FINAL EVALUATION REPORT

"Support to the Kunene regional Health System for the Improvement of Safe Motherhood and Newborn Care"

(March 2009 – 14 March 2013)

Implemented by:

The Directorate of Policy Planning And Human Resource Development in the Ministry of Health and Social Services in Namibia & with Financial and Technical Support from the Spanish Agency for International Development Cooperation

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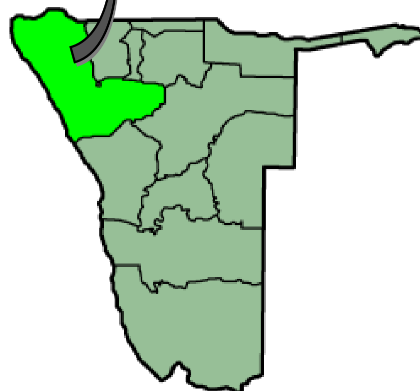
MAP OF NAMIBIA



Namibia at a Glance

Table 1 Statistical Overviews of Namibia and Kunene Region

Location	Situated on the south-western Atlantic coast of the African sub-continent	Borders Omusati to the northeast; Oshana northeast between Omusati and Oshikoto; Oshikoto northeast; Otjozondjupa to the east and Erongo in the south.
Area	824,268 square kilometres	115,260 square kilometres
Natural resources	Diamonds, copper, uranium, gold, silver, lead, tin, lithium, cadmium, tungsten, zinc, salt, hydropower, fish	Forest and semi precious stones
Bordering countries	Angola, Botswana, South Africa, Zambia and Zimbabwe.	Angola,
Regions	14 Administrative Regions and 121 constituencies: Regions: Karas, Hardap, Khomas, Otjozondjupa, Erongo, Kavango East, Kavango West, Zambezi, Oshikoto, Oshana, Ohangwena, Omusati, Kunene and Omaheke	Seven constituencies namely Epupa, Kamandjab, Khorixas, Opuwo, Opuwo rural, Outjo, Sessfontein
Population	2.1 million (2011 census) The population density: 2.5 persons per sq.km Female: 51%; Male: 49% Urban: 42% Rural: 58%	88,300 (2011 census) The population density: 0.8 persons per sq.km Female: 50%; Male: 50%
Government system	Multi-party democracy with general, presidential, regional and local elections are held every five years	Multi-party democracy with general, presidential, regional and local elections
Political system	Republic	Region & Constituencies
Capital City	Windhoek	
Currency	Namibian Dollar (N$) pegged 1:1 to the South African Rand	Namibian Dollar (N$) pegged 1:1 to the South African Rand
GDP growth (2001-2010)	4.5% average	National 4.5% average
Religion	Secular state but over 90% of population is Christian	Secular state, majority of population is Christian
Languages	English is the official language. The main indigenous languages are: Afrikaans, Otjiherero, Damara/Nama, Oshiwambo, Rukwangali, Silozi, Setswana, San	English is the official language. The Main indigenous languages are Otjiherero – Otjithemba

Source: http://www.gov.na

ACKNOWLEDGEMENT

Sincere appreciation goes to the Spanish Agency for International Development Cooperation (AECID) for availing funds for the implementation, technical support and evaluation of this project. A number of individuals and key institutions also provided invaluable contributions to the evaluation process as listed below. The project would not have materialized without the commitment from the steering committee, project staff and individuals that participated in the key informants interviews and focus group discussions. Special gratitude is also extended to the Health Director of the Kunene Region and his team for organizing logistical arrangements for the project evaluation exercise. A list of all those who participated is attached to this report as annexure one (1)

- Project Secretariat at MoHSS
- Steering Committee Members
- National Health Training Centre
- University of Namibia (UNAM) – School of Nursing and Public Health
- Spanish Agency for International Development Cooperation (AECID)
- Kunene Health Directorate and all Health Districts
- Obstetric Care Service Users
- Ambulance Services – Tertiary Health Care and Clinical Support Services

LIST OF ACRONYMS AND ABBREVIATIONS

ACNM	-	American College of Nurse Midwives
AECID	-	Spanish Agency for International Development Cooperation
CMO	-	Chief Medical Officer
EmONC	-	Emergency Obstetric and Neonatal Care
MCH	-	Maternal and Child Health
MDGs	-	Millennium Development Goals
M & E	-	Monitoring and Evaluation
MoHSS	-	Ministry of Health and Social Services
NHTC	-	National Health Training Centre
NPC	-	National Planning Commission
NTS	-	Namtranslation Services
PHC	-	Primary Health Care
PMO	-	Principal Medical Officer
PP & HRD	-	Policy, Planning and Human Resource Development
RHTC	-	Regional Health Training Centre
UNAM	-	University of Namibia
TOR	-	Terms of Reference

Glossary of Terms and Definitions in Maternal and Child Health

Maternal death: The death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.

Eclampsia: Is a disease occurring during the latter half of pregnancy and characterized by an acute elevation of blood pressure and convulsions or coma.

Skilled attendance: Refers exclusively to a professional with midwifery skills (for example, medical doctors, midwives and nurses) who has been trained to proficiency in the skills necessary to manage normal deliveries and diagnose, manage, or refer obstetric complications working within an enabling environment (necessary equipment, supplies and medicines and infrastructure) and a functional referral system.

Verbal autopsy: Is a process designed to facilitate the identification of maternal deaths where medical certification is inadequate through a reconstruction of the events surrounding deaths in the community by interviewing family and community members.

Perinatal period: Period of time from birth through the first week of life where there exists the highest risk of death for an infant.

Low birth weight (LBW): Infants born at weights under 2.5 kilograms at birth (about 5.5 pounds) are classified as having low birth weight. Newborns with low birth weight often have mothers who are underweight or undernourished; they are at increased risk of short- and long-term illnesses or disabilities.

Neonatal mortality rate (NMR): Number of deaths within the first 28 days of life per 1,000 live births in a specific time period.

Neonatal period: The first 28 days of life.

Child mortality rate (CMR): Deaths of children under age five years per 1,000 live births in a specific time period. Technically, it is the probability that a child will die before his or her fifth birthday.

Total fertility rates: The average number of live births per woman during her reproductive years.

Infant mortality rate (IMR): The number of deaths in the first year of life per 1,000 live births in a specific time period.

Sepsis: Infection and common cause of death for newborns.

Contraceptive prevalence rate (CPR): The percentage of women of reproductive age (15-49) who are practicing, or whose sexual partners are practicing, any form of contraception.

Emergency Obstetric and Neonatal Care (EmONC): Skilled health care to address pregnancy and childbirth-related complications, including access to the blood supplies, antibiotics, and other equipment needed.

