



## iCCM in Mozambique

# InSCALE Stakeholder Analysis Report

June 2010



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## EXECUTIVE SUMMARY

This report presents the results of a consultative mapping of stakeholders involved in the Integrated Community Case Management (ICCM) of childhood illnesses through a specific Community-Based Workers Strategy in Mozambique, known as the APE Programme. This mapping was conducted between March and April 2010, in Maputo City and Inhambane Province - including the provincial capital, Massinga and Vilanculos Districts - in Southern Mozambique.

The APE programme has more than 30 years of history in Mozambique, as it was first implemented in the late 1970s in the country. But in the course of its implementation it faced challenges, which influenced its official closure in different instances, which were followed by attempts to revitalize it.

Following an enthusiasm which gained momentum with the National Meeting on Community Involvement for Health, held in June 2007, the programme is being revitalized again. In that regard the Programme Document for the Revitalization of the APEs was approved by the Ministry of Health in March 2007, and preparations are being made to implement it.

APEs are regarded as one of the key community level actors who can help extend primary healthcare to local communities in Mozambique. Given the proposed syllabus of their training they are also a key factor in the management of childhood illnesses at the community level - an intervention area in which Malaria Consortium will be actively involved through its INSCALE project.

In this regard Malaria Consortium commissioned this consultative mapping exercise with the main to (i) identify the stakeholders involved in the ICCM of childhood illnesses (in particular diarrhoea, malaria and pneumonia) through the APE strategy in Mozambique; (ii) learn about the opportunities and threats to the program as well as current, planned and alternative solutions that have the potential to improve APE performance, retention and information utilization.

Data collection methods included individual and group stakeholder interviews, direct observation, and literature and other secondary documents were also used to supplement information. A stakeholder analysis was applied in order to prioritize stakeholders. Their opinions were analyzed using a SWOT analysis framework - that aimed at interpreting findings in terms of strengths and weaknesses and opportunities and threats to the APE program as a whole and, with special emphasis to the areas of APE supervision, training, motivation and use of data.

Thirty stakeholders were interviewed in Maputo City, Inhambane, Massinga and Vilaculos districts (in Inhambane Province) and they hold different positions at the Ministry of Health, International NGOs and bilateral and multilateral partners at the central level (in Maputo City); Provincial and District Politicians/government officials and health directorate personnel and; other stakeholders with vested interest and experience in the APE program in the country. Given time constraints of the mapping exercise and the busy agenda of stakeholders some interviews did not take place.

Findings based on stakeholders' analysis and interviews suggest that stakeholders interviewed are supportive of the program, independently of (i) their level of involvement in discussions and decision-making at the national level and (ii) of their level of knowledge about the program. Stakeholder analysis data also suggests a centralization of discussion and the decision-making process about this program in

Maputo City - based on a top down approach to the development of the policy and its instruments. This centralized tendency is also evident in the level of knowledge stakeholders have about the program: central level stakeholders showed a higher level of knowledge in relation to provincial level stakeholders, whose level of knowledge is higher than district level stakeholders. However, low levels of knowledge about the program seem to be based more on limited access to information, rather than on simple lack of interest or support for the program.

Stakeholders show support to the program and commitment to help developing instruments and, allocating and mobilizing resources to implement the program. They share the opinion that the program is important to address the need to extend primary healthcare to more Mozambicans, especially to "rural" communities. But their opinion is divided about the perceived sustainability of the program.

Optimistic stakeholders argue that the program has opportunities to become a success since there is Ministry of Health and partners' political will and commitment, and the long history of APEs in Mozambique helps the Ministry of Health realize the most appropriate approach to avoid the mistakes and overcome difficulties of the past. More skeptical stakeholders show reservations about the sustainability of the program, since in their opinion funds have yet to be secured, the Ministry of Health still needs human resources to allocate to the program, the decision-making process and management of the program needs to be decentralized to the district, community involvement and, the role of implementing NGOs and other cabinet ministries still needs to be clarified.

In order to overcome these barriers or threats to the program, stakeholders argue that action should be focused on ensuring that the Ministry of Health takes the leadership of the entire process; the role of all stakeholders (state and non-state actors, at the central, provincial, district and community levels) should be clearly defined; guidelines and other tools to monitor and evaluate the implementation of the program should be finalized, with a focus in the areas of APE training, motivation, supervision and data collection and use.

By and large, stakeholders had difficulties voicing their opinions about APE training, motivation, supervision and data collection and use, since the instruments for those components of the program are still being developed and stakeholders are part of the technical working group assigned for that task. Nevertheless, stakeholders shared some of their experiences and ideas related to those areas.

Stakeholders' general opinion about the training strategy and materials is that they still need to be developed and pre-tested before implementation, and a balance should be ensured between biomedical and community oriented contents of the training and those contents should be adjusted to the education level of the trainees.

Stakeholders associate motivation and retention of the APE with the selection process, the quality of supervision and regularity of incentives and the balance between monetary, material and non-material incentives. While most stakeholders support the allocation of a monetary subsidy to the APE, they argue that this should not be approached lightly - the reaction of local communities and 'voluntary' CHWs should be considered and managed. Novel motivation strategies employed by district health authorities in association with district governments were quoted by stakeholders as having a potential to improve motivation and ensure a great level of APEs.

The general stakeholder opinion about supervision is that it is either non-existent in some districts or communities or it is irregular, and thus not effective. Proposed solutions include allocating especially financial and logistical resources to the districts, so that they conduct regular supervision, regarded more as support, on-the-job-training in order to improve APE performance, rather than an inspection-like supervision. The provincial level's role was defined as one of providing technical assistance to the districts and monitoring the process. The central level, stakeholders argue, should focus more on strategic and policy issues, such as developing instruments to ensure effective supervision (eg. supervision guidelines and supervision report templates) and ensure overall monitoring and evaluation of the process.

While data collection tools for the APE are being developed the general stakeholder opinion about the use of innovations is divided. Some innovations suggested include the use of mobile phones, the creation of a Community Management Information System integrated in the HMIS and training of APEs to analyze data they collect. Other stakeholders argue that more than innovations what is needed is data collection instruments that are clear, simple and help APEs collect information that is relevant to analyze the health situation of communities and can be used by the national Health Management Information System (SIS). They add that computers can be used at the district, provincial and central level, to aggregate and analyze data sent by the APEs.

At the moment, data collected and reported by the APE is mainly used by district health authorities for the purpose of providing a kit containing essential medicines to the APE. Stakeholders noted that the distribution system, in general is adequate and it is functioning, but the supply of kits should be more based on reliable information about the quantity of medicines necessary for the APE or the quantity of medicines APEs use on a given period. Drug stock management is also deficient and done manually. To improve stock management stakeholders suggest that health authorities should use computer aided software. The availability of computers in all district capitals in the country is an opportunity to be used to implement this suggestion.

Based on these findings, the following recommendations are presented:

- National decision-making process could profit from involvement of stakeholders from provincial, district and community level as well as central level actors with a stake in the program who are not currently involved, such as Mozambican NGOs, and civil society
- Advocacy and communication strategies should be adopted to increase the level of knowledge of provincial, district and community level actors about the program and gain support of other cabinet ministries, by presenting the program as a state program (although a health-oriented one)
- The role of all stakeholders (state and non-state actors, at the central, provincial, district and community levels) needs to be clearly defined
- Guidelines and other tools to monitor and evaluate the implementation of the program should be finalized, with a focus in the areas of APE training, motivation and retention, supervision, data collection and use and, drug management and distribution

- The experience of implementation of the program in Mozambique and experiences in other countries with socio-cultural and economic contexts similar to the country should be taken into account in implementing and evaluating the program.

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## CHAPTER ONE: INTRODUCTION

This report presents the results of a consultative mapping of stakeholders involved in the Integrated Community Case Management (ICCM) of childhood illnesses through a specific Community-Based Workers Strategy in Mozambique, known as APE Strategy. This consultative mapping was conducted between March and April 2010, in Maputo City and Inhambane Province (including the provincial capital, Massingao and Vilanculos Districts), Southern Mozambique.

