EVALUATION OF THE ESSENTIAL SERVICES FOR HEALTH IN ETHIOPIA (ESHE) PROGRAM

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by

Gerald Moore
Mitik Beyene
Edward Green
Gary Leinen
Mark Robbins

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Population Technical Assistance Project
1611 North Kent Street, Suite 508
Arlington, VA 22209 USA
Phone: 703/247-8630
Fax: 703/247-8640
E-mail: poptech@bhm.com

The observations, conclusions, and recommendations set forth in this document are those of the authors alone and do not represent the views or opinions of POPTECH, BHM International, The Futures Group International, or the staffs of these organizations.

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ACKNOWLEDGEMENTS

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The extensive list of contacts included in this report attests to the high level of cooperation and support provided to the evaluation team.

The team wishes the USAID Mission in Ethiopia, the Government of Ethiopia, and all partner agencies great success with the ESHE Program/Project and the further improvement of primary and preventive health care services which will greatly contribute to the better health of the population.

LIST OF ACRONYMS

ACU	AIDS Control Unit
AIDS	acquired immunodeficiency syndrome
AIDSCAP	AIDS Control and Prevention Project
ANC	antenatal care
AVSC	AVSC International
BASICS	Basic Support for Institutionalizing Child Survival project
BESO	Basic Education System Overhaul
CA	Cooperating Agency
CBD	community-based distribution
CBDA	community-based distribution agent
CBRH	community-based reproductive health
CBRHA	community-based reproductive health agent
CHA	community health agent
CHC	community health clinic
CHW	community health worker
COFAP	Consortium of Family Planning
COP	Chief of Party
CPR	contraceptive prevalence rate
CSM	condom social marketing
CYP	couple year of protection
DDK	disposable delivery kit
DKT	Denke Kestet Letena [an essential element for health]
DO	delivery order
DTC	Demographic Training Center
EECMY	Ethiopian Evangelical Church Mekane Yesus'
EET	ESHE Evaluation Team
EFO	Ethiopian Framework of Objectives
EOP	end of project
EPI	Expanded Program on Immunization
ESC	ESHE Steering Committee
ESHE	Essential Services for Health in Ethiopia program/project
ESMP	Ethiopian Social Marketing Program
ETWG	ESHE Technical Working Group
FHD	Family Health Department
FGAE	Family Guidance Association of Ethiopia
FHI	Family Health International
FLE	Family Life Education
FPLM	Family Planning Logistics and Management project

FSR	Field Support Resources
GFDRE	Government of the Federal Democratic Republic of Ethiopia
FY	Fiscal Year
HC	health center
HCF	health care financing
HIV	human immunodeficiency virus
HMIS	Health Management Information System
HSDP	Health Sector Development Program
IR	Intermediate Results
IEC	information, education, and communication
IMCI	Integrated Management of Childhood Illness
JICA	Japan International Cooperating Agency (?)
KAP	knowledge, attitudes, and practices
LIDE	List of Drugs for Ethiopia
LOP	life of project
MAARD	Modified Acquisition and Assistance Request Document
MCH	maternal and child health
M&E	monitoring and evaluation
MEEC	Ministry of External Economic Cooperation
MEDAC	Ministry of Economic Development and Cooperation
ML/LA	minilaparotomy under local anesthesia
MOH	Ministry of Health
MSI-E	Marie Stopes International - Ethiopia
NGO	nongovernmental organization
NPA	non-project assistance
NOP	National Office of Population (Ethiopia)
NORAD	Norweigan Agency for Development Cooperation
ODA	Overseas Development Administration (United Kingdom)
OR	operations research
PAAD	Program Association Approval Document
PI	performance indicators
PMO	Prime Minister's Office
PP	Project Paper
PPHC	Primary and Preventive Health Care
PSI	Population Services International
PY	project year (BASICS)
RFP	request for proposal
RIF	Regional Incentive Fund
RP	Results Package
ROP	Regional Office of Population
RHB	Regional Health Bureau
RTC	Regional Training Center

SDP	service delivery point
SIDA	Swedish International Development Authority
SNNRP	Southern Nations, Nationalities and Peoples Region
SOW	Scope of Work
STAC	Support to AIDS Control project
STD	sexually transmitted diseases
STI	sexually transmitted infection
TA	technical assistance
TBA	traditional birth attendant
TC	Technical Committee
TFR	total fertility rate
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
USAID/E	USAID Mission in Ethiopia
USAID/G	USAID/Global Bureau
VSC	voluntary surgical contraception
WHO	World Health Organization

EXECUTIVE SUMMARY

Background

Ethiopia has the third lowest per capita income in the world (per data from the World Bank) and low per capita health expenditures. Despite an increase in health sector spending financed by the government (from around 3.1 percent to 5.8 percent in Fiscal Year 1994)[1], expenditure levels remain among the lowest in the world. Although close to half the population have access to health facilities, many government resources are underutilized and health services are underfunded.

Roughly half of the Ethiopian population live below or near the poverty line[1]. Their very low health status is only one symptom of a developing economy fraught with unbalanced resource allocations. Average life expectancy at birth is 47 years for males and 50 years for females. Morbidity and mortality statistics reveal a population still very vulnerable to infections and diseases, and the introduction of HIV/AIDS poses further challenges to a population already confronting high infant and maternal mortality rates.

The Essential Services for Health in Ethiopia Program/Project

The Essential Services for Health in Ethiopia (ESHE) Program/Project is an ambitious intervention of USAID/Ethiopia (USAID/E) and its partners, the Government of the Federal Democratic Republic of Ethiopia (GFDRE) and implementing agencies, to address the problem of low health status by improving the level of service of and access to primary and preventive health care in Ethiopia. Initiated by the governments of the United States and Ethiopia in August 1995, ESHE was to be implemented over a seven-year period (1995-2002). ESHE's Strategic Objective (SO) is *Increased use of Primary and Preventive Health Care (PPHC) Services*. This SO is supported by increased resources dedicated to PPHC, health policy reform, strengthening of family planning, STI/HIV/AIDS prevention and control, and rural health care delivery.

ESHE is divided into two components: program and project. The program component calls for the release by USAID of non-project assistance (NPA) in the amount of $30 million over the life of the project, dispersed in five tranches, and paid externally for debt relief. These funds support health policy reforms:

[1] Ibid.

- Increases in the share of the national budget for health,
- Increased resource allocation for PPHC,
- Elaboration and implementation of a health care financing policy,
- Dialogue with the GFDRE for the promulgation of the STI/HIV/AIDS policy,
- Continued availability of essential drugs,
- Accessibility and availability of family planning services, and
- An increase in the private sector share of health care.

The ESHE project component had a total budget of $40 million over the life of the project, of which $26.5 million were bilateral funds and $13.5 were "unilateral" funds. Because the GFDRE perceived a lack of influence over the use of unilateral funds, the amount of $13.5 million was omitted from the final signed agreement on the express wish of the GFDRE. Thus, the total amount of the ESHE project signed by the GFDRE was $56.5 million. Over and above this amount, additional funds from field support resources (FSR) were to be made available; however, these funds and their use are outside the scope of this evaluation.

As of December 1997, 11 percent of the $26.5 million bilateral funds and 20 percent of the $13.5 million "unilateral" funds had been expended. The first tranche of NPA funds of $7.5 million had been transferred to the GFDRE, the second tranche was in the process of negotiation, and conditions for the release of the third tranche had been established.

Constraints and Challenges

Overall, the ESHE Evaluation Team (EET) finds that the ESHE program/project is supporting national health policy as expressed in the Health Sector Development Program (HSDP) and contributing to ESHE's Strategic Objective of increased use of primary and preventive health services including family planning.

ESHE, as presently designed and with relatively minor modifications, is likely to have a favorable, long-term impact on the health status of the population of Ethiopia through its increased budgetary allocations to health and particularly to PPHC; more effective management and planning; and direct support to increased access and use of essential services, such as immunization, maternal/child health (MCH)/family planning (FP), STI/HIV/AIDS control, and curative services. The prospects are

favorable for ESHE to build on advances in improved services at the central level and in focal project areas and to have such advances replicated in other regions.

Progress has been made in family planning, including condom social marketing, through effective NGO programs, and in PPHC enhancement through capacity building and systems development in the project focus area, the Southern Nations, Nationalities and Peoples Region (SNNPR).

The "Major Findings, Conclusions, and Recommendations" section of this report summarizes EET's work. However, the EET also notes the following general observations:

Health Care Financing

Though studies and capacity building have been initiated at the central level in budgeting, planning, financial management, and health care financing, progress in health care financing has been constrained by the late start-up of the project and by delays in establishing formal counterpart structures, including the set up and staffing of the Health Care Financing Secretariat.

"Ownership"

The EET finds that insufficient "ownership" of the ESHE program/project by the GFDRE and in particular by the Ministry of Health (MOH) exists at the central level. However, this does not appear to be an issue in the main regional focal area, the SNNPR. The situation at the central level may have arisen because of communication problems emanating from all sides. The EET does not attribute the causes exclusively to any one partner; however, it seems that GFDRE departments are not receiving enough information on USAID/E's operational methods and funding mechanisms, or information is not well understood.

These communication problems are leading to a feeling of those departments being "left out" of the project's planning and implementation and could be a reason for the lack of coordination and cooperation between the project partners. For example, the changes and reductions made by USAID/E in the agreed project plan of activities for central-level support (August 1996) appear to have taken the MOH by surprise.

Another factor contributing to the lack of ownership may be USAID's system of project funding. Because of present USAID policies, it is difficult to pass bilateral funds directly through the GFDRE; substantial additional investment in management and accounting capacity would be needed to facilitate this process. Although progress is being made by ESHE to strengthen the relevant systems at the central and regional levels, there does not appear to be a more cost-effective option for the immediate future than using technical assistance contractors or other mechanisms to facilitate and account for the flow of funds.

ESHE should continue its program of training and capacity building at the MOH and regional health bureau levels and increase efforts to strengthen appropriate GFDRE systems, structures, and skills so that the government can assume greater responsibility for project management. In this process, increased efforts should be made to create more transparency and mutual ownership of the project.

Technical Assistance

Health care financing is a major support area of technical assistance (TA) of the ESHE project, is essential to the HSDP, and should continue to receive close support. However, several MOH departments expressed a need for other capacity-building activities at the central level, such as information, education, and communication (IEC) activities and supplies management (essential drugs and family planning commodities). These are two essential components of the HSDP and areas of intervention that will directly affect ESHE's Strategic Objective of increasing use of health services. This technical assistance could be planned for future ESHE project phases.

Short-term technical assistance could be considered until post-September 1998 project activities are formulated. This expansion of central-level TA may require reforming Results Package 1 (RP1), its Intermediate Results (IR), and Performance Indicators (PI). Suggestions for this expansion are in Chapters 4 and 10.

CA Technical Advisors

ESHE could have greater impact and improve communications and coordination, particularly at the central level, if the technical advisors of the project's Cooperating Agencies (CA) were located within the MOH and had well-defined terms of reference and job responsibilities agreed upon by all parties?USAID/E, the MOH, and the CAs. For maximum impact, the Basic Support for Institutionalizing Child Survival project's (BASICS) health care financing (HCF) advisor should be located in the Ministry of Health Projects and Planning Department with close links to the Health Services and Training Department.

SNNPR Focus

In the Southern Nations, Nationalities and Peoples Region (SNNPR), project progress has been more visible and the Regional Health Bureau has expressed its general satisfaction with achievements. However, TA for capacity building and systems strengthening in the SNNPR will be required beyond the life of the current contract. The new project Scope of Work (SOW) should reflect the importance of STI/HIV/AIDS prevention and FP in ESHE's objectives.

ESHE's Strategic Objective

The EET believes that ESHE's Strategic Objective, as originally formulated, is still valid, supports well the HSDP, and should not be changed. However, PIs for some components and Intermediate Results

(IR) relating to ESHE's Results Packages (RP) may be too numerous and too general, and it may be difficult to manage and measure progress adequately. Recommendations and suggestions have been made for their revision where appropriate. Such revisions should lead to better focusing and tracking of activities, management, and performance monitoring.

