TA GACOPI (now D.I)

ARCHITECT HEALTH FACILITY PLANNER - **BTC**

FINAL REPORT
Mozambique

D.I. - MISAU
28 NOV 2008

FINAL REPORT

TECHNICAL ASSISTANCE TO GACOPI (now Department of Infrastructures)
Architect, Health Facility Planner - MOZ0401011

BASIC INFORMATION ON THE PROJECT.

Country	:	Mozambique
DAC Sector and subsector	:	Health
National or regional institution in charge of the execution	:	Direcção de Planificação e Cooperação: DPC Ministério da Saúde
Agencies in charge of the execution	:	GACOPI (now D.I.)
Number of BTC international cooperation experts	:	1
Duration of the project (according to SA/SC)	:	48 months
Start date of the project:		
according to SA/SC	:	29 Nov 2004
effective	:	1 July 2005
End date of the project :		
according to SA/SC	:	28 Nov 2008
effective	:	28 Nov 2008
Project management methods	:	regie
Project total budget	:	530 000,- €
Report covering the period (general)	:	Final Report: 1 July 2005 to end
(specific)	:	1 Jan 2008 – 28 Nov 2008

Annexes	Yes	No
1. Results summary	X	
2. Situation of receipts and expenses	X	
3. Disbursement rate of the project	X	
4. Personnel of the project	X	
5. Subcontracting activities and invitations to tender	X	
6. Equipments	X	
7. Trainings	X	
8. Backers	X	

PART ONE: APPRAISAL

Evaluate the relevance and the performance of the project by means of the following assessments:

1. *- Very satisfactory* ***2***. *- Satisfactory* ***3***. *- Non satisfactory, in spite of some positive elements* ***4***. *- Non satisfactory* ***X***. *- Unfounded*

	National execution official	**BTC execution official**
RELEVANCE[1] (cf. PRIMA, §70, p.19)		
1. Is the project relevant compared to the national development priorities?	1	1
2. Is the project relevant compared to the Belgian development policy? Indicate results according to the three themes below: a) gender b) Environment c) Social economy	1 X X X	1 X X X
3. Were the objectives of the project always relevant?	1	1
4. Did the project meet the needs of the target groups?	1	1
5. According to its objectives, did the project rely on the appropriate local execution organs?	1	1

[1] According to the PRIMA, §70, p.19, it is a matter of «appreciating if the choices relative to the objectives, the target groups and the local execution organs remain relevant and consistent according to the general principles of a useful and efficient aid, and according to the execution of the local, regional, international and Belgian development policies and strategies».

	National execution official	BTC execution official
PERFORMANCE[2] (PRIMA, §71, pp.19-20)		
1. Did the project results contribute to the carrying out of its objectives[3] ? (efficiency)	1	1
2. Evaluate of the intermediate results. (efficiency)	1	1
3. Are the management methods of the project appropriate? (efficiency)	1	1
4. Were the following resources appropriate (efficiency) :		
a. Financial means?	1	1
b. Human resources ?	1	1
c. Material and equipment?	1	1
5. Were the project resources effectively used and optimized in order to reach the foreseen results? (efficiency)	1	1
6. Is the project satisfactory on a cost-efficiency approach in comparison to similar interventions? (efficiency)	1	1
7. According to the execution planning, assess the speed of the execution. (respect of deadlines)	2	2

[2] According to PRIMA, §71, pp. 19-20, it is a matter of « appreciate and measure the foreseen performances agreed during the preparation traineeships according to the 4 criteria and the indicators established during the formulation ». (The 4 criteria are efficiency, suitability, respect of deadlines and quality of the personnel).

[3] See annex 1 for further information

	National execution official	BTC execution official
Global evaluation of the project	1	1

Comment your evaluation, which can be broader than the strict framework of the abovementioned relevance and performance criteria and differ from the given evaluation.

Methodology and Support documents for Final Appraisal
The current evaluation is based on the following documents:
- The Light Evaluation Report, prepared the 31st of January 2008 (ER)
- The Annual Report for the year 2008 (AR08)
- The Annual Evaluation report for the year 2007 (AR07)
- Reports and Minutes of the Steering Committees held. (SC01; SC02; SC03)

The Appraisal looks at the results achieved at the end of the intervention, compared with the targets set during the 3rd Steering Committee, and the Conclusions and Recommendations of the Light Evaluation Report.

Assessment of Monitoring Criteria
No TFF, nor logframe was produced for the project. The TA created a framework of Key Result Areas (KRA), which guided the intervention throughout. These KRA functioned as the outline for all activities planned.
The timeframe for these results was (ref. SC02) planned in three phases:
a) Phase I: design
b) Phase II: implementation
c) Phase III: assessment of functioning and adjustments required

Efficiency
Considering that no logframe exists for the project, it is difficult to objectively quantify progress and performance. The number of projects that have been started, all based on new designs does show that there is positive progress on a large scale, and that this is achieved through a collaborative effort with the Department, which shows the strong signs of realized capacity development.

The targets that were set for the programme might have been however too optimistic. If this project is to continue, the recommendation n° 3 of the ER is imperative, namely: "setting clear and realistic targets in relation to planned resources, timeframe and risks and to the means for monitoring and reporting against them."

Effectiveness
The project is considered effective for the following reasons:
a) The design phase has been finalized
The project achieved a full cycle of redesign of public health facilities and referral district hospitals and adopted guidelines for all government controlled physical health centers.
b) All projects are currently being implemented as per new designs developed.
During construction of the hospitals and health centers, the project (and TA) continued adjusting the schemes, in liaison with the responsibles for implementation. Most of the activities planned in the KRA related to project management have been fully taken up by local architects and assisted by the EU-TA.
c) Phase three: the assessment of health facilities under operation will not be continued under this Technical Assistance Project. It has been highlighted on several occasions that this might jeopardize some of the results and objectives envisages, or at least is a missed opportunity for the Belgian Cooperation and especially D.I. to fully harvest permanent results from this programme.

