zambezia province related to the malaria project in particular, and as a means to supporting community capacity development strategies in general and make recommendations about future implementation.

Determine the added value of using community councils in terms of implementing a malaria project as the one being implemented.

Determine if there is a real potential to use the existing CCs to support other health related activities e.g. improved nutrition and care, increased attendance at immunisation sessions, activities in the field of girl's education, identification of vulnerable families etc.

IV *Scope of Work/Research Questions*

- Visit and study the design and implementation of the three separate World Vision projects in Zambia project namely OVATA, HSDS and the malaria project. In this investigation, the following needs to be noted:
 - What are the project steps in approaching communities and setting up CCs.
 - Is World Vision consistent in its approach to the formation of CCs?
 - If there are differences, which methods used are likely to best achieve the desired outputs in terms of Human Rights, CCD and sustainability.
 - Who makes up the CCs and what are the criteria if any? How are vulnerable groups represented through/on the CCs?
- Compare the finding of Zambia with other attempts to create sustainable and effective community structures elsewhere: such structures could include political or developmental structures. This should include visits to other programmes.
- Give recommendations to both World Vision and UNICEF on the potential strengths, weaknesses and possible improvements to the CC approach in terms of achieving the following
 - A Human Rights Approach to Programming (HRAP) as defined by UNICEF.
 - CCD.
 - As a vehicle for communication between communities and authorities.
 - Long term sustainability and what further inputs are needed (if any) to achieve this.
- Make recommendations as to whether UNICEF should further invest in this approach to community development and any improvements that can be made to the approach.
- Suggest mechanisms to enhance the sustainability and support of these CC after projects have pulled out. E.g. How would such groups realistically interact with local authorities.

Other Specific Information Required

- What traditional or existing community structures (if any) were already in place before these projects started?
- Are CCs basically new community structures, are they an improvement or modification on existing tradition structure? What is the linkage between existing structures and CCs.
- What is their interaction with local authorities?
- World Vision claims to have been creating community councils for some years and often work with the same communities for different projects. The question therefore arises whether World Vision is creating a different community structure each time there is a project, or is there a type of continuity throughout all their projects?
- What is the capacity of the existing CCs to take on a wide range of issues or are they formed to respond to a specific predetermined issue?
- What has happened to CCs between various projects. From such information it should be seen if the CC is a sustainable unit, or if it simply dies or lies dormant between each project.
- Are the CCs achieving a Human Rights Approach to Programming (HRAP) as defined by UNICEF.
- Are there any comparative advantages of this approach in terms of CCD to other methods employed elsewhere?
- In what way are the projects designed to be sustainable entities once World Vision pulls out of a particular area.
- Is the CC the most appropriate community structure to achieve the above aims.
- Are volunteers in the World Vision project part of the community councils?
- The basic role of these CC needs to be questioned. For example, is the project creating new Councils or are we strengthening or perhaps even weakening existing structures? Does the UNICEF CCD approach even need such councils in which to operate?
- How best can UNICEF support such community structures?
- As HIV/AIDS is both a national problem and a UNICEF priority, has HIV/AIDS been discussed within the context of the project?

V Process and Methods

Visit and study the design and implementation of the three separate World Vision projects in Zambézia project namely OVATA, HSDS and the malaria project.

The consultant would need to liaise with various actors at national, provincial and district levels including World Vision staff, volunteers, members of community councils, and local authorities at community and district levels. For a wider appreciation of existing and similar experiences the consultant should contact NGOs/CBOs (list can be provided by UNICEF) and other sectors at provincial levels such as DPMCAS, DPOPH, DPE.

VI Information Sources

UNICEF is able to supply a wide range of documentation in terms of the malaria project in Zambézia, but it would be up to the consultant to source data referring to other project both within Zambézia and elsewhere.

VII Geographical Coverage

The consultancy would be focused in Zambézia province but field work would also be necessary in Gaza Province. Other site visits can be considered if it can be shown that they would added value to the consultancy.

VIII Expected Output/Deliverables Of The Consultant

Written report in English with clear recommendations for way forward for UNICEF and World Vision in terms of future implementation of community councils. The report should include responses to all the questions posed above.

IX Time Frame

Fieldwork should be completed within four weeks of the signing of a contract with another two weeks to present a draft report to UNICEF. Following comments from UNICEF, the consultant would be given another week to produce a final report.

X Accountability

The consultants would report to the Malaria Project Officer of UNICEF who would report to the Head of Nutrition and Health as well as the chairman of the CCD working group.

XI Required Competencies of the Consultant

- Experience in rural community development.
- Experience of undertaking qualitative research.
- Knowledge and familiarity with the local context, community development strategies, role of UNICEF, CCD and HRAP.
- Good writing and communication skills in English and Portuguese.

XII Budget

This consultancy would be funded through the UNICEF malaria project in Zambezia Project 2, Subproject 3, Activity 304. The finalised budget would be agreed upon with the consultant selected after a bidding process.

18 August 2003

ANNEX 2: NOTES ON MEETINGS WITH HEALTH COUNCILS

Macuarro, Distrito de Guruè

Data Quarta feira, 09 de Junho

Localização Ao lado dum Centro de saúde, ao lado da estrada ao sul de Guruè. Dista 50 kms da Sede de Guruè.

O CC foi criado em 1999. Houve formação durante 6 meses, 1 dia por semana.

Um grupo de mães foi formado em 2003, com formação de 1 dia por semana por 3 meses (necessidade de controlar o peso, planeamento familiar, HIV, malária diarreia)

Houve uma formação específica sobre malária em 2003.

Um elemento também recebeu formação em AIDI em Morrumbala mais recentemente (10 dias).

Um elemento também recebeu formação em Guruè sobre sa'ude reproductiva mais recentemente (10 dias).

Os projectos são HSDS e malária. Língua local é Lomwe.

O contacto inicial era entre WV e os líderes tradicionais. Os líderes tradicionais organizaram um encontro com toda a comunidade que escolheu os membros do CC e os voluntários. Os membros do CC e os voluntários receberam a formação no mesmo tempo. Há pessoas que abandonaram a formação devido ao longo tempo da formação.

Há 13 membros do CC. Inclui membros de 3 partidos políticos (FRELIMO, RENAMO, PDD), o régulo, uma parteira tradicional, membro de 3 igrejas.

Há 26 voluntários. Trabalham nas áreas onde habitam.

Dia 20 de cada mês tem um encontro de todos (membros e voluntários) com o chefe da US.

Disseram que o preço duma ITN com insecticida é agora 35,000 meticais. Acham que o preço é alto, e que o retratamento é problemático (falta de insecticida regularmente).

Tem uma bicicleta ambulância, que actualmente é parada. Não tem dinheiro suficiente para as avarias, mesmo quando tiver dinheiro da venda das ITNs.

Disseram que não tem ideias claras como continuar no futuro e não tem experiência de gerir fundos.

Impacto é que há mais partos no Centro de saúde que antigamente.

Disseram que um problema é o transporte, porque algumas das áreas onde trabalham são distantes. Outro problema é matérias para o grupo de mães.

Enfermeira Luciana Vitorino (parteira no local): refere que os partos estão a aumentar de 20-25 por mês agora passaram para 60-70 devido ao trabalho de mobilização dos conselhos. Consequentemente as consultas pre-natais também aumentaram muito (~130/mês). Os membros e voluntários também participam em actividades do CDS. São escalados para dirigirem as palestras antes do início das consultas na US.

Dificuldades apresentadas: Incentivos, transporte (bicicleta avariada) e fardamento.

Intuba, Distrito de Gurue

Data Quarta feira, 09 de Junho

Localização 10 kms ao norte da pequena estrada (de terra batida)
que vai a Alto Molocue

O CC foi criado em 2002. Os projectos são HSDS e malária.

Houve uma formação durante um ano, 1 dia por semana nos sábados. Algumas pessoas não aguentaram todo o ano.

Há um grupo de mães, formação 1 dia por semana por 2 meses. Dois homens receberam formação em AIDI (10 dias em Morrumbala).

O curso de 1 ano: malária, diarreia, IRAs, SIDA, planeamento familiar, vacinas, consultas pós-parto, alimentação diversificada). Lembram-se dos cartazes: enfermeira Felicidade, preservativas, pílulas, IUD, ITNs.

O curso da AIDI: avaliação de crianças 0 – 5, sinais de perigo, malnutrição, curva de peso, alimentação diversificada, anemia, conselhos à mãe duma criança doente, métodos de prevenir diarreia, malária, tosse, febres.

O curso para o grupo de mães: papas enriquecidas para crianças malnutridas, os 3 diferentes tipos de alimentos (para crescer, proteger os doentes e para dar força) Houve um curso de dois dias para curandeiros (SIDA, cobras, ferver as lâminas e transferência de doentes)

Só as pessoas que fizeram o curso de AIDI receberam cartazes para fazer as palestras. Os membros do CC inclui pessoas importantes das igrejas, partidos políticos, um curandeiro, um enfermeiro. (Mas há 10 curandeiros na área).