The aim of this consultative mapping exercise was to identify the stakeholders involved in the ICCM of childhood illnesses (in particular diarrhoea, malaria and pneumonia) through the APE strategy in Mozambique; learn about the opportunities and threats to the program as well as current, planned and alternative solutions that have the potential to improve APE performance, retention and information utilization.

The mapping exercise included individual and group interviews with stakeholders and direct observations, with the aim to identify potential opportunities and threats to the program implementation and sustainability, as well as constraints within the areas of training, supervision, motivation and use of data produced by APEs.

Stakeholder interviews were conducted with national, provincial and district level health officials and current financing and implementing NGOs and other institutions to explore their role in planning and implementation of the APE strategy; the potential opportunities and threats to program sustainability and; the procedures, plans and resources available for the ICCM program in the areas of uninterrupted supervision and motivation of APEs; community engagement and APE recognition; methods and tools used for information collection and data flow; training procedures and content; and the necessary work aids and tools for APEs.

This mapping and consultation is the first step in identifying the key stakeholders, identifying the threats and opportunities, and will help narrowing down the key individuals and organisations that will act as enhancing or blockages for successful implementation of the program, and will also be a forum for identifying innovations that are deemed feasible and effective from the stakeholders perspective.

Findings from this mapping exercise are summarised into a SWOT analysis indicating the strengths and weaknesses and, opportunities and threats for each of the areas of training, supervision, motivation and use of data. The following documents were used to guide the analysis: (i) "Tools for Development" Handbook - DFID<sup>1</sup> and (ii) "Guideline for conducting stakeholder interviews - A Partnerships for Health Reform Publication"<sup>2</sup>. Other literature is acknowledged within the report and full references provided in footnotes.

Approval by the Ministry of Health of the APE program, in March 2010, is regarded by stakeholders as a decisive step into launching the basis for the implementation of the APE program. This is also regarded as ending a long period of uncertainty involving the Ministry of Health and its partners, which started soon after the National Meeting on Community Involvement for Health, held in June 2007, in which a decision to revitalize the APE program was taken. Ministry of Health, bilateral and multilateral partners and International NGOs based in Maputo City, were involved in developing the program and are involved in developing specific aspects of the program, such as guidelines and instruments.

Provincial and district level government, Ministry of Health and national and international NGOs are not actively involved in the development of the components of the program, but have been and are being consulted about specific aspects of the program. Stakeholders interviewed show support for the program planning and implementation, however their opinions about the sustainability of the program are divided between those who think that decisive steps should be taken to ensure sustainability of the program before the program is implemented and those who are for implementing aspects of the program that are possible now at the moment and working on sustainability as the program goes. Most stakeholders did not voice their opinions about training, supervision, motivation and use of data collected by APE, since these elements of the strategy are still being developed and stakeholders are involved in this work.

## 1.1 Background

After decades of disenchantment associated with shortcomings in the implementation of healthcare programs using Community Health Workers (CHWs), there is a renewed interest internationally about the role they can play in improving (i) access to primary healthcare and (ii) health conditions of populations especially those from developing countries, such as Mozambique.

The use of CHWs, in Mozambique dates back to 1978<sup>3</sup>, where they were (and still are) known as *Agentes Polivalentes Elementares* (APE's)<sup>4</sup>. But the first APE manual was developed in 1977<sup>5</sup>, and the first APEs were trained in the same year. They were trained and operated under a national program, locally known as the APE program. Due to the war that opposed the government of Mozambique to RENAMO guerrilla (1976-1992), the program started facing difficulties in the early 1980s and was officially interrupted in 1989, with the perspective of reopening later<sup>6</sup>. The program was revitalized after the war<sup>7</sup>, and in 1994 the APE training manual was revised<sup>8</sup>. However, this and other attempts to revitalize the program did not succeed, due to factors that are summarized in the APE Revitalization Program<sup>9</sup> as follows:

- Communities perceived APEs as part of the National Health care system instead of part of their communities;
- APEs focused more on curative care instead of health promotion and prevention (which had been defined as the main focus of their work), and they expected to be integrated in the national healthcare system;
- Deficiencies in APE the training, syllabus and methods;
- Deficiencies support, monitoring and evaluation of APE activities, specifically: deficient supervision and support the national healthcare system provided, problems in community support and for the APE, lack of incentives to the APE and problems in evaluation of the activities performed by the APE and;
- Frustration of the APE with the program, which causes many of them to abandon their job.

Despite these problems some APEs continued with their activities in some parts of the country, and they receive their kit. They operate alongside other CHWs, who work as volunteers with NGOs support. But these new CHWs bring with difficulties in coordinating healthcare activities at the community level, and increase the frustration of APEs who feel they are being ignored or put into a second-citizen category by

NGOs and district health authorities<sup>10</sup>. This is the background in which the revitalization of the APE program unfolds.

Current government (Ministry of Health) and partners' enthusiasm and commitment with the revitalization of the APE strategy date back to the early 2000s when a Community Involvement for Health Strategy was approved<sup>11</sup>, and gained momentum in 2007, in a National Meeting on Community Involvement for Health, held in June, in Maputo City<sup>12</sup>. The rationale for the current revitalization of the APE program is, as the Ministry of Health argues, that APEs are an important group to help in health promotion and disease prevention at the community level and, they could help expand the coverage of the national healthcare network in about 20 percent in Mozambique<sup>13</sup>.

Integrated Community Case Management (ICCM) of the most common childhood illnesses (malaria, diarrhea and ARIs) is one of the approaches regarded as being capable of helping extend primary healthcare to (remote) communities, especially in developing countries. In this regard, Malaria Consortium has secured funding to implement an ICCM project, using CHWs in Mozambique and Uganda.

## **1.2 Consultative mapping objectives**

This mapping was conducted for Malaria Consortium, with the aim to:

- Identify the stakeholders involved in the ICCM of childhood illnesses (in particular diarrhoea, malaria and pneumonia) in Mozambique, through the APE strategy;
- Learn about the threats and opportunities to the program and;
- Learn about current, planned and alternative solutions that have the potential to improve APE performance, retention and information utilization in Mozambique.

## CHAPTER TWO: METHODOLOGY

Consultative mapping was conducted with stakeholders holding different positions at the Ministry of Health, International NGOs and bilateral and multilateral partners at the central level (in Maputo City); Provincial and District Politicians/government officials and health directorate personnel and; other stakeholders with vested interest and experience in the APE program in the country. Interviews were completed at the Provincial and District levels, although a few stakeholders were not available for interview, but suitable substitutes were interviewed.

Individual interviews were conducted with most informants. Exceptionally two group interviews were conducted with informants who requested that type of interview given their time constraints. The consultant also participated in a review meeting on the APE program, held at the Ministry of Health, in Maputo City, on 31 March 2010. Data from interviews and the meeting was recorded verbatim in notebooks, and stakeholders' names or positions are not specified in the interview quotes, in order to ensure their anonymity and confidentiality of information they provided.

A total of 30 stakeholders were interviewed, 15 of which internal to the Ministry of Health, at the national, provincial and district level. Three health officers were interviewed at the national level, four at the provincial level (the City of Inhambane) and the remaining eight are associated with the Ministry at the District level. Three government officers/politicians were interviewed, one at the provincial level and the other two from each of the districts visited. Twelve interviewees were officials associated with international NGOs and multilateral or bilateral partners of the Ministry of Health. Ten of them are based in Maputo City and the remaining two are based in Inhambane Province. Finally, two key informants were interviewed, one in Maputo City and the other in Inhambane Province, based on their involvement with the APE program in the country in the past and at present. Twenty-five interviewees are key stakeholders, while the remaining five are either primary or secondary stakeholders.