Continuum of care: An approach to maternal, newborn, and child health that includes integrated service delivery for women and children from before pregnancy to delivery, the immediate postnatal period, and childhood.

Birth asphyxia: A condition in which insufficient oxygen is delivered to the fetus during labor and childbirth, leading to risk of stillbirth, neonatal death, or lifelong disability in the surviving infant.

Antenatal care coverage: The percentage of women who have given birth who received antenatal care from a skilled attendant at least once during their pregnancy.

Exchange Rate: N$13 to €1 Euro

(Adapted from the Maternal and Child Health Advocacy and Resource Mobilization tool kit, MoHSS, 2011)

Chapter 1: Executive Summary

Background and Introduction

The Namibia project titled *"Support to the Kunene Regional Health System for the Improvement of Safe Motherhood and New Born Care",* was a €1,787,531 an approximate equivalent of N$19.682,410.22. This amount was funded by the Spanish Agency for International Development Cooperation (AECID) through a bilateral agreement with the Namibia National Planning Commission (NPC). The overall objective of the project was to support the Ministry of Health and Social Services (MoHSS) in the implementation of its national strategic plan of reducing Maternal Mortality Rate from 449/100,000 in 2006 to 100/100,000 in 2013, the specific objective was to strengthen the Safe motherhood and Newborn Care Programme in the Kunene region.

Although the project officially was committed from April 2009, practical implementation lasted for 3 years from 22 April 2010 to 14 March 2013. An extension was granted in September 2013 for the justification process, until 14 December 2013, to ensure that project activities related to the final justification are wrapped up. The goals of the project were:

- To increase institutional birth attendance rate from 40% in 2010 to 70% in 2015;
- To contribute to the reduction of Maternal Mortality Rate in Opuwo District; and
- To reduce Newborn Mortality rate at Opuwo district hospital from 13 in 2009 to 6/1000 live birth in 2015.

The project had the following specific objectives:

- To improve maternal health facilities at Opuwo Health District;
- To provide training in EmONC to medical doctors, nurses and midwives; and
- To support transport referral system in the Kunene region.

Namtranslation Services (NTS) was commissioned by the MoHSS to measure program results and potential impact generated by the project as part of a final evaluation exercise. The objectives of the evaluation were amongst others (detailed in the attached

Terms of Reference - TOR) to determine the extent to which the project has contributed to addressing the needs as identified in the design and implementation phase.

Methodological approach

Data was gathered using mixed methods of qualitative and quantitative data. First documents and especially progress reports were reviewed to provide a detailed overview of the project progress. This information also provided mapping of key stakeholders that should be consulted during the evaluation process. Individuals at national, regional, district and organization levels were interviewed while focus groups discussions were conducted with service recipient and potential users of maternal services. Sites were the project was implemented as well as equipments made available through the project duration were also observed and evaluated. The findings were presented to a stakeholder group before concluding this final report.

Key Findings

The project met its primary objectives, in particular the 4 deliverables: vehicle donations, infrastructure construction, training in EMONC, equipment provision. Program activities not carried out were the provision of equipments to various district health facilities in the Kunene region. The overall implementation was met with unexpected delays which in part, affected the procurement of essential equipment and most of the delays were as a result of tender procedures, technical operations and administrative issues on the part of the contractor but also regarding consensus on the feasibility and the geographic location of the maternity ward.

The following were the project outputs.

1. An estimated N$8,592,193.97 modern maternity ward was constructed and finalized by July 2013.
2. Equipments for the maternity ward with a cost value of N$8,032.75 were purchased (refer to attached list of equipment).

3. Eight registered nurses and four medical doctors were trained in Comprehensive Emergency Obstetric and Neonatal Care while, 23 enrolled nurses where trained in Basic Emergency Obstetric and Neonatal Care. This exercise cost an estimate N$549,438.48.

4. The following equipments were also purchased with an actual costs of N$2,405,757.41

   a. Three ambulances were purchased and donated to the Kunene Health Directorate in April 2012.
   b. A Toyota Quantum was purchased and handed over to the School of Nursing and Public Health in February 2011
   c. A project vehicle, a TOYOTA Twin cab 3,0 Diesel and a laptop was purchased and used by the project Coordinator.

The programme proposal document had included the renovation of the operating theatre of Opuwo hospital and the renovation to Otjiwarongo Regional Health Centres. However during the deliberation of the Steering Committee these activities could not be undertaken due to the available limited funds. Nonetheless evidence for improved maternal health services should still be noted. Despite this perceived improved maternal health services as indicated in project reports[21] and through interviews with service providers and clients, this evaluation report cannot confidently provide such evidence.

Lessons Learned

As elaborated later in the document, the evaluation suggests that the project achieved its primary purpose, a number of lessons learned and recommendations are pointed out (in detailed at the end of the report):

- It is irrefutable that the maternal and new born care infrastructure development will be a long-term investment to the government and its beneficiaries. However, precautions should be taken through changes in regulatory policies to ensure its final completion, resourcing (human, material and finances) utilization and maintenance.
- The Kunene region is one of the unique regions in Namibia. Its sparsely distributed population, low economy and geographic nature, attract unique

challenges that could influence pregnancy outcomes. Therefore, special attention should be given in the provision of a comprehensive infrastructural development including a well-resourced structure.

- There should be a working mechanism to retain t trained staff, as well as transfer of knowledge and skills acquired.
- Finally, a project of this magnitude required a full-time project coordinator supported by a local coordinator to ensure close monitoring and timely implementation of the project.

CHAPTER 2: BACKGROUND

Namibia is a country known to be in economic, demographic and health transition.[1] Classified as an upper-middle income country since 2009, it continues to propel a positive economic growth and increasing income per capita.[2] The Gini Coefficient improved to 0.58 in 2009/10 from 0.70 in 1993/04[3].The Gross Domestic Product (GDP) grew from 3.6% in the period prior to 2001 to 4.7% in 2006.[4] The total fertility rate decreased from 4.2 births per woman in 2000 to 3.6 births per woman in 2006/07, one of the lowest in Southern Africa.[5] The fertility decline has been significant in rural and urban areas, as well as across the regions and educational levels. Contraceptive prevalence rate for all women has doubled from 23.3% in 1992 to 46.6% in 2006/06.[5]

Population growth rates declined to 2.6% between 1991 and 2001 and it is currently estimated at 2% per year.[6] Life expectancy has relatively improved after a sharp decline from 60 years observed in the early 1990s largely attributable to HIV/AIDS to 49 years in 2008. Lately life expectancy was estimated at 57 years in 2011. There is significant migration from rural to urban areas and the urban growth rate is greatest in the informal and low income areas.[6] Poor sanitation and inadequate living conditions are still driving disease and ill health. In addition, the NDHS 2006/07 estimated that in rural areas, nearly 90% of the population (86% of rural households) has non-improved sanitation facilities.