Tem encontros cada 5ª feira. Um dia por mês tem encontros na US. Cada trimestre tem encontros em Gurue (um representante rotativo dos CCs da área) No início, pessoas estranharam com a presença de voluntários. Chamaram “ninja”, Mas acostumaram.

ITNs. A WV trouxe 50 por viatura a primeira vez (Junho 2003), e entregou ao CCS. Vendeu a um preço de 30,000, e o CC guardou 5,000 e devolveu o dinheiro a WV mais tarde. A segunda vez a WV trouxe 50 e vendeu imediatamente, embora que tivesse dito que iria entregar aos voluntários para vender. As pessoas que não estavam presentes naquele dia não puderam comprar embora tivessem já guardado o dinheiro para o efeito. Ultimamente só podem ter acesso às ITNs na US e custam 35,000 meticais.

Tem uma bicicleta ambulância, que actualmente está parada. Os cubos das rodas da cama/ambulância estão avariados. Cada cubo custa 25,000 meticais e agora não têm este dinheiro. Era possível ter a bicicleta ambulância quando tinha dinheiro que era o lucro da venda das redes, mas agora é difícil.

Auto-Avaliação do conselho: redução dos casos de malária (uso de redes mosquiteiras e algumas plantas com poder de repelente – *Hupe Hupe*), aumento da afluência de mães a US para controle de peso das crianças e consultas pré-natais, aumento de número de partos na US, envio atempado dos doentes com malária e outras doenças graves a US.

Dificuldades apresentadas:

- Falta de transporte (bicicleta avariada) o que leva a muitas mães a fazerem partos em casa (há localidades que distam 20Km)
- Falta de fardamento.
- Há parteiras tradicionais mas nunca receberam uma formação, e acham que é necessária.
- O pagamento dos membros do conselho e voluntários nas consultas na US

Muximua, Distrito de Guruè

Data Quarta feira, 09 de Junho

Localização 5 kms da estrada ao sul de Guruè. Há 8 povoações na área do conselho, mas só 4 povoações são de facto cobertas pelo Conselho. Em total a área do Conselho é 66 kms quadrados com 10,365 pessoas.

Os projectos são HSDS e malária.

O número de pessoas envolvidas era 47 no início, agora é 38: alguns morreram e outros desistiram. Agora são 26 voluntários e 12 membros do Conselho. Quando iniciou em 1999, todos os membros se chamaram "voluntários". Só em 2001 escolheram alguns como membros do Conselho.

Um dos membros do Conselho é Presidente da Localidade (que deu um relatório).

O CC foi criado em Março 1999. Houve 3 meses de formação, 2 dias por semana. Temas:

Malária
Diarreia e água
SIDA e DTS
Planeamento familiar
IRAs
Papas ricas
Consultas pré-natais
Vacinas
Consultas pré-parto

Alguns tinham uma formação especial sobre saúde reprodutiva durante 10 dias, e os assuntos foram: visitas domiciliare para mães grávidas, planeamento familiar, malária na gravidez, consultas pré e pós parto. HIV/SIDA.

Alguns tinham uma formação especial sobre AIDI durante 10 dias, e o curso abarcou matérias sobre malária, visitas domiciliare, sinais de perigo, encaminhamento atempado à US, vacinas, papas ricas, sarna, malnutrição, diarreia, sarampo, conjuntivite, arrefecimento corporal e IRAS.

Cada voluntário tem uma ficha para indicar o que viu. Tem um encontro no dia 15 para ver as fichas, fazer um relatório.

ITNs. Há uma carência de insecticida. A primeira vez que tinha ITNs, O CC vendeu e o preço era 30,000 meticais. A segunda vez foram vendidas pela DDS e custaram 35,000 ao centro de saúde.

Ainda tem um fundo devido a primeira vez que vendeu ITNs, mas não decidiu como usar. Queria fazer um projecto mas ainda não realizou (por exemplo, comercialização de peixe).

Tem uma bicicleta ambulância, que actualmente está parada. A DDS levou para arranjar mas ainda não devolveu.

Dificuldades: A falta de redes mosquiteiras para venda poderá interromper o único recurso que possuíam para gerar fundos no conselho.

Muahupo, Distrito de Guruè

Data	Quinta feira, 10 de Junho
Localização	Ao lado da estrada (da terra batida) ao norte de Lioma (quase na Província de Nampula)

O CCS foi criado em Novembro 2002.

O projecto é Ovata. (Lioma tem 12 CCs criados pelo Ovata. Há 39 conselhos no Distrito de Guruè). Os membros e os voluntários receberam a mesma formação: 2 dias por semana durante 3 meses:-

Nutrição
Malária
Diarreia
Vitamina A e cega nocturna
SIDA
Pólio PFA
Levar os doentes ao hospital
Higiene individual/ambiental
Nutrição de pessoas com SIDA
Meter o lixo nas covas
Latrinas
Tapar comida e usar copas
Amamentação desde o primeiro dia incluindo o Colesterol
Culturas para Vitamina A (batata doce de polpa alaranjada)
Algumas técnicas agrícolas

Houve demonstrações de tratar as ITNs. Houve demonstrações agrícolas. Tem uma machamaba para observar e aprender e dar um lucro ao Conselho. O grupo de mães faz uma demonstração de papas enriquecidas numa casa para um grupo de mulheres.

Tem um encontro cada 2 semanas para fazer um relatório que vai a Lioma e depois a Guruè. Deveria ir também a encontros a Guruè, mas não sempre vai (é longe). Houve um técnico agrícola que estava envolvido com o Conselho mas morreu.

Este CC só recebeu 13 ITNs. Parece que só recebeu porque era fim do projecto e queria usar o stock (fim 2003). Mas não era a intenção que este CC vende ITNs.

Auto-avaliação: O CC acha que algumas pessoas seguem os conselhos mas alguns não seguem. Mas parece que mais pessoas vão ao Hospital, há mais partos com parteiras e também na US. Certas culturas são melhores. Certas pessoas usam papas ricas, mas ainda há malnutrição.

Dificuldades: Acham que deve haver formação para parteiras tradicionais. Acham que deve ter mais material, por exemplo cartazes, pastas, livro de demonstrações, material para as demonstrações agrícolas. Há falta de água potável. Falta de material de campo (metros, linhas) para demonstrações locais. Não existe nenhuma rede (ITN) que sirva para demonstração prática.

Gostariam de ter um posto de socorro. Tem falta de sabão. Foi dito que iam receber uma bicicleta através do projecto de malária, mas não receberam.
Escola primária dista 12 kms.

Namiepe, Distrito de Gurue

Data Quinta feira, 10 de Junho

Localização Ao lado da estrada (da terra batida) 15kms ao sul de Lioma.

O CC foi criado em 1997

Os projectos são HSDS e Ovata.

Há 16 voluntários e 4 membros do Conselho. Tinha uma formação inicial em 1997. Em 2001-2 fizeram curso sobre papas ricas e SIDA. Em 2002 fizeram um curso sobre nutrição e 4 tipos de alimentos, comercialização (venda de produtos como um grupo), melhoramento de várias culturas (milho, gergelim, girassol e hortícolas). Tiveram também apoio para repovoamento de animais caprinos.

Só tinha ITNs em Dezembro 2003 e Janeiro 2004, um total de 30 redes.

Organização do Conselho: Tem feito encontros semanais entre os membros do conselho, e encontros mensais com o chefe de saúde de Lioma.

Auto-avaliação: Houve um impacto, porque mais pessoas vão ao hospital quando se sentem doentes. Há um melhoramento de culturas e as pessoas já se sentem capazes de produzir com qualidade. Há um aumento de consultas pré-natais nas US, aumentaram os conhecimentos sobre malária na comunidade, a população vai atempadamente à US quando se sente com sintomas de malária e sabe-se como proteger da malária.

Com o lucro da venda das redes mosquiteiras compraram patos que estão a criar para multiplicação.

Dificuldades: Falta dum posto de saúde, pois a USD mais próxima dista 15kms do sítio; subsídio; falta de transporte.

Na altura de venda de ITNs, foi na casa de pessoas que compraram para mostrar como tratar e usar.

Os membros e os voluntários e o grupo de mães tem um encontro uma vez por semana, fazem um relatório cada mês e um encontro cada mês na US (que é na vila de Mocuba).

Havia um socorrista no Posto de Socorro, mas morreu.

Auto-avaliação: referiram haver melhorias significativas em relação a saúde em todos os aspectos.

Dificuldades: Sentem a falta de ITNs. Falaram da necessidade de fardos, bicicletas, uma lanterna e cama para a parteira fazer os partos. Falta de posto de saúde e incentivos (bens materiais, por exemplo sabão).

Mbuma 1, Distrito de Mocuba

Data	Sábado 12 de Junho
Localização	10 kms a leste da estrada ao sul de Mocuba (30 kms da vila de Mocuba)

O CCS foi criado em 2003. O CCS só teve formação em malária e diarreia.