Over the years, the project has built capacity of junior architects and engineers. Evidence is not only visible in the Department, but also in the Consultancies dealing with the health infrastructure. Although a high turn-over drained the Department of valuable staff, these architects continue their activities through consultancies, and hence, returning their knowledge to the health sector.

Sustainability

The priorities of the partner have been from the start: large scale construction of health infra-structures designed on the new principles of compactness, flexibility and minimum standards. To achieve this, the project embarked on the design of a number of core elements that would allow the built-up of a variety of different hospitals and Health centers. (D.I. called this technique: plug-in). About 34 major hospitals are now under construction or tendered for, while full developed standard files have been distributed to the Provinces for the smaller health centers. Considering that these hospitals and health centers (including their documentation) will form the benchmark for the future of Health Facility design, the outcome of project can be considered fully sustainable.

However, failure to embark on phase three might prejudice this outcome:
1) It is imperative to identify mistakes, errors and functional glitches before the schemes are repeated.
2) It is an opportunity to distillate out of this broad exercise, an number of tools, norms and legal instruments that can guide future investment projects in the health sector.

Indicators of Paris Declaration

Ownership and Alignment

The Specific Agreement states: "The Architect will assist and support the management of the health investment plan in preparation of projects, tendering procedures and monitoring of implementation programmes". This clear accountability towards the partner became an opportunity for the project team and Steering Committee to rethink the way to achieve the objectives taking into account the recommendations of the Paris Declaration: harmonization, alignment, managing for results, mutual accountability and ownership. From the first Steering Committee it was agreed to follow Mozambican systems, procedures and leadership. On several occasions the Ministry repeated their concurrence on the way the assistance was rendered and that it realizes the capacity the Department required at this moment in time. It was observed however that, the project is in "regie", which does not give the partner the control of the funds provided.

Harmonization

Upon request of the Ministry, another donor (EU) joined the programme, based on the same principles as the Belgian intervention. This TA took up the activities related to the implementation of the projects, bringing more balance of the support to the units: the design office and the implementation office.

National execution official	BTC execution official
	K. DE MULDER, ARCH.
[signature]	[signature]

PART TWO: SUMMARY OF THE PROJECT IMPLEMENTATION

1. If necessary, describe the Specific Objectives and the Intermediate Results of the project, as mentioned in the project document, as well as the implemented changes (when, how, why)

(Ref: Specific Agreement)
The General Objective: to accelerate the rehabilitation of the country's medical infrastructures.
The Specific Objective: to strengthen the Investment Programme Implementation Unit GACOPI, through the delivery of technical assistance.
The Tasks in ToR are defined as follows:
The Architect will assist the MoH, DPC, through GACOPI in all technical management matters. In his duties of supporting GACOPI activities, the Architect shall be requested to attend and participate in day-to-day activities of other projects under implementation related to the development of all investment activities of the health sector.
The Duties in ToR are as follows:
The Architect will assist and support the management of the health investment plan in preparation of projects, tendering procedures and monitoring of implementation programmes.

Project Implementation
Because of lack of TFF and logframe for the project, an alternative set of tools was developed to steer the intervention. At the start of the project, the requirements of the Department were analysed, its challenges, priorities and problems, and compared with the listing of duties mentioned in the Terms of Reference. It was agreed to organize these into a workable framework, streamlining all activities and qualifying into a result-oriented approach to achieve the desired impact of the intervention. This resulted into a three-fold working instrument, complementing the Specific Agreement:

a) Definition of Intervention
"To prepare conceptual designs and master-plans and to enhance quality of design and management of the project units, through standardisation of design models and to streamline implementation of projects through establishing uniform methods and procedures."

b) Key Result Area
The resulting activities were defined in the First Steering Committee, clustered in 7 different categories: key result areas (KRA), guiding all the activities of the intervention.

- Conceptual design and masterplanning
- Quality chamber
- Quality assessment system
- Health facility library
- Support research
- Norms formats and procedures
- Capacity building

c) Activities
The activities are scheduled over 3 phases:
a) Phase I: design
b) Phase II: implementation
c) Phase III: assessment of functioning and adjustments required

This lay-out is now being used as a blueprint for Capacity Development in the D.I.

2. To which extent was the specific objective of the project reached, according to the accepted indicators.

The exponential increase in projects under construction, the number of trained staff (four architects who meanwhile left the Department, two being trained directly and four supported on specific topics) is proof that the intervention had considerable impact on both the specific and general objective of the Agreement.

Without logframe or indicators, it is not possible to objectively measure the outcome. But the design into KRA gives an indication. Detailed per activity and totaling into categories, the progress achieved to date is estimated at 60%.

It has to be noted that the D.I.' staff, other TA's and external programs are active in the implementation of the activities and that some of the activities marked at 100% continue to be active by the department, but without "extraordinary" input from the TA.