Namibia is one of the five countries in the world with the highest HIV prevalence.[7] In 2011/12, HIV prevalence in the general population among people 15-49 years was estimated at 13.4%.[8] The HIV prevalence rate amongst pregnant women is high at 18.2%[8] (2012) but this figure fails to show the vast regional disparities, with the prevalence varying from 10% to 38% across the country. In addition, over the past 10 years, the number of women infected with HIV has grown at a faster pace than that of men. The Maternal Mortality Ratio (MMR) has significantly increased from 271 maternal deaths per 100,000 live births during the time period of 1991-2000 to 449 maternal deaths per 100,000 live births during the 1998-2007 period.[5] According to recent

estimates of trends in maternal mortality from 1990 – 2010, MMR in Namibia was 200 maternal deaths per 100,000 live births in 2010, indicating no progress since 1990.[9] Although there appear to be a decline in child mortality rates between 2000 and 2011. Under-five mortality is estimated at 92 per 1,000 live births in the lowest wealth quintile, as opposed to 29 per 1,000 live births in the highest wealth quintile.[5]

While infectious diseases are still dominant, communicable diseases are also reported to be emerging at an alarming rate including a high prevalence of violence (mainly gender based), injuries and death and disability caused by road traffic accidents and other causes.[1] The country has achieved polio free status, eliminated leprosy; measles is within reach of elimination levels and aims to eliminate malaria. Both malnutrition and over-nutrition are a problem in the country. While 29% of children under the age of five years are stunted, 16% of women are chronically malnourished, 28% are either overweight or obese and 30% of women aged 15-19 years are thin or undernourished.[5]

CHAPTER 3: INTRODUCTION

In Namibia, maternal health services are provided at different levels.[10] While the purpose of such an arrangement is to reduce workload at the referral level, it is also viewed to increase access to care. Critical maternal and newborn/neonatal health services are handled at referral hospital, while low risk cases are taken care at the district level. Additionally, antenatal care services are provided at clinics and health centres. Currently, there are three (3) district hospitals, three (3) health centers and 21 clinics in the Kunene region.[11] This Project was initially designed to support maternal and newborn care in Opuwo district hospital and its peripheral areas.

With an estimated population of 86,000 people and a fertility rate of 4.9, the Kunene region is one of the regions with low socio-economic and health indicators.[13] Until 2005, as with most of the regions, basic and comprehensive emergency obstetric care services were not available in Kunene region.[14] A recent study[15] conducted in selected regions identified a total number of 74 unreported maternal deaths for the period January 2008 to May 2010 while the routine reporting system had indicated 113 maternal deaths for the same reporting period for all women of childbearing age. Of these unreported deaths, 1 was from the Kunene region compared to 1 that was reported through routine reporting. The same study recommended further research to understand why the first delay contributes highly to maternal mortality at health facilities and why women fail to seek early maternal health care. The program evaluation for the Kunene region has therefore provided an excellent opportunity to address in part, some of these concerns.

Health system strengthening is central to improving the delivery of priority health programs and as such a number of developing nations are investing in the health system to achieve their health goals.[16] Hospital infrastructure and human resource training are the most prominent functions in the maternal health system in support of

obstetric care, while health policies, operational guidelines and program interventions facilitate community engagement and participation in services.

GOAL OF THE PROJECT

The project's overall objective is to support the MoHSS to attain its strategic goal of reducing Maternal Mortality Rate from 449/100,000 l.b. in 2006 to 100/100,000 in 2013, as well as contribute to achieving goals sets by international policies such as the Millennium Development Goals (MDGs). The project specific objectives were to strengthen safe motherhood and newborn care services in the Kunene region.

METHODOLOGICAL APPROACH

Unlike the use of experimental evaluation designs utilized in similar programs elsewhere[17], a non-experimental evaluation design was the appropriate method for this project evaluation. Given the nature of the program and the timeframe provided, the work methodology included visiting program site in order to engage key stakeholders, conducting in-depth review of documents, key informant interview, focus-group discussions and interviews with women attending maternal and neonatal health services and observing services being provided. Data collection focused primarily on knowledge and skills of staff, maternal health infrastructure, knowledge, perceptions and experiences of women and men on the appropriateness of maternal health services, and availability of essential equipment and supplies.

The aim was to primarily focus on process evaluation and little on outcome and impact evaluation. Process evaluation focuses on the effectiveness of the program implementation, in other words, it "verifies what the program is and whether or not it is delivered as intended to the recipients." It does not, however, attempt to assess the effects of the program on the target group. This approach therefore provided a descriptive analysis and not gather data to make causal inferences and determining the "true" program effect (attribution) of the program activities to the observed results.

The final scope of work together with data collection tools were confirmed in consultation with key stakeholders such as program staff, decision-makers and sponsors. Data gathered was reviewed, analyzed and compared against set targets and objectives.

PURPOSE OF THE EVALUATION

The objectives of the evaluation was to determine the extent to which the project has contributed to addressing the needs as identified in the design and implementation phase, its contribution to national priorities and assess the projects' degree of implementation, efficiency and quality delivered on outputs against intended results. Lastly the evaluation also assessed to what extent the project has attained the desired results for project beneficiaries.

In evaluating the effectiveness and impact of the proposed intervention, standards for evaluations are observed and integrated throughout the evaluation exercise. These standards include the following[18]

- ***Utility:*** ensuring that those who need the results (stakeholders – sponsors, program staff, program beneficiaries and politicians) of the evaluation get it in time in order to inform decisions for either expanding or improving the program.
- ***Feasibility:*** Ensuring that with the available resources (both human, material and financial), the evaluation plan is practical
- ***Propriety:*** conducting the evaluation in an ethical and legal manner while also respecting all stakeholders and participants
- ***Accuracy:*** ensuring that the evaluation employs a valid method of obtaining sound and valid results.

CHAPTER 4: KEY FINDINGS: DESCRIPTION OF DEVELOPMENT INTERVENTIONS

The overall goals of the project were 1) to increase institutional birth attendance, 2) contribute to the reduction of maternal mortality as well as the 3) education in newborn mortality in Opuwo district. The key findings of the project activities are organized in accordance with the following specific objectives of the project:

1. To improve maternal health facilities at Opuwo Health District;
2. To provide training in EmONC to medical doctors, nurses and midwives; and
3. To support transport referral system in the Kunene region.