O Conselho foi criado no início de 2003. Pessoal da DDS e da WV foi a várias partes da aldeia e pediu que cada parte da aldeia escolhesse um membro do Conselho e um voluntário. Houve formação duas vezes por semana durante 2 meses, sobre a malária e a diarreia. A formação sobre a malária incluiu o uso de ITNs e o retratamento delas. A formação foi feita por um Sr Lima que depois seguiu e acompanhou a grupo até terminar o projecto.

A formação incluiu o uso de cartazes, mas não muito: houve muitas coisas que foram ensinadas só por falar. Aprenderam temas relacionadas com:

- Uso correcto de latrinas
- Higiene ambiental
- Construção de copas
- Construção de casas de banho
- Malária e suas complicações assim como prevenção
- Higiene pessoal.

Houve venda de ITNs em Março de 2003 quando foram vendidas 130 ITNs.

A formação incluiu um pouco sobre um fundo do Conselho, mas o Conselho não se sente que sabe gerir um fundo e fazer contas.

O Conselho terminou em Dezembro 2003. O Sr Lima disse que não ia vir mais. Sr Lima não explicou porque não ia vir mais ou como o Conselho devia continuar. O Conselho não se encontrou desde Dezembro 2003.

O Conselho sente que a população não aceita bem as propostas do Conselho. A população não gosta certas ideias e tem receio de mudar certas práticas.

O Conselho tem informações sobre as actividades de outros Conselhos no Distrito que receberam mais formação e material (bicicletas, sacolas, pastas), continuaram a receber supervisão por mais tempo. O Conselho sente abandonado e não está contente com isso. Os enfermeiros criticam o facto que os doentes chegam atrasados na US e assim é mais difícil tratar: mas isso não é a culpa do Conselho porque funcionou por pouco tempo que não chegou para mudar os hábitos da população, a US é distante e não tem uma bicicleta – ambulância.

Referiram poder reactivar as actividades mas sentem que necessitam de uma reciclagem porque ficaram muito tempo parados. Gostariam também de receber outras formações para além de malária e diarreia. Sentem-se muito limitados só a falar sobre malária e diarreia.

Dificuldades: falta de bicicleta ambulância, poço com água potável, posto de socorro, redes mosquiteiras para venda.

Mpasso, Distrito de Mocuba

Data	Domingo, 13 de Junho
Localização	Perto da estrada (de terra batida) que vai de Mocuba para Alta Benfica

O CCS foi criado em Julho 2001. O CCS só teve formação em malária e diarreia.

Língua local Chuabo.

O CCS foi criado em Julho 2001. Houve uma formação de 3 meses, duas vezes por semana sobre malária e diarreia. A formação sobre a malária incluiu o uso de ITNs e o retratamento delas. Depois o grupo se dividiu em Conselho e voluntários, e começou a dar palestras sobre a necessidade de tapar o lixo, construir latrinas, construir copas, higiene do corpo e do ambiente, arrefecimento corporal. Rehidratação oral com papas leves e sinais de desidratação grave.

Em Agosto 2001 recebeu e vendeu 48 ITNs, no fim de 2001 recebeu e vendeu mais 20 ITNs. O lucro de 340,000 meticais foi utilizado para suportar os custos dum óbito.

Uma brigada móvel visitou uma vez em Fevereiro 2004 e vendeu ITNs. O preço era 35,000 Meticais (com uma Força de Rede adicional). O Conselho não estava contente com o comportamento da brigada móvel porque não permitiu o Conselho participar na venda embora que o Conselho tenha ajudado a avisar e organizar as pessoas para participarem nas vacinações e na compra de redes. Sentiram-se utilizados.

O Conselho uma vez vendeu Força de Rede mas tinha que pedir a Força de Rede dum outro Conselho e devolveu o lucro da venda da Força de Rede ao outro conselho que lhes pediu apoio na venda.

De 2001 até 2003 o Conselho não aprendeu outras coisas novas. Sabe que há outros Conselho que aprendeu muito mais (porque um membro do Conselho assiste encontros em Mocuba na DDS com outros Conselho). Ouviu falar de SIDA e de DTS que parece importante, mas não aprendeu esta componente.

Em Dezembro 2003, Sr Brás (o formador) disse que o projecto terminou. Desde esta data o Conselho continua mas se sente desmoralizado. "Não temos patrão." Não recebeu explicação satisfatória. Continua numa maneira menos organizada, e não sabe que actividades fazer. Quando pessoas construíram latrinas ou copas, que podem fazer depois com o material que aprenderam. "Latrina umodja bas!" o que significa que em cada casa só pode ter uma latrina e não podem passar de novo na mesma casa para obrigar a construir outra.

Não é necessário mobilizar pessoas usar ITNs: o problema é que não receberam mais desde 2001 e que só conseguiram ter Força de Rede porque procuraram. Não podem continuar a dizer as mesmas coisas às pessoas para sempre. A atitude da Brigada Móvel quando vendeu ITNs criou desmoralização.

Uma pessoa assistiu as reuniões Distritais mensais até Fevereiro 2004, mas desistiu. Não compreendeu muitas coisas nos encontros, porque falava de assuntos que este Conselho nunca tinha aprendido (SIDA, DTS, IRAs, saúde maternal). Ouviu falar de coisas que outros Conselhos tinham aprendido ou recebido e assim ficou mais desmoralizado (bicicleta – ambulância, camisolas, formação de parteiras tradicionais).

Há outras áreas próximas que nunca tinha um Conselho, por exemplo Chingoma (a 5 kms) por isso não tinham a possibilidade de comprar as ITNs.

A população não sempre tem dinheiro, só tem dinheiro em mão de vez em quando. Para comprar uma ITN geralmente deve cortar um tronco e colher frutas, ir ao mercado vender.

Para comprar uma ITN deve ter crédito ou deve saber muitos dias antes que vai ter a possibilidade de comprar.

No início do projecto foi dito que ia distribuir cloroquina, mas isso nunca aconteceu.

Dificuldades:

- Falta de parteira treinada
- Querem um formador para outras componentes
- Povoada de Chingoma necessita de conselho
- Falta de material para IEC
- Gostariam de ter fardamento para ser identificados
- Ainda estão à espera da cloroquina para distribuição.

Maço, Distrito de Morrumbala

Data	Segunda feira, 14 de Junho
Localização	Na Localidade de Megaza, 5 kms de Megaza entre Megaza e o Rio Chire.

O CCS foi criado em 2001. Tem 7 membros do Conselho e 20 voluntários. Os projectos são malária, HSDS e Ovata. Língua local = Sena.

O Conselho deu um relatório sobre as suas actividades, fez uma peça teatral sobre malária e cantou várias canções. Apresentou informação sobre o calendário sazonal. Entregou um relatório por escrito. Tem um fundo que actualmente tem 500,000 meticais. Tem uma bicicleta – ambulância. Tiveram uma formação inicial em 2001. Depois tiveram uma formação adicional sobre malária só (2 vezes por semana durante 2 meses)

(A formação sobre mistura oral para diarreia não incluiu demonstrações práticas.)

A formação especial sobre doenças reprodutivas incluiu planeamento familiar, consultas pré- e pós parto, sinais de gravidez e partos difíceis. Falaram de várias formas de planeamento familiar, incluindo Depo Provera.

Em Novembro 2002, 2 pessoas fizeram uma formação sobre AIDI em Vila Morrumbala e outras duas sobre doenças reprodutivas. Estas formações incluíram treino sobre como falar com pessoas, como detectar doenças durante visitas domiciliárias, como dar palestras.

Receberam e venderam ITNs duas vezes em 2003. Conseguiram um fundo de 500,000 meticais. Utilizaram o lucro para reparação de bicicleta e apoiar as cerimónias de falecimento dum membro do conselho. O restante utilizaram para comprar sabão e distribuir entre eles.

O Conselho tem um raio de acção de 3 kms. Há outros Conselhos a 6 kms approx em cada lado.

No início era difícil convencer as populações das novas informações. Levou alguns meses para convencer. Os líderes da comunidade falou com pessoas que insultaram os voluntários, por isso é útil ter um Conselho que inclui os líderes da comunidade. Afinal há uma receptividade, por exemplo de tomar a sério os sinais de perigo para as grávidas.

Tem um encontro cada semana. Faz um relatório cada mês à US.

Na Localidade de Megaza tem 14 Conselhos, e tem um encontro mensal no dia 28 de cada mês. Um dos membros destes 14 Conselhos vai a um encontro trimestral a Morrumbala.

Auto-avaliação: Acham que existe um impacto, por exemplo mencionaram que não tiveram cólera durante o surto que assolou o Distrito recentemente, embora a zona seja muito propensa a doença. Há muito mais latrinas e menos doenças, citaram. Existe também a evacuação precoce dos doentes graves para a US, melhorou a higiene ambiental e individual.

Dificuldades: Incentivos (sabão, capulanas, etc..), falta de material (canetas, lápis, borracha), capas e botas de chuva, para poderem trabalhar durante o período chuvoso. Agua potável.

