

PD-ABQ-088

**Midterm Evaluation of
Eritrean Health and Population Project
(Project #661-006)
IQC# AEP-0085-I-00-6018-00, Delivery Order No. 803**

December 1997

UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT

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TABLE OF CONTENTS

Project Identification Data Sheet	1
List of Acronyms	2
I. Executive Summary	3
II. Background	6
A. Objective of the Evaluation.....	6
B. Team Composition and Methodology.....	6
C. Project Description.....	7
D. Relationship between the EHP Project and the PHC Strategic Investment Plan.....	8
III. Project Performance, Inputs, and Outputs	9
A. Project Performance.....	9
B. Project Inputs.....	11
C. Project Outputs.....	13
D. Management and Finance.....	21
IV. Project Impact and Sustainability	26
V. General Recommendations	27
VI. Next Steps	28
VII. Appendices	29
A. Appendix-List of Persons Contacted.....	30
B. Appendix-EHP Project Evaluation Scope of Work.....	31
C. Appendix-Maps.....	40
D. Appendix-Cooperating Agency Notes.....	41

Project Identification Data Sheet

1. Country: Eritrea
2. Project Title: Eritrean Health and Population Project
3. Project Number: 661-006
4. Project Dates:
 - a. First Project Agreement: 9/26/94
 - b. Final Obligation Date: FY 98 planned, actual FY99
 - c. Most recent Project Assistance Completion Date (PACD): 12/31/9
5. Project Funding: (amounts obligated to date in dollars or dollar equivalents from the following sources)
 - a. AID Bilateral Funding (grant and /or loan) US\$ 15,000,000
 - b. Other Major Donors 0
 - c. Host Country Counterpart Funds 0
 - i. Total 15,000,000
6. Mode of Implementation: (host country or AID direct contractor?):
Contractors: BASICS, SEATS, OMNI, PSI.
7. Project Designers: Government of State of Eritrea, USAID/REDSO/ESA,
USAID/ERITREA
8. Responsible Mission Officials: (for the full life of the project)
 - a. Mission Director: G. William Anderson
 - b. Project Officers: J. Robb-McCord, Anne Hirschey, Yohannes Ghebrat
9. Previous Evaluation: none

List of Acronyms and Abbreviations

ARI	Acute Respiratory Infection
BASICS	Basic Support for Institutionalizing Child Survival
CA	Cooperating Agencies
CSW	Commercial Sex Worker
CYP	Couple Years Protection
DHS	Demographic and Health Survey
ESMG	Eritrean Social Marketing Group
FP/RH	Family Planning / Reproductive Health
FTE	Full Time Effort
HMIS	Health Management Information Systems
IEC	Information, Education and Communication
ICIMI	Integrated Childhood Illness Management Initiative
IDA	Iron Deficiency Anemia
IDD	Iodine Deficiency Disorders
IMCI	Integrated Management of Childhood Illnesses
GOE	Government of Eritrea
GOSE	Government of the State of Eritrea
LOP	Life of Project
MCH	Maternal and Child Health
MOH	Ministry of Health
MSI	Management Systems International
NGO	Non Governmental Organizations
NUEYS	National Union of Eritrean Youth and Students
OMNI	Opportunities for Micronutrient Interventions
ORT	Oral Rehydration Salts
PHN	Population, Health and Nutrition
PILs	Project implementation letters
PPAE	Planned Parenthood Association of Eritrea
PVO	Private Voluntary Organizations
REDSO	Regional Economic Development Services Office
SOW	Scope of Work
STD	Sexually Transmitted Diseases
TAACS	Technical Assistance Child Survival
TBA	Traditional Birth Assistant
UNFPA	United Nations Fund for Population Assistance
VAD	Vitamin A Deficiency

USAID/Eritrea Eritrea Health and Population Project
Mid-Term Evaluation Report

I. Executive Summary

A. Background

The Eritrea Health and Population (EHP) Project is a five year, \$15 million project designed to achieve two major, interrelated outputs:

- 1) strengthening the public health delivery system to make it capable of delivering basic health and family planning services; and
- 2) increasing demand for, access to, and the quality of an integrated package of basic health and family planning services, especially by women and children.

The project was designed to be implemented in two phases over the five year (1994-1999) Life of Project (LOP). During the first two years, Phase I focused on those areas for which absorptive capacity was considered adequate and for which sufficient information existed to proceed in a cost-effective manner. Phase I actions related to capacity building at the zonal and central levels to enable the health system to more effectively use and absorb EHP project assistance during Phase II. Phase II activities, currently under way, concentrate on service delivery and the expansion of quality health services.

The EHP Project, with its broad scope and mandate, fits well with the USAID/Eritrea's Strategic Investment Objective. Most of the "bridging" and Phase I activities are preliminary to, and provide the basis for, the follow-on activities which will produce overall Strategic Investment Objective results and the intermediate results.

The objective of this mid-term evaluation is to assess the actions, accomplishments, and progress to date, to make recommendations on how to proceed on certain components of the project (e.g.: health and training infrastructure), and to provide direction for future planning. The evaluation covered several key activities:

- 1) Strategic Planning and Budgeting
- 2) Demographic and Health System Information Base Development
- 3) Health Management Information System Development
- 4) Logistic Systems for Drugs and Medical Supplies
- 5) Health Services Training
- 6) Operations Research on Integrated Basic Health Services
- 7) Health and Family Planning Education (IEC)

- 8) National Laboratory System Development
- 9) Health Care Financing

During the evaluation team's three weeks in Eritrea, interviews were conducted with personnel from USAID, the Cooperating Agencies and the Ministry of Health. The team met with the medical officers of the three EHP focus zones and visited five health facilities in two zones.

In addition, the team reviewed corresponding reports, work plans, and other relevant documentation.

B. Findings

For the most part, the Project objectives for Phase I were realistic, given the project's time frame and its regional focus.

The Contracts, Delivery Orders, Scopes of Work, results to date, and 1998 work plans from the cooperating agencies are supportive of the overall mandate of the EHP Project. The technical assistance, provided by USAID and the Cooperating Agencies to the Ministry of Health (MOH) has been found to be relevant to, and supportive of, the EHP Project goals and objectives. The evaluation of Phase I activities shows that most of the inputs carried out during 1996 and 1997 fall well within the expected activities for this phase. However, other activities, such as the Integrated Management of Childhood Illness (IMCI) were begun early. Some phase I activities, such as those relating to health financing, are still in very early stages of development, and the Health Management Information Systems (HMIS) and logistics activities have yet to be completed.

Although many activities were seriously delayed, others have been successfully completed. Their status is discussed in the body of this evaluation report.

In spite of significant delays, a cadre of personnel has received training in strategic planning, management information systems, the Primary Health Care (PHC), Family Planning/ Reproductive Health (FP/RH), and Information Education and Communications (IEC). This has resulted in an enhanced capacity of the MOH to deliver essential health and family planning services in the focus zones. There is clear evidence that the MOH's capacity to produce action plans at the central and zonal levels has been increased.

There are very few indicators of impact, due to the lack of related health statistics. However, the 1995, the Demographic and Health Survey (DHS) established some important baseline measurements. It is anticipated that the follow-on DHS could provide relevant and appropriate progress on impact.

C. Recommendations

- **Give higher priority and increase the proportion of resources for capacity building, through both long term and short term training, during the remainder of the project.**
- **Extend the current EHP Project end date from January 1999 to the end of 2001 to match the planned life of the investment objective.**
- **USAID and MOH should develop and adopt a continuation plan, in support of the investment objective for the period January 1998 to 2001. They should determine priorities, activities, a workplan and time schedule, and identify realistic mechanisms for implementing the plan. The workplan should include an "umbrella" implementation schedule as well as individual workplans for each funding mechanism, as appropriate. The current Cooperating Agencies (CAs) should realign their workplans to fit into the continuation plan.**
- **Conduct formal, periodic reviews at the representative and ministerial levels, to assess progress, results, and overall direction of the EHP. This is in addition to the current technical collaboration between the USAID investment objective team and the MOH technical departments.**
- **The remaining activities should focus on the accelerated implementation at the zonal level in support of improved service delivery.**
- **Facilitate the supervision, monitoring and evaluation of zonal action plans during the life of the EHP Project.**
- **Immediate action should be taken to ensure that the health finance results of the EHP Project are achieved. The mechanism for achieving these objectives should be revisited.**
- **Immediate action should be taken to ensure that a quality, state-of-the-art software program is in place to support the HMIS.**

II. Background

A. Objectives of the evaluation

The objectives of the evaluation of the Eritrea Health and Population Project are to:

1. Assess the progress of the project to date and the actions that were to be taken during the *First Phase*, including:
 - building the strategic planning capability and producing the strategic health plan, including financial planning;
 - developing and testing the Health Management Information Systems (HMIS) at zonal and central levels;
 - conducting the nationwide demographic and health survey; upgrading the logistics system for drugs and medical supplies at zonal and central levels;
 - logistics for Drugs and Medical Supplies;
 - participant training to upgrade capacity of training schools and management capacity for implementing decentralization;
 - conducting an assessment for information, education and communication (IEC) and developing the national communications plan;
 - conducting operations research on integrated basic health services;
 - expansion of NGO and private sector role in health and family planning service delivery; and
 - procurement of vehicles and an initial quantity of drugs and equipment for provincial health facilities.
2. Make specific suggestions for the phase one components
3. Provide general guidance for improved management of the EHP Project

Moreover, the EHP project paper stated that the mid-term evaluation would help make recommendations on how to proceed with certain major components, such as health and training infrastructure strengthening, and the approach to take in primary health care service delivery.

B. Team composition and Methodology

Robertino Mera M.D., Ph.D.	MSI, Team Leader, LSU Medical Center
Abdi Wardere M.B.A.	USAID/Washington Global Bureau
Shirley Hoffmann Ph.D.	USAID/Eritrea Program Office
Eyasu Hadgu M.P.H.	MOH, EHP Project Manager
Melinda Wilson Ph.D.	REDSO/ESA Regional Reproductive & Child Health Advisor

The MSI, USAID/Washington, USAID/Eritrea and MOH team members spent three weeks in Eritrea (November 17- December 6, 1997) conducting the evaluation. They were joined in the last week by the REDSO advisor (December 1-10). The members of the team conducted

interviews with 17 people. Several of these people were interviewed twice (see Appendix A for a list). The evaluators also reviewed a number of key documents and USAID's general project files (see Appendix B). The evaluators also visited two health zones, two health stations, one health center, one zonal hospital, and one mini hospital.