Improve maternal health facilities at Opuwo Health District

A modern maternity ward was constructed at Opuwo Hospital with the aim of providing relevant and quality care[12] . The maternity ward consists of the state of the art units including a new born care unit, feeding, and delivery rooms. The modern building which is 95% complete is expected to house twenty eight patients, with a capacity of 28 beds. The necessary equipment and supplies have already been ordered and the critical medical equipments are still to be delivered at Opuwo hospital. A list of equipment included patient beds, medicine trolleys, sanitary and cleaning equipments to mention a few (refer to annex five for a detailed list of equipment)

To provide training in EmONC to medical doctors, nurses and midwives

Training in EmONC:

Capacity development of staff is an equally important component of the project to ensure skilled birth attendance.[19] Skilled birth attendance is as critical for the newborn baby as it is for the mother. For example, effective midwifery ensures non-traumatic birth and reduces death and disability from birth asphyxia, while at the same time strict asepsis at delivery and cord care reduce the risk of infection. Skilled care makes it possible to resuscitate babies who cannot breathe at birth and to deal with or refer unpredictable complications as they happen to mother and baby. This means therefore

that when birth is managed by a skilled professional, it is safer for both mother and baby.

- EmONC training for nurses; took place in Oshakati (2011) and Swakomund (2012) over a period of two week each while a refresher training (2013) was conducted in Opuwo and lasted for one week. The NHTC conducted the training using the American College of Nurse Midwives (ACNM) pre development materials. Twenty five (25) health workers (14 fourteen Registered nurses and seven (7) enrolled nurses) from all three Health District (Opuwo, Khorixas and Outjo) in the Kunene Health Directorate were trained over a two (2) week period. A refresher course was conducted in February 2013 again in EmONC by the NHTC and PHC. A concern was raised that training was conducted at institutions (hospitals) with adequate equipments and facilities were as original duty stations lacked some needed equipments as directed in the training especially. Another issue raised was, due to staff shortages, nurses trained are placed at work units with no obstetric and newborn care needs. Some of the nurses trained have resigned or were transferred to areas outside the region.

- EmONC training for medical doctors; overall four (4) medical doctors have been trained three of whom are no longer with the Kunene Health Directorate. Evidence indicates that the training in Aneasthesia was clearly outlined and took place in Oshakati over a period of three (3) months. The latest training which took place at Katutura and Windhoek Central Hospitals was not clearly outlined, had not assessment tools, was not properly monitored, for example the candidate felt he was not evaluated. To date four (4) medical doctors were trained in Aneasthesia, and Obstetric Care. Unfortunately information in this regard is really very scanty as the progress reports are not succinctly clear on the type of training, methods of training medical doctors received. One of the trained medical doctor was transferred on promotion to Katima Mulilo Intermediate hospital in the Zambezi region as Chief Medical Officer (CMO).

To support transport referral system in the Kunene region.

Without a functional referral and transportation system in place, maternal and child health services become poorly organized[16]. Mothers and their newborns who may need urgent obstetric attention rely on the efficiency of the referral system. Hence, this component is critical in delivering emergency obstetric care. The project supported the following procurements:

- Three (3) ambulances were purchased and handed over to the Kunene Health Directorate. Two ambulances are currently at the Opuwo Hospital while one was placed at the Kamandjab Health Centre. Unfortunately the ambulance at the Kamadjab Health Centre is currently parked as there are no drivers. At Opuwo Hospital one ambulance is parked mainly because of worned out tyres and lack of service, including a minor panel beating need, replacement of the front window screen and placement of a bull steel. The remainder (ambulance) was mobile and used to transport emergency cases.
- One (1) TOYOTA Quantum bus was purchased and handed over to UNAM in transportation of nursing students to and from health facilities. This was done mainly to ensure that student timely practice obstetric cases at rural facilities as well as urban based hospitals and clinics in the Khomas region.
- A Project vehicle, a TOYOTA Twin cab, 3.0 Diesel and a laptop was purchase for use by the Project Coordinator, Dr. Manzanares. The two items were handed over to MoHSS upon the Coordinator's return.

Financial resources

The table below show the amount of funds committed and utilized in support of project activities (a detailed report is attached as annex four). As illustrated below and as initially planned, the maternity ward infrastructure took up 88% of the budget while the remaining funds were committed to training, technical support and administrative support, and monitoring and evaluation of the project.[12]

An amount of Euros 566,584.83 (3%) was not utilized, by the end date of the project, due to a number of constraints as elaborated previously such as delays in awarding construction and procurement tenders. These delays led to the need to extend the

duration of the project without additional cost. Despite these extensions, all disbursed funds to the government could not be expended in time. It is not known if there were suggestions made to expedite the implementation rate and or authority to move funds between budget lines to ensure that funds are utilized where it is most needed. For example, the project had minimal monitoring and evaluation activities. There was no supportive supervision and follow up to EmONC trainees partly due to budgetary constraints. Efforts would have been made to support this important post-trainings follow up activities.

Table 2 Overview of Project financial progress from April 2009 – December 2013 (check with the ministry the final data)

Budget concept	AECID approved budget in Euros	Funds Expended	Balances
Running cost including training and support to sustainability	207,531.00	191,463.46	16,067.54
Investment cost: construction of the maternity ward including purchasing of equipment and supplies and vehicles	1,580,000.00	1,029,482.72	550,517.28
TOTAL COST	**1,787, 531.00**	**1,220, 946.17**	**566, 584.83**

CHAPTER 5: DETAILED DESCRIPTIONS OF THE INTERVENTIONS UNDERTAKEN

Project start up

The original project time frame was 2009 – 2011. However, two extensions were granted, for a one year period each. Due to the reasons stipulated below in the discussion section, the actual project duration was 2009 – 2013. Upon agreements a project steering committee (with TOR) was appointed and its functions supported by a secretariat based at the MoHSS in the Directorate Policy Planning and Human Resource Development (PP&HRD). The steering committee consisted of the Spanish Cooperation, the MoHSS represented by the Policy Planning and HRD Directorate, NPC, Kunene Health Directorate and the National Health Training Centre (NHTC), PHC Directorate and NPC. However there seems not to have been a similar structure at the Kunene Health regional level, as it was not established during the data collection process. Meetings were coordinated from the PP & HRD Directorate which also chaired the meetings.

The project appointed Dr. Manzanares, as a time based, Project Coordinator with a primary role of coordinating project activities, provide support to the project site and liaising with key stakeholders.