Referiram também que uma vez que estes fazem estas actividades sem remuneração e estes estão conscientes do assunto, seria bom que a título de apoio, se pudesse pensar neles quando existem actividades na localidade. Citaram o exemplo da pulverização para malária e peste bubónica, que normalmente a brigada chega com pessoal das províncias em vez de seleccionar pessoal das localidades que poderiam ser treinados e integrados nas brigadas para servir de incentivo e apoio ao esforço que estes têm feito na melhoria dos cuidados de saúde da comunidade.

Mecange, Distrito de Morrumbala

Data Segunda feira, 14 de Junho

Localização A 10 kms da estrada (de terra batida) ao sul de Morrumbala

O CCS foi criado em 2001 na forma duma associação de camponeses e se tornou um Conselho para saúde em Janeiro 2003. Os projectos são Ovata e malária. Tem 14 voluntários e 5 membros do Conselho. Receberam formação sobre malária e sobre SIDA e sobre nutrição durante 2003. Três formadores diferentes. Cada um era 1 dia por semana durante 2 meses.

Aprendeu o que é malária, as causas, como evitar, o uso de ITNs, a necessidade de tratar as ITNs. Aprendeu na nutrição os 3 grupos de alimentos, o uso de papas enriquecidas. Também aprenderam informação sobre a cólera e diarreia, como evitar, higiene ambiental e individual. Falou-se da necessidade de não comer só nsima (massa de farinha) sobretudo pelas mulheres grávidas. Sobre a SIDA, houve uma recomendação de comer mais frutas e hortaliças e micro – nutrientes.

Uma vez o formador trouxe um técnico agrícola que falou de milho, compassos, desbaste. Houve uma experiência dum celeiro melhorado que tem saias (defesas) nos pilares para evitar que os ratos subam no celeiro.

O Conselho recebeu sementes e outro material de propagação agrícola (ananazeiras, bananeiras, coqueiros, gergelim, amendoim, laranjeiras) para multiplicar e entregar aos outros na comunidade. A mensagem sobre agricultura era que deveria garantir a segurança alimentar em primeiro lugar mas depois pode passar a falar de comercialização.

Vendeu um total de 100 ITNs (50 ITNs x 2 vezes). Tem um saldo no fundo do Conselho de 450,000 Meticais. (Lucro 500,000, gastou 50,000 para arranjar uma bicicleta.) Geralmente faz o tratamento das ITNs com os donos das ITNs, porque pode ser que o dono da rede não vai tratar correctamente se não houver controle. Também visita as casas para ver se utilizam a ITN. A WV não traz Força de Rede: está a venda no mercado às vezes ao mesmo preço.

O Conselho tem um encontro semanal interno, e uma reunião mensal para elabora um relatório que vai à DDS. Há um encontro no dia 28 de cada mês na DDS. Apesar das actividades agrícolas, não tem encontros com a DDA, mas alguém da DDA assiste os encontros na DDS.

Tem ideia de fazer um negócio com o saldo do fundo, por exemplo de peixe, mas tem dificuldade de arrancar.

O sítio está longe duma US. A população acha que o Conselho é um Hospital porque tem recebido bastante assistência no conselho, confundindo o local de concentração com um hospital. O Conselho tem pessoal escalado durante toda a semana para ficar no local de concentração.

Há visitas pelas Brigadas Moveis 4 vezes por ano. Este ano visitou no dia 10 de Maio, mas não se lembra duma outra visita durante o ano. A Brigada Móvel faz vacinação, e controle de peso de crianças.

Dificuldades: água potável, bicicleta – ambulância, falta de posto de saúde, incentivos (sabão e outros)

Murda, Distrito de Morrumbala

Data	Terça feira, 15 de Junho
Localização	Quase 10 kms da estrada (de terra batida) a leste de Morrumbala (mais que 25 kms distância total de Morrumbala) 15 kms da US

O CCS foi criado em Outubro de 2003. Um dos últimos Conselhos a ser criado.

O CCS só foi formado em malária.

Fala uma língua local que é uma mistura de outras línguas locais. A área tem uma população de 1180. O Conselho tem 13 membros e além disso há 15 voluntários. Tem uma bicicleta (do projecto de malária).

Faz um relatório mensal à US de Mipinha. Há um encontro lá no dia 28 de cada mês.

No total vendeu 55 ITNs. Assim tinham um fundo de 275,000 meticais, gastaram 105,000 com reparação de bicicleta: a formadora veio levar 75,00 meticais dizendo que iria trazer mais ITNs e não voltou mais. (Tivemos conhecimento que esta já não se encontra a fazer actividades com a WV.) Ficaram só com 25,000 meticais. O Conselho pensa que a quantidade de ITNs é pouca. (Agora recebeu informação que a Maternidade tem ITNs mas não tem certeza e é distante e poucos vão lá.)

Só tiveram um total de 3 dias de formação (2ª 4ª e 6ª dum semana) (mas é interessante que se lembra de muitas coisas com pouca formação).

Tem uma frustração porque não sabe o que deve fazer no futuro. Começou e logo depois terminou a formação. Quer receber mais formação para que pode continuar. Os membros ouviram falar de SIDA mas neste sítio afastado da estrada não receberam este tipo de informação e acham necessário. Querem informação sobre vacinações porque não receberam isso, e em Novembro 2003 30 pessoas morreram de sarampo. (Mas recentemente não houve cólera – talvez o Conselho tinha um impacto nos resultados.)

A brigada móvel veio em Março 2004, mas a anterior vez que veio era Outubro 2003. Parece que só começou a passar devido ao CCS e o sarampo.

O Conselho continua a funcionar e os voluntários continuam a trabalhar. Encontram cada 15 dias. Cada mês envia relatório à US.

Há dificuldades de convencer a população de mudar certas atitudes. Por exemplo depois do parto a mae não pode dormir com o marido então muitas vezes dorme no chão com o bebé: é difícil mudar este comportamento tradicional embora que pode fazer mal ao bebé.

Dificuldades: falta de água potável, falta de posto de socorro e falta de escola.

Vungantinta, Distrito de Morrumbala

Data Terça feira, 15 de Junho

Localização 15 kms a leste de Morrumbala

O CCS foi criado em Janeiro 1999.

Os projectos são malária, HSDS e Ovata.

Entre Janeiro e Junho 1999 houve uma formação duas vezes por semana. (Diarreia, malária, SIDA – um pouco, planeamento familiar.)

Depois tiveram uma formação sobre malária em 2002 (3 meses, 2 vezes por semana) e sobre SIDA em 2002 (durante 1 mês).

Eram 21 voluntários mas 6 desistiram. Tem um encontro 3 vezes por mês e dia 15 de cada mês na US. Faz um relatório cada mês.

Venderam ITNs em Julho 2002 (45) e em Outubro 2002 (50). Agora é uma pessoa que vai ao Hospital para buscar as ITNs para vender. O Conselho tem dificuldade de saber quem é que tem ITNs agora, sendo difícil fazer o seguimento em relação à qualidade de tratamento ou retratamento. Quando o CCS vendeu as ITNs o Conselho ia às casas para mostrar como tratar e como montar.

Ainda tem o fundo, embora que algum dinheiro foi utilizado para peças de bicicleta. Tinha uma ideia de comprar cabritos com o dinheiro para manter o valor, mas não concretizou. O dinheiro só chega para comprar um cabrito.

Fazem demonstrações de papas enriquecidas quando a brigada de vacinação vem, para aproveitar a concentração grande, para além de outras demonstrações regulares. Quando vão às casas também informam a comunidade sobre a necessidade de cultivar e como fazer a sementeira para ter uma boa colheita.

Pensam que houve vários impactos:

- o comportamento é diferente em relação a diarreia agora, as pessoas seguem as orientações dos voluntários

- antes não ia às sessões de vacinação, agora pedem que haja sessões e há uma bicha até o enfermeiro é cansado

- quando uma criança tem febre, cobrem com um pano molhado e não com uma manta

- não há cólera desde 2 – 3 anos

- há mais conhecimento sobre (e uso de) colesterol no leite materno

- há mais conhecimento da Vitamina A

-há visitas pela brigada móvel de vacinações cada mês. Pensam que a Brigada visita regularmente porque está perto da US.

Tem dúvidas como ter acesso às ITNs no futuro. Referiram que tinha sarampo em Novembro 2003.

ANNEX 3: MAIN QUESTIONS

INICIO DAS ACTIVIDADES

Quando iniciou? Ano/data
Sabe como surgiu esta iniciativa?
Que actividades desenvolvem?
Fases da vida do projecto? Modificações do projecto?

SELECÇÃO

Como tem sido feita a selecção dos activistas/voluntários e membros do Conselho?
Que critérios? Quem seleccionou?
Porque decidiu ser um activista ou membro?

FORMAÇÃO

Que formação houve para os activistas e membros do Conselho? Quando?
Foi no início do projecto ou ao longo do projecto?
Quanto tempo levou (meses, semanas, dias)?
Que áreas e tópicos foram incluídos?
Que métodos foram usados?
Que material usaram?
Participou em toda a formação?