Interviews at the central level:

- 3 Ministry of Health officers: 1 deputy national director, 1 head of department, national APE program coordinator
- 10 officers from 8 bilateral/multilateral partners and NGOs (Aga Khan Foundation, Irish Aid, Malaria Consortium, Save the Children, Swiss Cooperation, Irish Embassy, USAID, World Health Organization and, the World Bank)
- 1 key informant.

Interviews at the provincial Level (the City of Inhambane):

- 1 Provincial Government representative: Permanent Secretary/Local Politician
- 4 Representatives of the Provincial Directorate of Health: 1 chief medical officer and 3 heads of department
- 2 International NGO officers

- 1 key informant

Interviews at the district level (Massinga and Vilanculos):

- 2 District Government representatives: Permanent Secretaries/Local politicians
- 7 district Health Officers: 1 district health director, 1 chief medical officer, 1 chief nurse, 2 heads of district and 1 head of health training centre.

Not all potential interviewees and key stakeholders could be interviewed, especially those from the Ministry of Health at the national level. A few other stakeholders at the provincial and national level could not be interviewed because they were not available at the time interviews were conducted.

Nevertheless 86 percent of the potential interviewees identified were interviewed. Table 1 lists all stakeholders interviewed and present them according to their characteristics, namely stakeholder organization and position within the organization, their internal or external status in relation to the Ministry of Health and their category (key, primary or secondary stakeholders).

For ethical reasons - ensure anonymity and confidentiality -in all interview quotes in this report interviewees' names and specific positions were not specified.

Literature and other secondary documents were also used to supplement information. These sources are relatively limited to the current and earlier APE programs and training manuals and a major evaluation of the APE performance, as well as some international literature. Training materials and other guidelines and tools are still being drafted, and thus not available for consultation or reference.

Data consists mainly on stakeholders' views about the APE program, which were recording during interviews and direct observation. This data was analyzed using a SWOT analysis framework that aimed at interpreting findings in terms of strengths and weaknesses and opportunities and threats to the APE program as a whole and in with special emphasis to the areas of APE supervision, training, motivation and use of data.

## CHAPTER THREE: STAKEHOLDERS CHARACTERISTICS

### 3.1. Summary stakeholder analysis

#### 3.1.1 Stakeholders' position in relation to the program

In this section stakeholders' position about the program, their knowledge and importance is presented and briefly analyzed. While a great majority of the stakeholders support the program, their level of knowledge and importance in relation to the program varies based on their location to the center of the national decision-making about the program (Maputo City), and reveals an apparent centralization of the decision-making process in Maputo City.

The position of stakeholders in relation to the program is defined here in terms of degrees of support or opposition to the program. Specifically, stakeholder position in relation to the program includes: Supporter (S), Moderate Supporter (MS), Neutral (N), Moderate Opponent (MO) and Opponent. Twenty nine out of the 30 stakeholders interviewed showed support for the program, and the only stakeholder who did not show support for the program was neutral - not an opponent. Given that this stakeholder is not actively involved in the development of the program neither in the technical working group, it seems that the stakeholder will not mobilize their power or alliances to oppose or block the implementation of the program.

Support for the program was shown independently of involvement in discussions at the national level and independently of the level of knowledge about the program. The table below shows the stakeholders' positions in relation to the program. Only supporters and a neutral stakeholder are shown in the table since other positions were not voiced by stakeholders.

Table 2: Stakeholder position in relation to the program		
	S: Supporter	N: Neutral
Stakeholders	Ministry of Health officers: central level	International NGO officer: central level
	Ministry of Health officers: provincial level	
	Ministry of Health officers: district level	
	International NGOs and multilateral and bilateral partners: central level	
	Key informants: central and provincial level	
	International NGO officers: provincial level	

#### 3.1.2 Stakeholders' knowledge about the program

Differences in the level of knowledge stakeholders interviewed have about the program are visible based on the geographic area (central level, province and district) and involvement in national discussions or decision-making process related to the program. All stakeholders based at the central level, who are (with the exception of two), involved in discussions and the development of the program show a high level of knowledge about the program. Most stakeholders based at the provincial level show some knowledge about the program while a few others have limited knowledge or have never heard of the current program. One exception is a stakeholder who has a high level of knowledge about the program, due to their long term involvement in previous programs, although this stakeholder is not directly involved in the development of the current program.

This shows the need to disseminate information about the program, both for healthcare personnel as well as at the provincial government level and find ways of promoting their involvement in the development of the components of the program. This is because the successful implementation of the program will have to count on these provincial actors, whom, despite their limited involvement and knowledge of the program are supportive of the program. Their support is based on the general idea that it will help achieve government goals of extending the coverage of the healthcare network and providing primary healthcare to communities at the provincial level.

In the two districts visited, the level of knowledge about the program is very limited, and this could be related to the limited involvement these actors have in discussions and developments of the program - a program that seems centralized at the national/central level. Given that the districts will have an important role in the management of the program promoting the involvement of the district government and district health officials in national discussions and developments of the program seems very important. Raising the level of knowledge district stakeholders have about the program seems to be another reasonable priority.

Table 3: Level of knowledge about the program			
	3: High or a lot	2: Some	1. Limited or none
<b>Stakeholders</b>	Ministry of Health officers: central level	Ministry of Health officers: provincial level	Local politicians: provincial and district level
	Officer of International NGOs and multilateral and bilateral partners: central level	International NGO officer: principal level	Ministry of Health officers: district level
	Central level key informant	Ministry of Health officer: district level	Provincial level key informant
	International NGO officer: provincial level		

### 2.1.3 Stakeholders' importance

Stakeholder importance is here defined on the basis of the level of participation of stakeholders in discussions and decision-making process about the program and leadership, understood as willingness to take action for or against the policy. The

importance of stakeholders could be also defined in terms of a power index, which would show the amount of resources (financial, material and human) stakeholders have or have access to and the ability to mobilize those resources to influence the direction of the program. At this point, however, for many stakeholders it is not clear what financial resources are available or could be mobilized for the program. Given that those resources are very important to drive the activity, including to train and retain human resources on the job, power is not here analyzed in those terms.

In presenting the importance matrix some stakeholders were organized into organizations. This has been done in an effort to ensure some anonymity of the stakeholders, but also because, the leadership and involvement stakeholders have in the program makes sense as part of an organization. In some other stances, it was not possible to aggregate stakeholders into organizations.

In the table below, stakeholders have been organized into three groups, which reflect their current importance in the development of the program. Their importance is defined on the basis of their leadership and their level of involvement in the national decision-making process or discussions about the program. Stakeholders with no leadership were not included in this importance matrix.

Group 1 includes stakeholders with high leadership and high involvement in the decision-making process and discussions about the program at the national level. Here stakeholders external to the Ministry of Health reminded that they participate in discussions about the program at the national level, but decision-making is the responsibility of the ministry. In this regard, decision-making process is here defined loosely. In this group we find all stakeholders at the central level - Ministry of Health, its partners and a key informant.

Group 2 includes stakeholders with leadership, but whose involvement in national decision-making process related to the program is moderate or even sporadic. This includes healthcare professionals at the provincial level.

In group 3 we find stakeholders with leadership, but with little or no involvement in the decision-making process about the policy at the national level. These are mainly district level stakeholders of the government and healthcare sector, but also a provincial level politician and key informant.

This grouping of stakeholders into the importance matrix reflects a centralization of the discussion and the decision-making process about this program, which is apparently based on a top down approach in the development of the policy and its instruments. This tendency was also evident in the analyses of knowledge stakeholders have about the policy, as it was based more on limited access to information, rather than simple lack of interest or support for the program.