The tentative conclusions and recommendations of the evaluators were discussed with the USAID and MOH personnel during a debriefing. At the end of the field visit, a draft report was prepared and delivered before the debriefing.

C. Project Description

According to the original project paper, "the Eritrea Health Project (EHP) is a five year, \$15 million project designed to achieve two major, interrelated outputs which address the principal constraints to providing high quality basic health services: 1. Strengthening the public health service delivery systems; and 2. Increasing demand for, access to, and the quality of an integrated package of basic health and family planning services, especially by women and children in the four focus provinces (see Appendix C); in short, systems strengthening and improving quality service delivery. The project was intended to "focus on both the national and provincial (zonal) levels of the health systems." Following the independence of the State of Eritrea in 1993, the project design was completed by the end of fiscal year 1994 which made it timely and relevant. This project was conceived at a time when the Ministry of Health was eager to build its capacity centrally and at the zonal level.

In order to provide the technical assistance called for, the EHP Project was divided into two phases. The first phase focused on capacity building through provision of substantial technical assistance to develop and strengthen management systems; training a cadre of personnel in crucial skills; increasing the knowledge and establishing data bases needed to rationalize the health delivery system with respect to drugs, manpower, and facilities; and providing a logistics infrastructure and medical supplies and systems to support this infrastructure.

EHP's second phase will focus on implementation of lessons learned and the consolidation of the capacity strengthening at all levels down to the community in the focus zones. (Specific activities and progress to date are described in more detail in Section IIC of this evaluation report.) It is important to note that it was envisioned that after the completion of Phase I, "EHP Project Managers will have sufficient information" to judge which approaches to take. Therefore, it is not unusual that over the course of project implementation some changes may be made, some of which may incorporate or address recommendations made in this evaluation.

Eritrea went through an administrative change from provinces to zones in 1996. This change caused the reassignment of the four provinces (originally envisioned in the project design) into three focus zones (Central, Southern, and Gash-Barka). The Central and Southern zones correspond to the central highlands and to the old provinces of Hamasien and Akele Guzai. The new zone, Gash-Barka, is located in the western lowlands, covering an important part of the

highlands and the western escarpment. It is noteworthy that the shift from provinces to focus zones changed the scope of the project coverage. The geographic area covered under the current zonal structure and the size of the population are both larger than the original provinces. (See the map in the Appendix D).

To carry out the scope of work in the project, several cooperating agencies (CAs) with central mechanisms were identified to provide technical assistance. These CAs include BASICS, SEATS, OMNI, and PSI which have been working closely with the MOH (Refer to Appendix E for specific SOWs and progress to date CA and activity.) In addition, a significant portion of the project was directly implemented by the Ministry of Health through project implementation letters (PILs).

The EHP was well designed and has proven its flexibility. The design coincided with both USAID reengineering and MOH reorganization and decentralization. As part of USAID's reengineering, the investment partnership plan was designed through an iterative process which involved other health sector partners and many members of the MOH. Although this process was very useful and involved MOH and other health sector partners in Eritrea, it took time. In the end, however, the broad design of the EHP created the linkages between the existing project components and USAID/Eritrea's Investment Objective (IO).

D. Relationship between the EHP Project and the PHC Strategic Investment Plan

The EHP project, with its broad scope and mandate, fits well with the Strategic Investment Objective, "Increased use of sustainable, integrated primary health care services by Eritreans". However, much of the "bridging" and Phase I activities are preliminary to, and provide the basis for, the Phase II activities which will produce overall IO results, and the intermediate results which are "access to and quality of PHC services improved, and client demand for PHC services enhanced." Considering the level of development of health services in 1994, supporting the development of basic MOH systems and the fundamental frameworks for improvement of service delivery was an essential first step in progress toward the relatively high level results as outlined in the Strategic Investment Plan. It is only through support for the development of basic MOH systems and fundamental programs to improve services that the level of results as outlined in the strategic plan can be reached.

EHP background assessments provided data for prioritization of activities and determined the steps needed to produce results. From these assessments, the MOH and USAID were later able to more realistically focus the strategic objective and determine reasonable targets for achievement.

The Phase I activities, while strengthening the health delivery system, will provide the basis for an increased access, demand and quality of health services. These three results

appropriately fit with the Intermediate Results 1, 2, and 3 of the Investment Objective's performance monitoring plan (PMP). (For a detailed link between the outputs of the EHP Project and the Investment Objective, refer to Section IIIC of this evaluation report.)

For the most part, the activities ongoing and planned for Phase II are appropriate for achieving the Investment Objective (IO) and the Intermediate Results (IR) level results as outlined in the IO PMP. Both the EHP Project and the IO stress capacity building below central levels. This complements the major new component of the USAID health portfolio: support for decentralization of the Eritrea health system.

The overall fit between the EHP Project and the Strategic Investment Objective is good. Only one component should be deleted, that supporting the strengthening of NGOs, as this component has been removed from the overall MOH strategy.

MOH Perception of the EHP Project and the Investment Objective

In general, Ministry of Health priorities for capacity building-- especially those supporting human resource development -- match the EHP Project scope. MOH officials emphasized the importance to focus the capacity building aspect of the project on training of "all types of health care providers." There is the perception that the EHP Project has already made headway in restoration of health care facilities (e.g., refurbishing hospitals, health centers and health stations) in the focus zones. Therefore, it is time to focus on training health personnel. Furthermore, it is felt that the EHP Project has made an important contribution in capacity building, and it is necessary to further expand the training initiatives at the zonal level.

Early in its design, the EHP Project recognized human resource development as an important component, calling for "an intensive effort at human resource development - training at all levels and at all stages: new recruits as well as upgrading of current staff" (EHP Project PP: p.19).

The Ministry of Health officials who participated in the MOH-USAID Investment Objective Review in May 1997 have an adequate understanding of the issues regarding strategic planning. Many of them participated in seminars in early 1996, using consensus to develop the strategic framework. Since the time of the seminars, several reviews within USAID have taken place and the indicators have changed. During the interviews with this evaluation team, the MOH officials suggested some lack of ownership. The Investment Objective indicators were criticized as not having a direct relationship with the indicators at the IR level. Moreover, they were considered to be overly ambitious and not directly responsive to MOH data needs.

III. Project Performance, Inputs and Outputs

A. Project Performance

The bilateral agreement between the Government of Eritrea (GSE) was signed in September 1994. However, the delivery order between USAID and the leading CA (BASICS) was not signed until September 1995. (There was a "bridging period" before the contract was signed). Similarly, SEATS, PSI and OMNI activities did not start until 1996. As a result, most activities for which these CAs were to be responsible fell behind schedule.

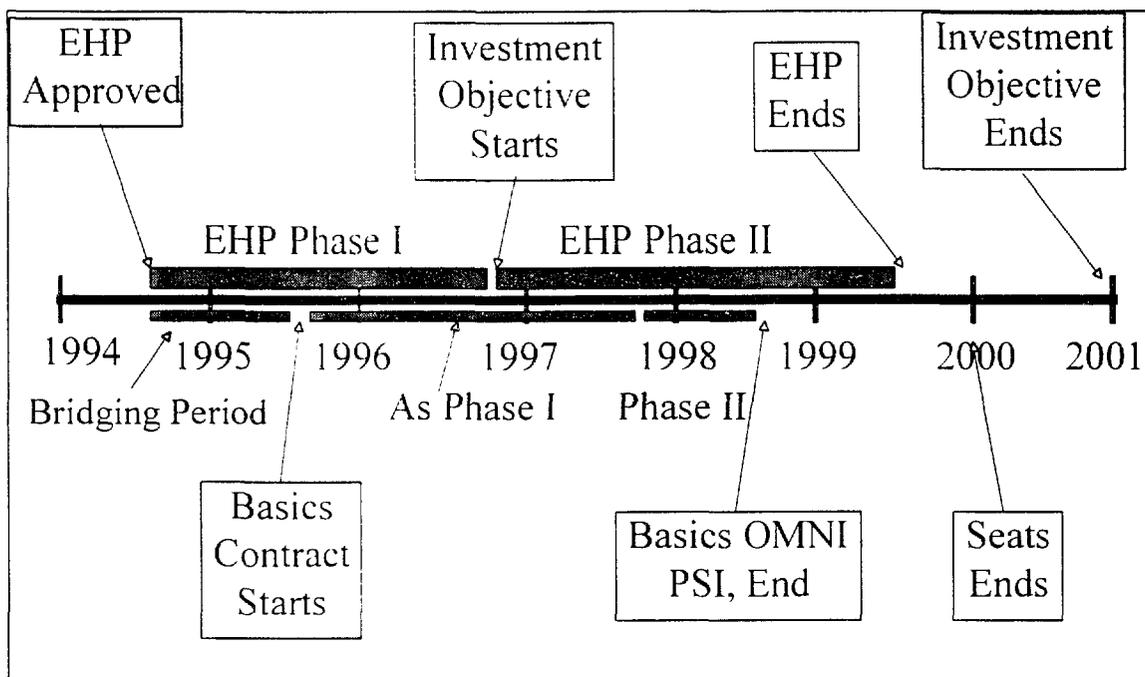
The EHP project contained two phases. Phase I went from September 1994 to September 1996 and Phase II from September 1996 to September 1999. Some Phased I activities, mainly regarding systems strengthening, would continue into Phase II of the project, which would focus on the implementation of PHC services at the zonal level. As it turned out, the project dates had to be modified due to the timing of the signing of the delivery order for the main contractor (Sep 95). The current Deliver Order, Phase I was extended to September 1997. Phase II will start in October 1997 and end in September 1999. (See Figure 1.) A continuation plan to bridge the gap for the period Jan 1998 through 2001 should be jointly developed.

The EHP Project Phase I goals, regarding capacity building, and systems strengthening, were for the most part, realistic given the project's time frame and regional focus. The main constraints that were not considered in the project, which caused certain objectives to remain to be carried out were primarily delays in the signing of agreements with cooperating agencies (CAs) and staffing problems both by the MOH and the CAs.

Staffing problems plagued both BASICS and the MOH well into 1996. The MOH replaced some key personnel (Planning, PHC, Project Coordination) and BASICS could field only two of the three resident team members.