ORGANIZAÇÃO DO CONSELHO

Número de membros? Como está organizado o Conselho?
Como o Conselho faz a coordenação das suas actividades? (encontros?) Quem coordena?
Como é feita a coordenação com os activistas? (encontros?)
Quais são as responsabilidades do conselho? Dos membros do Conselho?
Dos activistas/voluntários?
Quais são as organizações que tem tido colaboração para o desenvolvimento das suas actividades? (ONGs, direcções, administrações?)

ACTIVIDADES DOS VOLUNTÁRIOS

Em que tipo de actividades os activistas estão envolvidos?
(por exemplo malária, SIDA, nutrição)
Todos os activistas estão envolvidos em todas as actividades?
(Dentro de malária, SIDA etc, que actividades)
Modificações das actividades ao longo do tempo? (por exemplo na distribuição de redes)
Que objectivos tem estas actividades?
Quais são as vossas responsabilidades?
Como estão organizadas as actividades?

- tipos de materiais?
- onde, quando recebe material, como fazem distribuição?
- distribuição gratuita ou venda ?
- como faz a venda (casa em casa)
- quanto custa o material, lucro
- como recebe material
- como envia dinheiro

Recebe incentivo? Que tipo? Quanto? Periodicidade?
Tem bicicletas? Quem tem?
Além da distribuição/venda, que outro tipo de actividades desenvolve? Quais? (palestras, contactos)
Como faz a disseminação dessa informação? Material? Apoios?
Há contactos regulares com a Visão Mundial? Periodicidade? O que discutem nestes encontros?
Quando vendem as redes, uma parte do dinheiro fica na aldeia? Que tipo de actividade realizou com este dinheiro? Como tomaram as decisões sobre isso? Como organizaram estas actividades?
Além da Visão Mundial, outras entidades locais apoiam as vossas actividades? Quais? Como?
Qual é o papel dos líderes comunitários (conselho) no desenvolvimento das vossas actividades? (encontros de coordenação, actividades conjuntas).
Relacionamento com centros ou postos de saúde?
Há outras organizações comunitárias ou actividades comunitárias ou colectivas? Quais são?
Há actividades que tradicionalmente as pessoas fazem em conjunto? Quem organiza?
Que outros contactos tem havido, com outras entidades? (administrações locais, OMM, ONGs, OJM, Agric, Saúde, Acção social etc)

OPINIÕES

Acha que tem havido melhorias na população em termos da redução dos problemas de saúde para quais vocês estão empenhados?
Sabe quais são os objectivos ou resultados que esperam da vossa actividade?
Se sim, como sabe? (indicadores)
Acha que o sistema que está a ser utilizado para desenvolver a sua actividade é o mais adequado? Porque?

FUTURO

Pensa desenvolver esta actividade por muito mais tempo? Porque? Quais os problemas que enfrenta? Tem sugestões para contribuir?

PROBLEMAS DE SAÚDE

Que problemas de saúde a vossa comunidade enfrenta?
Acha que os activistas estão a responder a estas preocupações? Porque?
Como acham que os activistas estão a desenvolver as actividades?
Que actividades realizam? Malária, SIDA, nutrição, outros?
Dentro de cada uma destas, que tipo de actividades os activistas realizam?
Como o Conselho faz ligação com as actividades dos activistas? (faz monitoria? Como?)
Que aspectos gostaria ver solucionados com o apoio da Visão Mundial mas com a vossa colaboração?
Qual tem sido o vosso apoio na melhoria dos cuidados de saúde da população?
Tem tido contactos regulares com a Visão Mundial? Qual é a periodicidade? Que assuntos?
Tem tido contactos com a Direcção da Saúde? Que relacionamento tem com a Direcção da Saúde? Que tipo de actividades desenvolvem em coordenação com a Direcção da Saúde?
Contactos com outras direcções? Relacionamentos?
Quando vendem as redes, uma parte do dinheiro fica na aldeia? Que tipo de actividade realizou com este dinheiro? Como tomaram as decisões sobre isso? Como organizaram estas actividades?
Sente que o vosso envolvimento tem resultados positivos? Se sim, como?

Problemas enfrentados?
Quais são as vossas sugestões para resolver?

ANNEX 4: NOTES ON OTHER MEETINGS

Titus Angui ex- Visão Mundial, Quelimane (actualmente USAID) (em Maputo)

Sábado, 05 de Junho

Trabalhava em Quelimane 2001 -2003.

Ideia de conselhos de líderes da comunidade originou num projecto financiado pelo USAID de reabilitação pós-guerra 1995-2000, com ênfase na promoção de saúde: era um ponto de contacto. A ideia foi reactivada para o projecto de malária 2001, em Quelimane e Mocuba. Em Quelimane não houve anteriormente conselhos de líderes da comunidade, em Mocuba houve alguns que foram reactivados.

O critério no projecto de malária era que os Conselhos devem estar mais que 10 kms duma unidade sanitária.

Os Conselhos de líderes da comunidade são uma ideia de WV em várias partes do mundo. Há um livro pela Universidade de John Hopkins sobre saúde internacional em Nepal, China. Afeganistão e América Latina.

As responsabilidades do Conselho e dos voluntários são diferentes. Embora que a formação dos dois grupos é feito em conjunto. O Conselho tem que fazer a gestão das actividades. Os voluntários devem transmitir a formação para os agregados familiares, e devem levar as ITNs do conselho para os agregados, e devolver o dinheiro.

Um conselho deveria construir um alpendre para os encontros, e para mostrar os dados e material educativo. Para cada Conselho há uma bicicleta para várias tarefas, incluindo o transporte de doentes.

A WV faz a supervisão. Nos encontros com o supervisor, o Conselho deveria fazer uma lista dos problemas que pode resolver, e daqueles que precisa de ajuda para resolver (neste caso o supervisor deve informar ao Governo). No primeiro caso o supervisor deveria ajudar ao Conselho de fazer um plano de trabalho. Cada conselho tem um livro de contas. Faz um relatório mensal de actividades e do dinheiro.

No projecto de malária, a primeira fase era Mocuba e Quelimane. A segunda fase era Mopeia, Nicoadala, Namarroi, Morrumbala, Inhassunge.

O retratamento não é tão alto que desejava. O fornecimento de insecticida é irregular.

A venda de ITNs ao nível comunitário é uma maneira de capacitação das comunidades. O novo sistema da venda não é tão bom, e deve ser repensado.

O Ministério acha a ideia dos Conselhos interessante. Criou uma redução de cólera, por exemplo. Mas é uma ideia muito nova para o pessoal do Ministério nos Distritos. O Ministério pode adoptar a ideia como uma política, embora que a Direcção de Saúde Comunitária está a estudar uma estratégia.

Sr Bernardo Ngwenya, Visão Mundial, Quelimane, Saúde

Segunda feira, 07 de Junho

O projecto de malária iniciou em Janeiro 2001 e terminou em Dezembro 2003. A partir de Janeiro 2004 é uma extensão, com uma mudança importante.

Em 2003 houve um estudo piloto no Distrito de Ile. A ideia era estudar um sistema mais sustentável. O piloto tinha o apoio do Projecto Hope, que transportava as ITNs sem custo de Quelimane para Ile. O piloto não resolveu quanto custa de transportar as ITNs de Quelimane para um Distrito. O método utilizado no Ile foi adaptado para a Província a partir de Janeiro 2004. Mas parece que o piloto de Ile era eficiente, só porque não contava o custo de transporte de Quelimane para o Distrito.

Em 2004, a WV está envolvido nos Distrito seguintes, utilizando o modelo do piloto de Ile:

Alto Molocue
Gile
Gurue
Namarroi
Lugela
Milange

A WV fornece a educação (PMPT), e a formação do pessoal das Unidades Sanitárias que vendem as ITNs. Há 9 pessoal da WV neste trabalho.

A PSI fornece as ITNs aos Distritos (DDS) que

- fornecem as Unidades Sanitárias que vendem as ITNs
- fornecem aos Conselhos que são mais 10 kms duma Unidade Sanitária.

Assim sendo, actualmente, o papel da WV é apoio. Objectivo é que a comunidade tem conhecimento da malária e da maneira de controlar.

Actualmente nos Distritos como Morrumbala, a WV não está envolvido num projecto de malária, A DPS e a DDS faz gestão do projecto. A DDS deve ter a capacidade de obter as ITNs e enviar às US e aos Conselhos. Ainda está numa fase experimental, ainda é cedo saber se o sistema vai ter êxito sem WV.

Vai continuar a haver uma necessidade de educação no futuro, e julga que vai continuar haver problemas na distribuição. Há também frustrações por causa do PSI e o fornecimento errático. O transporte tem que ser bem programado, e actualmente há dificuldades sérias.

Sr Ausse, Visão Mundial, Quelimane, HSDS
com
Sra Otília Rodas, Visão Mundial, Quelimane, Malária
com
Dr Osvaldo, Visão Mundial, Quelimane, OVATA

Segunda feira, 07 de Junho

Os mobilizadores dizem a comunidade que tipo de pessoa deve ser num Conselho, mas é a comunidade que decide que vai ser um membro.