Project Steering Committee and Secretarial functions: Evidence in relation to programme management suggests that the project had a coordinated platform, especially during the presence of the project coordinator. This is evidence from all steering committee meetings conducted and minutes recorded. However with the end of the contractual agreement of the project coordinator adequate focus could not be given to the project, because the replacement had many other ministerial responsibilities. Nonetheless minutes are clearly noted as to activities conducted, when and by whom. Minutes are also clear on the delays and the types of reason fuelling those delays. The

minutes are however slightly superficial as those tasks with responsibilities were not held accountable in terms of reporting progress. *It's also not clear from the minutes provided if the Steering Committee and the secretariat will continue its functions post donor funding or project closure. In such absence* as well as a lack of ministerial directives of project of such nature a gap is slightly to exist. A lack of a coordinated effort might negatively influence a proper conclusion of activities such as the effective structural set up of the newly constructed maternity ward in Opuwo hospital.

Project equipment; This is making reference to the project vehicle, laptop, ambulances, quantum bus and maternity equipments which as delivered and constructed as envisaged. Currently basic organizational guidelines exist which ensure that these assets / equipment becomes part and parcel of the inventory list of these organizations. At times organizations and especially regional structures possess limited expertise and resources to maintain assets in functional conditions.

Training in EmONC: it's evident from the interviews conducted that the training in Emergency Obstetric and Neonatal Care added value to health care worker's knowledge and skills and had subsequent positive influence on service delivery. While this might be regarded as a step in the right direction those who resign, for various reasons identified earlier, or wrong placement of those trained due to various realistic factors. Resources and efforts place in training might in a long run not benefit those intended to benefit.

Overall "Integrated support to the Kunene Regional health system for the improvement of safe motherhood and new born care" focused on **Strengthening Health Delivery Systems** in the Kunene region. At the moment the delivery of the expected outputs, except slightly for the short term impact detailed in EmONC, will surely not have a massive change to the health delivery systems whiles some fundamental areas are not addressed. The issues of staff shortages, high resignations will surely negatively affect these gains.

LEVELS OF ANALYSIS

Relevance Levels

Relevancy of project deliverables, measured to what extent interventions was consistent and in line with the needs and interest of the beneficiaries, national and international goals for maternal and infant mortality reduction, existed as reviewed. Overall the Namibian constitution in Chapter Three (3) 'F*undamental Human Rights and Freedom*' described that '*The right to life shall be respected and protected",* under Article six (6). In Chapter 11 *'Principles of State Policy'* Article 95 '*Promotion of the Welfare of the people'* talks of '*ensuring that every citizen has a right to a fair and reasonable access to public facilities and services'* (Namibian Constitution, 1990). Project results areas respond particularly to the *'Right to Life'* through providing quality obstetric services and facilities.

Vision 2030's Chapter four (4) address '*Quality of Life'.* The *fourth* theme provides directives to achieving '*Population, Health and Development'* aspirations by 2030. HIV/AIDS and other health risks have curtailed human longevity. In relation to this project Vision 2030 clearly outlines target which amongst others includes '*reduction in infant mortality from 53/1000 live births in 2001 to 30/1000 lb by 2015, 15/1000lb by 2025 and 10/1000lb by 2030; . reduction of maternal mortality from 271/100,000 lb in 2002 to 80/100,000lb in 2015; 50/100,000 in 2025 and 20/100,000 in 2030.* Similarly time – bound National Development Plans (NDPs), national budgets and the MoHSS Strategic Plan 2009 – 2013 address these national health priorities. Vision 2013 is Namibia's aspiring economic and social development roadmap.

Article 144 of the Namibian Constitution stipulates that international laws and agreements addressing general public rules shall be binding in Namibia provided the state has signed to be part of such law. The Millennium Development Goals, in particular Goal number four (4) and five (5) *Reduced Child Mortality* and *Improve Maternal Health* are relevant to this project.

The project fund was 1,787,531 Euros (approximately N$19.682,410.22). An estimated 1,220,946.17 Euros were utilized as of 14 March 2013. Project deliverables, an equipped maternity ward, three (3) ambulances), project vehicle & laptop, a bus to UNAM and enhancement of skills and knowledge in EmONC for the Kunene region, can and will be measured by the number of people benefitting from the project activities / deliverables.

The project had a very basic Monitoring and Evaluation (M & E) strategy represented in the form of feedback detailed in Steering Committee progress reports. The absence of a pre-designed M & E system might have also contributed to the postponements and project time frame extension. It could have served to inform about the project complexities such as tender and procurement bureaucracy and optimally designed within befitting timeframes. Moreover prior planned project activities and deliverables such as 'purchasing of equipments for health facilities in Kunene' as well as 'various support to the Otjiwarongo Regional Health Training Centre (RHCT) could have materialized and not as currently dismissed as merely as a results of limited funds during the project revision phase. Lastly the project has an estimated surplus fund amounting to over half a million. In actual fact surplus funds no longer benefit the project as this funds are revert back whereas it could have been used as intended.

Process levels

Efficiently, resources were not depleted as intended. Financial estimates availed to the evaluation team reveals that a project surplus exists. This was reasoned against the fact that the project funding period ended on 14 March 2013, a time when project activities mainly the maternity unit was under construction. Payment beyond the 14 March 2013 was therefore paid by the MoHSS as oppose to be paid by the project funds. It also appeared that funds budgeted initially for the purchase of equipments for the maternity ward was insufficient to purchase all equipments as envisaged; nevertheless remaining funds under construction could have been used in order to purchase all the planned equipment Amidst the attainment of all proposed project activities the time duration of the project seems to be a concern, taking into cognizance the period of extension and the influenced on project funds.

The project management model, which mainly consisted of a steering committee and a secretariat as an operational platform might have negatively influenced efficient project performance, especially after the time – based Project Coordinator's time was exhausted. The project had no similar structure at regional level and the evaluation revealed that most regional activities were implemented through a delegated channel from the already piled Health Director's office to staff designated with other tasks and a region heavily plunged with massive staff shortages. Overall it could have worked better if during the project proposal review period a number of issues such as procurement of equipments and construction related aspects such as architecture and engineering interventions were accelerated or even pre-notified.

This Bilateral Agreement Project was managed by a joint and stakeholder steering committee. Thus basic leadership and steering was achieved. However the evaluation learned that at time some steering committee members were not represented during steering committee meetings. Particularly the NPC and the PHC unit were the most under represented. Although this might in no way have affected the implementation of the project, mainly because no prima facts exist to indicate so. It is assumed that their representation would have rendered some muscle to the project.

Therefore a certain level of **ownership** was exercised. Another form of ownership exercised by the recipient, being it UNAM and the Kunene Health Directorate, was the institutionalization of donated assets, enhancement of knowledge and skills as well as practices of capacity acquired. Amidst the resignation and transfer of those trained and especially the absence of a measure to utilize or retain the capacity of those who remained revealed to the evaluation team that deliverables have become worthy assets utilized on a daily basis. A continuation of resignation by trained staff might render some project fields such as rendering emergency obstetric and neonatal care ineffective.