The main objectives of Phase I were systems strengthening, training MOH personnel in crucial skills (planning, budgeting, etc.), increasing the knowledge and data base needed to rationalize the health delivery system with respect to drugs, manpower and facilities, and providing logistics infrastructure and supplies. A certain number of these objectives have been accomplished.

Although many or most of the Phase I activities are on track (e.g., Strategic Planning and DHS), some are incomplete (HMIS, Logistics) or substantially delayed (Health Financing). The capacity of the MOH to plan and implement at the central level is adequate, but much needs to be done at the zonal level. Now, training has to shift to the periphery in order to capitalize on the advances made at the central level to support decentralization. (A detailed account of the activities and their status is described in Section IIIC, Outputs.)



B. Project Inputs

The inputs of the project, in relation to training a cadre of personnel in crucial skills, have resulted in an enhanced absorptive capacity of the MOH in terms of: a) increased capability to conduct planning at the zonal level, b) the potential use of data provided by the HMIS at the zonal level, and c) the potential for the implementation of the basic health package throughout the zones of the project (Central, Southern and Gash-Barka). The technical assistance and other inputs carried out by the MOH with the help of the CAs have been for the most part relevant within the context of the EHP Project. Some activities were not expected during the first phase of the project, such as the adoption of Integrated Management of Childhood Illnesses (IMCI), and the development of a twelve-month framework for action. Some activities to be completed during this phase were delayed, such as the Health Management Information Systems, which has yet to have a completed software component. Others had serious problems with continuity, (for example, the health financing activities), and some activities were never initiated (such as the increased role of NGOs in the delivery of health services and information .)

Technical assistance is adequate with respect to the transition from Phase I to Phase II.. There are inputs from Phase I that are critical to the delivery of improved services (e.g., the successful implementation of the HMIS) that need to be completed in order to proceed to Phase II. Moreover, there are some activities from Phase II that have already started, such as IMCI. Due to personnel changes within the MOH, an important input for this transitional phase

will be to have the most Investment Objectives. This activity has the potential to focus next year's activities around a renewal commitment of the MOH to the investment objectives and the impact indicators.

Several constraints present at the time of the initial project implementation (and mentioned in the program paper); namely, human resource development, quality of services, infrastructure, community health services, family planning services and woman's status have been adequately addressed by the framework of USAID-funded technical assistance to the MOH. There are still a few constraints in areas of human resource development and health finance. In addition, there is a time element in regards to the impact indicators: the activities haven't been in implementation long enough to measure impact.

The evaluation team did not find significant gaps or opportunities for technical assistance which the EHP Project has not addressed. The original diagnostic studies, systems building, and the service improvement envisioned for the latter stages of the EHP were appropriately designed as part of the project. Inputs and technical assistance made to date are supportive of the overall goal and purpose of the EHP Project. In addition, the current and planned technical assistance and inputs support the overall goal and purpose of the EHP Project and Investment Objective. (See Figures 2 and 3.)

Figure 2. Investment Objective Framework

C. Project Outputs

Output 1: ***Strengthened systems: Strengthened public health delivery systems capable of delivering basic health and family planning services***

a. MOH Strategic Planning and Budgeting

IR 1.2 Capacity to Manage and Plan for PHC Services Enhanced

- Guidelines for Decentralized planning developed, tested and used by all six zones for planning
- National Primary Health Care Policy Guidelines produced and disseminated
- National and regional EPI plans developed by central and zonal level MOH officials
- Regional health teams for the focus zones have developed their regional action plans
- Guidelines for sub-regional planning prepared by Gash Barka Regional Health Team
- National Standard Treatment Guidelines produced by MOH
- Essential list of drugs produced and being used for procurement and planning
- National Drug Policy drafted by MOH expected to be ratified in first quarter FY98
- Health Manpower and Facility Survey conducted and data analyzed

- A five-year Program of Action for Nutrition was developed for the State of Eritrea and adopted by the MOH
- Training in FP/RH at the zonal level (six zones)

Key national policies and guidelines (decentralization, PHC guidelines, EPI, nutrition) are in place. The target regions have increased capacity to undertake decentralized planning and implement PHC. (A recent survey of health workers stated that the regional health management teams use data for planning and decision making.) The delivery of services based on priorities described in national policies is a key component of Phase II of this project.

The delivery order of the main contracting agency called for a health finance specialist as part of the long term technical assistance, as well as a number of related health financing activities. The recruitment of a health financing long term advisor did not happen, so activities in this area have been substantially delayed. In order to achieve MOH's long term health financing goals and promote decentralization, this should be addressed through the continuation of short-term technical assistance. With the important exception of health financing, activities for this output are on track.

Recommendations:

- Prompt action should be taken to ensure that the health financing results of the EHP Project are achieved. The mechanism for achieving these objectives should be revisited and a plan and schedule adopted.
- A review or re-addressing of the Investment Objective framework is warranted to attain an increased level of "ownership" by the MOH officials.
- Additional time is required to accurately illustrate the impact of the program.

b. Development of a Demographic and Health System Information Base

IR 1.2 Capacity to Manage and Plan for PHC Services Enhanced

- National and broad-based consensus obtained on a list of essential national health indicators. Facility-level workers (67) and policy makers involved
- DHS carried out in 1995

The set of essential health indicators was adopted for use by the Eritrea MOH. The DHS data are available (1996). The data set is not available to the MOH for further analysis; however, MOH management utilizes DHS results in planning and prioritizing services.

Recommendation:

- Ensure that the follow-up DHS, due to be implemented in the year 2001, is planned in

close coordination with the MOH.

c. Health Management Information System

IR 1.2 Capacity to Manage and Plan for PHC Services Enhanced

- A consultative process was used successfully to obtain inputs from over 300 facility based health workers in all six regions on the design of forms and registers for HMIS data collection
- Forms and registers for HMIS data collection were designed, adopted by national consensus, and printed
- An instruction manual for facility-based workers on how to use forms and registers for HMIS was written, translated into Tigringya and printed
- A computer outpatient registration system for use by Mekane Hiwot Hospital was developed and is in use
- The computer literacy skills of 12 regional HMIS officers from six regions were enhanced through training programs
- Training was given to the MOH Health Information Officers on the logic and use of the HMIS software

Considerable progress has been made in the development of an information system. However, the custom software for the input and output forms of the HMIS needs to be de-bugged, completed and upgraded to a Windows format. Local capability must be developed to modify the custom software, so that zonal chiefs can design or ask for specialized reports or indicators, or recommend other reports to be used nationally.

The current situation of the Health Information System is troubling. The HMIS resident advisor left the country, in September 1997, leaving the custom software portion incomplete and riddled with bugs. Significant input is required to make the software serviceable. The former HMIS resident advisor has agreed to return in March 1998 for two weeks, but additional TA may be needed to ensure that the custom program is "state-of -the-art." The evaluation team believes that his amount of time will be too short to complete coding and de-bugging of program. The evaluation team thinks that a seven-month delay in completing this critical piece of work may be problematic.

MOH personnel have not been trained to modify the current software, and no effort was made by the HMIS resident advisor to train Eritrean personnel in the de-bugging or completion of the software. The personnel at the zones have been trained to handle the new paper forms, and they have already begun the process. At present, there is no plan to make the custom software available to the zones (with the corresponding hardware), due to the lack of a finished