MAJOR FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

1. COMPONENT: INCREASED RESOURCES DEDICATED TO PRIMARY AND PREVENTIVE HEALTH CARE (RP1)

Findings: Within the conditions for disbursement of the second tranche of funds, two call for enactment of legislation by the Ethiopian Parliament to approve (1) the national health care financing policy and (2) public advertisement, sale, and distribution of contraceptives.

Conclusions: Despite the good faith efforts of USAID and the relevant government ministries, the outcome of this component depends on the action of the Council of Ministers and the Parliament. Even if their objectives are desirable, conditions that are set too high and that cannot be directly influenced or controlled by project partners may not be reasonable, because they may impede the disbursement of non-project assistance funds.

Recommendation:

1. Conditionalities for tranches four and five, the last planned NPA disbursements, should be carefully negotiated to avoid creating agreements that go beyond the abilities of USAID and the government ministries on ESHE's Steering Committee to influence directly. (p.18)

Findings: The goal of IR1.3 is "Increased capacity for resource management at central and regional levels." Continued central-level TA will be required by the MOH beyond the September 1998 expiration of the present CA contract with BASICS and over the life of project to institute and implement an effective health care financing policy, address budget reforms, and assist in the decentralization process.

Conclusions: The EET, conscious of what has been achieved in the area of central management capacity strengthening, of the perceived management and capacity needs in the MOH, and of the limited time left under the present BASICS contract, recommends that activities under this sub-component be focused on health care financing activities. In addition, the SOW for the follow-on project should be developed and the request for proposal (RFP) issued as soon as possible to prevent a lapse in TA to the MOH.

Recommendations:

2. BASICS should focus on two specific managerial strengthening activities for the central MOH: (1) assistance to the MOH in planning the implementation of an effective Health Care Financing Policy and (2) assistance to the MOH to initiate reform of the current MOH budget process as part of the government's civil service reform effort. (p.24)

3. USAID/Ethiopia should develop a SOW for the follow-on project to BASICS and issue the RFP as soon as possible. (p.25)

2. COMPONENT: INCREASED ACCESS TO AND DEMAND FOR MODERN CONTRACEPTIVES IN FOCUS AREAS (RP2)

Family Planning in the Private Sector

Findings: ESHE's RP2 strategies to achieve SO2 include (1) increased access to and availability of modern contraceptives services through the Consortium of Family Planning NGOs (COFAP) and member NGOs in focus areas, including the SNNPR; (2) expanded condom and oral contraceptive social marketing; (3) increased knowledge of modern contraceptives among women of reproductive age; and (4) increased government capacity to deliver modern family planning methods.

Technical assistance in the form of training and quality improvement was programmed for three COFAP members: Marie Stopes International, Mekane Yesus' (EECMY), and Good Shepherd. The project also provided financial assistance for key equipment and supplies and for limited facility renovation; TA in the supervision and management of these services; training in minilaparotomy under local anesthesia (ML/LA), vasectomy, and NORPLANT? insertion and removal; training for facility-based staff in counseling for all contraceptive methods (including postabortion counseling); and infection prevention.

In spite of efforts by the NGO community and the public sector reproductive health (RH)/FP program to improve existing services, RH/FP services are still characterized by inadequate facilities and service providers. Indicators depict a high fertility level, low contraceptive prevalence rate (CPR), high incidence of adolescent pregnancy and unsafe abortion, as well as a rising prevalence of HIV and other sexually transmitted infections (STI). Although a national population IEC strategy exists, IEC is weak due to lack of trained manpower; inadequate financing, materials, and equipment; and a shortage of materials for specific target groups.

Progress in promoting increased knowledge of modern contraception among reproductive age women has been limited. Ongoing and planned activities intended to increase government capacity to deliver modern family planning services have had limited impact. Pathfinder International, through COFAP, has assisted the MOH in developing and standardizing the national community-based reproductive health (CBRH) Curriculum, Protocol, Supervision Manual, and Guidelines for Clinical Standards and Practices and Infection Prevention, for use by both the public and private sectors. These materials have already been endorsed by the MOH, and the MOH staff, regional health bureau officers, and COFAP members have been trained as a national and regional core team in the new standards.

Conclusions: The EET notes considerable success in the delivery of FP services, including access to modern contraceptive methods through the NGO sector, under the ESHE project. Now, the challenge is to build on these advances to strengthen FP service delivery in the public sector to effectively support progress toward national population goals.

The demand for family planning and access to contraceptives has risen due to Family Guidance Association of Ethiopia (FGAE) and other Pathfinder-supported NGOs. These efforts have increased demand for and actual use of FP services in the private and public sectors. Moreover, the training and service delivery models developed by FGAE and other NGOs are very relevant to the needs of the public sector. The need to develop an effective IEC strategy and to expand IEC services and develop materials tailored to the situation and needs of adolescents is evident.

The good performance of programs developed and implemented by the FGAE suggests that there is a potential for program expansion (static clinics, outreach sites, youth programs, etc.) that should be explored during the next phase of the project.

Recommendations:

4. The potential for FGAE program expansion (static clinics, outreach sites, youth programs, etc.) should be explored during the next phase of the project with adequate resources allocated to support it. (p.34)

5. FGAE should strengthen its IEC and counseling capacity by developing a target-oriented IEC strategy, training core IEC personnel, training staff in FP/RH counseling, and developing an IEC manual (guideline) for service providers. The provision of technical assistance for IEC should be considered. (p.34)

6. Increased resources should be allocated to FGAE to (1) strengthen and expand adolescent RH counseling and services in branches, (2) integrate adolescent reproductive health services in all static clinics, (3) develop standards of practice for adolescent reproductive health counseling and services, and (4) train adolescent health service providers. (p.34)

7. The potential for expanding other NGO programs? Marie Stopes International, Mekane Yesus, and Good Shepherd? needs to be explored, and if expansion is feasible, commensurate resources should be allocated during the next phase of the project. (p.34)

12. Continued support should be given to COFAP by allocating increased resources to strengthen its FP program management and by providing appropriate technical assistance to strengthen the institutional capacity of its members and to expand the NGO's RH/FP service delivery network. (p.40)

13. There must be continued effort to register COFAP with the appropriate government office in accordance with prevailing laws. (p.40)

Family Planning in the Public Sector

Findings: Although there has been solid progress in the private NGO sector with family planning activities, the expansion of services in the public sector has not received the same emphasis.

Pathfinder International was selected by USAID/E to manage the five-year project designed to strengthen Ethiopia's FP/RH service delivery in partnership with FHI and AVSC as collaborating agencies. Pathfinder has the overall responsibility to manage the project and to provide technical assistance, training, subgrant funding, and commodities to COFAP and its members for institutional and program development. As manager of the project, Pathfinder coordinates AVSC's and FHI's activities and acts as a principal liaison between the project and COFAP, Consortium members, the National Office of Population (NOP), the MOH, USAID/E, and other CAs.

Pathfinder International, in collaboration with FHI and AVSC, has been responsible for preparing the project's five-year workplan and coordinates annual meetings to develop annual workplans, including technical assistance plans. In addition, Pathfinder conducts quarterly program meetings, coordinates the sharing of trip and program reports, arranges meetings with involved parties, and obtains travel concurrences. This arrangement has helped the CAs to effectively coordinate and jointly plan their activities.

Conclusions: Future project focus should address problems of the public sector, which has served less than expected numbers of permanent and long-term method clients. The effort in this regard should address obstacles that limit the capacity of the public sector to provide increased quality clinical contraceptive services and should address the question of responsibility and ownership of voluntary surgical contraceptive services in the public sector. With their capacity to offer integrated reproductive health? MCH as well as comprehensive FP services? public health facilities should receive more attention and support in the future of ESHE. NGO's active in FP could play a useful role in this process.

Recommendations:

8. USAID/Ethiopia should review the resources available to expand FP and related services in the public sector and allocate more resources to strengthening this sector for the next project phase. (p.35)

9. Future AVSC involvement to support NGOs and the public sector should be reviewed to streamline and/or strengthen its direction. Coordination of AVSC's activities with NGOs and the public sector needs to be improved. (p.37)

10. During phase two of the project implementation, additional funds should be made available to expand Family Health International's technical assistance to the public sector to develop similar monitoring and evaluation systems for the overall management of the public sector FP/RH services. (p.38)

11. FHI activities should be expanded to undertake programmatic and operational research covering such areas as new approaches to expand FP/RH services through new networks, such as the workplace and marketplace; male involvement in FP/RH activities; impact of IEC in creating awareness; changing attitude and behavior; client willingness and ability to pay for services, and remuneration for community-based reproductive health services. (p.38)

14. USAID/Ethiopia should consider expanding Pathfinder International's mandate into the public sector, as well as increasing the resources made available to Pathfinder to enable it to meet current and future demands for assistance by the public sector (MOH, Regional Health Bureaus (RHB), and Regional Offices of Populations (ROP). In addition, USAID/Ethiopia should consider expanding such assistance to a greater number of RHBs than ESHE is currently working in. (p.43)

3. COMPONENT: ENHANCED CAPACITY OF ETHIOPIAN SOCIETY TO EXPAND ACCESS TO AND USE OF STI/HIV/AIDS SERVICES IN RESPONSE TO THE EPIDEMIC (IR3)

Support for STI/HIV/AIDS Supplies and Construction

Findings: Bilateral ESHE funds totaling $1.9 million were allocated to the World Health Organization for STI/HIV drugs, kits, and supplies and for construction of a warehouse in Addis Ababa, as well as for an extension to the Regional Training Center (RTC) in Awassa. Based on positive experience during the Support for AIDS Control Project (STAC), WHO was asked to procure the supplies and construction services through a grant mechanism (support for the Awassa RT2).

Although the MOH submitted its drugs and supplies request in September 1996 (with the first consignment requested to arrive in February 1998), negotiations over the warehouse have continued. First, the MOH requested a $2 million, three-block facility, far in excess of the $300,000 initially allocated by USAID. The MOH request was reduced to a one-block warehouse costing $400,000, but the proposed surface space exceeded USAID's limit of 10,000 square feet. This issue is still unresolved.

Conclusions: The planned procurement of STI/HIV/AIDS supplies through a grant to WHO was delayed but now appears to be on track. The status of the planned construction of a warehouse, under the same WHO grant, is unresolved. This same grant procurement process (including a Letter of Credit) worked smoothly on two prior occasions, so it is difficult to understand why that experience could not be replicated. Given the multiple steps and relatively high cost associated with accessing WHO procurement services, the option of granting funds to Pharmid (or using some other mechanism) to procure pharmaceutical supplies should be explored. Such consideration would have to be taken realistically and innovatively in view of USAID's legal restrictions on procuring pharmaceuticals. It might be possible to "swap" with other donors the purchase of pharmaceuticals for support of equal value in another area such as training.

Recommendations:

15. **The Health, Population and Nutrition (HPN) Office within USAID/E should work with its Contracts Office and with USAID/W's Office of Financial Management to ensure that the Letter of Credit is issued and with WHO to ensure that the order is placed quickly once the Letter of Credit is received. (p.50)**

16. **USAID's HPN Office should immediately clarify the status of the warehouse with the MOH/AIDS Control Unit (ACU) and negotiate the best option available. The EET believes that either option 1 (construction of a smaller warehouse) or 2 (renovation of existing space) would be preferable to dropping the warehouse plan altogether. (p.51)**

Transition from STAC to ESHE

Findings: ESHE funds were used to extend STAC through June 1997. Despite significant progress in reaching a national, multisectoral consensus on objectives and forging better donor coordination, the details of the new ESHE HIV/AIDS component are still being finalized, and the MOH/ACU does not feel fully informed and involved in this process.

Despite important achievements in broadening participation and building consensus on STI/HIV/AIDS objectives, the specific details of USAID/E's proposed support and activities under RP3 remain unclear to the MOH/ACU. This support includes planned interventions and arrangements for technical assistance to be supported under ESHE. Although USAID/E briefed the MOH on the overall contents of the proposed RP3 in October 1997, the Planning Document apparently could not be disseminated pending final clearance within USAID/E. Also, the direct link between the contents of the Planning Document and the consensus reached on the Ethiopian Framework of Objectives (EFO) (through the three participatory workshops) may be more clear to USAID than to the MOH.