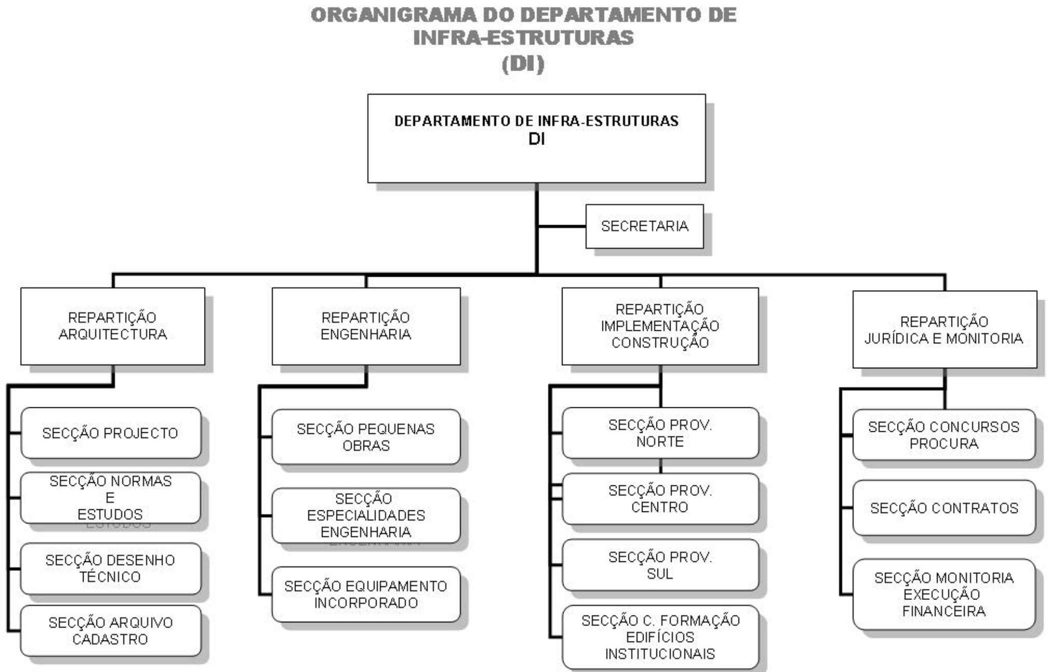
PROGRESS	*weight*	*dd. 15 Nov 08*
IR 1: Conceptual Design and Masterplanning		
1) Dept	*0,25*	*100%*
2) Masterplan	*0,25*	*100%*
3) Concepts	*0,25*	*100%*
4) Specific	*0,25*	*100%*
IR 2: Quality Chamber		
1) ToR	*0,2*	*100%*
2) Masterplan	*0,2*	*100%*
3) Preliminary Design	*0,2*	*100%*
4) Final Design	*0,2*	*100%*
5) During Construction	*0,2*	*30%*
IR 3: Quality Assessment System		
1) QLC - Design	*0,33*	*50%*
2) QLC – Implementation	*0,33*	*50%*
3) Specifications & BQ	*0,33*	*70%*
IR 4: Health Facility Library		
1) Standard Design	*0,5*	*40%*
2) Specifications & BQ	*0,5*	*50%*
IR 5: Support Research		
1) Architectural Models	*0,2*	*100%*
2) Materials - Techniques	*0,2*	*50%*
3) Gender Equality	*0,05*	*0%*
4) Environment	*0,05*	*0%*
5) Design for Disabled	*0,05*	*50%*
6) Indigenous Empowerment	*0,05*	*0%*
7) Construction Market	*0,4*	*60%*
IR 6: Norms Formats and Procedures		
1) Terms of Reference	*0,2*	*50%*
2) Norms	*0,2*	*50%*
3) Room to Room	*0,2*	*0%*
4) Project Management scenarios	*0,2*	*0%*
5) Simplify Formats	*0,2*	*40%*
IR 7: Capacity Building (extra)		
1) Structure GACOPI	*0,5*	*90%*
2) Workshops	*0,2*	*0%*
3) External Training	*0,3*	*0%*
	100%	***60%***

3. To which extent were the intermediate results of the project reached, according to the accepted indicators?

Without logframe, the intermediate results are those agreed in the Steering Committees, and based on the schedules of activities.

1) To achieve full cycle of redesign in the first phase of 2 years:
This has been achieved

2) Follow-up during construction, to allow feed-back on design, and to standardize procurement and supervision tools, while building-up support research to enable final documentation in 3rd phase. 2 year period.
Construction has started on several sites. Unfortunately, delays have been encountered during the year 2007, due to lack of funds, which forced the D.I. to hold the awarding of several contracts. For this reason, the expected results for this phase will only be achieved around the end of 2009. On the other hand, the Department received the additional assistance of one TA (EU) who backed the area of management of the projects. Through internal reorganization, one senior architect became available to assist in the coordination of the implementation of the projects, while a new section within D.I. (legal and monitoring) took up the tasks related to procurement and financial monitoring of the projects.



These additional efforts, from within the D.I. but, outside the scope of the TA-BTC project, have fit-in well in the overall capacity development design, explaining the overall 60% achievement to date.

3) Assessment of functioning and adjustments required:
The final phase will have to be deferred to the Department and other donors considering that the (BTC-) project remains suspended.

The biggest challenge this decision created to the Department is now how - and especially how quickly - new experts will be able to acquire the specific knowledge that has been painstakingly build-up by D.I., to enable a new team to control the architectural and functional quality while construction is ongoing!

4. Describe the follow-up evaluation system established when the project was implemented.

Specific Agreement
The Specific Agreement foresees in a Steering Committee to coordinate and follow-up of the project, consisting of two representatives from MISAU (chair) and one from DGDC, one from BTC - GACOPI (D.I.) and TA are observers.

No TFF nor logframe for the project was available. The TA in collaboration with the partner elaborated a control mechanism based on KRA and activities. These were plotted into a timeframe consisting of three campaigns of each +/- two years.

Steering Committee
The Steering Committee (SC) was scheduled to meet every six months, but for smooth running of the project this was reduced to the minimum necessary (one per year, as it was felt that a project consisting of one TA within a Government Department did not justify two-yearly meeting) This was explained by MISAU as follows (confirmed in writing by MISAU of 9th of May 2007:
- To reduce the burden on the responsibles from MISAU for the project, considering their busy agenda and in view of increased efforts from the donor community to harmonize and align through simplifying the procedures.
- The regular meetings for other projects between the parties function as a forum where possible problems can also be highlighted / addressed.
- The small number of participants (MISAU, DGDC, BTC) allowed for confirming decisions through "virtual" SC, namely: confirming consensus in writing.