Table 4: Stakeholders importance matrix			
	Group 1: High Leadership & Involvement	Group 2: Leadership & Medium Involvement	Group 3: Leadership & Little or no Involvement
<b>Stakeholders</b>	Ministry of Health: Central level	Ministry of Health: Provincial Level	Ministry of Health: District Level
	Key informant: central level		Provincial Government/Local politician

	World Bank	District politicians	Government/Local
	American government	Key informant: provincial level	
	Save the Children		
	Swiss cooperation		
	WHO		
	UNICEF <sup>14</sup>		
	Malaria Consortium		
	Irish Embassy		

## CHAPTER 4: STAKEHOLDERS' OPINIONS ABOUT THE APE PROGRAM

### 4.1 Stakeholders' position and views in relation to the APE strategy

Stakeholders show general support for the APE programme, readiness to help develop instruments for the implementation phase, and willingness to mobilize or allocate resources to implement the programme. Their general opinion about the programme is that it is appropriate to address the need to extend the coverage of the national healthcare system and provide primary healthcare to more Mozambicans, especially to rural communities, as stated in the program document (cf. MISAU 2010: 4). While some stakeholders are optimistic about the success of the program, other show reservations about its sustainability

Stakeholders more optimistic about the possibilities of success for the program argue that the APE strategy "can be a success story", as it was for some years after its first implementation in the late 1970s, in the country. They argue that the program was one of the most successful interventions of the Ministry of Health, and only failed due to circumstances beyond the ministry's control. These circumstances include the war that opposed the government and RENAMO guerrilla for 16 years, from 1976 to 1992, and changes from socialist oriented and centralized to liberal political and economic policies of the country, which made it difficult for the Ministry of Health to ensure control over the national healthcare sector.

More sceptical stakeholders quote what they feel to be a lack of clarity from the Ministry of Health about the approach to implementation of the program, reduced human, financial and logistical resources to implement and manage the program, lack of district and community involvement in planning of the process, and the possibility of centralization of the implementation process at the national level. Additional reservations include what they regard as lack of clarity about (i) current and future availability of funding for the program (ii) the role implementing NGOs and provincial, district and community level actors will play during the implementation of the program.

Despite this divide, all stakeholders interviewed show commitment in developing the implementation tools for the program and readiness to implement the program. At the moment, Ministry of Health, international NGO's and multilateral and bilateral partners at the central level are working on ensuring sustainable implementation of the recently approved Program for the Revitalization of the APE. However, involvement of provincial, district and local community actors as well as actors from the private sector and from other cabinet ministries is either limited or not visible. Provincial level actors, especially provincial directorate of health are more involved than district level actors, but they regard themselves as recipients of central level guidelines and "commands". District level state and non-state actors are not much involved and do not have knowledge about the program.

Stakeholders external to the Ministry of Health clarified that they are not part of the decision-making process about the program, as this is a responsibility of the Ministry of Health. They regard their role as getting involved in discussions to help the Ministry develop the program and implementing instruments. In this regard they participate in technical working groups that meet almost on a regular basis, and partners of the Ministry of Health also commit to continue providing technical assistance during the implementation of the program and finance components of the program.

## 4.2 Potential opportunities and threats to the program implementation and sustainability

### *Opportunities for the program sustainability*

The major opportunity quoted by stakeholders for the success of the APE program is political commitment from the Ministry of Health and its partners in launching and implementing the program. Other stakeholders also quote the long history of the APE program in the country as a possible opportunity that can be taken advantage of to implement the program with success.

The commitment from the Ministry of Health in developing the APE strategy in the country is presented in a chronological manner by stakeholders interviewed. They date this commitment back to the National Meeting on Community Involvement for Health, held in 2007, in which the Community Involvement for Health Strategy was revised and a decision to revitalize the APE program was taken. This was followed by meetings involving Ministry of Health officers and the ministry's partners that made it possible the development and recent approval of the APE Revitalization Program in March 2010. The approval of this program and the decision taken to provide a monetary subsidy to the APE is regarded as an additional and important sign of the Ministry of Health political commitment.

Stakeholders remind that Ministry of Health partners - including international NGOs and multilateral and bilateral institutions - have been showing commitment to the program. One example is funding provided by USAID for the consultancy which resulted in the development a draft of the APE Revitalization Program and an APE Training Manual. Other examples include the participation of technical personnel of the Ministry of Health partners in technical working groups which are discussing and developing instruments and operational plans for the implementation of the program. Partners have also committed to providing financial and technical assistance to the program in the implementation phase.

The long history of the APE program in Mozambique, which dates back to the late-1970s, the limited coverage of the national healthcare network and the need to provide primary healthcare to communities without access to it were also mentioned as opportunities that the program can benefit from. These opportunities were coupled with the expressed need from government (cf. MISAU 2010:4), partners and local communities to see the healthcare coverage increased and, thus improve health indicators in the country and achieve the MDGs for health. But this optimism about the program was also countered by some reservations, especially expressed as possible threats and barriers to the program.

### *Barriers or threats foreseen or experienced with relation to APE program*

Barriers or threats to the program expressed by interviewed stakeholders are associated with financial sustainability, institutional limitations within the Ministry of Health (including deficiencies in planning for the program), and community participation in the selection of APEs.

Many interviewed stakeholders either expressed doubts about the ability of the Ministry of Health to ensure financial sustainability of the program on a medium to long-term basis, or suggested implicitly that they are not sure about the possibility of financial sustainability of such a financially and institutionally demanding program. In addition they remind that funding to start the program is not yet available, and

contributions from the Ministry of Health partners are not yet clear in terms of which program components and geographic areas will be covered and how much will be made available to the program. In more than one occasion, as a way out to this doubt a stakeholder suggested that instead of raising doubts about the financial sustainability of the program stakeholders should opt for implementing the program and mobilize resources for its success implementation.

since there is general agreement that this program is important everyone should go for it [...] “We should judge the program not for its financial costs, but for what could be gained from the program once it is implemented - and well implemented<sup>15</sup>”.

According to this stakeholder, financial [un]sustainability is not particular to this program, but is applicable to many more Mozambican government programs and projects, including the State Budget - which is heavily financed by international partners. This stakeholder argues that financial sustainability is part of a long term discussion about the dependency the country from donors. This call, however, seems to have gone unnoticed.

Most stakeholders argue that there is a need for the Ministry of Health to take leadership in securing sustainable funding for the program. This could be done, they suggest, by a commitment to cover the program’s expenses from a certain time, after the program implementation starts. Some stakeholders suggest that Ministry of Health partners could mobilize or allocate funds to the Ministry once it shows this commitment. One way to do this could be by defining a certain percentage of partners’ contribution to the Ministry of Health Common Fund as being the necessary amount to finance the program. Another way, some argue, could consist in the Ministry of Health initiating discussions with other Ministries with a stake in the financial matters associated with the APE program, such as the Ministry of Finance and that of Public Service, to have the budget of the APE program covered by the State Budget.

Other stakeholders, on the other hand are of the opinion that partners should clarify to which components of the program they are ready to contribute, how much that contribution will be, in which provinces or districts. In this regard a spread-sheet was circulated to the partners on a meeting held at the Ministry of Health on 31 March, which should be filled by partners and submitted to the Ministry by 20 April 2010.

The second set of perceived threats or barriers to the programme is located is conceptualized as institutional limitations within the Ministry of Health. Some stakeholders argue that the Ministry of Health has reduced human resources which have limited technical capacity to implement this program and; reduced infrastructure to support the programme, especially at the district and local community level.

The third set of barriers or threats internal to the Ministry of Health is located within planning process for the program, which is regarded as having some shortcomings. Stakeholders argue that in spite of a relatively long history of APEs in Mozambique, people who are part of this experience are not involved in technical working groups<sup>16</sup>. In addition, the program development seems not to be based on reliable information about the APE situation in the field. Finally, the Ministry of Health approach to the programme is regarded as fragmented as there seems not to be a unified view within the Ministry as to what is expected to be the role of NGOs within the program. The provision of a financial subsidy to APEs is also regarded as having to be based on considerations about its impact in communities were the APE used to be cared for by

the community because he was regarded as a voluntary worker and, a question should be raised about 'how paying APEs will impact on other CHWs who are still working as voluntaries - and whom, it seems, will remain as such in the near future'.