Conclusions: USAID/E should consider the possibility and appropriateness of sharing a clearly marked "draft" copy of the unapproved RP3 Planning Document with the ACU and other partners to solicit early formal comment and participation. Furthermore, USAID/E should intensify consultation and joint planning with the ACU and other partners. Likewise, the ACU and other partners should give adequate priority to completing this process to help avoid further delays. This will ensure GFDRE ownership. Such consultations would also be a good opportunity to consider the recommendations of this evaluation that relate to RP3 plans.

Recommendation:

17. USAID/E should intensify consultation and joint planning with the ACU and other GFDRE offices as appropriate as soon as possible to develop or revise RP3 plans collaboratively. (p.52)

RP3 Design

Findings: Current plans to continue and build on the STI and IEC strategies and activities begun under STAC appear to be consistent with the government's HSDP and to have the support, in principle, of the MOH/ACU. Support for conducting programmatic research and strengthening surveillance capacity were also high priorities of the MOH/ACU.

Conclusions: Over time, the nature and mechanisms of USAID support in the health sector may evolve in accordance with the HSDP and be commensurate with improved and audited GFDRE financial management capacity. In the shorter term, building on support begun under STAC (for improved STI control and youth-oriented IEC in focus areas) would be beneficial, consistent with the current ESHE project, and, as noted, supportive of the HSDP.

In addition to support for increased STI and IEC capacity and services in focus areas, the EET would recommend consideration of a programmatic research component, centered in the ACU and designed to assist policymakers and program managers to better design or assess STI/HIV/AIDS interventions. Although this area of activity does not appear to score high on the EFO, it may be implicit in the objectives relating to policy/strategy/guidelines development, lobbying, and management. Moreover, in discussions with the ACU, this area was identified as one of their greatest areas of need. Careful assessment of available technical capacity and interest in the medical, social science, and other academic communities would be needed to conduct relevant research in a timely and competent manner, if a mechanism for awarding and coordinating research project grants could be established within the ACU. Such an assessment was not possible within this evaluation.

Recommendations for consolidating and modifying RP3 sub-intermediate results and reducing the number of corresponding PIs are provided in Chapter 10. These changes are aimed at promoting integration of HIV/AIDS activities and support with other areas of ESHE and reducing the monitoring burden. These changes would not substantially change the content of HIV/AIDS activities (as reflected in the RP3 Planning Document), except for the possible addition of a research support component.

Recommendations:

18. ESHE should, as currently planned, build on earlier USAID/E support for increased capacity and services for STI case management and youth-oriented IEC in focus areas of the country. In addition, the appropriate ESHE partners should consider including in RP3 an STI/HIV/AIDS applied research component. (p.53)

19. As currently planned, the ESHE RP3 SOW and budget should include mechanisms for providing material and financial support to revive the national HIV surveillance system and to support surveillance capacity in the SNNPR. To help meet this critical need, special attention should be given to close coordination with UNAIDS and WHO to support and/or complement their involvement, particularly with respect to the planned placement by UNAIDS of a biostatistician within the ACU. (p.53)

Procurement and Implementation of the New STI/HIV/AIDS Component

Findings: To expedite approval and implementation of RP3, USAID/E, the MOH, and other partners need to work closely to finalize detailed plans and to agree on an appropriate procurement mechanism. The ESHE Steering Committee (ESC) will need to endorse the content and mechanism for accessing needed technical assistance (e.g., direct competitive procurement versus a buy-in to a central USAID contract). Depending on decisions made on the contractor for the follow-on project, the ESC may also have to decide whether STI/HIV/AIDS technical assistance should fall under the same contract or a separate contract.

Conclusion: The ESHE partners need to take fairly urgent and concerted action to initiate a new HIV/AIDS component by the end of FY98, as planned.

Recommendation:

20. In consultation with ESHE partners, USAID/E should proceed immediately to develop the RP3 objectives, SOW, and time line for the new STI/HIV/AIDS component and its corresponding procurement mechanism. All ESHE partners, under guidance of the ESC, should make an effort to expedite implementation of RP3. (p.54)

4. COMPONENT: INCREASED USE OF INTEGRATED RURAL PRIMARY AND PREVENTIVE HEALTH CARE SERVICES IN SOUTHERN NATIONS AND NATIONALITIES PEOPLES REGION (IR4)

Findings: The objective of ESHE's RP4 is to "increase the use of integrated rural PPHC services in the SNNPR." The main contractor for this activity is BASICS, a USAID centrally-funded child survival project scheduled to end in September 1998. However, some of the individual results under IR4 are ESHE and USAID's direct responsibility. BASICS was involved in some of ESHE's predesign (baseline survey and information gathering) and design work. As ESHE developed, USAID/E wished to bring the project in the SNNPR more in line with ESHE's overall goal to "Improve the Health Status of Ethiopians and Begin to Reduce Population Growth." Accordingly, BASICS was asked to work with Pathfinder in the SNNPR to begin to integrate family planning with its child survival project.

In spite of a set of problems that have constrained ESHE's ability to achieve its planned objectives, it has made commendable progress in meeting results under Sub-Intermediate Results 4.1 and 4.2. However, several activity areas require more time than is available in the time period up to September 1998. Among these are health care financing reform and revitalization of community health services, as well as promotion of PPHC and behavior change in focus communities. The RHB informed the EET that it does not feel ready to take over the incumbent technical assistance contractor activities and would prefer to continue with simila arrangements after expiration of the current contract.

Moreover, the RHB would like to see project activities expand to the whole region. In fact, a good deal of project support at the central (i.e., the RHB and the Regional Training Center) level has strengthened the health system of the whole region.

Conclusions: Expatriate TA ought to be continued beyond September 1998. Progress has been limited by the project's late start and other factors already mentioned. For gains to be sustained and for the capacity of the region to operate new systems and procedures, a new USAID contract for TA will be needed for perhaps an additional two years.

Such TA should continue to follow BASICS's current approach of systems strengthening and capacity building, involving government counterparts in every phase of project planning, implementation, and

evaluation. Responsibility for project activities should be transferred from the project to the RHB in a phased, continuous manner during the life of the successor ESHE project in the SNNPR.

Recommendations:

25. There should be continued, long-term technical assistance to the RHB after September 1998. Such TA should continue to follow the current approach of systems strengthening and capacity building, involving government counterparts in every phase of project planning, implementation, and evaluation. There should be a phased, continuous transfer of responsibility from the project to RHB during the life of the successor ESHE project in the SNNPR. (p.77)

26. In a post-September 1998 project continuation, there should be a phased expansion into more zones and woredas in the SNNPR, after the first year. The number and identification of new zones and woredas should be primarily the responsibility of the Regional Steering Committee, in consultation with national bodies of ESHE. (p.78)

Findings: As a centrally-funded contract, BASICS has been able to draw on a pool of technical assistance through a relatively easy contracting mechanism. Advantages offered by a centrally-funded contract include (1) ability to tap into a greater depth of technical resources than could be found with a single contractor, (2) ability to provide funding and TA for complementary activities not originally envisaged in the contract as alternative financing may be available to respond to opportunities, (3) ability to assist missions and governments with start-up activities in advance of project approval and signing of delivery orders, and 4) ability to draw on experiences from a great number of other country programs.

On the other hand, disadvantages are large overhead costs and possible differences in the agendas and mandates of BASICS/Global and BASICS in a particular country. For example, there has been some tension between BASICS/SNNPR staff and BASICS/Global over the latter initiating unrequested technical consultancies relating to BASICS/Global's core areas, namely integrated management of child illness (IMCI) sustainable immunization, behavior change, nutrition, and private sector participation.

Conclusion: Overall, the disadvantages of continuing with a centrally-funded child survival contractor outweigh the advantages. Moreover, a new contractor other than BASICS does not necessarily preclude continuation of incumbent staff under a different contract or grant mechanism. Retaining at least some incumbent staff under a different mechanism would speak to the RHB's concern about having to start over with new expatriate TA.

Recommendation:

27. A mechanism other than a centrally-funded project and a contractor other than one focused primarily on child survival would better serve the needs of the ESHE project. USAID/Ethiopia should proceed to develop objectives and a SOW for a new

contract or grant for the ESHE project. It should proceed immediately to avoid a hiatus between the expiration of BASICS and the beginning of successor technical assistance provider. (p.79)

Findings: At the September 1997 meeting of the Technical Working Group, the RHB asked if it could receive some sort of tranche paid directly to the region if ESHE's conditions are met. This issue appears to have arisen because USAID's Basic Education System Overhaul project (BESO) pays what is called a Regional Incentive Fund (RIF) to the Regional Council when conditionalities in the education sector are met.

Conclusions: Although there may be pros and cons from the government viewpoint, the RHB and GFDRE's position seems to be that the overriding consideration should be that the RHB would feel a greater sense of ownership if it had a RIF. The central government should also be better informed and develop a better sense of project ownership.

Recommendation:

21. The RHB in the SNNPR should receive a Regional Incentive Fund as it meets conditionalities specified by ESHE. (p.59)

Finding: It is not clear how closely the MOH wants to, or should, follow activities in the South in light of the current policy of decentralization and regional autonomy. But, given the issue of questionable central GFDRE support for a post-September 1998 contract and the importance of BASICS's activities as a pilot or test case area for new policies and program initiatives, it is clear that the MOH, as well as the Ministry of Economic Development and Cooperation (MEDAC) and the prime minister's (PM) Office, ought to be not only better informed, but also play a more active role in monitoring project activities in the southern region.

Conclusion: It appears that in the original ESHE plan, there was supposed to be a project manager attached directly to the central MOH, to supervise, liaise, and keep the MOH fully informed. Although this is part of the COP's responsibilities, a stronger, more direct link between the project in the SNNPR and central government is needed.

Recommendation:

23. The MOH, as well as MEDAC and the PMO, needs to be better informed and play a more active role in monitoring project activities in the southern region. There needs to be a more participatory and responsive monitoring system, perhaps including assigning a representative of a post-September 1998 contractor to the MOH. USAID should be a partner in planning and developing such a system, after which monitoring should primarily involve relevant branches of the MOH and the SNNPR's project contractor. (p.60)

Finding: The RHB is satisfied with BASIC's scope and accomplishments in the SNNPR, in spite of the late

start-up. The RHB fully supports BASICS's systems strengthening, capacity-building approach. It does not believe that there has been more emphasis on quickly reaching targets directly related to child survival. In fact, BASICS and the RHB developed the project workplan and the systems approach jointly.

The RHB also fully supports BASICS's community-level project initiatives. It feels that these initiatives may be replicable by the regional government, although there needs to be "objective assessments" (operations research) to examine models of local financing, incentives for community health workers (CHW), and other initiatives being piloted.

The RHB commented that much of BASICS's community work has been resource-intensive in the early phases, but that need not be the case when these activities are expanded to elsewhere in the region, once viable approaches are found and local staff are trained and gain practical experience in such work. The EET is in agreement.

Conclusion: The project is pioneering innovative ways to mobilize communities to improve health and strengthen linkages with local health services. Once viable models are developed and refined, the project needs to determine the level of effort and resources needed by different levels of regional health services to replicate and sustain such approaches.

Recommendation:

22. There needs to be operations research to better determine how much external input is needed to mobilize a community in ways that improve health. The RHB needs to know better how to replicate the community-based work that has been pioneered in BASICS's focus communities. (p.59)

Finding: In BASICS's five focus villages, CHWs currently work without cash incentives of any kind. The nearest health center may provide free health services and drugs (representing very small amounts of money) for CHWs and their families, as a government-provided incentive. Although BASICS is experimenting with non-cash community incentive schemes for CHWs, Pathfinder is paying its integrated community-based distribution (CBD) agents who work in the same areas as CHWs. CHWs are aware of this and naturally wonder why some community health agents are paid and others are not. This, along with the HSDP, are both strong arguments for piloting some sort of cash incentives for CHWs in Ethiopia, although this should not be considered until a post-September 1998 contract is in place. It would not make sense to begin something that might not continue beyond a few months (and the timetable for the RHB hiring CHWs to work at peripheral health facilities is uncertain).