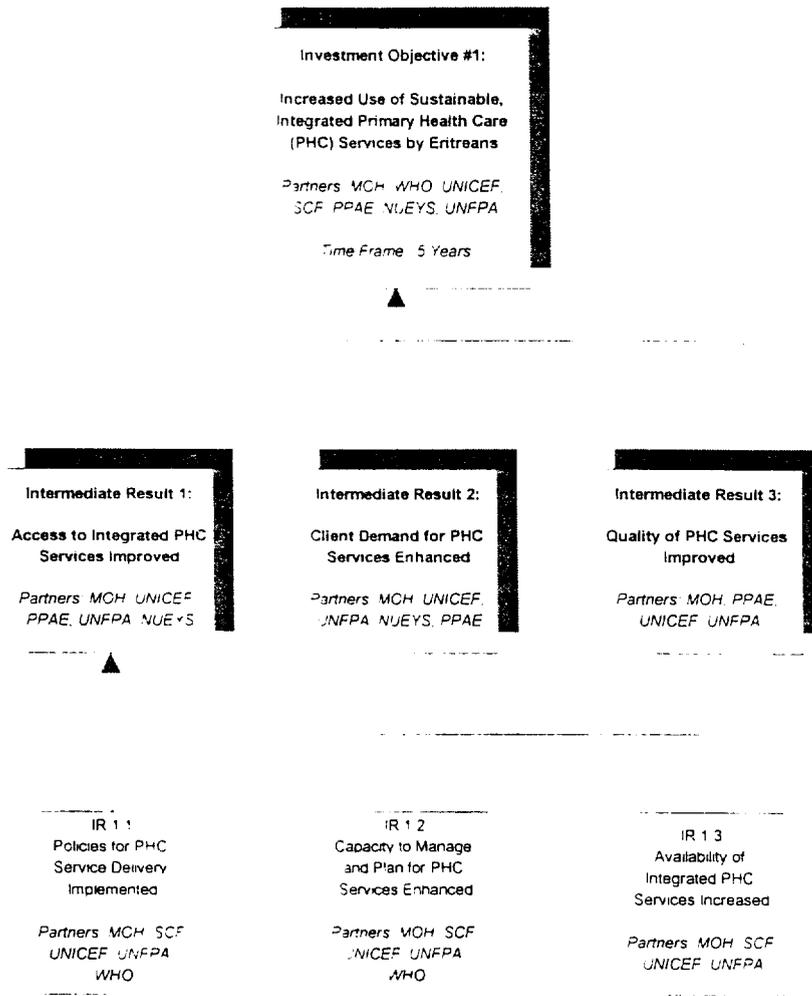


Figure 2. Investment Objective Framework

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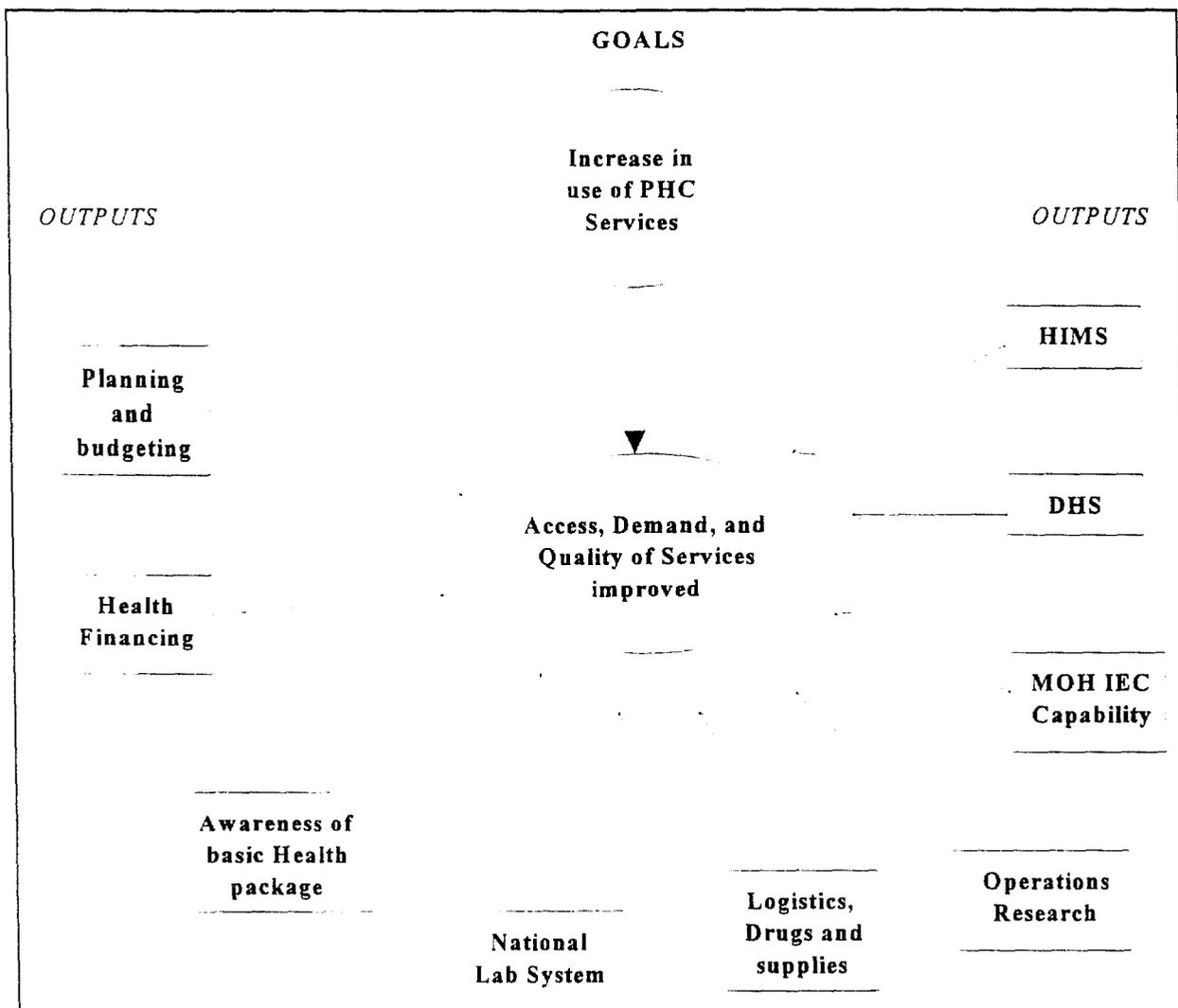


Figure 3. Project Goals and current and planned outputs

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product.

Another HMIS problem is that the computers are new and running Windows 95, while the software in which the custom program was developed is a DOS version of dBase. This outdated arrangement prevents full utilization of the computer's capabilities for printing, data transfer and mapping.

Recommendations:

- Provide TA that will assess the software component of the HMIS, which can recommend the necessary changes that will build flexibility into the information system outputs. Take immediate action to ensure that a "state-of-the-art" software program is operational by July 1998 as a key component of the HMIS.
- Replace the DOS version of dBase with an upgrade that can take advantage of all the coding written so far.
- Train MOH individuals in coding and report generation, so that even when the project finishes, they can modify the program, append or create new reports.

d. Logistics for Drugs and Medical Supplies

IR 1.3 Availability of Integrated PHC Services Increased

- Furniture essential for the operation of the Drug Quality Control Laboratory was procured and installed (renovation and construction of the Drug Quality Control Laboratory is complete)
- Instruments and chemical supplies were ordered through international bid supervised by Pharmecor. Of these, 75% have been delivered and received by the MOH
- A study tour to Zimbabwe for three Pharmecor staff on the use of the computerized inventory system was conducted
- Computers and services for use by Pharmecor to install the software on a network, were purchased
- One lab technician was sent to a six month training program in South Africa
- A logistics assessment, focusing on both contraceptive logistics and essential drugs completed
- Pharmecor Director trained in drug policy and management

Most of the activities regarding the Drug Quality Control Laboratory have been accomplished. However, the drug inventory control system is not yet operational. Much progress has been made to attain both objectives, but the main Life of Project objective of health facilities having

essential drugs, supplies and equipment to meet PHC needs has to be stressed during the Phase II of this project.

Recommendation:

- As part of the overall continuation plan, include a schedule for logistics system follow-up activities and completion.

e. Supervision

IR 3. Quality of PHC Services Improved

- A proposal for effective and sustainable supervision linked to quality assurance has been developed and submitted to the MOH for consideration
- Assessments on quality of care at first level facilities completed and results used in IMCI and regional planning activities
- A supervision system for PF activities has been initiated
- Completion of construction and renovation of the Central Health Laboratory and Drug Quality Control Laboratory

Performance standards and indicators have been suggested, but much needs to be done in the development of job descriptions for primary supervisors, associated guidelines, supervisory checklists, visit schedules and standardized reporting formats. This activity is in early stages.

Recommendation:

- As part of the overall continuation plan, include a schedule for supervision follow up activities.

f. Build national capacity to train health workers to plan, manage, and implement integrated child health and family planning programs

IR 3. Quality of PHC Services Improved

- A curriculum has been revised and improved for the Bachelor of Science in Nursing with emphasis on PHC, and is currently in use by the College of Health Sciences
- Administrative structures and processes to facilitate the implementation of the nursing program were developed and adopted by the Department of Nursing, College of Health Sciences
- An analysis of a national health human resources database was prepared and

submitted to the MOH for review

- National consensus at the political and technical levels was achieved for the adoption of IMCI as a strategy to improve the quality of PHC services in Eritrea
- A nutritional status report was produced and its results will be used to guide the preparation of feeding recommendations in the IMCI modules
- SEATS trained 42 health providers in family planning counseling. This training was intended for health workers already providing MCH services in the form of structured on-the-job-training. At least five health professionals also received training of trainers (TOT) orientation. Moreover, in collaboration with UNFPA, TOT and peer counseling was conducted for 21 youth members of NUEYS. Four NUEYS members and three health providers were trained in contraceptive technology.
- Two MOH/pharmacy staff members trained in management of essential drugs
- Long term training in the United States was provided to an HMIS staff member in computer skills and basic programming, and four nurses are studying for B.Sc. degrees
- Three Eritreans were supported to go to Kenya and observe FGM programs
- Three midwives were supported to go to Zimbabwe to examine reproductive health programs and share experience
- 21 peer counselors from schools and communities have been trained to communicate with other youth on reproductive health matters
- Family Planning clinical protocols were developed and are utilized for FP training

Additional training is needed in drug management, logistics, health care financing and drug policy issues.

Recommendation:

- As a key priority area for the MOH and a component of the EHP Project, USAID and MOH should work on a comprehensive plan of action for human resource development during the remainder of the project. MOH and USAID should re-think the level of funding allocated to this component within the EHP Project budget. Training should include both long-term and short-term training including study tours, skills upgrade workshops, and in-service training. This increased focus on training and skill building could serve as much-needed support for MOH decentralization.

g. Physical Infrastructure

IR 1 and IR 3. Quality of PHC Services Improved

- 46 health facilities furnished
- Computer equipment procured (HMIS)
- IEC materials (books, flip charts, etc.) procured

Support was initially intended for rehabilitating the three principal health training facilities, the nursing school, the midwifery school and the health assistants school, but the Ministry has proposed a new training complex and is in the process of arranging other donor support for this objective. Other activities regarding refurbishing of health facilities will be initiated.

h. Health Facilities

IR1. Access to Integrated PHC Services Increased

The only infrastructure which is funded by the EHP Project at this time is the rehabilitation or construction of warehouse facilities at the zonal level, and repairs to the central and zonal laboratories. At the time of this evaluation only the central lab rehabilitation was underway and in the last stages of completion.

Output 2: Improved Services: Increased demand for, access to, and quality of an integrated package of basic health and family planning services, especially by women and children in the three focus zones

a. Strengthen the planning, delivery and evaluation of integrated health services through Operations Research

IR 1.2 Capacity to Manage and Plan for PHC Services Increased

- A study of the Prescribing Habits of Doctors in three hospital was designed and implemented.
- A study of Drug Purchases by Rural Drug Vendors from Pharmecor between 1994-97 was implemented
- A study on Health System Decentralization was performed by the MOH Planning unit with technical assistance from BASICS
- Manpower and Health Facility Inventories completed
- Assessments on quality of care at first level facilities completed and results used in IMCI and regional planning activities
- Health Logistics assessment conducted and recommendations submitted to MOH

Operation research results like the decentralization study or the rural drug vendors study are being utilized for project or policy creation / implementation. The evaluation team noted that most of the studies completed to date fall under a “diagnostic” type of assessment, rather than the more generally accepted “problem solving/solution development” type of operations research studies.

b. Expansion of NGO and Private sector role in Health and Family Planning

Service Delivery

Recommendation:

Based on the policy of the Government of the State of Eritrea to phase out all expatriate NGO assistance and to require all local NGOs to provide their own resources without outside help, the NGO grant activity should be eliminated from the EHP Project.

c. Health and Family Planning Education (IEC)

IR 1, 2, and 3.