The fourth set of barriers or threats to the programme is as associated with the participation of local communities in the selection of APEs. According to stakeholders, in the remote as well as recent past, the selection of APEs within communities was done by community leaders instead of a wider community forum. As a result the selection process was not only non-participative as it was not transparent. In fact, community leaders often tended to select relatives and other people closely related to them. As an interview explained, the rationale for this biased selection was that

there was no employment in those days and APEs had a subsidy. So the community leader did not hold a community meeting. He selected his relatives<sup>17</sup>.

#### *Nature of expected involvement in finding the solutions to barriers identified*

Stakeholders show a proactive attitude towards finding solutions to overcome threats or barriers they identified which could complicate the national scale up of the APE programme. The nature of their involvement in finding solutions to overcome the barriers and threats identified is associated with the resources they have or have access to (for example, human resources and, funding), leadership to initiate action; mobilize resources and alliances, lobbying abilities and, whether they are policy-makers, funding or implementing agencies, etc..

In that regard NGOs expect to use their experience of implementing projects in the field to conduct advocacy for community involvement and appropriation of the APE program, for example; relying on alliances with other NGOs and partners to strengthen their positions and views about the program; seeking advice from international experts they have on similar programs, especially ICCM, to back their positions; lobbying and fundraise or fund program components and even train personnel or implement some aspects of the program.

Central, provincial and district government officials expects to use their position as policy-makers and public managers to influence and strengthen local community capacity to support the program; influence NGOs and other partners to provide technical, logistical and financial assistance to the program and; ensure mid to long-term financial and technical sustainability of the program. They expect this to be done by covering part of the expenses of the program with state budget, providing and training personnel to manage the program at central, provincial and district levels.

Funding agencies or stakeholders more oriented to provide funding, rely on their ability and resources to contract technical assistance and fund some portions of the entire program or some components of the program at the central as well as provincial and district levels. As a stakeholder explained:

We do not get directly involved in implementation and do not fund the Ministry of Health directly. We can contract consultancy services, hire specialists to provide technical assistance, and finance implementing NGOs who will implement the program in two provinces<sup>18</sup>.

### 4.3 Priorities for improvement of the APE program

Given the balance between opportunities and barriers or threats for the sustainability of the program, stakeholders define some priorities, which are located within the areas of leadership of the entire process; coordination and implementation of the program, and more specifically within the areas of (i) training and continued capacity building of APE, (ii) motivation of the APE, (iv) APE supervision, (v) data generation and use, and (vi) drug management.

Stakeholders think that the Ministry of Health should lead the entire process, by lobbying for the program's acceptance and arguing for its importance vis-a-vis other cabinet ministries, and partners, clarifying its position about the approach to be followed and ensuring the adopted plan is followed during implementation of the program.

They also argue that an important stage in planning activities should start with mapping the districts or local communities where APEs should be assigned to. They further contend that the roles of all stakeholders and important actors within the program should be clearly defined. This includes clarifying the role of Mozambican state and government institutions and national and international NGOs and other partners. Specifically, they think that while the central level government entities should be dealing with strategic issues such as defining the program guidelines, Monitoring & Evaluation of the overall program, routine management of the program should be handled by districts and local communities, with technical assistance and supervision from the provincial level.

The involvement of non-state local actors and other cabinet ministries in the program as well as coordination between the APE and other community health workers and traditional healers are also regarded as key to the success of the program.

Stakeholders noted the need to clearly define the Terms of Reference (TORs) of the APE and then provide them with initial technical training in clinical, community mobilization, disease prevention and community dynamics and relationships components. Then continued quality performance through on the job training should be ensured by providing regular and effective supervision and regular refresher trainings.

#### **Status of training and proposed solutions for improvement**

Training is the more comprehensively described aspect of the APE program. In this regard, I also describe it more comprehensively in this report. Before APEs are trained training packages and instruments will be developed and pretested, and trainers will be trained. National or regional trainers will train provincial trainers, who will train district trainers who will train APEs. Trainers will become familiar with the training materials will be empowered to conduct APE supervision and support<sup>19</sup>. Training of the APEs will be preceded by their selection. This selection is expected to be at the community level, but facilitated by provincial and district level health personnel. It is recommended that a community meeting is called in which all members of the community can participate and the role of the APE in the community is explained<sup>20</sup>.

Then, the criteria for the selection of the APE should be explained, as part of the following profile:

- All women and man can apply to become APE, with special preference for women;

- Applicants should be fluent in Portuguese - now how to read, write and speak - and have basic knowledge or arithmetic.

The facilitators should highlight the qualities of the APE, namely: being respected members of the community; with proven involvement in community activities and; willing to be APEs and expressed availability to serve the community after being trained as an APE. After selection of the applicants, they should be sent to participate in a training which should take place in the district where the community is located<sup>21</sup>.

The APEs will be trained to work in their communities of origin and will be able to contribute to improvement of the health situation in their communities through health promotion and prevention of health conditions; provide first aid and treatment/management limited to the most common child diseases, namely malaria, diarrhoea and respiratory infections and; will be the link between the community and district healthcare personnel<sup>22</sup>.

The training is planned to last 18 weeks, the first 16 weeks being of lectures and practice and the last two weeks for review and assessment of the trainers. For each training block/part, with the exception of review and assessment, two weeks will be devoted to lectures and two weeks will be dedicated to practice. Training will be provided by healthcare personnel, who should have teaching experience, at least the equivalent to grade 12, and they will undergo trainers-training before they start training the APEs. In each district, coordination of the training of APEs will be under the responsibility of a Director of APE training<sup>23</sup>.

Community leaders and healthcare personnel from the “remote” healthcare facilities within the area where the APE will work will be involved in supervising field practice activities during training of the APEs. This strategy is aimed at empowering them to supervise APEs when they start work<sup>24</sup>. After the training, the APEs will undergo an internship at the healthcare facility within the community where they will work<sup>25</sup>, and then will be presented to the community in a public meeting<sup>26</sup>.

Stakeholders are currently involved and will be involved in different ways in development and improvement of the training strategy. Their involvement includes not only developing the guidelines, curriculum, training aids and a timeline for the training, but also in securing funds for the implementation of the activity. At this point a decision seems to have been made for starting training of trainers at the national or regional level and then go to the levels below. Some partners have already secured funding for training, but it is not yet clear how much will be available for the activity and to what parts of the country. As a way of preparing training teams composed by officers from the Ministry of Health at the central and provincial levels have visited some districts of Inhambane and Nampula Province to assess the resources available and accommodation and training facilities available for training of the APEs. But a list of the training conditions available is still to be drafted.

Stakeholders’ feelings about the training strategy range from caution, to some reservations about the effectiveness of this strategy. Caution is associated with the fact that the training strategy is still being developed. But, reservations are shown by some stakeholders, who note that the training strategy needs to be pre-tested before it is implemented as some improvements might still be necessary and in general it needs to be adjusted to the education level of the APEs. The training packages were also regarded as still in need for improvement, as information is still mostly textual, complex and with substantial biomedical content. The following table summarizes stakeholders’ suggestions to improve the training strategy and package.



Table 5: Suggested improvements to training components	
Training strategy	Training package
Pre-test before implementation	Adjust to the education level of APEs
Increase practice exercises	Pre-test before implementation
Improve APE communication skills	Reduce text; increase images and drawings
	Include neo-natal components
	Reduce biomedical contents

### Priorities and proposed changes to improve motivation

Motivation of the APE was associated with the selection process, regularity and nature of supervision and the type of incentives given to the APE. Stakeholders reminded the need to ensure transparency of the selection process at the community level as a decisive step to ensure APE retention, as in the past people who did not belong to the communities were selected as APEs with the main expectation of benefiting from the subsidy, but when it came to work they were not available, especially when the subsidy and other monetary incentives could not be given to them. Stakeholders also quoted many instances in which, against the plan, local leadership selected APEs without the participation of local communities. The payment of a monetary subsidy to the APEs divide stakeholders' opinions - some regard it as beneficial while other think that it depending on how it is managed it could raise threats to the programme success.