Conclusion: The value of having two models of community-based health and family planning workers under the same ESHE project, and sometimes even working in the same areas, is that it provides an unusual opportunity for operations research to determine the relative cost-effectiveness and sustainability of the two approaches. A variety of economic, social, cultural, geographic, and other relevant variables can be held constant where the two models are being implemented side by side.

Recommendation:

24. There needs to be operations research to determine the comparative cost-effectiveness and sustainability of three or more types of CHWs? CHWs working on sales commissions in the SNNPR under Irish Aid, CHWs working without cash incentives in BASICS's focus communities, and two to three models of CBD agents working with Pathfinder-supported NGOs. A closely related question is the degree to which the CHW/community-based distribution agent (CBDA) should serve in a preventive or curative role. There should be a thorough review of pertinent published and unpublished literature on African CHWs as part of this research. (p.73)

Finding: An HIV/AIDS component was part of the original ESHE design, but this is said to have been dropped before the contract with BASICS was finalized. As discussed in the previous section, STI/HIV/AIDS should be integrated with child survival and family planning as part of PPHC in the SNNPR. Some of the mechanisms for integration at all levels (RHB, zone, woreda, and village) are already in place for such integration. Moreover, there is compatibility and overlap between the messages, behaviors, technologies, and target audiences involved in child survival, family planning, and STI/HIV/AIDS. Therefore, there are synergies, cost savings, and mutual reinforcements to the extent that the three programs are integrated with one another.

Conclusion: PPHC is incomplete without an AIDS/STI component. Moreover, there are natural compatibilities and synergies between child survival, FP, and AIDS/STI. As ESHE develops a new AIDS component, it should be integrated with the ongoing project.

Recommendation:

28. STI/HIV/AIDS should be integrated with child survival and family planning as part of PPHC in the SNNPR. (p.79)

5. MANAGEMENT

Findings: Management of ESHE is entrusted to the Steering Committee and its Technical Working Group. Both groups are now operational and have the capacity and expertise to manage the project satisfactorily. However, terms of reference have only recently (September 1997) been established and relatively few meetings have been held. The conclusions from these meetings do not appear to have been widely disseminated to partners and other interested parties that are not ESC members. Furthermore, some government departments in the MOH particularly do not have a feeling of close and equal participation in project management decisions, which may lead to a sense of lack of ownership of the project.

Conclusions: The EET respects the MOH's position as the lead implementing agency for ESHE, but also notes the important involvement and authority of the Prime Minister's Office (PMO) in health sector matters, including its strong role in coordinating the development and implementation of the HSDP. Moreover, involving the PMO in ESHE program and project deliberations may serve to avoid unexpected delays or concerns at the highest levels.

Recommendations:

29. To improve awareness and information on the project, formal mechanisms should be established by the ESC to ensure adequate and timely liaison and communication with the PMO. This might take the form of written aide-mémoire immediately following each ESC meeting or an in-person briefing of the PMO by a designated member. The success of such measures should be reviewed and, if not satisfactory, the issue of direct PMO representation on the ESC should be reconsidered. (p.82)

30. ESC and ESHE Technical Working Group (ETWG) meetings should be held on schedule, full participation of the membership obtained, and careful records of its decisions and responsibility for follow-up actions promptly recorded and disseminated by the ESC chairman. (p.82)

Findings: A program and project as large and complex as ESHE needs corresponding and managerial resources and skills at all levels: USAID/E; GFDRE departments; CAs; and regional, zonal, and woreda bureaus. To function properly, management needs established operating procedures, clear and defined reporting responsibilities, and functional communications channels. There must be well-established monitoring procedures and controls, including financial controls.

There seem to be several weaknesses in ESHE's current management system that could, unless rectified, lessen the impact of the project and make the achievement of objectives more difficult. There was, in some cases, less-than-optimal coordination and communication in reviewing project workplans and satisfactorily informing partners in the GFDRE or CAs of project performance and events. Thus, it was difficult for partners to discuss and agree with any necessary countermeasures or modifications, and particularly for GFDRE partners to feel a sense of close involvement in the project.

Management of the project's central-level activities may be hampered and somewhat isolated by the fact that there is as yet no CA adviser actually situated in any government department, such as the MOH, although one major component of ESHE is the strengthening of managerial capacity and skills in that Ministry. This managerial isolation may have contributed to misunderstandings and negative attitudes in some central government circles, giving rise to complaints regarding lack of transparency and communication.

Conclusions: In some part, this lack of communication and coordination between all partners may be due to insufficient staff resources at USAID/E; however, steps are underway to rectify this situation. It is clear that communication and coordination between all ESHE partners must improve if achievement of ESHE

objectives is to continue.

Recommendations:

31. The ESC and ETWG meetings should be used as formal mechanisms for informing all partners on ESHE's progress and for discussing and planning modifications and changes. These meetings should however be backed up by regular and frequent communications on a more informal basis. It is essential that the present feeling of nonparticipation in the project's progress at the MOH and other government agency level be overcome. (p.83)

33. USAID/E and the MOH should meet semiannually to review in detail allocation and expenditure data on this large and complex project. In addition, the government should be substantially involved in discussions to program the funds available for future activities, especially the post-September 1998 technical assistance and the new STI/HIV/AIDS program component. (p.89)

1. INTRODUCTION

Initiated in August 1995, the Essential Services for Health in Ethiopia (ESHE) Program/Project includes both program and project support from the U. S. Agency for International Development (USAID) toward improving the health of Ethiopians and reducing population growth. ESHE's purpose is to increase the use of primary and preventive health care (PPHC) services[2] in family planning (FP), maternal/child health (MCH), child survival (CS), sexually transmitted diseases (STD), and the human immunodeficiency virus (HIV)/acquired immunodeficiency virus (AIDS). Behind ESHE's development was the idea that without access to PPHC, most women would not seek family planning, and thus population growth could not be reduced.

ESHE is a seven-year (1995-2002) effort by USAID's Mission in Ethiopia (USAID/E) and its partners, the Government of the Federal Democratic Republic of Ethiopia (GFDRE) and implementing agencies. USAID/E's priority *Strategic Objective* (SO) for health in Ethiopia is to *increase the use of primary and preventive health care (PPHC) services*. Under USAID's results management system, USAID/E's *Strategic Objective 2 (SO2)* is composed of four Intermediate Results (IR); each IR is in turn supported by a Results Package (RP) that breaks the IRs into Sub-Results and Sub-Intermediate Results.[2]

The four Intermediate Results/Results Packages are as follows:

- RP1, Increased Resources Dedicated to the Health Sector, Particularly PPHC
- PR2, Increased Access to and Demand for Modern Contraceptive Services in the Focus Area
- RP3, Enhanced Capacity of Ethiopian Society to Expand Access to and Use of STI/HIV/AIDS Services in Response to the Epidemic
- RP4, Increased Use of Integrated Rural PPHC Delivery in the SNNPR

ESHE's main components are health policy reform, managerial capacity building, family planning, sexually transmitted infections (STI)/HIV/AIDS prevention and control, and rural health service delivery. They are to be delivered through the program and project components.

1.1 The Program Component

The program component calls for the release by USAID of non-project assistance (NPA) US$30

[2] Performance Monitoring Plan distributed by USAID/Ethiopia.

million over the life of ESHE to support health policy reforms:

- Increases in the share of the national budget for health,
- Increased budget allocation for PPHC,
- Elaboration and implementation of a health care financing policy,
- Dialogue with the GFDRE for the promulgation of the STI/HIV/AIDS policy,
- Continued availability of essential drugs,
- Accessibility and availability of FP services, and
- An increase in the private sector share of health care provision.

The funds will be disbursed in five tranches, paid externally for debt relief.

1.2 The Project Component

The ESHE project component had a total budget of $40 million over the life of project (LOP), of which $26.5 million were bilateral funds and $13.5 were "unilateral" funds. Because the GFDRE perceived a lack of influence over the use of unilateral funds, the amount of $13.5 million was omitted from the final signed agreement on the express wish of the GFDRE. Thus, the total amount of the ESHE project signed by the GFDRE was $56.5 million.[3] Over and above this amount, additional funds from field support resources (FSR) were to be made available. However, these funds and their uses are outside the scope of this evaluation.

As of December 1997, 11 percent of the total $26.5 million bilateral funds and 20 percent of the total $13.5 million unilateral funds had been expended. The first tranche of $7.5 million NPA funds had been transferred to the GFDRE, the second tranche was being negotiated, and conditionalities for the release of the third tranche had been established.

1.3 Assumptions for ESHE

The Performance Monitoring Plan for USAID/E's SO2 links critical assumptions to planned activities. Following are the key critical assumptions for SO2:

- Enactment and adoption of appropriate health and population policies by central and regional governments, including adequate financing for PPHC, and

liberalization of laws concerning FP commodities promotion, distribution, and sale;

- Availability of FP services and commodities through public and private providers;
- Commitment of central and regional governments to PPHC; and
- Increased economic growth to improve health status and to generate increased resources dedicated to the health sector in general and to PPHC in particular.

As of December 1997, these assumptions were substantially but not completely valid. Legislation relating to health care financing and cost recovery and to FP commodities promotion and sale is still not enacted, although it is well through the draft stage. In practice, cost recovery, including the full cost of drugs, is being carried out on a pilot basis in the regions (i.e., the SNNPR) and contraceptives are freely available in public health facilities and in the private sector. Furthermore, contraceptives are included in the List of Drugs for Ethiopia (LIDE), which authorizes such items to be imported, produced, and freely sold in the country. Family planning services and commodities are freely available in a wide range of public and private health care facilities, as well as through community-based distribution (CBD) providers; the central and regional governments are committed to PPHC, as evidenced by their increasing budget allocations to health in general and to PPHC in particular; and a gross domestic product increase of 4 percent per annum indicates improved economic conditions and increasing resources available to support health services.

1.4 Evaluation of ESHE

The Scope of Work (SOW) for this evaluation, developed by USAID/E with project/program partners, was for "a comprehensive evaluation of the ESHE Program and Project activities supported with unilateral funds and Global Field Resources." However, in early discussions with USAID/E, the ESHE Evaluation Team (EET) was instructed to omit any evaluation of the use of Global Field Resources.

The objective of the evaluation as described in the SOW appeared to be a mixture of (1) an evaluation of the existing project and its progress and (2) guidance on how to proceed in the future:

> ...guidance on how best to proceed with the implementation of ESHE so as to achieve USAID/E's *Strategic Objective 2: "Increased use of PPHC services over the next 5 years.*"

The EET felt that the second objective was more suitable for a separate, more long-term

consultancy as it represents in practical terms the approach to designing a new project and will need considerably more time and research. The team tried to address this objective in the time available, but focused on evaluating ESHE's progress.

Conscious of the late start-up of program/project implementation, the EET focused not only on the progress achieved as measured by IRs, but also on the following areas:

1. The IRs and their performance indicators (PIs) as appropriate and relevant tools for measuring achievement.

2. The Results Packages (RP's) as management tools.

3. The validity and realism of the original objectives and targets.

4. The achievement of objectives and targets and the likelihood of their completion by the end of the project.

5. Prospects for their replicability and sustainability throughout the country.

The EET also looked at management structures and systems, communications and coordination, financial status, relations and operations with other United Nations (UN) agencies and donors, and partnership and ownership matters, as well as any key unresolved issues.

The EET was composed of five expatriate consultants and one Ethiopian. Between them, the team possessed some 75 years of professional health care experience with expertise in project development and management, health economy and finance, child survival and non-project assistance, reproductive health, and maternal and child health. The team's combined experience covered a scope of some 40 countries in Africa, Asia, and Latin America.

The team began the evaluation with briefings by USAID/E and an all-partners meeting that included government agencies, nongovernmental organizations (NGO) and other interested parties. The team spent approximately one week traveling in the regions of the SNNPR and Amhara. The rest of the time was spent in Addis Ababa, meeting with government departments and agencies, USAID/E, UN agencies, private and nongovernmental organizations, Cooperating Agencies (CAs), and others. In the final week, the team held wrap-up meetings and debriefings with USAID/E and another all-partners meeting to summarize the evaluation conclusions and recommendations and to present and discuss an outline of the draft report. During the evaluation, the team conducted over 100 separate interviews and consultations and studied over 50 documents. (See Appendices B and C for the Bibliography and List of Contacts.)