The major and probably most crucial aspect of the project at this point is the operational needs of the newly constructed maternity ward. The needs of Human Resources,

thought address through a request for a complimentary staff establishment, while also recognizing that this particular issue might be outside the scope of the project, remain absent. There are no clear directives that it will be addressed time – limitedly. However this was recognized by MoHSS, AECID and the Kunene Health Directorate as a burning issue. The project did not require a direct engagement from project beneficiaries however the evaluation during focus groups discussion revealed that emergency access to Opuwo Hospital is visible and maternal services rendered have improved though challenges still exist.

Results Levels

Project deliverables are tangible and short term benefits are derived. The Kunene Health Directorate Systems are strengthened. In the longer term deliverables would have to be measured against set neo-natal and maternal mortalities reduced. Although there were numerous challenges and those anticipated or unforeseen the **effective** implementation of the project activities was in a way satisfactory. The steering committee will in due time wrap-up its activities and finally conclude and close of the project, as there are no post project engagements.

In terms of **sustainability** there exist overwhelming evidence that the ambulances and the bus donated to UNAM, if well maintained, can have extended lifetime and benefits in servicing the obstetric and newborn care in the Kunene Region. Unfortunately the same cannot be said about the EmONC capacity initiative. Evidence collated indicates a possible challenge in retaining those trained especially amongst the registered nurses and medical doctor's trained. There exist no measure to retain knowledge and skills obtained. The geographic and remote positioning coupled with limited social support infrastructure in Opuwo further undermines sustainability in some areas of the project.

It is also acknowledged that once the project came to an end ownership of the newly constructed and equipped maternity ward seized to the Namibian Government through the MoHSS and in particular the Kunene Health Directorate. The onus therefore sits with MoHSS to fully take ownership, in its entirety and proudly observe the operations of the maternity ward post project closure.

CHAPTER 6: DISCUSSION OF THE FINDINGS

As with many other developing countries, an asymmetric distribution of health workers is believed to be linked to the unwillingness of highly trained personnel to reside in rural and remote areas.[17] This scenario is also evident in the Kunene region. While, incentives has been identified and applied elsewhere to address this problem, resource constraints is usually a barrier.[20] Examples of incentives used include financial rewards, career development, continuing education and recognition. These and other motivational interventions have been implemented elsewhere.

In most developing countries, the shortage of human resources in health is a major obstacle to reaching national and international health goals. Addressing this challenge will require long-term changes, but ‘task shifting’ (delegating clinical functions to less specialised health workers) has been recommended as an effective interim measure in a number of countries.[20] Knowledge transfer is another important aspect in capacity enhancement programs. While knowledge transfer pertains to shared learning, replicated or used to scale-up interventions, create value and improve effectiveness, the best way to facilitate this has not always been clear.[20] With this project, it was not clear how the trainees have shared and used their “knew knowledge and skills”. In other words, a mechanism for continuing assessing and providing supportive supervision appear not to have been established.

In short, key discussions are organized around the following points:

- The project met its objectives, in particular the 4 deliverables: vehicles donations, infrastructure construction, training in EmONC, equipment provision. Program activities not carried out were the provision of equipments to various district facilities in the Kunene region.
- The technical committee which met on a regular basis followed up all secretariat work to ensure that the functions of the steering committee are executed.

- The Spanish Cooperation and the project secretariat liaised regularly to see activities being implemented and to carry out administrative aspects such as the financial accountability.
- The overall implementation was met with unexpected delays which in part, affected the procurement of essential equipment. Most of the delays were as a result of tender procedures, technical operations and administrative issues on the part of the contractor but also regarding consensus on the feasibility and the geographic location of the maternity ward. This took time and in the process the time delays were inevitable. If possible some of these issues could have been avoided if the pre-planning phase was thoroughly scrutinized. The equipment procurement process took much longer and affected purchasing times which was also met with an increase in cost due to inflations. The implementation of the maternity ward took a lot of time and had led to many delays which might have been realistic but had an influence on a number of issues mentioned earlier such as cost.
- The delivery of vehicles had no major implementation delays. The UNAM van was delivered timely and used accordingly. The utilization of ambulances took a while due to tendering process and their conversions to ensure adherence to ambulances standards.
- Although the training component was implemented, it was not materialized without challenges. For example, medical doctors trained were transferred to other regions while other trainees resigned and others allocated at non-MCH sections. Unfortunately there was no built-in mechanism of retaining those who have been trained neither was there any condition attached to the training itself. The steering committee discussed issues around 'holding or tied up the person trained to retain the knowledge and skill and also ensure transfer of such however the ministry appears to have no jurisdiction over these arrangements.

CONSTRAINTS AND LIMITATIONS

- Due to financial and time factors, the most rigorous evaluation research methods were not practical. Data collection methods included:
  - Selected interviews with health providers and clients using the health facility;
  - Selected interviews with facilitators of the trainings
  - Selected interviews with the recipients of equipment and vehicles
  - Selected interviews with project support staff and implementers
  - Use of observation check lists
  - Reviews of project documents and progress reports, and other relevant documents
  - Review of service records
- Limited resources and evaluation timeframe has not allowed for the most rigorous evaluation research methods to be employed. As a result, evaluation objectives may not have been adequately addressed, especially those pertaining to measuring maternal health utilization and outcomes, clients' perceptions/attitudes knowledge and behaviors.
- Delays in timely implementing program activities resulted into some activities being suspended, e.g. equipment for peripheral health facilities, improvement of the operating theatre;
- A clear project logical framework/theory would probably have facilitated an effective and efficient implementation.
- Other limitations especially those pertaining to program delivery as it may have related to staff skills, timely access to funds, lengthy tendering processes, limited technical support from the national level, staff turnover will be discussed and further elaborated in the next sections.

CHAPTER 7: LESSONS LEARNT AND CONCLUSSION

Lessons learned in this project give rise to some key points to consider for the future. Firstly, the project conceptualization/theory appears to be inadequately articulated in the program document which thus in part resulted into delays of a number of primary activities. Secondly, the slow progress in constructing the maternity ward has further disliked important activities that could only be meaningfully implemented along/following the completion of the construction of the maternity ward. For example, health providers trained prior to the completion of the maternity ward had little chance to transfer their skills and to provide the required health service. Thirdly, a mechanism to retain trained providers was not established. Those benefitted from the training were therefore free to internally move or separate from their duties. Finally, even if some activities were not carried out or incomplete, for example, the absence of an operating room, evidence for improved maternal health services should still be observable. Despite this perceived improved maternal health services as reported through interviews with program providers and clients, this evaluation report cannot confidently provide such evidence.

In conclusion, the maternal and child health care infrastructure development will be a long-term investment to the government and its beneficiaries. However, precautions should be taken through changes in regulatory policies to ensure its final completion, resourcing (human, material and finances) utilization and maintenance.