- An IEC Policy was drafted and included into the National Primary Health Care Policy Guidelines Document
- A needs analysis for IEC training was conducted and recommendations accepted by the MOH
- A 5 year Plan of Action for IEC was drafted and submitted to MOH
- IEC equipment including training equipment was purchased
- TA and on-the-job training was provided to three MOH trainers on practical approaches and training techniques
- Development of curriculum for training health workers, including performance oriented skills training
- Design, editing, production and dissemination of a new MOH newsletter - *Health Focus*
- In collaboration with UNFPA and NUEYS "Artists Against AIDS" activity launched FP/RH IEC materials (books, flip charts, etc.) distributed. Materials were written in two languages
- IDD IEC Strategy workshop completed
- FP/RH IEC strategy drafted and ready for implementation in 1998
- Video on causes of maternal mortality produced and used in training health workers
- Micronutrient campaign (communication strategies) designed
- Vitamin A supplementation added to NIDS for under 5s and post partum women
- IEC coordination committee established

Recommendation:

- World Vision IEC activities with substantial support from Canadian CIDA have been canceled. The continuation plan should consider and include any essential activities which have fallen out, due to this cancellation.

d. National Laboratory Systems

IR 3. Quality of Services Improved

- Central laboratory equipment and repairs are complete
- Support by Pathologists Overseas (training, equipment) provided

As mentioned in the health facilities section, only the central lab facilities have been repaired and most of the equipment is in place. Activities for this output are slightly delayed.

e. Commodities

IR 3. Quality of Services Improved

- 140 solar refrigerators, 30 vaccine kits, 4 maternity kits, 22 MCH kits and 7 pediatric kits, along with 10 vehicles for the health centers and 18 motorbikes for health stations were procured through a UNICEF grant (not directly part of the EHP Project)
- 1997 contraceptives procured
- 1996 condoms procured

D. Management and Finance

1- Management

a. USAID PHC Staffing

See Figure 4.

b. Overall Management structure for the EHP Project

Presently, the EHP Project is managed well and there is sufficient staff in the mission to manage and oversee the project. A three member IO nucleus Team (see chart above) and a full time MOH counterpart oversee the day to day project operations. Cooperating agencies work with appropriate MOH departments on technical matters.

In the past, however, the lack of PHC staff in the Mission contributed to some of the implementation difficulties during the first year and half. There was no PHC backstop FTE position in the Mission, which then relied on REDSO/ESA and the Global PHN Center for program development and short term coverage. Real continuity of PHC staff had not materialized prior to June 1996.

In addition to the absence of the PHC staff in the Mission, MOH has also gone through a long reorganization process in which top officials were moved to other responsibilities.. The changes

and lack of continuity on both sides has contributed to delays in project implementation.

3. USAID and MOH coordination

Overall, there is a good working relationship between USAID and MOH. The presence of a person specifically assigned by the MOH as the EHP Project Manager has provided significantly improved coordination.

In order to improve communication, the Mission developed standard operating procedures. And as a result, coordination and communication between the MOH and Cooperating Agencies significantly improved. For example, in the past, CAs contacted MOH on their own in an ad hoc manner, sometimes without USAID knowledge. Now that the procedures are in place, all parties coordinate effectively.

Coordination was tested when other offices of USAID or MOH proposed activities not necessarily covered in the EHP scope (e.g., orthopedic training). While such activities may be worthwhile, they required additional resources and effort. The level of coordination and focus has improved considerably during the last year.

CA coordination with the MOH

In general, CAs work with the technical people in the MOH to facilitate program implementation. USAID relies on MOH's EHP Project manager, who is the counterpart directly responsible for all implementation processes and dialogue with the Directors General and the Minister, to verify that relations/activities are on track. Also, CAs work with zonal administrators, so far, the relationship has not been as direct as some of the zonal administrators would like it to be. Given the decentralization currently underway, it is essential that the coordination with the zones be improved.

The current Minister has a good grasp of activities and has a vision for primary health care (e.g., nurse training, quality assurance, human capacity building, etc.).

2. Finance

Financial Status

EHP Project commitments and expenditures fall slightly short of the levels projected during project design. It was estimated that by September 30, 1997 expenditures would reach approximately \$10.8 million. In actual terms, current expenditures are \$3.4 million (which excludes \$6.9 million commitments made through September 1998) (See Tables for details.) This discrepancy is partly explained by the slow start of project activities during the first 18 months and additional non-EHP funds -- field support and OYB transfers -- which complemented the project activities and absorbed some of the project costs.

In terms of the current obligations schedule, the project is on target, obligating \$12.56 by the end

of September 30, 1997 (Year 3). Significant commitments have been made to date (\$6.9 million), and USAID has come to a formal agreement with the MOH on how this will be committed. Project expenditures are well behind schedule. The slow “burn rate” is attributed to delays experienced in project implementation and the limited absorptive capacity.

Financial actions related to timeliness are and have been the most difficult aspect of the project implementation. Both USAID and MOH have stringent financial procedures which have caused delays in all significant procurement.

In USAID/Eritrea, as a result of a lack of full time Contracting Officer and Controller, the mission relies on REDSO in Nairobi and Addis (USAID/Ethiopia) for all major financial and procurement actions. The time-consuming procedures of these transactions are one of the frustrations voiced by the MOH officials interviewed. In addition to the long time it takes to make transactions, the threshold level for USAID procurement has also been a bottleneck. For example, all major procurements exceeding \$50,000 required additional approvals.

In addition to USAID/Eritrea restrictions, GSE has its own limiting procurement rules with a threshold lower than that of USAID/Eritrea's levels. For example, the MOH has a “bids” committee which controls all procurements under 10,000 Nakfa (approximately US \$1,400) and all other procurements over 18,000 Nakfa must be approved by the Ministry of Finance. For example, a purchaser (e.g., MOH Department) is required to bring three proforma invoices from three different dealers and submit them to the committee. Using cost as the main criterion, the committee then decides which of the three proformas to accept.

For all procurements above 10,000 Nakfa, figure 5 below explains the necessary steps that must be taken before any procurement goes through.

The Bids Board of the Ministry of Finance is responsible for clearing all requests for procurement submitted by all government agencies. Therefore, the process from the beginning of bid invitation to actual procurement may take a long time. For repair and construction work, the MOH, through its own bids committee, is authorized to spend a much higher threshold of up to 100,000 Nakfa.

Recommendation:

It is important that USAID and MOH work together to plan ahead for any major procurements in order to have time to obtain potential waivers. In addition, USAID and MOH should revisit the issue of reimbursement of funds. MOH indicated difficulties in obtaining advances from USAID and the difficulties of obtaining reimbursement. USAID and MOH need to review the procedures and processes together and plan accordingly. The option would be to devise a procurement plan for a specific period of time.

Table 1 - ERITREA HEALTH AND POPULATION PROGRAM BUDGET OVERVIEW (1994-1999)

(FY94-FY97 Financial Obligations as of 30 September 1997)

BUDGET ELEMENT	<i>Obligated</i>	<i>Committed</i> ¹	<i>Expenditures to date</i> ²	<i>Balance Remaining Against Commitment</i>
Technical Assistance	3,829,000	3,290,058	1,003,143	2,286,915
Training	1,855,000	749,598	501,127	248,471
Research	352,000	57,690	49,646	8,044
Commodities	2,033,000	1,507,372	669,372	838,000
Rehabilitation &	1,696,000	196,056	190,940	5,116
Project Management	1,145,000	860,894	303,798	557,096
Evaluation	0	0	0	
Contingency	655,000	0	0	
Condom Social Marketing	1,000,000	1,000,000	702,051	297,949
TOTAL	12,565,000	7,661,668	3,420,077	4,241,591

¹ A commitment makes money that has been obligated available for expenditure. The amount is tied specifically to a contract, cooperative agreement, grant or a Project Implementation Letter (PIL) with the Ministry of Health.

² Expenditures are only against those monies which have been committed.

³ These monies are uncommitted and are available to be committed or assigned to a specific activity.

c. Other Donor Relationships

In addition to USAID's support in the health sector, there are number of other agencies with health activities in Eritrea. These agencies include: UNICEF, WHO, and UNFPA; World Bank; Africare; Save the Children-UK; GTZ; Norwegian Church Aid; and Italian Aid. Separate from the EHP Project budget, both UNICEF and Africare received grants to support health delivery systems, mainly for zones outside the EHP Project focus area and for activities outside USAID's normal scope of work.

UNICEF, with funding from USAID, has worked to strengthen the provision of immunization services and Vitamin A and iron deficiency interventions. Also through USAID funding, UNICEF provided equipment, supplies, and Technical Assistance to the salt factories in Masawa and Assab, which are now iodizing all salt sold for human consumption. In addition, four health stations have been constructed, and 140 solar refrigerators, 30 vaccine kits, 4 maternity kits, 22 MCH kits, and 7 pediatric kits have been procured.

USAID central support also complements the EHP Project. Most notably, in 1995, the Demographic and Health Survey (DHS) was conducted through a combination of field support and EHP Project funding. The Environmental Health Project is working on the development of "National Malaria Stratification as the Basis for a Prevention Strategy."

So far, the most significant leveraging of other donor resources was the important collaboration between UNFPA and SEATS in building the capabilities and services of the National Union of Eritrean Youth and Students. In addition, a grant to UNICEF has strengthened UNICEF's ability to assist the MOH at the national level beyond the EHP Project's focus zones. UNFPA has also procured condoms for the Eritrean Condom Social Marketing activity.

Another important activity which leveraged additional outside funds involved providing resources from the EHP to Pathologists Overseas (PO). This US-based PVO contributed significant funding itself and provided assistance in the rehabilitation of laboratories and the training of lab technicians. Through the provision of volunteer experts, PO was able to significantly leverage USAID's small grant.

In order to build synergy and avoid duplication among various donors, the MOH is taking a lead role on donor coordination. For instance, there are working groups built around some specific technical areas such as Safe Motherhood and IEC, which could function better with more coordination. The MOH, and especially the Planning Department, may need assistance (or donor cooperation, at minimum) to develop broader joint planning of donor activities.