Three SC were held so far, one is planned as final SC to close the project and approve the Final Report:
- **SC01** held on the 6th of October 2006: project approach was presented and approved.
- **SC02** held on the 2nd of November 2006: progress report was presented and approved; extension was recommended (horizon of 5 years from start).
- **SC03** held on the 10th of October 2007: progress report was presented and approved; extension was recommended (horizon of 5 years from start). To this purpose an Extension Report was approved, as well as the ToR for a Light Evaluation to be commissioned in January 2008 to allow DGDC to formulate a decision on the request for extension.
- **SCO4** is scheduled in Q1 of 2009 to close the project and approve the final report.

Annual Reports
- Annual Report 2008 (year considered 2007)
- Annual Report 2007: Follow-up Evaluation Report (year considered 2006)

Mid Term Evaluation Report
In January 2008 an independent consultant was commissioned to produce a (Light) Evaluation Report on the project, presented as draft to the SC and approved in its version of 31st of January 2008.

This allowed DGDC to grant the extension of the project up to the end of the validity of the Specific Agreement with increase of the budget.

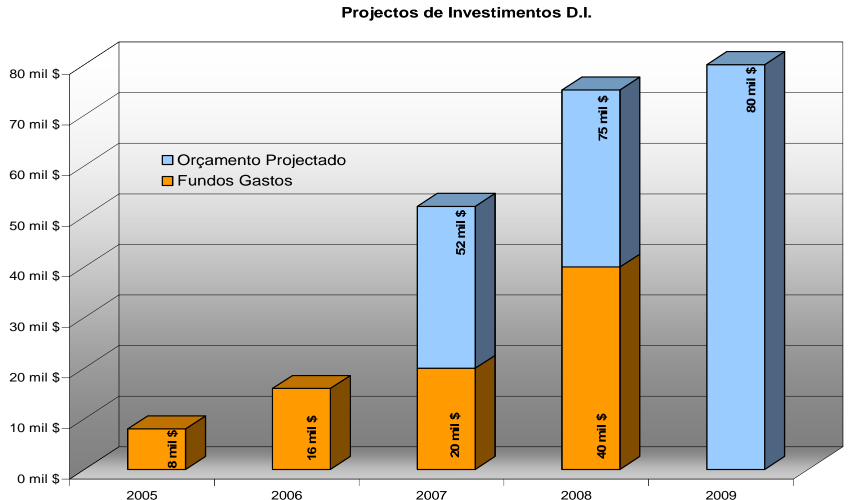
The recommendations of the Evaluation Report have been captured, and incorporated into an identification document (and addendum) to allow the second extension of the project until end 2010. The exercise of extension was aborted due to disagreements between partner and DGDC/BTC regarding conditions set for an upgrade into a broader capacity development project.

PART THREE: COMMENTS AND ANALYSIS.

1. What are the <u>major</u> problems and questions having influenced the project implementation and how did the project attempt to solve them?

Health Services Infrastructure

The overall national objective of the GoM of accelerating development of health service infrastructure resulted in exponential increase in projects and value of investments, strenghtened by very high levels of donor commitment to the Mozambican development. The increase is estimated for 2008 up to 75m USD and for the year 2009 a projected 80m USD compared to the 6m USD in 2005 and 12m in 2006.



To tackle this challenge, a restructuring exercise of the PMU from the investment unit "GACOPI" to the Department of Infra-structures relieved the Department of non core-business activities. Over the years, through several shifts in organizational structure, the Department grew from three architects and three engineers to currently eleven architects and 6 engineers, including a reinforced legal and monitoring section.

Independently, Government established a policy aimed at ensuring that civil service is operated by its own nationals, ensuring that all new employees are paid at gazetted salary levels.

Technical Assistance to the Department of Infra-structure

The concept of "Technical Assistance" went through important redefinitions over the last years. BTC is currently working towards a new policy on Technical Assistance. The Specific Agreement and the Terms of Reference were vague regarding accountability (project set up in "regie", but in the ToR request full accountability towards the partner through the Coordinator of D.I.). In the Steering Committee it was agreed that the TA would follow the ToR of the SA, and align as much as possible with the Department, being not project specific and to avoid "substitution" having a broad lateral impact on different levels instead of a vertical project related approach. This approach is not the usual way donors provide technical assistance to receiving countries, and therefore, was not always perceived correctly by partners acting from a distance.

We identify the parameters in which the implementation of the project evolved:
1) Increased rate of construction of health services infrastructure.
2) Increased presence of Donor Agencies, each requiring a different approach.
3) Public Service employment policy resulting in difficulties retaining experienced staff.
4) Expansion of the Department with mainly inexperienced, young professionals.
5) Lack of a clear TA policy

Solving the Problems
To address the major problem of managing increased production, while maintaining focus on the priorities of the Department, namely a quantitative and qualitative impact on the health service infrastructure, the D.I. team decided after the first year of developing new basic architectural schemes, to embark on elaborating the specific projects as prototypes, with a view of adjusting, if and when required, during the tender and construction phases: "fast-tracking" construction.

The original planning:
embryonal design -> standard layouts -> norms -> stocktypes -> building
was reversed to
embryonal design -> standard layouts -> building prototypes -> stocktypes -> norms.

This has been working well so far, although a high risk is taken to realize a large number of hospitals, while working with "unfinished" documents. The pressure on supervision and on consultants might grow above the capacity available.

The project is now fully at the stage of "building prototypes". Suspending the project at this stage, will have of course a negative impact on the results envisaged. The advantages of the mentioned strategy is that the health facilities will be countrywide available to the public, and will act as a manifest benchmark for future developments in the health facility design sector. Mozambique is a rapidly changing society and past standardization programmes have failed because they remained solely a paper exercise, losing relevance by the time these standards were ready for construction.