1.5 Evaluation of Strategic Objective 2

USAID/E's and ESHE's Strategic Objective are one and the same: *Increased use of primary and preventive health care services*. Using strategic planning, some USAID missions develop a large and complex project centered around the achievement of a single strategic objective.[4] The SO is supported by Results Packages that consist of the people, funding, authorities, activities, and associated documentation required to achieve a specified result or results within a specified time frame. The concept behind RPs emphasizes an underlying focus on a Results Framework and allows flexibility to change approaches and tactics as situations change or lessons are learned. The Results Framework consists of a hierarchy of Intermediate Results, each having a causal relationship with the next level Intermediate Result up to the SO.[3]

During the evaluation, the EET considered whether SO2 meets the following criteria:

(1) Supports USAID/E's goal of smaller, healthier, and better-educated families;

(2) Supports the GFDRE's goal as expressed in the HSDP of universal access to essential primary health care services within the next two decades;

(3) Can be considered realistic and achievable over the life of project (LOP);

(4) Captures ESHE's results adequately; and

(5) Relates well to the Results Packages and their Intermediate Results as set.

In addition, the EET explored whether or not the SO continues to be supported by the two critical assumptions: (1) effective use of government resources to increase PPHC access, with donor support in other regions, and (2) national and regional authorities remaining committed to PPHC. Further, it reviewed the IRs and their PIs for the project components to assess if they adequately measure progress of the project components toward the SO.

The SO, with its emphasis on increasing access to and use of primary and preventive health care, family planning, and HIV/AIDS prevention, directly supports USAID's overall goal, as well as that of the HSDP, and should be retained. As stated, the SO is realistic and achievable over the LOP in the central, regional, and focus areas. However, the two PIs related to the SO? (1) percent of the population using facility-based health services (national level) and (2) percent using modern contraceptives (contraceptive prevalence rate [CPR] at the national level? are designed to measure the project's progress on a national basis, whereas ESHE is focused on two main areas of activity, the SNNPR and periurban and urban areas. Therefore, achievement of the SO on a national basis would require that either the project scope be redefined and expanded or the PIs restated to reflect the narrower geographical scope.

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[3] On Track Vol.1, No.6/October 1995.

Although it is possible that these indicators are too broad, it is also possible that in another sense they are too narrow and do not fully measure ESHE's impact. They should be restated as follows to reflect community-based outreach health care services, as well as the geographic focus of the project: "Percent of the population using *Primary and Preventive Health Care* services (*project focus areas*)," and "Percent using modern contraceptives. Contraceptive prevalence rate *in project focus areas for both*."

Furthermore, to measure more accurately the impact of the project at the central and SNNPR level, an additional PI for the SO could be: "Enhanced capacity of government agencies to design, plan, and deliver PPHC services at central and regional levels."

2. THE HEALTH SECTOR DEVELOPMENT PROGRAM

2.1 The Health Sector Development Program

The GFDRE's Health Sector Development Program demonstrates the government's commitment to improving the very low health status of the Ethiopian population. The program's goal is to ensure that all Ethiopians have access to essential primary care services by Fiscal Year 2018.[5] Developed after ESHE, the HSDP has a 20-year perspective on rolling five-year program periods. The first five-year phase of the HSDP focuses on increased use of PPHC, managerial capacity building, and support for health policy reforms.

The HSDP was conceived in an environment dominated by an inadequate and inappropriate health system that failed to address the prevailing health needs in both rural and urban areas. At that time, the health system was highly centralized, services were fragmented with a reliance on vertical programs, and the orientation was that of curative, hospital-based services. In addition, the health system remained largely underutilized, with poor access to health services and health facilities. To address these problems, the GFDRE identified nine strategic health sector investment components:

- Improved PPHC service access to the population including expansion and rehabilitation of health facilities;
- Improved technical quality of PPHC service provision;
- Improved health sector management;
- Improved financial sustainability of the health sector;
- Encouragement of private sector investment in the health sector;
- Direct attention to the pharmaceutical sector;
- Development of an information, education, and communication (IEC) implementation plan to extend PHC messages to the periphery;
- Investment in expanding the supply and productivity of health personnel; and
- Strengthening of local capacity of evaluation, research, and development for Ethiopia's health sector.

These health sector investments were to take place in the larger scheme of democratization and decentralization of the health system and restructuring to a four-tiered system. In effect, the GFDRE sought to strengthen the regional, zonal, and woreda health departments by providing

them administrative authority over the following service delivery structures:

- Primary Health Care Units (PHCU) and Community Health Clinics (CHC) that provide comprehensive primary care services,
- District Hospitals that act as a referral and training center for PHCUs,
- Zonal hospitals that provide specialist services and training, and
- Specialized hospitals that provide comprehensive specialist services and in some instances conduct research and post-basic training.[4]

2.2 The Quality of Life in Ethiopia

The impetus for the GFDRE's Health Sector Development Program can best be understood by looking at the quality of life of the people of Ethiopia.

Ethiopia's health status is among the poorest in the world, and its average life expectancy is approximately 50 years. Its high infant and child mortality rate? over half a million children under five die each year? represents a mortality rate of 177 per 1,000 live births (UNICEF, 1996). The maternal mortality rate approaches 1,400 per 100,000 live births (UNICEF, 1997), almost half due to abortion complications. Ethiopia's total fertility rate is 7.0 children per woman with an overall modern CPR of 2 percent, which decreases to less than 1 percent in rural areas. Ethiopia's national adult HIV prevalence rate is approximately 5.2 percent and rising.

Malaria, diarrheal diseases, intestinal parasitic infections, and respiratory diseases continue to be the main causes of morbidity, particularly in the rural areas where the majority of income is derived from agriculture.[6] In Ethiopia, as in many other countries, tuberculosis (TB) is resurging along with the HIV/AIDS epidemic and is again becoming a major health problem with severe implications for drug budgets and other resources. The seriousness of the present situation is exacerbated by inadequate diagnosis and treatment, the poor physical state of many health posts, lack of access, and lack of trained health workers.

Goals for improving a number of health indicators have been set for the HSPD's 20-year period as follows:

- Increase life expectancy from 47-54 to 60 years,
- Decrease the infant mortality rate from 105-128 to 50 per 1,000 live births,

[4] Ibid.

- Decrease the maternal mortality rate from 1,400 to 300 per 100,000 live births,
- Increase immunization coverage from 28-44 percent to 90 percent,
- Increase (modern) contraceptive use from 2 percent to 40 percent,
- Decrease the population growth rate from 2.5 percent to 2.0 percent, and
- Increase PHC service coverage from 35-45 percent to 100 percent.

Women and children will be the ultimate beneficiaries of PPHC in Ethiopia where women's health is particularly vulnerable. Although antenatal care (ANC) services are reported to be available at almost all health facilities, above the health-center level use remains low. Only 16 to 35 percent of pregnant women are currently said to receive ANC (UNICEF 1993, MOH 1995, 1996). Helminth infections in women are reported to be high, reaching 60 percent in some rural areas. STD infections are similarly common, with 40 percent for gonorrhea and 54 percent for chlamydia among women attending MCH/FP clinics in Addis Ababa. In 1992, HIV prevalence was reported to be 11 to 13 percent among pregnant women in Addis Ababa and other urban centers, and by 1996, prevalence among ANC attenders in parts of Addis Ababa grew to 29 percent. Each year, more than half a million women in Ethiopia suffer a pregnancy-related morbidity, a considerable proportion due to female genital mutilation (FGM) (Howson, UNFPA 1996). Without proper attention to these practices, the number of deaths will continue.

3. COLLABORATION BETWEEN THE ESHE PROGRAM/PROJECT AND THE HSDP

The EET's findings and conclusions on the ESHE program/project's progress toward its own objectives and its provision of support for the GFDRE's HSDP are analyzed in the following chapters. In addition, the EET provides recommendations for corrective actions, modifications, or adjustments deemed necessary to achieve the stated goals and objectives not only of ESHE itself but also in support of the HSDP. This chapter outlines some specific examples of collaboration between ESHE and HSDP, while acknowledging where ESHE deviates from the scope of the HSDP.

3.1 Primary and Preventive Health Care Services

One important element of the GFDRE's health sector investment strategy is improvement of the population's access to primary health care services. The 20-year HSDP encompasses broad health indicator goals to ensure all Ethiopians access to basic PHC services by 2017. Similarly, USAID/E's SO2 and ESHE's objective is "*Increased Use of Primary and Preventive Health Care Services in Focus Areas*." At first glance, this SO appears to directly support the HSDP's movement toward developing a health system that provides comprehensive and integrated PHC services; however, the HSDP incorporates two approaches not present in ESHE's objective.

(1) **Construction:** The HSDP's main goals concern building basic infrastructure, developing standard facilities, and providing necessary supplies. The first five years of the HSDP emphasize expanding PHCUs and district hospital sites, including equipping and staffing these new facilities.

ESHE does not provide funding for new building but rather allocates funds for rehabilitation and refurbishing.

(2) **Pastoral Populations:** Ethiopia hosts a significant number of pastoral communities that require innovative service delivery. The HSDP cites the potential of mobile clinics and migratory health personnel using modern communications to maintain contact with regional, zonal, and woreda staff.

ESHE does not address service delivery to pastoral populations.

3.2 Health Policy Environment

The GFDRE appears committed to a health policy that will improve primary and preventive health care in the country according to the HSDP's objectives and goals: increasing budgetary allocations to the health sector, in particular for PPHC; providing support for adequate supplies of essential drugs in both private and public sectors; and providing unrestricted availability of FP services and contraceptives, as well as promoting their legitimacy by including them in the LIDE

and moving toward legislation on health care financing and liberalization of contraceptive promotion and sale. Overall, the health policy environment appears favorable for the successful implementation of the ESHE program/project.

3.2.1 National Health Policy

Ethiopia's National Health Policy, as expressed and implemented through the HSDP, places considerable emphasis on PPHC, including the adequate provision of essential drugs, availability of family planning services and commodities, immunization, maternal and child health, and HIV/AIDS control.

Legislation relating to other conditionalities under the ESHE program agreement, such as (1) the health care financing (HCF) policy and (2) public advertisement, sale, and popularization of contraceptive methods, has been drafted; however, this legislation awaits enactment by the Council of Ministers and the House of Representatives.

3.2.2 The National Population Policy

Adopted in 1993, the National Population Policy calls for an increase in the national CPR from 4 percent to 44 percent by 2015, and a decrease in the total fertility rate (TFR) from 7.0 to 4.0 over the same period.

The National Office of Population (NOP) has existed since 1993 and is placed administratively under the Ministry of Economic Development and Cooperation (MEDAC). Its main responsibilities are to recommend and disseminate national policy on population and coordinate the activities of other agencies active in population.

It was reported to the EET that the NOP lacks resources and has difficulties coordinating activities with regional offices of population (ref: discussions with Director, NOP). It has also been reported that the United Nations Population Fund's (UNFPA) previous practice of working directly with the regions and transferring funds directly to them is no longer acceptable because it does not conform to official government procedures. All such funds destined for the regions are to be channeled through the Central Bank and the Ministry of Finance. With good coordination and communication, this should not affect UNFPA's support.

3.2.3 Essential Drugs

The GFDRE's support for providing essential drugs throughout the country appears encouraging and effective. Although supplies are still determined by the availability of foreign exchange and the needs of the population are expanding every year by at least 3 percent, the availability in public health facilities of essential drugs on the national LIDE in public health facilities appears to be satisfactory and in some cases, because of uncoordinated donations, even excessive (ref: discussions MOH/pharmacy dept, Pharmid, WHO representative).

3.2.4 The National AIDS Policy

A National AIDS Policy has been drafted but not yet finally promulgated. Discussion of this and implications for the NPA and ESHE project components are discussed in Chapter 6.

3.2.5 The Health Care Financing Policy

At the time of the EET's visit, the draft legislation on the Health Care Financing Policy was still with the MOH prior to being passed to the Office of the Prime Minister and then to Parliament. In the meantime, however, charges for out-patient drugs are being levied, mostly at the level of actual purchase cost, and there is a small consultation fee (1 Birr). Under the present system, these revenues are returned to the Ministry of Finance and do not directly help the health sector. Moreover, because revenues collected are offset by reductions in budgets, there is little incentive to recover the full costs of service delivery.