RECOMMENDATIONS FOR FUTURE PROGRAMS

- It is the Government's responsibility to ensure through policies and available norms that investments made are taken care of and maintained in a sustainable manner. This also includes the provision of sustainable human resources especially for the maternity ward if the maternal and child health goals are to be realized.

- Future trainings should strive towards providing such training at well-resourced facilities. This approach could reduce time loss and cost.
- Kunene region is one of the unique regions in Namibia. Its sparsely distributed population, low economy and geographic nature, attract unique challenges that could influence pregnancy outcomes. Therefore, special attention should be given in the provision of a comprehensive infrastructural development including a well-resourced structure.
- There should be a working mechanism to retain those trained, as well as transfer of knowledge and skills acquired.
- Setting criteria and agreement principles prior to selecting trainees could be also useful (as a major reason for turnover or unable to work in the Kunene and Opuwo in particular for longer periods) need to be addressed as this might equally have an negative impact on the human resource for MCH.
- A project of this magnitude required a full-time project coordinator supported by a local coordinator to ensure close monitoring and timely implementation of the project.

References

1. United Nations Partnership Framework 2014-2018. United Nations Country Team – Namibia (2013).

2. National Planning Commission. Fourth National Development Plan (NDP4), 2012/13 – 2016/17. Windhoek: Government of the Republic of Namibia. (2012).

3. National Statistics Agency. Windhoek, Namibia. (2012)

4. National Planning Commission. Third National Development Plan (NDP3), 2007/08 – 2011/12. Windhoek: Government of the Republic of Namibia. (2008).

5. Namibia Demographic and Health Survey 2006/07, Ministry of Health and Social Services, 2008.

6. Central Bureau of Statistics. An atlas of Namibia's population: monitoring and understanding its characteristics. Central Bureau of Statistics, Windhoek. (2010) http://www.raison.com.na/Atlas%20of%20Namibian%20demography.pdf

7. Ministry of Health and Social Services, Namibia. *Global AIDS Response Progress reporting 2012. Monitoring the 2011 Political declaration on HIV/AIDS.* Reporting Period 2010 & 2011*.* *http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2012countries/ce_NA_Narrative_Report[1].pdf.*

8. Ministry of Health and Social Services. *Report on the 2012 National HIV Sentinel Survey.* DSP: Windhoek, Namibia. (2012).
9. Trends in maternal mortality: 190-2010. UNFPA, UNICEF, WHO and World Bank. (2012). http://www.who.int/pmnch/media/news/2012/20120516_unfpa_report/en/

10. Roadmap for the Reduction of Maternal and Child Morbidity and Mortality in Namibia. Windhoek, Namibia: Ministry of Health and Social Services. (2009).

11. Namibia Health Facility Censu, Ministry of Health and Social Services. Windhoek, Namibia. (2009).

12. Progress Reports (1-5). Support to the Kunene Regional Health Systems for the improvement of Safe Motherhood and Newborn care. Ministry of Health and Social Services. (2010-2013).

13. National Planning Commission (NPC). Namibia 2011 population and housing census indicators. (2012). National Planning Commission. (2012).

14. Ministry of Health and Social Services. Report on Needs Assessment on Emergency Obstetric Care. Windhoek, Namibia. (2006).

15. Ministry of Health and Social Services. Report of the Survey on the Factors Contributing to Maternal Mortality and the Prevalence of Missed Maternal Deaths in Namibia. Republic of Namibia, Windhoek. (2011).

16. Gonzalez-Block MA, Mariel Rouvier M , Victor Becerril V and , Paola Sesia P. Mapping of health system functions to strengthen priority programs. The case of maternal health in Mexico. BMC Public Health 2011, 11:164.

17. Hounton S, Hounton Byass P and Brahima B. Towards reduction of maternal mortality in rural Burkina Faso: communities are not empty vessels. *Trop Med Int Health* 2009; 13: 44_52.

18. Rossi, PH., Freeman, HE., and Lipsey, MW. Evaluation: A systematic approach, 7th Edition. Sage Publications. (2004).

19. Health and Social Services System Review. Windhoek, Namibia: Ministry of Health and Social Services. Ministry of Health and Social Services. (2008).

20. Freedam L., et al. Practical lessons from global safemotherhood initiatives: time for a new focus on implementation. *Lancet,* 370-1383-91. (2007).

21. Kunene Regional Health Directorate. Annual report 2012/2013. Ministry of Health and Social Services. (2013).

Annexes I : Table 3: List of People Interviewed

#	FULL NAME	POSITION ON THE PROJECT	DATE OF INTERVIEW
1.	Mr. Lawrence Siyanga	Project Coordinator & Member of Secretariat	3rd September 2013
2.	Mr. Issy Tsidisa /Oxurub	Enrolled Nurse Trained in EmONC – Kamanjab Health Centre	4th September 2013
3.	Ms. Katarina Tjiveza	Acting Health Director - Senior Health Programme Administrator	4th September 2013
4.	Ms. Togbeth K. Karutjaiva	Head of Family Services – Kunene Health Directorate	4th September 2013
5.	Mr. Lisias Ashivuthi	Principal Registered Nurse – Opuwo Hospital	4th September 2013
6.	Attendance Register	Focus Group Discussion with 11 Post Natal Clients Opuwo Hospital	4th September 2013
7.	Attendance Register	Focus Group Discussion with 15 Antenatal Clients Opuwo Hospital	4th September 2013
8.	Dr. Refanus Kooper	PMO Opuwo Hospital	4th September 2013
9.	Maternity Ward	Observation of the maternity ward	4th September 2013
10.	Ms. Rauna David	Registred Nurse Trained in EmONC – Opuwo Hospital	4th September 2013
11.	Mr. Ndangi Kantewa	Chief Administrator Opuwo Hospital	5th September 2013
12.	Goerge A. Hartley	Operator / Driver Opuwo Hospital	5th September 2013
13.	Ambulances	Observation of Ambulances	5th September 2013
14.	Attendance registred	Focus Groups Discussion with Community members Opuwo	5th September 2013
15.	Ms. Njema Pauline	Registered Nurse Trained in EmONC – Khorixa Hospital	6th September 2013
16.	Ms. Loide Kaiyamo	Chief Health Programmes Administrator – Head of Development Coorperation	9th September 2013
17.	Ms.Elize Magano Shikongo	Chief Health Programme Administrator – Ambulance Services management	9th September 2013
18.	Dr. K. Hofni - Hoëbes	Acting DEAN – UNAM School of Nursing and Public Health	10th September 2013
19.	Ms. Olga Martin Gonzalez	Project Officer - AECID	10th September 2013
20.	Mr. Tomas Shapumba	Director Kunene Health Directorate (telephonic interview)	17th September 2013
21.	Ms. Sofia Black	National Health Training Centre	19th September 2013