Lack of a clear TA policy
BTC has embarked on an exercise to define a TA policy, and as a result, over the years many interesting papers became available. (ref. "Changing Minds And Attitudes" as a reflection document for BTC by ECDPM / ACE; "The Challenge of Capacity Development," by OECD; "ECDPM-study on Capacity Change and Performance: Monitoring and Evaluation of Capacity and Capacity Development" by David Watson)

Based on this up-to-date information, and in the spirit of the Paris Declaration the project took the initiative to mold the intervention into plain Capacity Development, tailored to the explicit needs of the partner and answerable to the partner.

2. What factors explain the differences in relation to the awaited results?

The initial expectations of the project in producing norms, guidelines and standard projects at an earlier stage of the intervention was reconsidered taking into account the Governments priorities of immediate construction of health centers and hospitals on a countrywide scale. (refer to "Problems Solving" for more details).

The listing of activities within the seven KRA categories has proved to be very useful as a guide for the intervention, but the planning of these activities was felt to be too cumbersome for monitoring progress and too rigid for realistic targeting. The TA proposed the use of more specific capacity development tools for this purpose, as for example "outcome mapping" (see Lessons Learned for more details).

3. Which lessons can we learn from the project experience? Please give a detailed answer on the impact and the durability of the results.

The main lesson learned is that the impact on set targets and objectives of a project is much larger when the intervention is run from within a partner institution, aligned with country systems and priorities, answerable to the responsibles assigned by the partners Ministries. In this way, the full expertise available can be absorbed and assimilated by individuals and organizational systems in open dialogue with the partner. The trust gained and mutual understanding is much more beneficial in achieving realistic results.

To allow this ownership to take place, however, the role of the TA as "controller" for the donor cannot be maintained. Also, the role of the TA as "manager" of specific donor projects is difficult to maintain: or it turns the activity into pure substitution of local counterparts, or it will create a unbalance between the donor managed project and the "regular" projects. One of the successes of this specific project is that it avoided becoming neither one nor the other. The intervention remained from the start to date a purely quality intervention with a broad field of action.

To be based within the delicate environment of a government institution (refer to Public Sector employment policies) also means that it is often impossible NOT to dedicate a percentage of the time to regular work. This is especially true if the institution goes through important changes. As an example, high turn-over of staff creates temporary gaps that need to be filled in ad-hoc, through redistribution of workload to ensure that the minimum service remains guaranteed to avoid problems, or even collapse!

The evaluation and monitoring activities held for the project indicate that a strict logframe for this type of capacity development is not the ideal approach. The TA suggested to develop more sophisticated tools like "outcome mapping". In a partner driven environment, influence on activities, results and procedures is mostly "indirect", because decisions are (rightfully) taken by the partner. To be able to still plan and monitor the intervention and measure intermediate results of the capacity development taken place, a more gradual range of results gives a much better picture on *how* these are being achieved. The deeper understanding of the stakeholders of the project is also essential to be able to monitor "change". For example, in the "outcome mapping" technique these concepts are further refined. For instance, results can be grouped into "minimum results to be achieved; targeted results; aimed for results (expect to see – like to see – love to see). Translated to this specific project, this approach would help to keep focus on the basic priority, namely to have the health facilities built with appropriate design, while "aiming for" a full set of norms and guidelines, tested and approved. The same differentiation can be designed for indicators (progress markers) and beneficiaries or stakeholders (boundary partners).

One of the most interesting outcomes of the project is the impact on the private sector. Because of the decision to work towards standardization through developing first specific hospitals rather than the other way around, a close collaboration with the architects (#10) involved for the consultancies awarded with hospital projects had to be very intense. Simultaneously, the high turn-over of staff, drove the already in-house trained architects (#4) towards this same private sector.

It is without dispute that the impact and the durability of the intervention is real and sound. A broad platform is created, construction of all planned hospitals and health centers (+/- 100 so far) have started or are ready to start: the results are there, and they will remain.

4. According to you, how was the project perceived by the target groups?

The main beneficiary of the project (ref. Specific Agreement, ToR) is the management of the MISAU, GACOPI (D.I.).

The beneficiaries of the specific objective "to strengthen the Investment Programme implementation unit (now D.I.) through the delivery of technical assistance" are the architects, engineer and other (procurement, administrative) staff of the Department.

The beneficiaries of the general objective "to accelerate the rehabilitation of the country's medical infrastructure" is the broad consortium of private and public entities involved in the rehabilitation of health infrastructure.

The leadership of the Ministry on several occasions affirmed their satisfaction on how the project is conducted and on the results achieved so far regarding impact on health infrastructure as well as on capacity development. (ref. to communications from MISAU, incl. a writing from HE the Minister for Health)

The department has suffered a number of set-backs caused by the departure of trained architects. It has, though, always managed to keep the average level required to continue with the large rehabilitation and construction campaign. From our side, we have from the start acknowledged the broad capacity already existent within the department. We felt that the nature of Capacity Development and technical assistance required should rather be seen in the perspective of the specific need to redesign the health facilities in line with the present-day Mozambican reality and a support to cope with the sheer multiplication of work. I have been assured by the staff of D.I. and specifically my direct colleagues, that the intervention was always perceived as a basic touch-stone on design, and - with the architectural team - generated a new refreshing view on hospital design and construction possibilities.

The private companies (contractors and consultants) active within the sector have often been stretched to the limits to enable achieving the high quality goals set by the Department. This might not always been accepted in gratitude. In this respect there is still a lot of work to be done and to "tame" consultants and contractors into raising their standards into real value for money.

The donor community involved in supporting the rehabilitation of infrastructure in the health sector has been actively pushing for more standardized approach towards planning and executing (by government) and towards directing funding in a more unified effort (by donors). In this perspective, the TA intervention from BTC is very positively received by the donor community.

5. Did the follow-up evaluation or the monitoring, and the possible audits and controls have any result? How were the recommendations taken into account?

One of the major results of the follow-up evaluation (ref. Light Evaluation dd. 31 January 2008) is the increased awareness by all that the project is indeed on the "right track", and that the partner has full ownership, which was identified as the cornerstone of success in this specific capacity development project.