The novelty in the motivation strategy within the APE program is Ministry of Health commitment to pay a monthly monetary subsidy to the APE. Other incentives will be non-monetary and will include bicycles, uniform and identification cards. To this strategy stakeholders add:

- The need to provide regular supervision, regarded more as technical support than inspection
- refresher trainings to be held at least once a year
- Give APEs and their relatives priority treatment in benefiting from public service in times of need
- Grant APEs access to income-related health sector opportunities, such as community mobilization campaigns and
- Give to the best performing APEs opportunity to apply for and become official healthcare personnel.

As described in the box below, some of the strategies proposed above are being put in place, for example in Massinga and Vilanculos Districts, in Inhambane province.

### **Experiments with APE motivation in Massinga and Vilanculos:**

In Massinga District a stakeholder interviewed noted that APEs in that district do not have bicycles and do not earn any subsidy. But the district directorate finds alternatives to maintain their motivation. It is known that they charge token amounts for consultations or for medicines they give to community members. But the health authorities do not interfere with this. And every month APEs come to the district health directorate to bring their reports and take a new kit. So, whenever the district is able to, the APEs are given money for their transportation back to their communities.

The stakeholder also recounted that the District Administrator helps in motivating the APEs, because whenever he has an opportunity he praises the excellent work done by the APEs. And according to the interviewee, APEs feel highly motivated because of this.

Another interesting effort at maintaining APE motivation was narrated by a stakeholder in Vilanculos. According to this stakeholder, the district directorate of health received bicycles for the pulverization campaign. But those bicycles could not be used for that purpose, as most roads are sandy. So the district directorate requested authorization from the provincial directorate of health to give bicycles to the seven APEs from the district. That authorization was granted and they gave the bicycles to the APEs.

Although most stakeholders support giving a monetary subsidy to the APE, their views about paying APEs vary from open to cautious support to that strategy. Stakeholders who support that strategy unconditionally remind that in the past when the first time APEs were created in Mozambique they were expected to work as volunteers for only a short portion of their daily time. But the reality in the field is that they became healthcare community workers, who had no time to do anything else. In this regard, they had no opportunity to be involved in other livelihood activities.

These stakeholders also argue that, at that time, given the independence euphoria, and the mobilization of the ruling part, voluntarism came easy. But, times have changed; earning a livelihood has become so necessary these days that voluntarism will not work. In defence of paying APEs, a stakeholder states:

paying APEs is logistically appropriate, it is sustainable and it is fair, and helps increase control over the APE<sup>27</sup>”.

Other stakeholders caution that before deciding to pay APEs, the Ministry of Health should ensure that once it starts paying this payment will continue in the future. Or otherwise, the Ministry of Health partners could provide the funds for the payment of subsidies for a few years and then the Ministry should take into its hands the responsibility of paying the subsidy thereafter. This is because, in the past, the lack of subsidy was identified as one of the reasons for APE underperformance, charge for consultations of medicines and even for abandonment.

Stakeholders also argue that the payment of a monetary subsidy to the APE should take into consideration the possible impact in the community where APEs will work, and where APEs have worked for so long without regular monetary subsidies. On the one hand, stakeholders wonder whether local communities could continue regarding and accepting APEs as part of their communities, once they start receiving a monetary subsidy or could start treating them as if they were part of the official healthcare network. On the other, stakeholders foresee a possibility for social unrest. They argue that since APEs will be paid a monetary subsidy and work in communities

were, by and large, other CHWs who work on a volunteer basis, such as those employed by NGOs work, what will be the reaction of these volunteer CHWs? Won't they sabotage the work of the APEs to be trained and work under the new revitalization program?

### **Difficulties, opportunities and proposed solutions to supervision**

Description of the supervision strategy within the APE revitalization program is not allocated a specific section, but it is scattered throughout the document. It is mentioned *en passant* in the description about training. One understands that supervision will be conducted from the community to the national level, by community leaders at the community level, and healthcare personnel from the nearest health facility, district and provincial directorate of health, and national health authorities. The operational plan also provides some information about supervision, especially the funds that will be involved in the activity. One reason for the lack of explicit and a little detailed reference to supervision could be that this is one of the components of the program that is still being developed.

Opinions about supervision range from those who argue that there is no supervision of the APEs as such, to those who argue that there is some irregular and scattered supervision, but conducted by provincial level health officials and implementing NGOs, with district level health officials not conducting any supervision at all or at times doing some supervision as part of provincial teams or taking the opportunity of visits to remote healthcare facilities, especially with NGO resources. The conclusion most stakeholders reach is that "there is no district supervision", and "there is no effective supervision".

While some stakeholders argue that the district has enough human resources to conduct supervision, others argue that the district does not have either human, nor logistical resources or know-how to conduct APE supervision. Thus, they argue that district health directorates should be empowered and supported to conduct effective APE supervision.

Some stakeholders are willing to try innovations, though, which range from creating a so-called Community Health Management Information System (CHMIS) particular to the APE, and create a system to ensure collection and analysis of data by the APE, local community and the nearest healthcare facility and district, and ensure feedback to the APE. In this regard an NGO is experimenting with the following supervision strategy:

APEs are not being supervised at the moment. We want to strengthen supervision of the APE, by involving the nearest health facility personnel in supervision. These personnel will have a supervision guideline. We have developed a supervision strategy within [a] project in which the provincial directorate of health does not conduct supervision. Supervision is conducted by the district medical officer, a laboratory technician and a maternal and child health nurse. These are regional supervisions, in the sense that we divide the province in three regions: north, centre and south. Personnel from each district visit APEs from other districts within their region, but do not visit APEs in their district, in order to avoid conflicts of interest<sup>28</sup>

Stakeholders advocate some changes to improve supervision of the APEs. They argue that supervision should be conducted by district health authorities and personnel from healthcare facilities within the communities where APEs work/live. This is because, according to them, districts have enough human resources and technical capabilities, but they lack logistical and financial resources to conduct

supervision on a regular basis. On the other, decentralizing to the district not only aligns with overall government approach to governance and development as it could be a way to improve the district's autonomy.

Stakeholders also argue for a change in the supervision attitude, from an inspection-like attitude to one oriented to technical support, on-the-job-training and motivation. And to make supervision effective the role of all levels of supervision should be clarified and there should be clear guidelines, which should state exactly what should be done, the findings of the supervision, recommendations for improvement and what aspects should be addressed in the following supervisions visit. A stakeholder is of the opinion that at the end of a supervision mission

Supervisors should submit supervision reports to their superiors, and these reports should show: what was done, what issues or problems were identified, what solutions were found or suggested<sup>29</sup>.

Stakeholders espouse the view that supervision could be mainly conducted by local community, and district health personnel, and nearest healthcare facility personnel should be kept informed about APE activities. To be effective, stakeholders reminded, supervision should have clear guidelines and tools, and should be conducted on a regular basis. Regular supervision should aim at helping the APE improve their work, instead of being inspection-like activities. Stakeholders further argue that effective supervision helps improving performance, retention and motivation. Providing material, monetary and more symbolic incentives were also regarded as effective. In this regard, the Ministry's commitment to provide a monetary subsidy plans about providing bicycles, uniform, identity card as forms of non-material incentives were regarded as important for motivation. But, almost all stakeholders argue that a monetary incentive is one of the key elements to keep the APE working. As one stakeholder remarked:

a t-shirt, an identity card are not part of the motivation package. They are tool kits. The basis for motivating is the subsidy. The other factors are additional<sup>30</sup>.

## **Use of data generated by APEs and drug distribution: are innovations necessary?**

Data collection tools for the APE are still being developed, and stakeholders remind that these tools should be as simpler and user friendlier as possible to ensure that data collected by the APE can be used by the HMIS. Stakeholders recommend that as part of the motivation strategy there should be feedback of the information or reports provided by the APE to the district. Some stakeholders suggest some innovations to improve data collection and the use of data collected by the APE, while others argue that all the system needs is simple, clear and easy to use tools that help APEs collect data that can be used by the system. The argument being that, before innovating, an effort should be made to use the data.