Recommendation:

- MOH may wish to strengthen donor collaboration. Joint planning is essential for effective

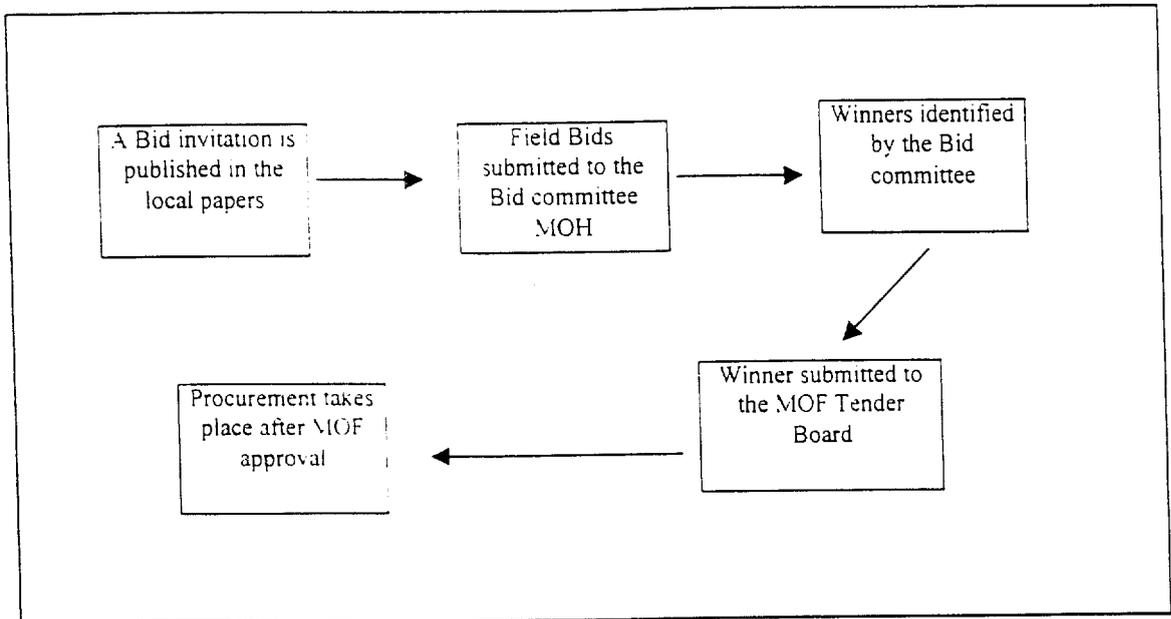


Figure 5. Bid Procedure

collaboration. By reviewing the "big picture" of all health sector activities, an overall plan should be developed which will allow complementarity and synergy among donor programs.

IV. Project Impact and Sustainability

There are very few indicators of impact due to the lack of appropriate health statistics. Baseline values are available from the 1995 DHS. Only a new DHS, the adequate functioning of the HMIS, or focused surveys such as the National Census to be done in 1998, can provide estimates of impact for the future. It is the opinion of MOH officials that a two year time span is too brief for the project activities to have any significant impact. The evaluation team feels that the inputs and TA have been appropriate and will likely provide some measurable impact by the time of the next DHS.

Institutional sustainability, an EHP Project objective, depends on the capability of the MOH to effectively plan and budget for more efficient utilization of material, financial and manpower resources. Another objective, financial sustainability, depends on recurrent costs and the MOH's ability and commitment to covering these costs. The MOH has made significant progress in cost sharing with 1996 estimate of 14% recovered revenue on recurrent expenditures⁷.

Systems development, training, and managerial capacity building in the focus zones and MOH central departments contribute to the overall sustainability of health services.

Strategic planning capability has improved and zonal action plans have already been produced. Similarly, other inputs toward sustainability of health services include the development of National Primary Health Care Policy, long term participant training conducted to date, HMIS and IEC units created within the MOH, upgrading the logistics system for drug and medical supplies, and an improved national laboratory system.

Current MOH Needs and Long-Term Sustainability

MOH made sustainability one of its highest priorities. This commitment, coupled with EHP's focus to capacity building, presents a tremendous opportunity to achieve MOH's sustainability goals. Among MOH's approach to sustainability is to build a cadre of health personnel at all levels. However, officials also cited the need for coverage in health facilities while some health personnel (e.g., doctors, nurses, and health assistants) are attending training inside or outside the country. This issue needs to be addressed through a comprehensive training schedule.

CA Technical Assistance and Long-Term Sustainability

Almost all CAs have included sustainability plans in their scopes of work. However, it is too early to tell exactly how much of the TA they would be able to transfer by the end of their contract or cooperative agreement.

It is noteworthy that each CA has specific plans and/or a commitment to sustainability. For example, PSI plans to provide TA to NUEYS and ESMG to improve their institutional capacity by training core management and administrative personnel in management, strategic planning, sales and marketing, financial management, accounting/budgeting, contract negotiation, MIS, and IEC. This type of TA transfer is crucial for the continuation of social marketing activities and institutional sustainability of both organizations.

The MOH has already taken steps toward sustainability. For example, it is testing a cost recovery initiative in two zones, working to encourage communities to pay for the services of community health agents (CHAs and TBAs) and traditional birth attendants. The MOH, in turn, will provide some basic training to the CHAs and TBAs and birthing kits for the latter. This model, if effective, would provide interesting lessons for the other zones and take important steps toward sustainability, especially at the subzone level.

V. General Recommendations

- Give higher priority and increase the proportion of resources for capacity building, through both long term and short term training, during the remainder of the project.
-
- Extend the current EHP Project end date from January 1999 to the end of 2001 to match the planned life of the investment objective.
-
- USAID and MOH should develop and adopt a continuation plan, in support of the investment objective for the period January 1998 to 2001. They should determine priorities, activities, a workplan and time schedule, and identify realistic mechanisms for implementing the plan. The workplan should include an "umbrella" implementation schedule as well as individual workplans for each funding mechanism, as appropriate. The current CAs should realign their workplans to fit into the continuation plan.
- Conduct formal, periodic reviews at the representative and ministerial levels, to assess progress, results, and overall direction of the EHP. This is in addition to the current technical collaboration between the USAID investment objective team and the MOH technical departments.
- The remaining activities should focus on the accelerated implementation at the zonal level in support of improved service delivery.
- Facilitate the supervision, monitoring and evaluation of zonal action plans during the life of the EHP Project.
- Immediate action should be taken to ensure that the health finance results of the EHP

Project are achieved. The mechanism for achieving these objectives should be revisited.

- Immediate action should be taken to ensure that a quality, state-of-the-art software program is in place to support the HMIS.

Next Steps:

The most important next step is to organize a forum to prepare a "joint" continuation plan for the EHP Project. This should include the necessary preparations for the phase-out of some of the current funding mechanisms; the completion of all activities in current delivery orders and contracts; and the decisions about possible additional funding mechanisms, levels of effort, and length of agreements. The continuation plan should include clear objectives, an overall implementation plan for all activities, and clear statements of how the activities will support the investment objective and its intermediate results. It is at this time that indicators could be reviewed, MOH input sought, and appropriate revisions made.

VII. Appendices

A. Persons Contacted

B. Documents Reviewed

C. Scope of Work

D. Maps

E. Cooperating Agency Notes

Appendix A: Persons Contacted

Dr. Ghirmay Andemichael, SEATS Project Officer
Glenn Anders, Former USAID/Eritrea Representative
Ms. Astier Araya, USAID Long Term Training Specialist
Dr. Kesete Araya, Gash-Barka Medical Director
Mr. Berhane, Embaderho Health Station
Dr. Berhane Debeu, Southern Zone Medical Director
Pam Delargy, UNFPA
Mr. Yohannes Embaye, Director General Pharmaceutical Services
Tera Emny, Health Station Mingesteab
Mr. Berhane G-Tinsae, Director General Medical Services
Mr. Semere Gebregiorgis, OMNI Project Officer
Genet Gebrehiwet, Tera Emny Health Station
Yohannes Ghebrat, USAID/Eritrea SO Team
Greziher, Debarewa Health Center
Mr. Eyasu Hadgu, EHP Project Manager
Dr. Bisrat Hagos, Human Resources, Research Division MOH
Ms. Berhana Haile, HMIS MOH
Mr. Debessai Haile, Project Officer UNICEF
Pam Delargy, UNFPA
Ms. Anne Hirschey, USAID/Eritrea SO Team
Mr. Tewolde Johannes, Chief Planning and Evaluation MOH
Ms. Rebecca Kohler, OMNI IEC Specialist
Dr. Goiton Mebrahtu, Director CDC
Dr. Saba Mebrahtu, Project Officer UNICEF
Mr. Saleh Meky, GSE/Ministry of Health
Ms. Melinda Ojermark, SEATS Africa Advisor
Dr. Nosa Orobato, BASICS Advisor
Ms. Judith Robb-McCord, USAID/Eritrea SO Team Leader
Dr. Melles Sayoum, Central Lab Director
Dr. Mineab Sebhatu, Central Zone Medical Director
Muhiaddin Shengeb, NUEYS
Dr. Iyob Tecele, MOH liason with the World Bank
Ms. Mesghina Teclu, SEATS NUEYS
Dr. Asafaw Tekeste, College of Health Sciences
Ms. Mesgina Tekleab, Pharmacor
Dr. Weldu, Adi Ugri Hospital Genet Gebrehiwet
Ghirmai Woreade, Southern Zone Malaria Staffer
Dr. Efren Zeweldi, Edaga Hamus Mini Hospital

Appendix B: Documents Reviewed

- A Proposal for an Investment Partnership between the USAID and the State of Eritrea, March 1997
- Agreement between the Eritrean Ministry of Health and the National Union of Eritrea Youth and Students and Population
- Achieving USI in Eritrea: The Final Step
- BASICS Annual Program Report. Eritrea. FY 96
- BASICS Delivery Order, September 29, 1995
- BASICS Eritrea Health and Population Project. Summary Report and Recommendations, Calendar Year 1995
- BASICS FY 97 Annual Program Report and FY 98 Workplan
- BASICS Quarterly Reports
- BASICS Scope of Work (Delivery Order No. 17)
- BASICS. Status as of May 15, 1997
- Communication Campaign to Promote the Use of Micronutrients in Eritrea
- Cooperative Agreement Between USAID/Ethiopia and PSI
- DHS
- Eritrea Health and Population (EHP) Project Number 661-0006 Project Paper
- Eritrean Social Marketing Group. Quarterly Report, November 1997
- Every Opportunity: Eritrea Family Planning Service Delivery Subproject. Three-Year SEATS II Subproject
- Family Planning Service Expansion and Technical Support (SEATS) Eritrea. Program Description 1997
- IDD Communication Campaign Design Workshop by OMNI Eritrea, November 1997
- Investment Objective One. Primary Health Care Team Charter, November 1997
- Micronutrient Formative Research. Findings from all Target Groups, November 1997
- Micronutrient Interventions Training Workshop. Ministry of Health and OMNI / Eritrea, November 1997
- Mission Order Contractor and Grantee Standard Operating Procedures
- MOH-USAID Investment Objective Partnership, Status as of November 1997
- MOH-USAID Investment Objective Review. May 16, 1997. Ambassador Hotel, Asmara
- National Malaria Stratification and Vector Distribution and Behavior Assessment as Basis for a Prevention / Control Strategy. Project Proposal 1998-2000. Health Project Profile
- OMNI Quarterly Reports
- Opportunities for Micronutrient Interventions (OMNI)/Eritrea Accomplishments, January-November 1997
- Opportunities for Micronutrient Interventions (OMNI) Eritrea Health & Population Project