The basic recommendation of the Evaluation Report was the continuation of the existing project. This was for administrative reasons conceived into two steps.
1) The first step: continuation until expiry of existing Specific Agreement up to 28th of November 2008 has been achieved.
2) The planned next step (up to end of 2010) has been subjected to conditions, which - up to now - haven't been fulfilled. Hence the decision by the Belgian Cooperation not to extend beyond the 28th of November.

Recapitulation of the Recommendations:

1. The focus should be generally guided by the "Recommendations regarding the continuation of the project" as set out in the report to the third steering committee meeting of 10 October 2007. These should however be subject to the recommendations that follow on the overall design process for a second phase. The recommendations made at the Steering Committee were:
   - Finalization of the design phase
   - Follow up of projects currently being tendered for
   - Testing of the designs in engineering and architectural terms (during a two year construction period)
   - Complete feed back and adjustments (within one year after the above period)
   - Achieving the following Outputs:
     a. Publication of norms and room to room books
     b. Handing over of design and master planning functions to GTA and the private sector
     c. Simplification of formats and procedures (scenario hand book)
     d. Specifications and bill of quantity master file
     e. Project management outlines
     f. Quality control systems outlines

   Recommendation followed. Because of suspension of the project, only progress is achieved up to the construction period.

2. The innovative design of having a TA located within and answerable to the Unit and serving the Unit and the Ministry as a whole has proved effective and should be maintained.

   Recommendation followed.

3. The detailed design process for the second phase must deal with setting clear and realistic targets in relation to planned resources, time frame and risks and to the means for monitoring and reporting against them. The existing KRAs should provide significant guidance in this regard.

   Recommendation not yet implemented (re: Outcome Mapping). Pending the approval of the identification document - planned during formulation.

4. Given the precondition that the envisaged next phase of the project include capacity development and knowledge transfer, it is essential this should receive special attention in the planning of the second phase. It would be desirable if, in the process, a clearer picture of capacity development that has already taken place could be documented.

   Recommendation partially followed through the identification document and addendum explaining that the intervention is in fact ONLY Capacity Development, in the broad sense of the concept. Formulation phase would have taken care of mapping out the capacity development achieved so far.

5. In the process of undertaking activities under Recommendations 3 and 4 attention needs to be given to defining what would enable the Unit to sustain the outcomes independently. By specifying this clearly, an Exit Strategy will be built in from the start of the second phase and capacity building outcomes that will be integral to achieving the Exit Strategy will also be clear.

   Recommendation partially followed. Further Capacity Development was planned to be detailed during formulation.

6. It is important that, in carrying out recommendations 3 to 5, care is taken to avoid diverting scarce professional expertise away from its core competencies and the contribution that have created successes in the current project. The professionals nevertheless obviously do need to make major input into the design process, including setting of targets and monitoring activities to ensure this.

   Recommendation partially followed. Administrative burden of BTC processes and formats remain high for this type of projects. The suggestion to have the project assisted through the RESREP-office (Junior programme) failed through the limited perspective given by DGDC.

7. A clear definition of the powers of each player of the Steering Committee has to be established

   Recommendation followed. A next phase would require further discussion of the regie/cogestion modality.

8. Reliance on capacity building on the job should be back-stopped by assessing what additional/ missing skills might be included in the curriculum or short courses for undergraduates (architecture and engineering in particular) so that graduates are in general more adequately prepared to engage with health sector design work

   Recommendation followed. Several options and funds have been identified to back-stop the architects and engineers.

9. BTC should consider carrying out a case study of the project with special reference to devolved control of the TA as an effective mechanism and in relation to capacity building. Recommendation 6 would also have application to this process.

   Recommendation not followed. Due to other priorities BTC-HQ opted not to get involved.

6. Which are your recommendations for the consolidation and the appropriation of post-project period (policy to be followed or implemented, necessary national resources, make target groups aware of their responsibilities, way to apply the recommendations ...)?

Due to the abrupt decision of the Belgian Cooperation to abort the project, the MISAU will have to hire new experts in the field to continue unfinished business.

Recommendations to avoid evaporation of the results so far: involving the architects trained by the projectwhich are now in private sector, to act as free-lancers or through contracts with consultancies, for various tasks as a means to strengthen the department and to alleviate the negative impact of the closure of the project. A strategy to enable this has been tabled.

7. Conclusions

The General Objective is to accelerate the rehabilitation of the country's medical infrastructures. The Specific Objective is to strengthen the Investment Programme Implementation Unit (GACOPI) through the delivery of technical assistance. The project aims to contribute to the achievement of the General Objective by means of the Specific Objective.

The General Objective is still valid because the project has initiated work to facilitate the rehabilitation process but the tools for doing so are now being generally applied in the case of design factors and are in the process of being tested during construction and come short of being adjusted and crystallized after the operational phase.

The Specific Objective is being achieved as per requirement of the Specific Agreement. The intervention of the TA, through a carefully designed capacity development approach, resulted for the Department into a leap forward especially on two specific fronts:
1) It brought to the D.I. the capacity and the tools to be the driver in Health Facility design. This allowed the GoM to take full lead of the projects and to be in control of the final results. Before the TA-intervention, GACOPI was merely accompanying the design done by consultants, without capacity nor instruments to impose Government's vision.
2) The variety of design solutions elaborated by the D.I. team, all within the same clear vision of the GoM, became a trademark of the D.I.: recognizably modern and innovative, symbolizing a new era for hospital and health center design and construction.

The ambitious blueprint of the intervention however is far from complete. It would be a missed opportunity if at this stage if the department would abandon the approach that worked so well up to now.

Worth noting is that all intermediate results of the intervention have been incorporated into the structure of the Department, with a number of activities already at an early stage being developed and run independently of the TA (refer to monitoring and supervision, tender procedures and formats). It showed that the proposed structure of intervention allows for sufficient flexibility to distribute tasks as per available expertise from within and outside the Department.