Os membros e os voluntários recebem a mesma formação. Os voluntários levam a cabo a formação ao nível de agregados familiares. Os membros do Conselho tomam decisões ao nível da aldeia. Os mobilizadores/supervisores avaliam se aprendem suficiente.

Há certos conselhos que tem Grupos de Mães.

Um conselho tem um encontro pelo menos uma vez por mês, mais um encontro na US uma vez por mês, mais um encontro cada trimestre ao nível do Distrito. A ideia é de criar uma federação de Conselhos ao nível duma localidade.

O impacto é que o número de pessoas que atendem a US aumentou. Os Conselhos fazem uma lista das pessoas que foram aconselhadas ir à US.

Os membros e os voluntários não recebem, só de vez em quando uma camisola.

Ovata é “crescimento ramificado”. O foco é segurança alimentar, com HIV, nutrição e agricultura.

HSDS = “Apoio aos serviços de saúde”.

Vão haver um novo projecto, RITA, com foco no HIV.

Um desafio no futuro será a supervisão dos Conselhos. Vai continuar haver uma necessidade dum ponto de contacto específico, para receber informação e opiniões e apoio material. Outro desafio será formação para a gestão dos recursos ao nível da comunidade.

Uma ligação com agricultura será importante, sobretudo porque um melhoramento da saúde implica uma dieta melhor e um rendimento melhor.

Uma fase do projecto de malária terminou em Dezembro 2003. Agora a WV está focada nos Distritos de

Alto Molocue
Gile
Gurue
Namarroi
Lugela
Milange

Use agora de CCs já criados por outros projectos, para o PMPT. Também há formação dos enfermeiros. Prevê-se a necessidade de seguimento e supervisão, por exemplo para o retratamento.

Dra Veronica, Médica-Chefe, DPS da Zambézia
Sr. António Mapelamarebo, Malária – DPS da Zambézia
Sr. Titus Guambe, Chefe de Saúde da Comunidade. DPS , Zambézia

Segunda feira, 07 de Junho

HSDS é um projecto de duas ONGs, WV and Project Hope com um forte envolvimento da DPS. Funciona em 8 Distritos, 5 com WV, 3 com Project Hope.

O elemento da WV no Distrito é integrado na DDS e faz parte da colectiva do Director. O Administrador Distrital recebe os relatórios sobre as actividades dos CCs.

É uma Província-Piloto dum abordagem que pode se tornar nacional.

	WV	Project Hope
Gurue	Sim	
Ile		Sim
Milanje	?	?
Mocuba	Sim	
Morrumbala	Sim	
Namarroi	?	?
Quelimane Cidade	?	?
??		

Há encontros trimestrais entre os parceiros.

Os CCs são o centro do HSDS. Os CCs até agora só tratam de saúde mas a ideia é de ser mais abrangente.

Tem muitas vantagens:-

- há mais participação nas campanhas de vacinação e contra cólera
- mobiliza os doentes ir à US, há mais procura de serviços)
- detecta casos suspeitos (paralisia flácida aguda, sarampo)
- mudou certos comportamentos

(mas há certas barreiras de cultura que ainda fica para ultrapassar)

Há também certos CCs que só tratam de malária e, embora que há tentativa de integrar com outras actividades, ficam muitos nesta situação.

Provavelmente o nível de retratamento de redes é fraco. Quando tem o produto as quantidades são baixas.

Não há um entendimento claro da nova abordagem do projecto malária 2004. Há vários mal - entendimentos.

Miguel Standart - Responsável da Saúde Preventiva, DDS, Distrito de Ile

Terça feira, 08 de Junho

Tem 600 voluntários de saúde no Distrito. Estás na fase de criação de 20 Conselhos de Saúde. Visita cada um dia por mês. Ainda não faz cobertura de todo o Distrito.

O pessoal da US faz um relatório mensal em conjunto com os responsáveis dos CCs na área da US.

Durante 2003 houve vendas de ITNs numa US (piloto). E depois em todas as US do Distrito. Durante 2003, só houve venda das ITNs nas US, e durante 2004 está em processo de expandir aos CCs. Até agora, 4 CCs envolvido na venda de redes.

Há vários transtornos, por exemplo o transporte de redes de Quelimane ao Distrito e o espaço de armazenamento. As ITNs são voluminosas.

Há um livro de formação em Lomwe. Os voluntários fazem vigilância comunitária em

Malária
Menengite
Sarampo
Cólera
PFA

Tem formação para detectar.

Projecto Hope tem fundos que cobrem actividades como os custos de vacinadores no campo durante uma semana (e outros). A DDS não pode suportar estes custos.

Na 1ª fase, Projecto Hope não estava integrado na DDS, agora está dentro da DDS. Mas Projecto Hope contribui um alto nível de fundos em várias áreas.

Há projectos de agricultura de ADRA (os adventistas) Parece que tem conselhos em algumas áreas. E difícil saber o que faz ADRA, e todos os seus projectos.

**Sr Eduardo, DDS de Mocuba
com
Sra Estela Cônsula, Visão Mundial, Mocuba, Saude**

Quarta feira, 09 de Junho

Distrito de Gurue: população 239,000. Há 12 centros de saúde, incluindo o Hospital Rural na vila de Gurue (renovado em 2002, era antes um Centro de Saúde). Há menos US no norte do Distrito, porque não era uma área de chá e as US são geralmente onde as Companhias de chá construíram. Apesar da altitude, há malária.

No Distrito de Gurue: 39 Conselhos e mais que 1000 voluntários. Ligados a 3 projectos: HSDS, Ovata e malária.

A impressão é que os CCs têm um impacto: menos cólera, mais vacinações. Duas vezes mais partos nas maternidades (56%).

Há encontros mensais no nível das US e trimestrais ao nível do Distrito. Os voluntários preenchem fichas sobre as doenças detectadas e as transferências à US. Mas a DDS terá dificuldades de suportar sozinha os custos de supervisão, encontros, fichas etc para qual não existem verbas.

Há malária. Há uma procura de ITNs e insecticida. No ano 2003, a WV entregou as ITNs aos CCs para a venda. No ano 2004 a WV entrega ao DDS que entrega aos Centros de Saúde que entrega aos voluntários. Ainda há muitas coisas a resolver na divisão de tarefas entre os Centros de Saúde e os CCs.

Há certas dificuldades no armazenamento das ITNs, não há muito espaço. Manda vir as ITNs de Quelimane conforme o espaço de armazenamento disponível.

Até agora só uma loja vende ITNs. Parece que vai levar algum tempo para saber o potencial da rede comercial para a venda das ITNs. Ainda não se sabe se pode depender da rede comercial.

É importante incluir os curandeiros e parteiras tradicionais nos CCs. Ajuda dialogar com eles, evitar certas práticas perigosas.

Sr Eduardo, DDS de Guruè
com
Sra Estela Cônsula, Visão Mundial, Guruè, Saude

Quinta feira, 10 de Junho

Discussão sobre os problemas detectados de preços diferentes das redes (30,000 ou 35,000).

Sr. Amisse Gonçalves -Visão Mundial, Mocuba, Saude

Sexta feira, 11 de Junho

Havia 103 Conselhos no Distrito de Mocuba. Destes, 40 era CCs do HSDS (que incluíram actividades de malária). Os outros 63 CCs já não têm muito contacto. Alguns continuam a ter o encontro mensal com a US mas outros não têm, sobretudo quando estão distantes da US. Alguns CCs já não funcionam.

Todos os 103 receberam uma bicicleta do projecto de malária. Os 40 tem uma bicicleta - ambulância do HSDS.

Até Dez. 2003 houve um formador em cada localidade que visitou cada CC pelo menos uma vez por mês. Agora não têm estes formadores, então têm pouco contacto. O projecto de malária era de Jan 2001 até Dez 2003.

Actualmente a venda de ITNs é so nas US. Os CCs devem mobilizar as pessoas ir comprar ITNs nas USs, Os CCs não são satisfeitos com esta situação. Em 2001 as US não venderam ITNs. Começaram a vender antes de 2004. Mas é só a partir de Jan 2004 que os CCs deixaram de vender ITNs. 12,000 ITNs vendidas em 3 anos.

Até 2003, WV transportou as ITNs de PSI em Quelimane e entregou aos CCs. Agora em Mocuba, PSI entrega à DDS em Mocuba. Os 500 meticais ficam com a pessoa que vendeu a ITN, geralmente o pessoal da US.

Na localidade de Umakiwa, há uma US que não tem uma maternidade, e assim não tem enfermeiro da SMI. Por isso não vende ITNs.

**Sr Luís Armazia - DDS de Mocuba
com
Sr. Amisse Gonçalves - Visão Mundial, Mocuba, Saude**

Domingo, 13 de Junho

290,000 pessoas no Distrito.

O DDS não está de acordo com o hábito dos formadores se apresentarem como pessoal da WV, e não está de acordo com o facto que certo pessoal da WV disse aos CCs que “o projecto terminou”. O facto que certas verbas terminaram não implica que o trabalho terminou.