The HCF strategy aims to redress this situation by creating systems for (1) retaining all revenues collected by health facilities in the health system; (2) adding such revenues to government health allocations rather than deducting them; and (3) revising the number of exemptions, which otherwise can exempt the majority of patients treated.

The GFDRE estimates that the revenue from fees and drugs covered some 18 percent of its recurrent health expenditures in 1996 (HSDP), although some observers (Dunlop) estimate that it was only 9 percent. This figure could rise to 15 to 24 percent of health expenditures by the end of the century, which may be an ambitious target. Pilot schemes are being tested (e.g., in SNNPR, health posts) where drugs initially provided through the zonal health development fund are marked up by 30 percent to patients and the proceeds retained in the woreda for new drug supplies.[7]

The Basic Support for Institutionalizing Child Survival project (BASICS) is conducting central-, regional-, and zonal-level studies to determine the optimal level of patient fees, including drug charges, to have a functional, sustainable, and affordable cost-recovery system as a key element of the overall health care financing system. In the meantime, general policy guidelines on cost-recovery and health care financing await official proclamation and legislation by the government.

Overall, ESHE's program and project activities are in line with the MOH's policies and strategies as contained in the HSDP. Results Package 1 conformes with ESHE's Strategic Objective and is realistic and achievable during the LOP at the central and regional focus level. The EET believes that the use of the $30 million NPA planned under ESHE to assist health policy reform and increase resources to PPHC is appropriate and should be continued. Discussions with senior officials at MEDAC and the MOH, coupled with the team's review of the HSDP, clearly indicate that ESHE's policy reform agenda is in line with the GFDRE's policy agenda.

Health care financing and capacity building in planning, budgeting, and financial control are key elements of the GFDRE's health management policy, as well as of ESHE's support activities. However, the decentralization process and the absence of a firm HIV/AIDS policy may lead to uncertainty of action on this issue in the regions, as will the absence of legislation on health care financing.

3.3 The SNNPR Project

The Southern Nations and Nationalities People's Region (SNNPR) has a population of about 11.3 million. The region is ethnically diverse (Cushitic, Omotic, Hamitic, and Bantu language groups), and is poorer economically and has lower health status indicators than Ethiopia as a whole. A health center (HC) is supposed to cover 25,000 people. By this standard, the SNNPR has less than 10 percent of the HCs needed to serve its population adequately. The ESHE project and the HSDP is intended to make health care, especially primary and preventive health care, more available to more people.

In both design (including IRs and sub-IRs) and implementation, the ESHE project is fully in line with the "basic principles" of the HSDP (ref. HSDP for Ethiopia, Nov. 1996, p.11-12), notably the "development of appropriate capacity...." As noted, BASICS has emphasized training, systems strengthening, and generally developing the capacity of health personnel in the SNNPR, with a view toward improving the sustainability of the improved health management and related systems that BASICS technical assistance is helping to put in place.

Another of HSDP's basic principles is "development of preventive and promotive components of health care." Again, primary and preventive health care related to child survival is the focus of the ESHE project in the SNNPR. Yet, another HSDP principle is "development of an equitable and acceptable standard of health service...." As one example of how the ESHE project

contributes to this, BASICS is improving health center management in part by developing a more useful, user-friendly health management information system (HMIS) form. This form provides pertinent information on PPHC and quality of care so that these elements can be improved and improvement monitored. BASICS is also working at the local, rural community level to improve awareness, capacity, and self-reliance in health matters. This work contributes to two other HSDP principles, "democratization and decentralization of the health system" and "assurance of accessibility of health care for all segments of the population."

3.4 Increased Resources Allocated to the Health Sector

Despite the poor health indicators, there are encouraging signs of the GFDRE's determination to improve the health of the population. Such signs include the GFDRE's commitment to allocating additional resources to health care, with an increase in allocation to health from 3 percent of the national budget in 1993, to 5.8 percent in 1995, to 6.2 percent in 1996; regional budget allocations to health increased from 9.9 percent in 1995 to 12.5 percent in 1996 (16 percent for health allocated in the total SNNPR 1995/96 budget), and there were increased allocations to primary, preventive health care in particular (68 percent of SNNPR health care budget in 1995). These allocations also represent conditions under the ESHE program component for the release of disbursement tranche two (Ref: letter Ministry of Economic Development and Cooperation to USAID/Ethiopia, October 6, 1997).

In addition, the GFDRE is changing from the previous six-tier health care system to a four-tier system that will require constructing and staffing many new community health clinics as replacements for the old, largely defunct health posts and health stations. These CHC's will operate as satellites around health centers, with five CHCs to one health center. When operational, this new system should strengthen the provision of PPHC and facilitate management at all levels.

4. RP1: INCREASED RESOURCES DEDICATED TO THE HEALTH SECTOR, PARTICULARLY TO PRIMARY AND PREVENTIVE HEALTH CARE

Results Package 1 is directly related to IRI. This Intermediate Result is implemented through (1) the NPA program component that provides support for the implementation of national policies to increase resources dedicated to the health sector and assist in the implementation of a revised health care financing strategy, and (2) technical assistance through the project component to increase the capacity for resource management at central and regional levels. The NPA component directly supports implementation of activities under each of ESHE's four Results Packages, including promulgation of the STI/HIV/AIDS policy, increased resources to the Regional Health Bureaus (RHB), and policy changes to improve the environment for private sector investments in health.

4.1 RP1 Program Component: Implementation of National Policies that Will Increase Resources Dedicated to the Health Sector and Assist in the Implementation of a Revised Health Care Financing Strategy

The RP1 program component is carried out through ESHE NPA funds that resulted from a Program Grant Agreement for US$30 million. These funds are programmed into five tranches over the life of the ESHE program and are to be used for Ethiopia's external debt relief. In return for this debt relief, certain program conditionalities are established by the GFDRE and USAID/E, whereby the government agrees to undertake and institute specific policy changes.

The conditions for the first tranche of funds were successfully fulfilled in August 1996 and US$7.5 million was disbursed accordingly. For the release of this first tranche of funds the GFDRE agreed to and met seven conditions, the most important ones being (1) completing a draft "National Health Care Financing Strategy," (2) approving a government budget for Ethiopian Calendar 1987 (Western Calendar 1995/1996) that increased the health sector allocation in real terms and as a percentage of the government's overall annual budget, and (3) establishing the ESHE Central Policy Steering Committee.

Within the conditions for the second tranche of funds, two conditions call for enactment of legislation by the Ethiopian Parliament: (1) to approve a national health care financing policy and 2) to approve public advertisement, sale, and distribution of contraceptives. A conditionality that is set this high is risky because despite the good faith efforts of USAID and the government ministries involved, the outcome depends on the action of the Council of Ministers and the Parliament. However, given that the ESHE Steering Committee (ESC) is chaired by the Minister of Health and that it has representation from the MEDAC and Finance, the EET believes there exists sufficient government representation to ensure that the new HCF policy moves forward.

The MOH is fully supportive of the new Health Care Financing Policy and is reviewing the final draft policy paper before submitting it to the Office of the Prime Minister for review. Next, the Council of Ministers will review the draft policy. Finally, the policy legislation will be submitted to Parliament for action and passage.

USAID is reviewing MEDAC's submission to determine compliance for the release of tranche two. At present, the conditions for tranche three have been negotiated with the government and appear to be reasonable and probably achievable. However, the conditionality of the submission of a national policy on STI/HIV/AIDS to Parliament depends on a prior approval by the Council of Ministers? a step still not taken with regard to the HCF policy.

Recommendation:

1. **Conditionalities for tranches four and five, the last planned NPA disbursements, should be carefully negotiated to avoid creating agreements that cite conditionalities that USAID and the government ministries on ESHE's Steering Committee cannot directly influence.**

The EET does not assume that the $7.5 million disbursed to date under NPA has, by itself, leveraged the increased resources programmed to the health sector. A review of USAID's experience with NPA in sub-Saharan Africa concludes that "direct links between NPA and subsequent policy change are almost always tenuous at best because of the influence of other donors and overall government reform efforts currently under way." Reviews of NPA programs in support of the health sector in other countries indicate that NPA is most effective in bringing about policy changes and increasing resource allocations to the health sector when the NPA is used with other donors' efforts and with direct project assistance. This is the case with ESHE.

4.2 Intermediate Result 1, Sub-Results, and Performance Indicators

4.2.1 Intermediate Result 1: Increased Resources Dedicated to the Health Sector (Particularly to Primary and Preventive Health Care)

IR1 is devoted to increasing resources to the health sector and presently contains four sub-intermediate results: (1) increases in the government budget allocation to health, (2) increases in the proportion of public health expenditure covered through cost recovery and retention within the sector, (3) increases in capacity for resource management at both the central and regional levels, and (4) increases in private (NGO and for-profit) sector investment in PPHC service delivery.

This IR should be expanded to include increased capacity building at the MOH. USAID/E should consolidate and reword IR1 as follows: "Resources dedicated to health sector increased and *managerial capacity of the MOH strengthened*." The rationale for this suggested change is to consolidate within RP1 and its sub-IRs all health care financing activities and private and NGO sector activities aimed at increasing the total resources available to the health sector. Moreover, USAID should increase its focus on two key capacity strengthening activities that are high priorities for the MOH and the HSDP: (1) IEC and (2) central logistics support for the MOH's

overall forecasting, procuring, clearing, warehousing, and distributing of contraceptives, essential drugs, vaccines, and PPHC supplies.

The critical assumptions relating to IR1, "growth of the economy leading to increased budget allocations for health leading to increased expenditures for PPHC delivery," appear to be valid. However, the appropriateness or likelihood of the third critical assumption, "Private sector investment expanding delivery of PPHC" is questionable. The private sector, with the exception of NGO activity, has not been noted for delivering PPHC in any country, although in Ethiopia the service provided by rural drug vendors could conceivably fill such a role. In addition, it is unlikely that the higher prices associated with private sector delivery of PPHC would contribute much to the expansion in the face of the strengthening of the lower-cost public PPHC services.

Performance Indicator 1: Per Capita Expenditure on Health (or Percent of Gross Domestic Product Spent within the Health Sector) Increased

Budget allocations to the MOH increased from 5.8 percent in 1995 to 6.2 percent in 1996 and support the achievement of PI1. This is an appropriate indicator and should be maintained. Close coordination should be maintained by USAID/E with the World Bank and other funding agencies, and in particular for the next World Bank Appraisal Mission scheduled for March or April 1998. The team recommends that USAID/E continue participation with the Bank appraisal mission, preferably on a full-time basis.

4.2.2 Intermediate Result 1.1: Government Budgetary Allocations to Health (and PPHC) Increase

Performance Indicator 2: Share of Health Budget Allocated to Primary and Preventive Health Care Services

The second performance indicator under IR1.1 refers to increases in the share of the health budget allocated to health centers and community health clinics (proxy for PPHC services). USAID/E should retain this indicator recognizing that the GFDRE may increase the capital budget more quickly than the recurrent budget. If this occurs, the percentage of the overall budget available for PPHC could be decreased, but increased in real terms.

ESHE technical assistance through the Health Care Financing Secretariat and special studies can assist the MOH in bringing together and harmonizing these separate budget exercises within the government's overall policy reform efforts. USAID/E should explore with the ESHE Steering Committee ways in which these two budget exercises at the MOH's central and regional levels can be brought together and coordinated to complement each other. The use of conditionality, to be negotiated and amended into future incremental funding amendments of the Program Grant Agreement, should be explored.

4.2.3 Intermediate Result 1.2: Increased Proportion of Public Health Expenditure Covered through Cost Recovery and Retention within the Sector

This is the critical area of health care financing and carries with it two specific performance indicators:

- Performance Indicator 1: Increased share of public non-salary expenditure covered through cost recovery, and
- Performance Indicator 2: Increased proportion of resources generated by health institutions that is retained within the health sector.

The wording and the description of activities covered by this sub-IR are too general. The Mission should consider changing the wording and the objectives/indicators to "Increased self-financing of public sector health facilities through cost recovery and increased role of the private sector in delivering health services." Furthermore, the PIs for this IR merely repeat more or less what the IR states; they should be made more specific. As part of the HCF strategy development process, the EET recommends that USAID/E and ESHE program/project partners develop PIs to track the following:

- revised fee structures,
- the level of fee retention at the facility level (additivity),
- revised exemption policies, and
- increases in the number of private (NGO and for-profit) clinics registered.