Stakeholders' general opinion about the data produced by APEs is that it is only used for the purpose of presentation to the district health authorities and then to ensure they receive a kit on a monthly basis. This data is then archived and sent to the provincial directorate of health, where no one is sure whether it is analysed and used or not. For the purpose of reporting, APEs are either given an A4 table which they fill and write their report. But often, scarcity of paper has been reported and in that case, APEs and district health personnel find local alternatives to ensure data is collected.

In this regard some stakeholders suggest that some innovations could be used to improve the use of data produced by APEs. These innovations include:

- Use of cell phones as a means to send data
- Use of visual or pictographic information to describe illnesses, such as pneumonia
- Create a CHMIS and incorporate it into the state HMIS
- Train APEs to analyse information they collect and use it to make decisions in the field.

Other stakeholders are more conservative about innovations. They argue that what are needed are not innovations, but simple and easy to use data collection and reporting tools that APEs would be able to understand, and that healthcare system could use for analysis and decision-making. At the district and provincial level, stakeholders argue, computer software should be used to process and analyze data produced by APEs; and this could be made easier by the fact that all districts in the country have at least one computer.

As stakeholders stated in various occasions, and direct observation at the district health authorities helped understand, data collected by APEs and presented on a monthly basis to district health authorities is used by APEs as a means to obtain the kit containing medicines. So, every end or beginning of a month, APEs usually go to the district healthcare facilities and present their report and get a new kit. At the moment APEs do not receive a monetary subsidy or another form of payment from the state. Since they usually live in areas relatively distant from the district health facility (located at the district capital), they use the following means to reach the district health facility.

Some of them charge a token amount for consultations or medicines at the community, and this is understood as reasonable by communities, and this money is

used to pay for transportation to the district health facility and back home at the end of the month.

Reportedly, at the end of the month some communities contribute with transportation money and give it to the APE who uses it for the trip to the district health facility and back.

Another example comes from Massinga District Health Authorities, who, whenever possible provide money for the APE transportation when they come to bring the report and collect the kit in their monthly visits. But, as a stakeholder from Massinga reported, sometimes the district authorities do not have the money, and the APE must find alternatives<sup>31</sup>.

As stakeholders explained the distribution of the APE kit is as follows. Kits are sent every three months from National Drug Storages located in Maputo City, Beira and Nampula, to provincial drug storages in the Southern, Central and Northern regions respectively. The provincial drug storage sends the kits to the district health facilities on a monthly basis. The APE receives the kits from the district health facility on a monthly basis, too.

Most stakeholders regarded the drug distribution system in place as appropriate or effective at least. But they reminded that APEs obtain their kit based on the report they give to the district, but there is no way to check the accuracy of the reports.

Stakeholders add that, while the national healthcare system ensures that existing APEs receive their kits regularly, there is no control as to how many of the drugs provided are used, which ones are more used and would need replenishment before the end of the established stocking period, and which ones are not being either used or only few quantities are used. This is also because at the provincial and district level the management of drug stocks is manual, and also related to deficiencies in supervision APE supervision. To counter these shortcomings some stakeholders argue that computer programs should be used for (drug) stock management.

There are some efforts from Ministry of Health partners and district health authorities to improve drug management. For example one Ministry of Health partner provided computers and computer software for the management of drug stocks. In the two district health directorates visited by the consultant, health personnel monitor the volume of drugs used by the APE and reduce the number of less frequently used drugs from the APE kit. However, they do not replenish the APE with the most frequently used drugs in the proportion necessary to the communities in which the APE works.

## CONCLUSIONS AND RECOMMENDATIONS

### Conclusions

This report presents the results of a consultative mapping of stakeholders involved in the Integrated Community Case Management (ICCM) of childhood illnesses through a specific Community-Based Workers Strategy in Mozambique, known as the APE Strategy/Programme. This mapping was conducted between March and April 2010, in Maputo City and Inhambane Province (including the provincial capital, Massinga and Vilanculos Districts), in Southern Mozambique.

The APE programme was first implemented in the late 1970s in Mozambique, but in the course of its implementation it faced several difficulties, and was closed. In different other instances it was revitalized. Following an enthusiasm which gained momentum with the National Meeting on Community Involvement for Health, held in June 2007, the programme is being revitalized again. In that regard the Programme for the Revitalization of the APEs was approved by the Ministry of Health in March 2007, and preparations are being made to implement the programme.

APEs are regarded as one of the key community level actors who can help extend primary healthcare to local communities in Mozambique. Given the proposed syllabus of their training they are also a key factor in the management of childhood illnesses at the community level, an area in which Malaria Consortium will be actively involved through the INSCALE project.

The aim of this consultative mapping exercise was to identify the stakeholders involved in the ICCM of childhood illnesses (in particular diarrhoea, malaria and pneumonia) through the APE strategy in Mozambique; learn about the opportunities and threats to the program as well as current, planned and alternative solutions that have the potential to improve APE performance, retention and information utilization.

Data collection methods included individual and group stakeholder interviews and direct observation. Literature and other secondary documents were also used to supplement information. A stakeholder analysis was applied in order to prioritize stakeholders and stakeholders' opinions were analyzed using a SWOT analysis framework that aimed at interpreting findings in terms of strengths and weaknesses and opportunities and threats to the APE program as a whole and with special emphasis to the areas of APE supervision, training, motivation and use of data.

Thirty stakeholders were interviewed in Maputo City, Inhambane, Massinga and Vilanculos districts (in Inhambane Province) and they hold different positions at the Ministry of Health, International NGOs and bilateral and multilateral partners at the central level (in Maputo City); Provincial and District Politicians/government officials and health directorate personnel and; other stakeholders with vested interest and experience in the APE program in the country.

Stakeholders interviewed are supportive of the program, independently of (i) their level involvement in discussions and decision-making at the national level and (ii) of their level of knowledge about the program. Stakeholder analysis data also suggest a centralization of discussion and the decision-making process about this program in Maputo City - apparently based on a top down approach to the development of the policy and its instruments. This centralized tendency is also evident in the level of knowledge stakeholders have about the program: central level stakeholders showed a higher level of knowledge in relation to provincial level stakeholders, whose level of

knowledge is higher than district level stakeholders. Low levels of knowledge about the program seem to be based more on limited access to information, rather than on simple lack of interest or support for the program.

Stakeholders are supportive of the APE program and are committed to help in developing instruments, allocating and mobilizing resources to implement the program. They share the opinion that the program is important to address the need to extend primary healthcare to more Mozambicans, especially to “rural” communities. But some argue that sustainability (especially financial sustainability) should be ensured before starting to implement the program.

Optimistic stakeholders argue that the program has opportunities to become a success since there is Ministry of Health and partners’ political will and commitment, and the long history of APEs in Mozambique helps the Ministry of Health realize the most appropriate approach to avoid the mistakes and overcome difficulties of the past.

More skeptical stakeholders show reservations about the sustainability of the program, since funds have to be secured, the Ministry of Health still needs human resources, the decision-making process and management of the program needs to be decentralized to the district, community involvement and the role of implementing NGOs and other cabinet ministries still needs to be clarified.

In order to overcome these barriers or threats to the program, stakeholders argue that action should be focused on ensuring that the Ministry of Health takes the leadership of the entire process; the role of all stakeholders (state and non-state actors, at the central, provincial, district and community levels) should be clearly defined; guidelines and other tools to monitor and evaluate the implementation of the program should be finalized, with a focus in the areas of APE training, motivation, supervision and data collection and use.

Stakeholders had difficulties voicing their opinions about APE training, motivation, supervision and data collection and use, since the instruments for those areas are still being developed and stakeholders are part of the technical working group assigned for that task. Nevertheless, stakeholders shared some of their experiences and ideas related to those areas.

Stakeholders’ general opinion about the training strategy and materials still need to be developed and pre-tested before implementation, and a balance should be ensured between biomedical and community oriented contents of the training and those contents should be adjusted to the education level of the trainees.