It is without dispute that the impact and the durability of the intervention is real and sound. A broad platform is created, construction of all planned hospitals and health centers have started or are ready to start: the results are there, and they will remain.

National execution official	BTC execution official
	R. DE MULDER, ARCH.
[signature]	[signature]

PART FOUR. ANNEXES.

ANNEX 1. Results summary

ANNEX 2. Situation of receipts and expenses

ANNEX 3. Disbursement rate of the project

ANNEX 4. Personnel of the project

ANNEX 5. Subcontracting activities and invitations to tender

ANNEX 6. Equipments

ANNEX 7. Trainings

ANNEX 8. Backers

ANNEX 1. Results summary

Note: The planning of activities refers to major involvement of the BTC TA in the activities mentioned, some of the activities itself will continue as part of the functions of GTA after the intervention.

PROGRESS	weight	dd. 15 Nov 08
IR 1: Conceptual Design and Masterplanning		
1) Dept	0,25	100%
2) Masterplan	0,25	100%
3) Concepts	0,25	100%
4) Specific	0,25	100%
IR 2: Quality Chamber		
1) ToR	0,2	100%
2) Masterplan	0,2	100%
3) Preliminary Design	0,2	100%
4) Final Design	0,2	100%
5) During Construction	0,2	30%
IR 3: Quality Assessment System		
1) QLC - Design	0,33	50%
2) QLC – Implementation	0,33	50%
3) Specifications & BQ	0,33	70%
IR 4: Health Facility Library		
1) Standard Design	0,5	40%
2) Specifications & BQ	0,5	50%
IR 5: Support Research		
1) Architectural Models	0,2	100%
2) Materials - Techniques	0,2	50%
3) Gender Equality	0,05	0%
4) Environment	0,05	0%
5) Design for Disabled	0,05	50%
6) Indigenous Empowerment	0,05	0%
7) Construction Market	0,4	60%
IR 6: Norms Formats and Procedures		
1) Terms of Reference	0,2	50%
2) Norms	0,2	50%
3) Room to Room	0,2	0%
4) Project Management scenarios	0,2	0%
5) Simplify Formats	0,2	40%
IR 7: Capacity Building (extra)		
1) Structure GACOPI	0,5	90%
2) Workshops	0,2	0%
3) External Training	0,3	0%
	100%	**60%**

ANNEX 2 : Budget Expenses

EX00	**EXPENSES KOEN DE MULDER**		
	Listing expenses Nov 2006 - Nov 2008		**amount paid**
EX01-09	Professional Literature	Detail subscription	154,00 €
EX01-08	Professional Literature	Space in Detail	5.650,00 JPY
EX01-07	Professional Literature	Fotocopias	2.275.000 MZM
EX01-06	Hardware	flash disc - lexar jumpdrive	689,00 ZAR
EX01-05	Per Diem	9 to 12-10-2005	701,71 ZAR
EX01-04	Professional Literature	Livros Arquitectura	110,19 €
EX01-03	Professional Literature	Hospital Design - Healthy Living Centers	219,00 €
EX01-02	Professional Literature	Correspondencia	23,10 €
EX01-01	Software	Promt Express	39,00 €
EX02-03	Postage	Postage (Belgium)	29,40 €
EX02-02	Professional Literature	Sistemas de Construção II & IV	48,44 €
EX02-01	Professional Literature	db detailbuch Band3	89,90 €
EX03-01	Professional Literature	Japan Architect JA 61	5.650,00 JPY
EX03-02	Camera	Digital - Canon IXUS + 1 Gigcard	3.438,00 SAR
EX03-02b	refund	VAT refund	*-1.455,20 MZMn*
EX04-01	Professional Literature	Japan Architect JA 62	5.200,00 JPY
EX04-02	Professional Literature	Construction Materials Manual	118,00 €
EX04-03	Office supplies	Moçambique map	9,00 €
EX04-04	Office supplies	Headphones	420,00 MZM
EX05-01	Professional Literature	Sistemas de Construção I - VII	125,09 €
EX05-02	Taxes	Import Taxes on 01	34,00 MZM
EX05-03	Office supplies	Cartridges for Lexmark Z33	2.265,00 MZM
EX05-04	Office supplies	Software Antivirus Upgrade/Renewal	£26,08
EX06-01	Office Supplies	Transparent copy paper	145,00 MZM
EX06-02	Office Supplies	Subscription Newspaper	1.197,23 MZM
EX06-03	Office supplies	Repair PC	1.105,65 MZM
EX06-04	Office supplies	Professional Literature	158,00 €
EX06-05	Office supplies	Professional Literature	5.650,00 JPY
EX07-01	Office Supplies	Subscription Newspaper	2.274,50 MZM
EX07-02	Office supplies	Professional Literature	18,75 €
EX07-03	Office supplies	Customs exp. on 02	34,00 €
EX07-04	Office supplies	2 Cartridges Printer	1.694,00 MZM
EX08-01	Office supplies	DETAIL Practice Building with Concrete	61,50 USD
EX08-02	Office Supplies	JA 67 Spatial Phantoms	5.200,00 JPY
EX09-01	Office supplies	Repair PC & update Norton antivirus	6.356,03 MZM
EX10-01	Office Supplies	Subscription Newspaper	1.197,00 MZN
EX10-02	Office Supplies	Professional Literature - Maputo Patrim.	41,91 €
EX10-03	Office supplies	Professional Literature - DETAIL	166,39 €
EX11-01	Office Supplies	Subscription Newspaper	3.108,00 MZN
EX11-02	Office supplies	Professional Literature - REGRAS MEDIÇÃO	92,43 €
EX12-01	Office Supplies	2 x Sistemas de Construção IX	34,16 €
EX12-02	Office supplies	Cartridges for Lexmark Z33	1.950,00 MZN