É uma das dificuldades de projectos. Que vai passar no fim dum projecto? O trabalho deve continuar mas o projecto terminou? Há a mesma dificuldade com as viaturas no fim dum projecto: onde vão os carros? Podem ser necessários para continuar o trabalho mas geralmente são transferidos para outras áreas. É uma questão do relacionamento dos projectos com as instituições do Estado.

O programa de venda de redes através dos CCs terminou, mas não deve ter terminado o trabalho de educação e venda através das US. No inicio era bom ter as redes a venda nos CCs porque ajudou convencer à população da utilidade das ITNs quando forem disponíveis nos CCs.

Mas é verdade que é difícil continuar a mobilizar os CCs e supervisionar agora. É necessário desenhar um pacote para sustentar os CCs. Os CCs têm que ser formados para a sustentabilidade. Actualmente não existe o pessoal para acompanhar todos os CCs que foram formados.

As brigadas móveis de vacinação também incluem pessoal para pesar crianças, detectar doenças etc. Cada Centro de Saúde no Distrito tem uma brigada móvel para fazer isso. Definem um grupo de CCs e um sítio onde a população destes CCs vão encontrar a brigada. Geralmente cada sítio da Brigada serve um grupo de CCs. Deve visitar cada mês, mas reconhece que não acontece sempre.

As bicicletas – ambulâncias só podem ser usadas para transportar doentes. Os CCs podem alugar as bicicletas de malária. Os CCs podem escolher a sua maneira de usar o dinheiro resultado da margem na venda das ITNs. Uma possibilidade é arranjar as bicicletas. Mas há certas tarefas na manutenção das bicicletas, por exemplo soldar o quadro, que só pode ser feito ao nível do Distrito: implica um envolvimento da DDS.

A política no Ministério é que só pode criar um posto de socorro quando é mais que 20 kms duma US existente. Não há as verbas para manter uma rede de postos de socorro. Mas há diferenças no Ministério sobre a política dos postos de socorro e APEs: há uma opinião que deve abolir Kit C. Geralmente deve comprar o Kit C e sabe que os socorristas cobram qualquer coisa.

Há menos diferenças no Ministério sobre as parteiras tradicionais. Mas não deve se transformar num trabalho oficial.

**Boné Rafael, DDS de Morrumbala
com
João Siquissonne, Visão Mundial, Morrumbala**

Segunda feira, 14 de Junho

É um Distrito de 2000 kilometros quadrados com 311,000 pessoas em 1995. Há 4 postos administrativos (Shire, Dere, Sede e Megaza) e 13 localidades.

Há 11 US mais 5 US em construção.

Há 85 CCs (HSDS, malária e Ovata). WV é o parceiro que financia e faz a formação, mas considera os CCs ligados à DDS.

Há um encontro de gestão cada mês, entre a US e os CCs na área. Há um encontro trimestral com a DDS.

Há um impacto, na óptica da DDS:

- os CCs produzem informação, assim há possibilidades de saber que há um risco de cólera, por exemplo
- fazem trabalho que reduzem os riscos de cólera e reduzir a maneira que se alastra.

A prioridade na criação de conselhos era Pinda e Megaza (perto do Rio Chire) porque tem mais risco de cólera e peste bubónica.

O projecto de malária terminou, mas faz tentativas de manter os CCs em funcionamento e localizar outras verbas.

Eventualmente, todos os projectos vão terminar. Mas a ideia (da DDS e do Administrador Distrital) é que os CCs continuem e são um ponto de contacto para qualquer projecto futuro: qualquer projecto futuro deveria começar com os CCs.

HSDS é um projecto mais abrangente, trata de mais tópicos. Ovata tem menos mas o projecto malária tinha poucos tópicos.

De Janeiro até Dezembro 2003, o projecto malária funcionava através dos CCs. Agora PSI distribui as ITNs às US. Criou muitos problemas sobre o dinheiro: dúvida se o preço novo é mais alto, e sobre como dividir os incentivos.

As quantidades vendidas são muito baixas agora em relação ao ano 2003. Todas as US, menos Chire, vendem ITNs. Chire vai vender dentro de breve.

**João Siquissonne, Visão Mundial, Morrumbala
com
Olympia Jacinto Collasso
com
Lúcia Alone
com
Oliveira Bernardo**

Terça feira, 15 de Junho

Há 85 CCs no Distrito. Todos tinham formação específica sobre a malária.

- Há 14 que só tinham as actividades do Projecto de Malária.
- Há 42 que foram formados no âmbito do projecto HSDS
- Há 29 que foram formados no âmbito do projecto Ovata.

O impacto dos CCs é que há melhor capacidade de controlar cólera. A comunicação da existência de doenças é mais rápida. Os voluntários fazem que há mais comunicação nos dois sentidos.

Vai haver um novo projecto RITA: Redução do impacto e transmissão do SIDA. Um projecto da WV e da DPS. Vai ser implementado através de 36 CCs no Distrito. É um projecto piloto de 15 meses. Vai identificar órfãs e doentes crónicos. Financiado pelo Fundo do Presidente das EUA.

A localidade de Chire tem menos conselhos: 75,000 pessoas só com 5 CCs. Actualmente as visitas aos CCs no Distrito são menos frequentes, sobretudo para aqueles que só tem um projecto.

A sustentabilidade dos CCs depende duma continuação de visitas. Também há necessidade de material, por exemplo cartazes plasticizadas e tecidos.

Os CCs podem ser mais sustentáveis se houver projectos de rendimento. Mas é difícil criar estes projectos para grupos. Por exemplo, projectos de moagens são complexos. É difícil trabalhar em grupos. Será necessário que os formadores igualmente tenham uma formação em este tipo de projecto.

O pessoal das US tem motorizadas. Podem visitar os CCs. Mas não sei se têm tempo para isso. E requer uma formação específica para o pessoal das US: como os CCs funcionam e como devem ligar com eles.

**Boné Rafael, DDS de Morrumbala
com Fernando Sócrates Monteiro, Visão Mundial, Morrumbala, Saúde (em Quelimane)**

Quarta feira, 16 de Junho

No projecto Ovata, houve uma mudança na ênfase durante o projecto. Desde a chegada do Dr Osvaldo, houve mais ênfase na integração com a agricultura. Há agora extensionistas que podem falar sobre nutrição e HIV por exemplo.

Há necessidade de integrar os CCs com o trabalho das brigadas moveis.

O processo de criar CCs é mais avançado na Província de Manica.

Dentro de breve vai haver uma avaliação do projecto HSDS (pode fechar em Setembro 2004). Vai incluir um inquérito para tentar de medir o impacto sobre conhecimentos da população.

Dra Veronica, Médica-Chefe, DPS da Zambézia
Sr. António Impalmarrebo – Malária, DPS da Zambázia

Quarta feira, 16 de Junho

Concorda em geral com as impressões dos consultores. Concorda que há certos CCs da malária que actualmente não recebem atenção suficiente. Em Mocuba é mais grave. Em Morrumbala há em certos casos possibilidades de integrar outros projectos com estes CCs.

A Direcção Provincial de Saúde, e o Director Dr Mussa, são da opinião que é necessário consolidar os CCs, mesmo quando são CCs mais remotos. São alguns CCs que talvez não era prioritário cria-los na altura que foram criados mas agora é necessário consolida-los.

Confirma que o preço dum pacote (rede e um tratamento) deve ser 30,000 Mts e vai investigar como o preço em certos sítios é 35,000 Mts.

Sr Ausse, Visão Mundial, Quelimane, HSDS

Quinta feira, 17 de Junho

Há um interesse, já por vários anos, pelo Ministério da Saúde de criar os CCs.

A política do HSDS era desde o início criar os CCs em certos sítios onde as US podem eventualmente supervisionar. Era uma medida de sustentabilidade porque sabia desde o início que o financiamento por um doador não era para sempre. A política do HSDS era desde o início fazer treino das DDSs e outro pessoal na supervisão os CCs, e de ter um sistema de ligações. O HSDS está a avaliar o contacto que os CCs tem com as US etc.

As bicicletas - ambulâncias chegaram tarde no projecto (eram difíceis comprar no Malawi). Há 219 distribuídas na Província. Há uma política que os CCS devem fazer as pequenas reparações (e suportar os custos) mas há certas reparações (eg soldadura) que o DDS deve resolver (levar à Sede do distrito para mandar soldar, e suportar os custos).

Os CCS têm várias maneiras de suportar os custos.

Os CCs têm vários níveis de compreensão e de organização.

Os CCs podiam escolher a programação do treino (um ou dois ou mais dias por semana).

Acha que era um erro que o Projecto de Malária criou tantos conselhos, e acha que o novo sistema de venda de redes não é o melhor.

Está a ser feito um inquérito tipo KAP com os CCs e com as populações abrangidas. No início do HSDS foi feito uma coisa semelhante, tipo base-line. É parte da avaliação do HSDS.