Annexes 2: Images from the project sites

1. Women in the post natal room

2. Entrance to the newly constructed modern maternity facility in Opuwo
3. One of the ambulances donated to the Kunene Health Directorate
4. Ambulance Driver
5. Unclear Ambulance instruction
6. Focus group Discussion with potential maternal service users
7. Some of the newly purchased equipments for the new maternity ward

Annexes 3: Table 4: Matrix of Key Findings

KEY RESULTS	KEY ACTIVITIES	KEY EVIDENCE /
Result 1 Improved quality of obstetric care services for pregnant women at the various health facilities in the Kunene Region	1.1. Identify needs for improvement of obstetric care. 1.2. Construct a maternity ward at the Opuwo Hospital. 1.3. Upgrade obstetric care health units in the region. 1.4. Purchase equipment for obstetric care heath units 1.5. Provide ECmONC and EmONC in-service training for staff responsible for obstetric care	1.1. Needs proposal revised, review and updated . 1.2. Modern maternity constructed at the Opuwo Hospital. 1.3. No upgradements of obstetric care health units in the regiόn done. 1.4. Equipment purchase and delivered to the Opuwo hospital only 1.5. Training provided on EmONC for medical doctors, registred and enrolled nurses in the Kunene region
Result 2 Pregnant women in the Kunene region who are deemed to be at risk (due to either pregnancy or delivery) receive programmed skilled attendance at the Kunene health facilities;	2.1. Review and update obstetric protocols in line with national protocols 2.2. Provide antenatal in-service training on assessment of risks for pregnant women 2.3. Improve the referral system through the provision of urgent transport for pregnancies at risk,	2.1. No protocol were review and updated 2.2. No antenatal in-service training conducted 2.3. three ambulances purchased and donated to the Kunene Health Directorate ,
Result 3 Enhanced capacity of human resources in the field of nursing at pre-service and in-service levels	3.1. Provide development of a management plan support to the Otjiwarongo RHTC 3.2. Improve and expand the Otjiwarongo RHTC. 3.3. Purchase equipments library and laboratory of the Otjiwarongo RHTC. 3.4. Enhance the mobility of teaching staff and students of the Faculty of Medical Sciences at the UNAM. 3.5. Train trainers in training and research methodologies in the field of maternal & child health.	3.1. No support provided 3.2. No expansion or improvement made. 3.3. No equipments purchase 3.4. A Toyota Quantum purchase and donated to UNAM 3.5. No training done for trainers on research methodologies.

Annexure 4: Table 4: Project Finances (please check final table with the Ministry)

Budget Concept	AECID Budget approved Euros	AECID budget implemented euros	Over or under expenditure over AECID budget	AECID Budget implemented N$
1. RUNNING COSTS				
1.1 Training Activities	42.000,00	56.993,82	-14.993,82	546.438,48
1.2 Hiring of technical assistance	56.240,00	88.000,00	-13.760,00	-
1.3 International travels	9.000,00	0,00	9.000,00	-
1.4 Preparations of studies and report	9.729,00	32.199.19	-22.470.19	301.761.48
1.5 External Evaluation	5.000,00	643,91	4.356,09	6,863.54
1.6 Support to sustainability / contingency cost	85.562,00	13.626,53	71.935,47	135.260,80
TOTAL RUNNING COSTS	**207.531,00**	**191.463,46**	**16.067,54**	**993.324,30**
2. INVESTMENT COSTS				
2.1 Construction works and improvement of facilities	1.2000.000,00	786.574,08	413.425,92	8.592.193,97
2.2 Purchase of medical equipment and furniture	183.000,00	740,59	182.259,41	8.032,75
2.3 Purchasing of vehicles / means of transport (3 ambulances, 1 microbus, 1 vehicle)	197.000,00	242.168,05	-45.168,05	2.405.757,41
TOTAL INVESTMENT COST	**1.580.000,00**	**1.029.482,72**	**555.517,28**	**11.005.984,13**
TOTAL COSTS	**1.787.531,00**	**1.220.946,17**	**566.584,83**	**11.999.308,43**

Annexes 5: Table 5: List of Equipment

Bed ward 3	Bed ward 2	Bed ward 4	Bed ward 1	Private ward 1	Private ward 2	Store room
2 beds and 2 mattresses 3 baby cots 4 footsteps 1 trolley oxygen cylinder holder 1 drip stand 1 linen hold stand 2 wheelchairs (in boxes) 2 theater light ceiling mount(in boxes) 1 stretcher with one mattress	4 beds with 6 mattresses (2 mattresses lying on the floor) 1 drip stand 8 Feet stands 1 trolley oxygen ylinder holder 1 washbasin 1 wash basin stand 1 linen standholder	4 beds with 4 mattresses 3 Baby cots with mattresses 1 linen stand holder	4 beds and 4 mattresses 3 babies cots with mattress 1 linen stand holder	5 examination lamp and one mistakenly written as ultrasound 2 curtain dividers 10 feet stand 8 bedside lockers 1 steel medicine cabinet 2 baby mobile beds	17 baby mobile beds 2 steel medicine cabinets 2 curtain divider	1 kervinator fridge 39 bed file holders

Utility store	Counseling room /rapid test room	Treatment	Prepation room	Delivery 2	Delivery 1	Sluice 2	Stage one room
5 urinary pans staff work cabinets, 3 Staff steel cabinet with 3 lockers each (9)	2 file cabinets 2 chairs 1 lazy chair 1 table with three drawers (separate) 2 steel lockers with 3 lockers each (6)	1 bed 1 drip stand 1 mattress	1 bed 1 mattress 1 linen holder stand 1 steel basin stand	2 beds 2 mattresses 2 standers 2 drip stands 3 steel bucket with lids on a stand 3 curtain dividers 1 trolley stands (for Oxygen cylinders urinary)	2 bed 3 steel buckets 1 drip stand 1 linen stand 1 trolley	2 floor cleaning buckets 1 pen stand 7 Bed pans 5 urinary cups /mugs 1 basin 1 basin stand	2 bed 2 mattresses 2 unassembled beds 3 drip stand 3 duster remover

Collidor (through out)	**Milk kitchen**	**Baby feeding room**	**Nursery**	**Medicine store**	**Linen store**	**Ward kitchen**	**High care ward**
1 patient trolley with a mattress 20 chairs	I fridge 1 electrical water cooker	Nothing	1 steel medicine trolley / holder	Overcrowded	Nothing	-Nothing	-2 curtain divider -2 bed