A restructuring of IR1.2 along these lines would obviate the need for the second performance indicator under IR1.2 and would begin to frame USAID's policy reform dialogue with the ESHE Steering Committee over the next five years. PIs specific to the SNNPR could also be formulated and tracked as a measure of success in USAID's focus region. If this change was adopted, then IR1.4 and its performance indicators would be amalgamated into IR1.2. This will allow the Health Care Financing Strategy and its technical assistance to address both the public and private health sectors. Reform of current policies on health care insurance should be explored to open up the market to urban-based health maintenance organizations and a wider range of employer-financed health care schemes.

4.2.4 Intermediate Result 1.3: Increased Capacity for Resource Management at Central and Regional Levels

As written, IR1.3 is an attempt to increase capacity for resource management, track budget allocations and expenditures, and increase the technical capacity to plan budgets at all levels of the MOH. If the Mission concurs with the previous suggested changes, then the budgeting activities shift to IR1. The language for IR1.3 should be changed to read: "Increased capacity of *selected MOH activities to better manage resources* at central and regional levels." This increased capacity should be applicable to all regions, not just to the ESHE focus region. This change focuses IR1.3 on two activities that the EET identified as high priorities for the MOH under the HSDP, and which ESHE is well positioned to support (1) strengthening the MOH's capacity to forecast, procure, clear, warehouse, and distribute contraceptives, essential drugs, vaccines, and PPHC supplies; and (2) strengthening IEC at the central MOH. Among the donors currently working in Ethiopia, USAID has the comparative advantage to address these two interventions.

The present PIs under IR1.3 are too vague and not able to measure progress in this IR adequately. For example, "budgetary allocations expended" does not reveal much about the quality or skills used to manage resources. Therefore, the EET recommends two new PIs:

(1) "Development of appropriate managerial skills in budgeting, planning, and financial management through targeted capacity building and training"; and

(2) "Strengthened supplies forecasting, management, and logistical systems, including computerization, at the central MOH and RHB."

4.2.5 IR1.4: Increased Private (NGO and for-profit) Sector Investment in Primary and Preventive Health Care Service Delivery

This IR is the most vulnerable to the critical assumptions stated. It cannot be assumed that the private sector, with the exception of NGO FP services, including condom social marketing (CSM), will increase its capacity or that its credibility will increase through quality controls and standards. It is not clear who will control the private sector's participation, who will set the standards, or what those standards will be.

Secondly, it cannot be assumed that the private sector will find increasing numbers of clients in the present economic circumstances, particularly when private sector fees will be greater than those of the public sector. Therefore, apart from an increase in service delivery by NGOs in FP, which is directly supported by ESHE and which looks likely to play an increasingly important role in FP and HIV/AIDS prevention, it is unlikely that this IR will be met or that its PIs are appropriate.

4.3 ESHE's Project Component: Intermediate Result 1

4.3.1 Basic Support for Institutionalizing Child Survival

BASICS is the USAID-funded contractor charged with a major role in implementing IR1.2, health care financing, and IR1.3, technical capacity in planning and budgeting improved. BASICS has experienced significant difficulties. There was a late start-up of technical assistance. The final selection for the BASICS chief of party was approved only in late 1996 and he arrived in January of 1997. In addition, there was a delay in recruiting and approving a long-term health care financing advisor. Although this position was finally filled in late September 1997, it was 18 months after the official start of the project, with only one year remaining in the BASICS contract. Furthermore, there appears to have been a problem finding an appropriate counterpart for the HCF advisor and establishing the HCF advisor within the MOH.

During ESHE's design phase, BASICS was selected with the knowledge that the central contract would expire in September of 1998. Given the scope of technical assistance called for under ESHE at both the central and regional level, it is clear that even if a fully-staffed BASICS team had been available from ESHE's early stages, the contractor's work would not have been fully completed by September 1998.

As predominantly a child survival project, BASICS may have lacked some necessary experience and expertise in national-level policy dialogue, health care financing, and delivery of reproductive health services. However, as a USAID/Washington centrally-funded contract, BASICS was able to offer USAID/E several advantages:

(1) Ability to tap into a greater depth of technical resources than could be found with a single contractor;

(2) Ability to provide funding and TA for complementary activities not originally envisaged in the contract as alternative financing may be available to respond to opportunities;

(3) Ability to assist missions and governments with start-up activities in advance of project approval and signing of delivery orders; and

(4) Ability to draw on experiences from a great number of other countries programs.

On the other hand, the disadvantages of this CA are large overhead costs and possible differences in the agendas and mandates between BASICS/Global and BASICS in a particular country. For example, there has been some tension between BASICS/SNNPR staff and BASICS/Global over the latter initiating unrequested technical consultancies relating to BASICS/Global's core areas, namely integrated management of child illness (IMCI), sustainable immunization, behavior change, nutrition, and private sector participation.

BASICS has supported ESHE's activities by participating in a national Expanded Program on Immunization (EPI) review and formulating recommendations on EPI policies and implementation; participating in the national IMCI Task Force to develop national policies and guidelines for implementing integrated child health care; conducting study tours for health systems design to Ghana and Uganda, and a study tour to Kenya on government cost-sharing programs; and providing computer training for staff from the central MOH. Since the signing of the BASICS contract and the arrival of the chief of party, BASICS has conducted two workshops and has sponsored six staff from the central MOH and thirteen other MOH staff from regions other than the SNNPR for short-term training.

Table 1 lists the intended activities for BASICS support to HCF. BASICS's strategy as stated in BASICS's report to USAID on accomplishments as of September 30, 1997, and its future plans are as follows: To conduct background studies on HCF, and once the HCF policy has been enacted, support its implementation through technical assistance and financial support to the Health Care Financing Secretariat.

Table 1

BASICS - Status of Key Indicators - HCF

Indicator/ Results	# of Planned Financing Studies Completed	# of HCF Workshops or Seminars Conducted	# of Health Care Financing Meetings Held with National Secretariat (or Equivalent)
Unit of Measurement	Number of studies	Number	Number of meetings
Source	BASICS's project reports	BASICS's project reports	BASICS's project reports
Frequency of Measurement	End of Project	End of Project	End of Project
1998-Planned	4	2-3	
1998-Actual			
Comments			As of 9/30/97, HCF strategy had not been adopted and HCF Secretariat was not established

There has not been enough time for BASICS to develop close relations with a cadre of staff within the MOH and begin initial "gap studies," analyze capacity-building needs, conduct studies into costs for both preventive and curative services, assess the ability and willingness to pay for health services, and generally set the stage for implementation of cost recovery. Both BASICS and USAID/E can play a more proactive role in setting the stage for the government's adoption of the HCF act. At this time, the BASICS HCF advisor should be working within the MOH and have appropriate counterparts assigned and lines of communication established to the vice-minister for health. An ad hoc working group of MOH personnel has been identified and increased efforts are needed to unite this group to undertake the HCF background studies at this time. The rationale for this is to create the Secretariat for HCF as an ad hoc group in advance of the legislation.

4.3.2 ESHE Project Component Summary

With regard to IR1.3, "Increased capacity for resource management at central and regional levels," this activity is vital but far too ambitious under the present contractual arrangement with BASICS. Because of what has been achieved in the areas of central management capacity strengthening, the perceived management and capacity needs in the MOH, and the limited time left under the present BASICS contract, the EET recommends that activities under this subcomponent be focused on HCF-specific activities, which BASICS can carry out, as well as on the two technical areas listed in the following recommendations.

Recommendation:

2. BASICS should focus on two specific managerial strengthening activities for the central MOH: (1) assistance to the MOH in planning the implementation of an effective Health Care Financing Policy and (2) assistance to the MOH to initiate reform of the current MOH budget process as part of the government's civil service reform effort.

At this time, USAID/E should use the services of two USAID/Washington centrally-funded projects, Family Planning Logistics and Management (FPLM) and the Johns Hopkins University Population Communication Services (JHU/PCS). FPLM could be engaged to devise a workplan, in close collaboration with UNFPA, to improve the Ministry's capacity, expertise, and systems in forecasting, procuring, and handling inventory control and distribution of contraceptives, essential drugs, vaccines, and medical supplies. JHU/PCS could become active in providing assistance to the Health Education Department within the MOH to develop national-level IEC policies with special attention to HIV/AIDS prevention and the promotion of family planning. The policies and generic materials should be appropriate for dissemination to the regions. BASICS personnel should be positioned in the various departments within the MOH as soon as possible.

USAID/E should now design a new scope of work for technical assistance in HCF, capacity building, and regional focus (SNNPR) activities to fill the void that will be created when the BASICS contract expires. USAID/E should ensure that adequate technical expertise is available to the Mission to create specific work objectives for the next phase of technical assistance to the MOH in the area of HCF, policy analysis and formulation, and specific management strengthening interventions. A SOW should be completed as soon as possible to allow sufficient time for the Mission to advertise, review, and award this critical post-September 1998 funding agreement to support IR1, which needs to begin no later than October 1, 1998.

Recommendation:

3. USAID/Ethiopia should develop a SOW for the follow-on project to BASICS and issue the request for proposal as soon as possible.

5. RP2: INCREASED ACCESS TO AND DEMAND FOR MODERN CONTRACEPTIVE SERVICES IN FOCUS AREAS

RP2 is directly supported by IR2, increased access to and demand for modern contraceptive services in focus areas, and its four sub-IRs: increased availability of family planning services through the Consortium of Family Planning (COFAP)/Pathfinder International (IR2.1), expanded condom and oral contraceptive social marketing (IR2.2), increased knowledge of modern contraception among reproductive age women (IR2.3), and increased government capacity to deliver modern family planning methods (IR2.4). CAs and NGOs implement IR2 and its sub-IRs, working collaboratively with the NOP and the MOH.

5.1 The Technical Committee

During the early phase of project implementation, a Technical Committee (TC) was established to ensure effective coordination of the NGO sector RH/FP program. This TC is composed of representatives from the NOP, the Family Health Department (FHD)/MOH, COFAP, USAID/E, and Pathfinder International. This committee is responsible for the review and approval of all project proposals submitted by NGOs, workplan and budgets, programmatic and financial reports, and project progress. The TC also provides overall guidance for project implementors. The head of the NOP or his designee serves as the chairperson of the TC; the country director of Pathfinder International or his designee serves as the secretary of the TC.

The TC has helped to coordinate ESHE's family planning project activities with the national family planning program; facilitated effective and collaborative relationships among the NOP, the MOH, USAID/E, and Pathfinder; and assisted in developing, approving, and coordinating family planning program activities funded by the project in line with the government's health and population policies and USAID/E's country strategy. The TC's coordination mechanism has been effective and all partners are satisfied with the arrangement. Also, the TC has been instrumental in communicating CAs' activities and results to appropriate government counterparts and increasing the scope of coordination to integrate activities across RPs.

5.2 The Players, Their Roles, and Their Performances

5.2.1 Pathfinder International

Pathfinder International manages the five-year project designed to strengthen Ethiopia's family planning and reproductive health service delivery in partnership with the CAs Family Health International (FHI) and AVSC International (AVSC).

Pathfinder is responsible for project management and provides technical assistance, training, subgrant funding, and commodities to COFAP and its members for institutional and program development. As manager of the project, Pathfinder coordinates activities of AVSC and FHI and acts as a principal liaison between the project and COFAP, consortium members, the NOP, the

MOH, USAID/E, and other CAs. Pathfinder, in collaboration with FHI and AVSC, has been responsible for preparing the project's five-year workplan and coordinating annual meetings to develop annual workplans, including TA plans. In addition, Pathfinder conducts quarterly program meetings, coordinates sharing of trip and program reports, arranges meetings with involved parties, and obtains travel concurrences. This arrangement has helped the CAs to effectively coordinate and jointly plan their activities.