Sra Otília Rodas, Visão Mundial, Quelimane, Malária

Quinta feira, 17 de Junho

Inicialmente o Projecto de Malária não tinha um coordenador provincial. Só tinha coordenadores distritais. Foi modificado durante o projecto, e Otília recebeu as responsabilidades Provinciais. As tarefas principais são trabalhar com as DDSs e as US para formar para participar no projecto de redes mosquiteiras (ITM).

A WV está envolvida em 6 Distritos agora. Alguns onde a WV trabalhava, é agora a responsabilidade do PSI.

Deve haver a mesma informação sobre os preços e os sistemas em toda a província. Vai investigar as diferenças.

Pode ser que os enfermeiros não querem entregar as ITN aos CCs porque os enfermeiros podem perder um lucro.

Vai haver um encontro em Julho 2004 entre VM, UNICEF, DPS para planificar o futuro do projecto de malária.

Opinião da Otília é que deve haver uma recomendação que os CC devem ser envolvidos na venda dos ITM e ter uma parte do lucro. Opinião da Otília é que o stock inicial dos ITM na VM deve ser maior: o stock actual é pequeno e isso cria demora na rotação.

Questões pendentes do projecto da malária:-

- cofres nas US
- livros de registo.

Houve uma mudança na periodicidade de tratamento das ITN (de 4 para 6 meses): cria dificuldades quando houver uma mudança na mensagem às populações.

Parece que a nova insecticida (a partir de Maio de 2004) é diferente: vem com um outro rótulo que diz que não pode usar a mesma bacia para outros fins depois e que pode ser perigosa aos animais. Cria desconfianças. Pessoas só tem uma bacia e é difícil afastar os animais do lugar de tratamento. Cria dificuldades quando houver uma mudança na mensagem às populações.

Sr Bernardo Ngwenya, Visão Mundial, Quelimane, Saúde

Quinta feira, 17 de Junho

Há um certo abandono dos CCs da malária. Há uma certa frustração nos Distritos onde deixou de funcionar. Na maneira que o UNICEF decidiu isso, não deu à WV ou à DPS a possibilidade de preparar os vários intervenientes.

A meta do UNICEF é em termos do número de redes. Dá impressão que só está interessado nesta meta. Mas a meta não foi atingida ainda.

O conceito dos CCs é muito útil. Dá possibilidades de tratar certos problemas no lugar certo.

Pode haver um problema de redução de números dos membros com tempo, e deve pensar como recrutar novos membros.

Será necessário discutir com o DPS as dificuldades que a DPS terá na supervisão dos CCs.

É só agora que tenta de ligar a saúde com a agricultura. Só começa agora o treino pela Saúde aos extensionistas agrícolas sobre a nutrição.

A prioridade dentro do ovata é segurança alimentar. A comercialização vem depois.

HSDS. Era em 6 Distritos. Está quase para acabar. Não se sabe o futuro. Pode ser que o USAID ainda é interessado.

O Dr Mussa é gestor do HSDS, e há muito integração entre a WV e a DPS.

Os doadores têm interesse só nas suas próprias metas. E percebem pouco dos desafios. O projecto RITA levou 4 meses recrutar o pessoal mas o doador (projecto do Bush) está a já a perguntar se está a atingir as metas. No campo, se estamos fixados nas metas, há tendência de não dar atenção aos passos intermediários.

As dificuldades do projecto de malária incluíram o facto que houve um espaço de 3 – 4 meses depois do treino dos CCs quando não houve ITNs. E demorou muito a chegada dos carros.

Está ciente do facto que os pacotes de insecticida agora são diferentes. O PSI não é capaz de dizer se há diferença na insecticida.

Dr Osvaldo Neto, Visão Mundial, Quelimane, Ovata

Quinta feira, 17 de Junho

Ovata em 10 distritos.

Alto Molocue
Gile
Gurue
Inhassunge
Lugela
Mopeia
Morrumbala
Namacurra
Namarroi
Nicoadala

Ovata quer dizer “crescimento ramificado”. O objectivo é desenvolvimento equilibrado e sustentável. Equilíbrio entre agricultura e saúde, entre produção para auto-consumo e para comercialização. Continua até 2007.

Ovata usou vários CCs criados pelo projecto de malária quando chegou num Distrito. Em geral os CCs envolvidos no Ovata terão recebido formação em tudo salvo planeamento familiar.

Ovata tenta de mudar o nome dos CCs para Conselhos de Desenvolvimento.

Projecto RITA só vai trabalhar onde havia Ovata (mas não vai trabalhar em todos os sítios onde havia Ovata)

Os extensionistas agrícolas que estão envolvidos no Ovata não falam só de agricultura mas também de nutrição. Pretende uma planificação no nível distrital para que as actividades de nutrição e de agricultura são no mesmo sítio, e pretende uma ligação entre os CCs e associações de camponeses.

Este tipo de integração é um desafio. Cada um (sobretudo os doadores) quer atingir a sua própria meta, não as metas dos outros.

Não tem ligações com a ADRA. Parece que só na Mocuba trabalha no mesmo Distrito.

Rádios comunitários – as ONGs tem programas conjuntos no rádio.

Questões importantes, e problemáticas, são integração e sustentabilidade. Há muitas actividades, por vários actores, mas raramente tratam de estas questões. Geralmente a formação não é dum tipo que cria sustentabilidade.

Ouviu dizer que o USAID é agora mais interessado nos produtores agrícolas, aqueles que já produzem, e não nos camponeses que estão em vias de aumentar a produção. Isso pode provocar problemas para os projectos tipo ovata.

Dr Omo Olopua, Visão Mundial, Maputo

Quarta feira, 23 de Junho

É só necessário um Conselho numa Comunidade: pode fazer vários tipos de actividades. É necessário mobilizar a comunidade para a sustentabilidade, mas vai levar muito tempo.

Para o projecto de malária, é necessário que todos os intervenientes se sentarem para reprogramar. O Governo e as ONGs e os doadores e as comunidades devem se sentarem e ver quais são os meios que existem que podem garantir a sustentabilidade: como fazer a sustentabilidade dos Conselhos e o pessoal existente com custos menos de que os iniciais. Mas é importante que deveria ser feita a consultoria antes de se tomar qualquer decisão.

A Unidade Sanitária não deve ficar com o monopólio da venda de redes, que aparentemente é a situação actual em vários sítios: a US é para apoiar os Conselhos, não é para fazer concorrência.

Dra Laura Mavota, Ministério da Saúde

Quarta feira, 23 de Junho

Há uma estratégia de Conselhos Comunitários, que abrange todos os sectores. Não é uma estratégia que só diz respeito à saúde. Em outras Províncias tem o nome de Conselhos de Líderes Comunitários, só em Zambézia tem nome de Conselhos Comunitários de Saúde.

O papel das ONGs é a capacitação dos conselhos. Também há a questão da capacitação do pessoal da saúde para facilitar a integração dos Conselhos. A preocupação das DDSs é a sustentabilidade. Não existe uma diferença entre as Províncias neste assunto.

É de opinião que desde o início da formação dos conselhos, o pessoal de saúde nas localidades deverá estar integrado e devrá acompanhar as formações, para ficar previamente preparada a dar seguimento quando os projectos encerram.

A estratégia de Participação Comunitária está quase no final da elaboração e acha que o documento poderá ajudar como guião para as ONGs que estiverem a desenvolver esta actividade.

Dra Judite Langa, Project Hope, Maputo

Quarta feira, 23 de Junho

Para a sustentabilidade é necessário dar oportunidade aos Conselhos de se decidirem por si só o que fazer para gerar fundos.

As actividades de malária são muito restritas para as actividades dum Conselho. O seguimento dos Conselhos deve ser feito pela US e pela DDS. Deve ser um núcleo de gestão comunitária que engloba todas as Direcções.

É importante fornecer instrumentos de trabalho aos Conselhos: sapatilhas, botas, capas de chuva, fardamento, fundos para iniciar um negócio. Durante o tempo de urgência do projecto deve-se desenvolver algo sustentável.

Há sempre a questão difícil de recursos humanos, e se houver são sempre bem vindos.

Por enquanto não existem encontros com os várias organizações que estão a desenvolver os CCs ou CLCs, mas deve haver.

ANNEX 5: GLOSSARY

AIDI	
CCs	Conselhos Comunitários (Community Councils)
CCSs	Conselhos Comunitários de Saúde (Community Health Councils)
CLCs	Conselhos de Líderes Comunitários (Community Leaders Councils)
DDA	Director/Direcção Distrital de Agroicultura (District Agriculture Health Director or Department)
DDS	Director/Direcção Distrital de Saúde (District Health Director or Department)
DPS	Director/Direcção Provincial de Saúde (Provincial Health Director or Department)
HIV	
IEC	
HSDS	Health Service Delivery Support
ITN	
IUD	
Ovata	Multi-faceted development
PFA	Paralisia Flácida Aguda (Flaccid Acute Paralysis)
PMPT	Participatory Malaria Prevention and Treatment
SIDA	
WV	World Vision