Stakeholders associate motivation and retention of the APE with the selection process, the quality of supervision and regularity or incentives and the balance between monetary, material and non-material incentives. While most stakeholders support the allocation of a monetary subsidy to the APE, they argue that this should not be done lightly - the reaction of local communities and ‘voluntary’ CHWs should be considered and managed. Novel motivation strategies employed by district health authorities in association with district governments were quoted by stakeholders as having a potential to improve motivation and ensure a great level of APEs.

The general stakeholder opinion about supervision is that it is either non-existent in some districts or communities or it is not effective. They argue that supervision is irregular in time, and often ineffective. Proposed solutions include allocating especially financial and logistical resources to the districts, so that they conduct

regular supervision, regarded more as support, on-the-job-training in order to improve APE performance, rather than an inspection-like supervision. The provincial level's role was defined as one of providing technical assistance to the districts and monitoring the process. The central level, stakeholders argue, should focus more on developing instruments to ensure effective supervision, such as supervision guidelines and supervision report templates and ensure overall monitoring and evaluation of the process.

While data collection tools for the APE are being developed the general stakeholder opinion about the use of innovations is divided. Some innovations suggested include the use of mobile phones, the creation of a Community Management Information System integrated in the HMIS and training of APEs to analyze data they collect. Other stakeholders argue that more than innovations what is needed is data collection instruments that are clear, simple and help APEs collect information that is relevant to analyze the health situation of communities and can be used by the national Health Management Information System (SIS). They add that computers can be used at the district, provincial and central level, to aggregate and analyze data sent by the APEs.

At the moment, data collected and reported by the APE is mainly used by district health authorities for the purpose of providing a kit containing essential medicines to the APE. Stakeholders noted that the distribution system, in general is adequate and it is functioning, but the supply of kits should be more based on reliable information about the quantity of medicines necessary for the APE or the quantity of medicines APEs use on a given period. Drug stock management is also deficient and done manually. To improve stock management stakeholders suggest that health authorities should use computer aided software. The availability of computers in all district capitals in the country is an opportunity to be used to implement this suggestion.

## **Recommendations**

National decision-making process could profit from involvement of stakeholders from provincial, district and community level as well as central level actors with a stake in the program who are not currently involved, such as Mozambican NGOs, and civil society.

Advocacy and communication strategies should be adopted to increase the level of knowledge of provincial, district and community level actors about the program and gain support of other cabinet ministries, by presenting the program as a state program (although a health-oriented one).

The role of all stakeholders (state and non-state actors, at the central, provincial, district and community levels) needs to be clearly defined.

Guidelines and other tools to monitor and evaluate the implementation of the program should be finalized, with a focus in the areas of APE training, motivation and retention, supervision and data collection and use.

The experience of implementation of the program in Mozambique and experiences in other countries with socio-cultural and economic contexts similar to the country should be taken into account in implementing and evaluating the program.

<sup>1</sup> Department for International Development (DFID). 2003. *Tools for Development: A handbook for those engaged in development activity*.

<sup>2</sup> Schmeer, Kammi. 1999. *Guidelines for Conducting a Stakeholder Analysis*. Bethesda, MD: Partnerships for Health Reform, Abt Associates Inc.

<sup>3</sup> By 1977, Mozambique had developed a training manual for the APEs, and had trained the first APEs, in Chibuto, Gaza Province, in Southern Mozambique. According to one of the participants in the development of the APE training manual, this manual was a contribution of the country to the World Health Organization Conference on Primary Health Care held in Alma Ata, in the former USSR in 1978 (Cf. World Health Organization (WHO). 1978. Declaration of Alma-Ata: International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978).

<sup>4</sup> The same terminology (APE) is used in other Portuguese speaking countries such as Angola and Cape Verde (cf. Ministério da Saúde (MISAU). 1994. *Manual de Agentes Polivalentes Elementares (APE's)*. Maputo City: MISAU,; n.p.).

<sup>5</sup> Cf. Ministério da Saúde (MISAU). 1977. *Manual do Agente Polivalente Elementar*. Maputo City: MISAU

<sup>6</sup> Ali F, Mucache D, Scuccato R (1994). Avaliação do Programa dos APEs. MISAU/Cooperação Suíça, Moçambique: Maputo.

<sup>7</sup> See Ministério da Saúde (MISAU). 1992. *Program de Formação dos Agentes Polivalentes Elementares (APE's)*. Maputo City: MISAU.

<sup>8</sup> Cf. Ali F, Mucache D, Scuccato R (1994). Avaliação do Programa dos APEs. MISAU/Cooperação Suíça, Moçambique: Maputo; Malaria Consortium 2009. *Global Health Proposal Application for project Integrated Case Management of Common Childhood Diseases: Mocambique and Uganda*. Kampala, p.3; MISAU. 2010. *Programa de Revitalização dos Agentes Polivalentes Elementares*. Maputo City: MISAU , pp.2-3.

<sup>9</sup> MISAU. 2010. *Programa de Revitalização dos Agentes Polivalentes Elementares*. Maputo City: MISAU, pp.2-3.

<sup>10</sup> MISAU. 2010. *Programa de Revitalização dos Agentes Polivalentes Elementares*. Maputo City: MISAU , p.3.

<sup>11</sup> This strategy was approved in 2004, and has been under review since 2007 (cf. MISAU. 2007. *Estratégia de Envolvimento Comunitário*. Maputo City: MISAU).

<sup>12</sup> Cf. MISAU. 2007. Discurso de abertura: Reunião Nacional de Envolvimento Comunitário. Maputo: MISAU and; MISAU 2007. Comunicado Final da Reunião Nacional de Envolvimento Comunitário. Maputo: MISAU. This meeting followed a joint UNAIDS, UNICEF, World Bank and WHO International Conference on Community Health in the African Region, held in November 2006, in Addis Ababa, Ethiopia (cf. International Forum for Community Health in Africa. 2007. Joint UNAIDS, UNICEF, World Bank and WHO International Conference on Community Health in the African Region).

<sup>13</sup> Cf. MISAU. 2010. *Programa de Revitalização dos Agentes Polivalentes Elementares*. Maputo City: MISAU, p.4.

<sup>14</sup> It was not possible to interview a representative of the UNICEF. But some information from this organization and its position in relation to the policy was gathered through a brief conversation with a representative of the institution, direct observation at a meeting held at the Ministry of Health, and information provided by other stakeholders, who also identified UNICEF as a key stakeholder.

<sup>15</sup> Interview with stakeholder, April 13 2010, Maputo City.

<sup>16</sup> Interview with stakeholder, April 9 2010, Maputo City. In the meeting on the APE program held on March 31 a high level official of the Ministry of Health, urged the working groups to use the rich past experience of the implementation of the APE program in the country to improve the current program (notes from direct observation, March 31, Maputo City).

<sup>17</sup> Interview with stakeholder, March 4 2010, Inhambane.

<sup>18</sup> Interview with stakeholder, Abril 13 2010, Maputo City.

<sup>19</sup> MISAU. 2010. *Programa de Revitalização dos Agentes Polivalentes Elementares*. Maputo City: MISAU , p.13-14.

<sup>20</sup> Idem , p.4.

<sup>21</sup> Ibidem , p.5.

<sup>22</sup> Ibidem.

<sup>23</sup> MISAU. 2010. *Programa de Revitalização dos Agentes Polivalentes Elementares*. Maputo City: MISAU , pp. 6-9.

<sup>24</sup> Idem, p.10

<sup>25</sup> Ibidem.

<sup>26</sup> Idem, p.8.

<sup>27</sup> Interview with a secondary stakeholder, 25 March 2010, Maputo City.

<sup>28</sup> Interview with key stakeholder from International NGO, 22 March 2010, Maputo City.

<sup>29</sup> Interview with stakeholder, 13 2010, Maputo City.

<sup>30</sup> Interview with stakeholder, April 20 2010, Maputo City.

<sup>31</sup> Interview with stakeholder, April 6 2010, Massinga District.