Quarterly Narrative Report, July-September 1997

- Opportunities for Micronutrient Interventions (OMNI) Statement of Work (PIO/T No. 661-0006-A-00-6502-00), October 16, 1996
- Parameter Cable 96 State 107495
- PSI Cooperative Agreement, No. 661-0006-A-00-6502-00
- PSI/ESMG Quarterly Reports
- SEATS II Eritrea Scope of Work
- SEATS Quarterly Reports
- SEATS Quarterly Workplan Monitoring (July 1997- September 1997- MOH and NUYES)
- Three Year SEATS Subproject
- Tripartite Agreement (PSI, MOH and NUYES)
- USAID Direct Assistance to Ministry of Health Project Implementation Letters (PIL) Performance Period October 1994-September 1999
- USAID/Eritrea Grant to UNICEF. Primary Health Care Rehabilitation and Universal Salt Iodization, June 1997

Appendix C: Scope of Work

*Eritrean Health and Population Project
661-0006
October 1994 - December 1999*

*Mid-term Evaluation
Scope of Work*

BACKGROUND

The Eritrean Health and Population Project is a five year (1994-1999) \$15 million project designed to achieve two major, interrelated outputs which address the principal constraints to providing high quality basic health services: (1) strengthening the public health delivery system to make it capable of delivering basic health and family planning services; and (2) increasing demand for, access to, and the quality of an integrated package of basic health and family planning services, especially by women and children in the four focus provinces, now the three zones. The project was designed to lay the necessary foundations and build capacity for a sustainable national health care delivery system.

As defined in this context, basic health services refer to EPI, ORT, family planning, pre and post natal care, HIV/AIDS/STD control, nutrition, and ARI and malaria treatment and control. The terms, "health systems" and "health delivery systems," as used in reference to the EHP Project, subsumes both health and family planning.

The EHP Project was designed to focus both at the national and provincial levels of the health system. The four contiguous central provinces of Asmara, Akele Guzai, Hamasien, and Senhit were selected as focus areas for project implementation for four principal reasons: (1) the four central provinces are in critical need of improved health services; (2) the central provinces are the optimal place to model an improved and integrated health system for expansion to the rest of the country, while at the same time reaching the largest number of people with at least minimal health and family planning services; (3) the outlying provinces are already being served by a number of other donors; and (4) the selection of provinces contiguous to Asmara would facilitate USAID project management and oversight of project activities.⁴

In recognition of the MOH's limited absorptive capacity and lack of established systems, the project was designed to be implemented in two phases over the five year Life of Project (LOP). During the first two years of the project (1994-1996), Phase I was designed to focus on those areas for which absorptive capacity is considered adequate and for which sufficient information exists to proceed in a cost effective manner. The focus was intended to be on those aspects of systems building which will lay foundations for rational systems expansion during the second phase. The first phase was to lead to a greater absorptive capacity by the health system during the latter half of the project, as the systems developed or refined should be poised for expansion in the target provinces.

Project inputs consist of support for MOH strategic planning and budgeting; development of a

In 1995 the Eritrean National Assembly designed a new administrative structure for the country changing nine provinces to six zones. The EHP Project is based on the provincial administrative structure while the PHC Investment Objective is based on the zonal administrative structure.

demographic and health system information base, as well as a health management information system (HMIS); support for a logistical system for drug and medical supply procurement and distribution; development of a supervision program; health services training (both long and short term); evaluation of options for improving the physical infrastructure of the health facilities; improvements and integration of basic health services; expansion of NGO and private sector roles in service delivery; health and family planning education (IEC); operations research; and commodities procurement.

It is important to note that USAID/Eritrea's Investment Partnership with the Ministry of Health was approved in Washington in March 1997. The Investment Partnership outlines the strategic investment objective for primary health care which lays the framework for strategic interventions in the Eritrean health sector. This document is the product of intensive work with the Ministry of Health and other partners in the Eritrean health sector. The Eritrean Health and Population Project paper was a major source in the development of the PHC investment objective framework.

ARTICLE I -- TITLE

Eritrean Health and Population Project -- 661-0006

ARTICLE II - OBJECTIVE

The objective of this work order is to conduct a mid-term evaluation of the Eritrean Health and Population Project.

The project paper calls for a mid-term evaluation in year three of the project. The evaluation is to consist of a review of all data available from periodic reports, site visits, evaluation and assessment reports for the various components of the project, and if possible, short term focused surveys conducted during the evaluation period. It will also evaluate the performance of the contractors and cooperating agencies in managing the implementation of the project.

ARTICLE III - STATEMENT OF WORK

The following represent general key concerns and evaluation questions to be addressed by the contractor. These issues and concerns are divided into six categories: (1) the relationship between the EHP Project and the new Primary Health Care Strategic Investment Plan between USAID/Eritrea and the Ministry of Health; (2) overall project performance and impact; (3) the relationship between the EHP Project and scopes of work for BASICS, SEATS, OMNI and PSI; (4) management and finance; (5) general issues and (6) issues regarding sustainability of inputs and results.

1. Relationship between the EHP Project and the PHC Strategic Investment Plan

After reviewing the EHP Project Paper and the new Primary Health Care Strategic Investment Plan, the evaluation team will respond to the following questions:

- a. Do the approach, goals, objectives and results outlined in the new PHC investment strategy complement the EHP Project? Comment on complementarity and changes between the EHP Project and the Investment Objective (IO) as identified.
- b. Discuss the MOH's perception and understanding of the EHP Project and the Investment Objective.

2. Overall Project Performance and Results

A. Project Performance

After reviewing the Eritrean Health and Population Project Paper, USAID Project Implementation Reports and other documents related to the implementation and review of the EHP Project, and meeting with relevant MOH representatives and USAID Resident Advisors, the evaluation team will answer the following:

- a. Are the overall objectives and outputs listed in the EHP Project realistic given the project's time frame and environmental constraints and opportunities?
- b. Have inputs made to the Eritrean health sector as listed under Phase I of the EHP Project enhanced the absorptive capacity of the MOH?
- c. The EHP Project was designed to be implemented in two phases. Phase I focuses on strengthening the capacity of the public health delivery system to deliver basic health and family planning services. As compared to the Project Actions described in the EHP Project Paper, review USAID technical assistance and inputs to date. Are TA and inputs made to date relevant within the context of Phase I of the EHP Project? Is overall implementation of Phase I activities on track? Roughly, what percent of activities are complete with regard to overall goals and objectives?
- d. Have constraints noted in the EHP Project been adequately addressed within the framework of USAID-funded technical assistance to the Ministry of Health?
- e. What is the status of technical assistance with respect to the transition from Phase I to Phase II? Are inputs balancing Phase I, system strengthening and Phase II, delivery of improved services? If not, what is

needed to bring assistance and inputs to the health sector more in line with this balanced approach?

- f. List, if any, major gaps in assistance made to the Eritrean health sector as originally intended by the EHP Project. What changes need to be made, if any, to fill identified gaps.

B. Project Results

- a. Section III. C of the EHP Project paper defines the goal and purpose of the project. Are inputs and technical assistance made to date supportive of the overall goal and purpose of the EHP project? Are current and planned TA and inputs supportive of the overall goal and purpose of the EHP project and the Investment Objective? If not, how can they be tailored to address the overall goal and purpose?
- b. Discuss project impact to date and appropriateness of TA and inputs for continued impact in the health sector.

3. The Relationship between the EHP Project, Scopes of Work and performance for BASICS, SEATS, OMNI and PSI

- A. Agreements have been developed with the above listed Contractors/Grantees, USAID/Eritrea and the Ministry of Health. Following review of the agreements, scopes of work, annual work plans and documents discussing achievements to date and interviews with the Resident Advisors and Program Managers, respond to the following questions:
 - a. Are the agreements, SOWs and work plans supportive of the overall mandate of the EHP Project? Are they consistent with Phase I and Phase II of the Project?
 - b. What are achievements to date and will these achievements contribute to the attainment of goals and objectives of the project? Are achievements reasonable given the time frame for implementation as well as constraints/opportunities of working in the health sector? Discuss constraints identified and approaches that could be used to alleviate their programmatic impact.
 - c. Discuss limitations Contractors/Grantees may experience in implementing their activities. Discuss constraints/limitations experienced by the MOH in working with Contractors/Grantees.

- d. Do the Contractors/Grantees respond to MOH needs and requirements within the context of the mandate of the EHP Project? Are any modifications needed?

4. Management and Finance

A. Management

- a. Discuss current PHC staffing at USAID/Eritrea. Is staffing adequate and appropriate for successful project performance? Are key personnel in place? Are staff roles clearly defined and implemented? Do staff members have the expertise and skills necessary to effectively conduct their work?
- b. What is the overall management structure for the EHP Project? What are the responsibilities of USAID and the MOH? Are management functions between USAID and the MOH clear, coordinated and shared?
- c. How well do USAID and the MOH work together to identify and resolve problems in program planning and implementation? Is the role of contractors/grantees clear?
- d. What changes, if any, need to be made to improve overall management of the EHP Project activities?

B. Finance

- a. Review EHP Project finance documents. Outline obligations by year, by component and by activity. What has been obligated to date? Are obligations on track? Where have funds been earmarked and committed? Are finances targeted to effectively implement the EHP Project activities?
- b. What is the current EHP Project pipeline? Is this higher than expected? If so, what are some explanations for the pipeline?
- c. Are expenditures among the Contractors/Grantees on track? Is spending efficient and appropriate to level of effort?
- d. Are financial actions with the MOH moving efficiently and effectively? What steps need to be taken, if any, to improve fiscal efficiency and

effectiveness on the part of USAID and/or the MOH?