ANNEX 3 : Disbursement rate of the project

Budget vs Actuals (Year to Month, by Quarter) of MOZ0401011

Project Title : Technical assistance to GACOPI, the investment management unit of the Ministry of Health

Budget Version : D01

Currency : EUR

YtM : Report includes all closed transactions until the end date of the chosed closing

Year to month : 30/11/2008

	Status	Fin Mode	Amount	2007	2008							
					Q1	Q2	Q3	Q4	Total	Total Exp.	Balance	% Exec
A General means			530.000,00	350.361,17	32.403,71	36.195,80	31.769,71	19.427,30	119.796,52	470.157,69	59.842,31	89%
01 General means			530.000,00	350.361,17	32.403,71	36.195,80	31.769,71	19.427,30	119.796,52	470.157,69	59.842,31	89%
01 Assistance technique		REGIE	510.000,00	343.005,19	29.091,61	35.317,14	31.627,61	19.005,28	115.041,64	458.046,83	51.953,17	90%
02 Véhicule		REGIE	0,00	0,00						0,00	0,00	?%
03 frais de fonctionnment		REGIE	0,00	0,00						0,00	0,00	?%
04 Frais de communication et		REGIE	9.000,00	6.787,20	258,64	181,48	91,89	0,41	532,42	7.319,62	1.680,38	81%
05 Suivi technique		REGIE	11.000,00	568,78	3.053,46	697,18	50,21	421,61	4.222,46	4.791,24	6.208,76	44%
		REGIE	530.000,00	350.361,17	32.403,71	36.195,80	31.769,71	19.427,30	119.796,52	470.157,69	59.842,31	89,00
		COGEST										
		TOTAL	530.000,00	350.361,17	32.403,71	36.195,80	31.769,71	19.427,30	119.796,52	470.157,69	59.842,31	89,00

BTC CTB

Budget cs Actuals (Year to Month, by Quarter) of MOZ0401011 Printed on 3/12/2008 page: 1

ANNEX 4 : Personnel of the project

Considering the project is the provision of one BTC-TA, to a Government Department, it is not a typical PMU and normal local Public Service rules apply

Personnel type (title, name and gender)	**Duration of recruitment (start and end dates)**	**Comments (recruitment periods, profile relevance …)**
1. National personnel put at disposal by the Partner Country		Government Employees
2. Support personnel, locally recruited		Government Employees
3. Training personnel, locally recruited		Government Employees
4. International Personnel (outside BTC)	One TA – donor agency EU	2 year contract from start of 2007 until end of 2008
5. Expert in International Cooperation (BTC)	One TA – BTC	From 1 July 2005 until 28 November 2008

ANNEX 5: Subcontracting activities and invitations to tender

INTERNATIONAL CONSULTANT FOR THE LIGHT EVALUATION OF THE TECHNICAL ASSISTANCE TO THE DEPARTMENT OF INFRASTRUCTURE

Tendering mode	: Direct Tendering
Date of the invitation to tender	: N/A
Start date of the subcontracting contract	: 11 January 2008
Name of the consultant	: Jack Blaker Consulting cc.
Object of the contract	: Producing Light Evaluation Report
Cost of the contract	: SAR 22 464,-
Duration of the contract	: 6 days

Results : **Light Evaluation Report was accepted by the Steering Committee**

Light Evaluation Report was accepted by the Belgian Cooperation to allow for the extension of the project until end of validity of the Specific Agreement

LOCAL ARCHITECT - SERVICE PROVIDER FOR ARCHITECTURAL QUALITY ASSESSMENT TO ASSIST THE INTERNATIONAL CONSULTANT FOR THE LIGHT EVALUATION OF THE TECHNICAL ASSISTANCE TO THE DEPARTMENT OF INFRASTRUCTURE

Tendering mode	: Direct Tendering
Date of the invitation to tender	: N/A
Start date of the subcontracting contract	: 14 January 2008
Name of the consultant	: Arch. Carlos Manuel Menezes
Object of the contract	: Assisting the International Consultant
Cost of the contract	: MTN 27 788,-
Duration of the contract	: 3 days

Result : **Allowed the International Consultant to have insight into the local architectural environment and Health Facility in particular**

ANNEX 6. Equipments

Equipment type	Cost		Delivery date		Remarks
	Budget	Real	Planned	Real	
PC Dell Optiplex GX 520 Printer hp 9300 Dell 1500		3.396,08 €			Handed-Over D.I.
Office Furniture		2.456,12 €			Handed-Over D.I.
Digital Camera Canon IXUS		463,80 €			Faulty
Lexus Flash Disc Jumpdrive		689,00 SAR			Theft

National execution official For Acceptance Assets	BTC execution official For Handed-Over Assets

ANNEX 7. Trainings

The abortion of the project means that some of the planned activities will have to be pursued by the Department of other Donors.

Training type	Country, Institution, Duration	Name or number of trained people	Dates of the trainings	Subject, content and level
Scholarship	1) Belgium KULeuven PGC Human Settlements (1 Y) 2) Università "La Sapienza" – Roma (1 Y) 3) ABDEH – Brasil (6 M) Especialização em Arq. em Sistemas de Saúde	None 2 architects None	Scheduled 2008 (failed) Retry two arch in 2009 Scheduled one per year Scheduled for 2009	Master in Science - Architecture Master in Science – Health Facility Planning Specialization in Architectural Health Systems
Workshop	Maputo Provinces	Provincial Directors of Health None	Yearly Scheduled for 3rd phase: presentation of results to Provinces, District and other stakeholder	Standardization has been presented at MISAU Obtaining feed-back on standardization program from different stakeholders

ANNEX 8. Backers Interventions

Interventions of other backers for the same project or for project pursuing the same specific objective.

Backers contributing to the same Specific Objective			
Backers	Name of the Intervention	Budget	Main objectives
Arch. Francisco Pires	TA - EU (GTZ)	N/A	Strengthening Capacity of the Department of Infrastructure through delivery of Technical Assistance