5. General Issues

- a. List other donors and primary partners working in the health sector. Do USAID/Eritrea and the Ministry of Health work together to leverage resources from other donors and partners working in the health sector? Does USAID/Eritrea work to coordinate assistance with other donors and partners in the health sector?
- b. Describe the general climate in Eritrea with respect to donor assistance/investment? How does this climate enhance or detract from the success of the EHP Project?
- c. Describe the general climate in Eritrea with respect to the presence of NGOs, both local and international. What impact, positive or negative, does this have on the development of the private health sector? Who are the Ministry of Health's and USAID's primary NGO/private sector partners?

6. Sustainability of Inputs and Results

- a. Are inputs made to date appropriate to overall sustainability of health services delivery in Eritrea? Do inputs balance the immediate needs of the MOH and the long-term sustainability of program achievements?
- b. Is the technical assistance managed through the Contractors/Grantees appropriate to long-term sustainability?
- c. Are resources and TA effectively transferred to the MOH in order to enhance their capacity to deliver sustainable health care services? List positive examples and areas where this may not be the case. What changes, if any, should be made to more effectively transfer resources and TA to the MOH?
- d. Independent of USAID-funded technical assistance, what steps is the MOH taking to build their capacity and skills to more effectively manage the delivery of health services?
- e. It is expected that USAID inputs and TA will contribute to the overall sustainability of health services delivery in Eritrea. Is this realistic? Discuss.
- f. What steps has the MOH taken to build fiscal sustainability in the health sector? Have EHP Project inputs directly or indirectly supported MOH efforts in this area?

- g. Discuss areas where USAID/Eritrea could be more proactive in setting an agenda for sustainability with the MOH.

ARTICLE IV - REPORTS

The mid-term evaluation team will be responsible for, at a minimum, 1) initial meetings with relevant persons to further identify parameters for the evaluation and to clarify the scope of work, 2) interim briefing/meetings as required, and 3) final meeting to disseminate and discuss evaluation findings. At least two days prior to the conclusion of the evaluation, the team shall distribute a draft report to appropriate USAID and MOH representatives.

Following submission of the draft report a preliminary working session shall be held with USAID/Eritrea and Ministry of Health staff and other relevant persons (as identified) to review evaluation findings and recommendations. The evaluation team shall incorporate any questions or issues raised at the initial review meeting into the final report.

The team leader shall prepare and send to USAID/Eritrea ten (10) copies of a final draft report within one month after the evaluation ends. Within two weeks of receipt of USAID/Eritrea and MOH comments on draft evaluation report, the team leader will prepare fourteen (14) copies of the final evaluation report for distribution to USAID/Eritrea (8) and the Ministry of Health (6).

The final report shall include the following:

- 1) An executive summary;
- 2) The body of the report including the purpose of the evaluation, the methodology used, findings, conclusions, lessons learned and recommendations); and,
- 3) Annexes including, at a minimum:
 - a. Technical and management issues raised during the evaluation requiring greater elaboration;
 - b. A copy of the evaluation scope of work;
 - c. An annotated bibliography of the documents and reports consulted; and,
 - d. A list of persons and agencies contacted.

ARTICLE V - TEAM COMPOSITION

The basic team will be composed of five persons, one international consultant and a representative, respectively, from the Eritrean Ministry of Health, USAID/REDSO/ESA, USAID/Eritrea and USAID/G/HPN. Each focus zone will be asked to designate one staff person

to participate on the team during the site visit to that particular zone.

The international consultant will be a health and development specialist with extensive experience in USAID and bilateral programming. This person will serve as team leader and be ultimately responsible for the final report. The representative from USAID's HPN office will be a specialist in international reproductive health issues, programming and technology. The representative from REDSO ESA will be a specialist in child survival. USAID/Eritrea will designate a PHC staff person to participate on the team as will the Ministry of Health.

SCHEDULE

<u>DATE</u>	<u>ACTIVITY</u>
September 25-26	Review background materials
Nov. 16 to Dec 12	Conduct field work and draft report
Dec. 25, 1997	Finalize Report

Appendix E: Cooperating Agency Notes

This Appendix contains a brief overview of the scope of work and progress to date for the main cooperating Agencies providing technical assistance.

BASICS

BASICS is a worldwide USAID contract, awarded in October, 1993, to the Partnership for Child Health Care, Inc., a joint venture among a group of firms with long experience in public health work in developing countries. The delivery order for the EHP Project was signed in September 1995 and contained most of the EHP outputs.

The Delivery Order, Scope of Work, results so far, and the work plan for 1998 are supportive of the overall mandate of the EHP Project. The evaluation of the Phase I shows that most of the inputs carried out during 1996 and 1997, like capacity building, the HMIS, the Strategic Health Plan, Logistics, IEC, fall well within the expected activities for this phase. However, other activities (such as IMCI) were started early, mainly due to a request by the MOH. Some phase I activities were never started or have been delayed to 1998. This has been discussed earlier in the document.

The BASICS implementation plans can be divided into three periods: the "bridging period" from the time of the completion of the project paper in August 1994 to the delivery order signature in late September 1995, Phase I (September 95-September 97) and Phase II (September 97-September 98).

A number of activities during the bridging period, and Phase I were changed or postponed, largely due to the fact that the full team of three long-term advisors was not fielded until the last quarter of 1996, so the work had to be accomplished with short-term consultants.

The achievements to date directly contribute to the attainment of goals and objectives of the EHP Project. The main constraints that affected the consistency and the timing of the achievements were the delays in fielding both short term and long term advisors. Some activities, such as the quality control laboratory, could have been accomplished much earlier if the long term advisors from BASICS had been in place in a timely fashion. Another constraint was the requirement for MOH to sign off on every activity. In some instances, programmed activities did not take place because of lack of interest, or changing levels of interest, from the MOH in that particular activity (for example, cost studies).

BASICS responded to MOH needs and requirements within the context of the mandate of the EHP Project. It was noted by the Zonal Officers and other MOH officials that although the activities were satisfactory from the technical point of view, some were greatly delayed (for example, Quality Control Lab: more than a year; Central Lab: not finished yet; HMIS: not yet

complete; health financing; activities delayed). The reasons of the delays are complex with USAID, BASICS, and MOH all contributing.

SEATS (Reproductive Health/Safe Motherhood)

Working in the three focus zones (Central, Gash Barka, and Southern), SEATS contributes to the EHP in the areas of reproductive health and safe motherhood. REDSO/ESA, the MOH, and SEATS worked in close collaboration to develop a comprehensive scope of work and SEATS began activities in March 1996 when the Ministry of Health and USAID/Eritrea approved the project implementation document. Staffed by a Program Manager and Finance/Operations Officer in country, SEATS made significant progress to increase demand and knowledge of reproductive health services; expansion of service delivery in its subzones; training of MCH service providers to integrate FP/RH services; and improvement of physical infrastructure.

In many instances the delivery of furniture for health facilities was delayed, in some cases furnishings were considered redundant by the time they were delivered. Delays were primarily due to the central level MOH decision to re-review furnishings lists and samples.

Among other activities, accomplishments under SEATS include achievement of 16,600 CYPs in eighteen months through the expansion of service delivery; training 70% of service providers in clinical family planning in the subzones; and standard furnishing and clinical equipment procurement to 46 service delivery points. As part of the systems strengthening called for by the EHP, SEATS developed numerous protocols and manuals including: safe motherhood protocols, peer counselors' training curricula, and syllabi on management and integration principles.

Much of SEATS' progress builds on its collaboration with local partners and other donors. For example, a close working relationship was developed with the Ministry of Health, National Union of Eritrea Youth and Students (NUEYS), and UNFPA. SEATS ability to leverage UNFPA support to the NUEYS has been a remarkably cost effective intervention, especially in the areas of information, education and communications (IEC).

Despite the achievements, implementation has not been without its challenges. Nearly all activities required USAID and/or MOH approvals; processing of these approval requests contributed to the delay of scheduled activities. In all the zones, equipping health facilities was very slow as a result of the approval and procurement processes. Family Planning equipment shipments are still awaiting clearance at the airport.

There is a need for greater collaboration between SEATS and BASICS, especially in the areas of MIS and logistics. Both agencies are currently implementing or planning to implement MIS or IEC activities, and the two should be coordinated with the Ministry to avoid duplication.

OMNI

The MOH carried a rapid national micronutrient survey in 1994 which verified that Iodine Deficiency Disorders (IDD), Vitamin A Deficiency (VAD) and Iron Deficiency Anemia (IDA) were all widespread and significant public health problems. The Government of the State of Eritrea asked Opportunities for Micronutrient Intervention (OMNI) to assist in the virtual elimination of IDD and to undertake steps to control VAD and IDA.

The OMNI SOW and work plan indirectly support of the overall mandate of the EHP Project without direct coordination with the EHP's phases. OMNI's delivery order began in November 1996 and finishes in September 1998.

OMNI has provided effective technical assistance to the IDD Task Force for universal salt iodization to include quality assurance and control systems and improved salt production and distribution. They conducted a survey among small-scale salt producers for effective iodization and quality improvement, and developed a curriculum and agenda for training workshops for health workers and small-scale salt producers.

Many of the achievements which OMNI facilitated are found under the IEC outputs section of the main evaluation report. The achievements to date contribute to the attainment of goals and objectives of the project, especially in the IEC component. These achievements seem reasonable given the time frame of the project and the fact that the resident advisor position was filled in a timely manner. In general, the contractor has responded to MOH needs and has been flexible, while remaining focused on the original scope of work.

PSI (Population Services International)

On September 30, 1997, PSI entered into a cooperative agreement with USAID/Eritrea to carryout the Ministry of Health's policy to reduce HIV infection. Unfortunately, it took eight months before a tripartite agreement was signed in June 1997 between Population Services International (PSI), MOH, and NUEYS to begin the actual implementation of the Condom Social Marketing in Eritrea.

In this agreement, USAID will provide funding and NUEYS will "act as partner with PSI in the development of an Eritrean social marketing group (ESMG)" and in the overall project implementation. In addition, PSI will establish a social marketing unit within NUEYS. MOH will take overall responsibility and will oversee of the AIDS prevention activities, including the social marketing program.

If all goes well and as planned, this is a very important activity that could lead to sustainability of a social marketing program to combat HIV/AIDS and other sexually transmitted diseases. This will be especially true, if the creation of the social marketing unit within NUEYS and ESGM builds sufficient capacity to continue the social marketing activity beyond the life of the project.