The EET reviewed Pathfinder's workplans and project documents and proposals and has found them to be consistent with ESHE's objectives. Pathfinder has provided technical assistance, short-term training, and delivery of commodities in a timely and cost-effective manner. Pathfinder's assistance to COFAP and the public sector has contributed toward improving the capacity of and institutional strengthening in the NGO sector and, to some extent, the public sector. Government and NGO partners are highly satisfied with the results achieved through the technical assistance received and through their participation in program and project committees. The staff, which includes the country representative, two program officers, one financial and administrative officer, one administrative assistant, and three support staff, has been sufficient and cost-effective in complying with the current level of program and project requirements. The financial management and reporting system of Pathfinder and all relevant CAs have been adequate for Mission management requirements; however, it should be noted that the Mission receives very limited information on expenditures for its activities financed through field support resources, and all CAs under this RP receive funding through this mechanism.

5.2.2 AVSC International

AVSC International provides TA, training, and subproject funding to COFAP members to introduce or expand tubal ligation, vasectomy, and NORPLANT? services in NGO and public facilities. AVSC also collaborates with Pathfinder to introduce postpartum intrauterine devices in maternities and hospitals as appropriate.

AVSC has a subagreement with the Family Guidance Association of Ethiopia (FGAE), a leading NGO in the provision and promotion of population-related reproductive health and family planning activities in Ethiopia. The EET finds AVSC/FGAE's workplans to be consistent with ESHE's objectives. Technical assistance, in the form of short-term training and clinic- and client-based services, has increased. AVSC/FGAE assistance to COFAP members and the public sector has been a plus, though delays in activity implementation have occurred, particularly in the public sector. Finally, the EET notes the disadvantage of running the program from Nairobi and suggests USAID/E explore an alternative, cost-effective arrangement.

5.2.3 Family Health International

Family Health International is responsible for conducting baseline/demand and follow-up surveys, developing and implementing a standard program monitoring and evaluation system, monitoring and evaluating the impact of IEC interventions and setting up the management information system (MIS), and training COFAP members.

FHI's workplans, the monitoring and evaluation (M&E) system developed, and subagreements signed with four NGOs to facilitate the development and introduction of the M&E system, are consistent with ESHE's objectives; however, the partners view of the new M&E system is mixed and there is resistance among some NGOs.

FHI currently works with COFAP, the FGAE, Marie Stopes International-Ethiopia (MSI-E) and other COFAP-affiliated NGOs. FHI's activities to provide technical assistance in developing training manuals on data collection, management, and reporting to build NGOs' capacity to use data as a management tool is also consistent with ESHE's objectives and can open the venue for NGOs to work to improve the capacity of the public sector.

5.2.4 Denke Kestet Letena/Population Services International

In August 1995, USAID and Population Services International (PSI) signed a cooperative agreement under which Denke Kestet Letena (DKT)/PSI continues to socially market its highly subsidized Hiwot Trust condom and conduct innovative IEC activities throughout Ethiopia. During 1996 and 1997, activities under DKT/PSI's Ethiopian Social Marketing Program (ESMP) expanded the sales of condoms and oral contraceptives (OC).

The EET has reviewed DKT/PSI's cooperative agreement, workplans, and progress reports and has found them to be consistent with ESHE's objectives. All government and NGO partners are highly satisfied with the results achieved through DKT/PSI's activities and its innovative IEC programs to reach target audiences throughout Ethiopia. The staff composition is sufficient and cost-effective and complies with the current level of program activity requirements.

Table 2

CA Activities Under RP2

Area	Lead Agency
Clinical Methods	
Tubal ligation	AVSC
Vasectomy	AVSC
Norplant	AVSC
Other	Pathfinder
Non-Clinical Programs	
Community-Based Distribution	Pathfinder
Workplace	Pathfinder
Adolescents	Pathfinder
Service Delivery Support	
Client-Oriented Provider Efficient (COPE) Services	AVSC
Counselling	Pathfinder
IEC materials preparation	Pathfinder
Commodities; Logistics	Pathfinder
Monitoring & Evaluation	
Management Information System (MIS)	FHI
Catchment Area Surveys	FHI
Special Studies	FHI
Project Evaluation	FHI
Reporting	Pathfinder
Management	
Project Management	Pathfinder
FP Program Management	Pathfinder
Coordination with NGOs, Consortium, GOE, USAID, Other CAs	Pathfinder
Institutional Development	Pathfinder
Sustainability/Cost Recovery	Pathfinder

5.3 Intermediate Result 2: Increased Access to and Demand for Modern Contraceptive Services in Focus Areas

The mechanism for implementing the activities established under Pathfinder, AVSC, and FHI is established by a five-year (1995-1999) family planning project, "Project Proposal for Improvement and Expansion of Family Planning Services in the NGO and Private Sector in Ethiopia." The purpose of this project is to increase the access and availability of high-quality family planning services through the NGO Consortium and its members in focus areas. During phase one discussions, the distribution of program centers, the geographical area to be covered, and service sites were expanded; project activities were executed in accordance with the five-year project.

In the last two years, subgrants were given to NGOs to assist them in expanding the number of sites offering family planning service. Model NGO clinics were established in a number of regions to expand FP service. FP services were made available through community-based distribution, as well as through the workplace, private practitioners, outreach satellites, youth centers, and clinic-based and marketplace programs. Commodities and equipment were supplied to establish an effective service delivery system. Support to IEC efforts was provided in training and curriculum review and development of materials, and through addressing the needs of adolescents with IEC and counseling services to improve awareness.

Improved family planning service was provided in 27 urban and periurban centers, 27 clinics, and 22 community-based reproductive health agents programs. One marketplace, three adolescent programs, and seven workplace programs were initiated to serve those segments of the population and geographical areas that have been beyond the reach of existing FP facilities. Efforts were made to broaden method mix and services provided at project-supported health facilities. Model clinics and eight public hospitals were assisted in introducing long-acting and permanent methods of family planning. Three clinics were upgraded and equipped to diagnose and treat STDs, and one FGAE clinic was equipped and renovated to provide MCH and STI/HIV/AIDS services, as well as family planning services. The review of FGAE's activities and each individual NGO's interventions discussed in the relevant sections of this report highlights the progress made toward achieving ESHE's objects.

IR2, its sub-IRs, and relevant performance indicators are reasonable and well-stated; the achievement of IR2 is expected through ESHE project activities. The critical assumptions still appear to be valid, though full legitimacy of contraceptive promotion and sale still awaits legislative action by the GFDRE, and the issue of import taxes and duties on contraceptives still awaits resolution.

The overall assessment, as measured by RP2 performance indicators, confirms that by the end of 1996 and 1997, the number of families able to plan their families with support of COFAP/Pathfinder NGO support mechanisms and DKT/PSI-supported condom social marketing has increased significantly compared to the baseline year 1995. The performance indicators are technically sound and have provided basic information on how well the activities undertaken respond to sub-IRs 2.1 and 2.2.

The number of new clients receiving modern FP services in ESHE focus areas (24,000 in 1995) has increased significantly, reaching 39,000 in 1996, and is expected to increase to 41,000 by the end of 1997. The number of couple years of protection (CYP) generated under COFAP/Pathfinder activities was 54,000 in 1996, and the planned target for 1997 is 90,000 (the base year 1995 was 45,000); according to Pathfinder's quarterly reports, the planned target is expected to be achieved. Progress in implementing planned 1997 FP activities in ESHE's focus areas has been satisfactory. CSM, starting with 1995 baseline CYP of 60,000, reached 160,000 in 1996, and is planning to reach the target of 236,000 in 1997. The 1997 introduction of the oral contraceptive "Prudence" came with reported sales of 263,040 cycles compared to the planned 500,000 cycles target; thus, a shortfall in the planned CYP is likely.

5.4 RP2.1: Increased Availability of Family Planning Services Through COFAP/Pathfinder

Four specific strategies were adopted to achieve RP2.1: (1) expanding family planning services provided by the private sector for specific populations in targeted urban and periurban communities; (2) developing and operationalizing systems for assuring high-quality family planning services for specific populations in focus areas, (3) developing and integrating standardized and comprehensive monitoring and evaluation systems in overall project management, and (4) strengthening and sustaining the NGO Consortium and its members' capability to deliver high-quality family planning services.

5.4.1 Expansion of Family Planning Services Provided through the Private Sector

The Family Guidance Association of Ethiopia

For the last 30 years, FGAE has been the leading NGO in providing and promoting population-related reproductive health and family planning activities in Ethiopia. FGAE is also a major NGO in implementing ESHE-supported project activities and has been efficient and effective in delivering RH/FP and related services. Under this project, FGAE has established seven program centers to coordinate RH/FP services and seven model clinics to provide training and referral service linkages. FGAE has also initiated community-based reproductive health (CBRH) programs, outreach, adolescent, and workplace and marketplace programs. From the field visits to the Amhara Region and SNNPR, it was clear to the EET that FGAE knows how to plan, organize, operate, and expand CBRH of family planning services. Its community-based reproductive health agents (CBRHA) are serving substantial numbers of new acceptors within a relatively short time frame.

The field visits to the Amhara Region and SNNRP also confirmed that FGAE is capable of significantly expanding and replicating its CBD program if provided with additional resources. The program is implemented in collaboration with local health authorities (e.g., urban Kabeles actively select CBRHAs). FGAE has also begun to pilot some innovative service delivery activities through the promotion of youth programs run by peer family life education promoters. Programs operating at seven schools in Bahir Dar (five junior and senior secondary schools and two polytechnic colleges) are impressive because of their apparent acceptance and support by school administrators and parents.

With its CBRHA and related innovative outreach models, FGAE has the potential to significantly expand into rural areas where the need for RH/FP is greatest.

Marie Stopes International-Ethiopia

Marie Stopes International-Ethiopia (MSI-E) operates a CBRH activity in Woreda 4, Kebele 20, Addis Ababa, and Dire Dawa through the ESHE program with support from Pathfinder. However, in the past few years MSI-E has expanded its programs to the regions where most of the population have limited or no access to such services. MSI-E is also undertaking important RH/FP activities in MR, ANC, EPI, and contraceptive distributions. Pathfinder is currently reviewing a plan for MSI-E's expansion into other regions and, given the increased demands for service, MSI-E has expansion potential.

Ethiopian Evangelical Church Mekane Yesus'

The program focus areas of the Ethiopian Evangelical Church Mekane Yesus' (EECMY) are the whole Hadiya and Kembata, Alaba, and Timbaro zones of the southern region. The program is the first model of community-based reproductive health agents undertaken in Ethiopia with respect to area of coverage, rural focus, and number of agents trained and deployed at one time. It is the first program to use the National CBRH Curriculum and Protocols for training and guideline for the agents. Experience learned through this process is expected to be shared among

stakeholders. However, EECMY is not the only organization that uses the National CBRH Curriculum. The Curriculum is also being used by other COFAP members and the MOH. The outcome of this model has important implications on the direction of CBD models.

EECMY's CBRH model is similar to that of other Pathfinder-supported NGOs. First, it establishes selection criteria for CBRHAs, including education, length of residence in the community, and marital status. Local communities then choose from a list of qualified candidates in an open meeting and both males and females are selected.[8] There is also a two-day, awareness-raising workshop for religious and other local leaders in communities where CBDs will operate. CBDs are initially paid a monthly travel stipend that varies in amount by region and implementing NGO. In some areas (e.g., Alaba in the SNNPR) contraceptives are given away free in the early program stage but are later sold with profit margins that are retained to pay the CBRHA.[5]

CBRHAs also promote HIV and STI prevention, child immunizations, and several other PPHC elements. This seems to make the program more acceptable and preempts potential opposition from religious or traditional leaders. One measure of this is that contraceptive acceptance rates in Muslim areas in at least two SNNPR zones are as high as those in Christian areas, according to a EECMY zonal supervisor.

CBRHAs appear to be well-trained, well-supervised, and regularly resupplied with commodities. Each CBRHA is provided with a kit with contraceptives and other commodities and health education materials. STD cases are assessed symptomatically by the CBD, then referred to a health center. Out of 135 CBRH agents, there are only 28 males.

This CBD model has been successful in motivating CBRHAs. It has served to quickly educate Ethiopians about family planning and modern methods and has resulted in thousands of new acceptors in a relatively short time. Yet, the sustainability of the cash incentives has been questioned (see discussion of CHW incentives in Chapter 7 and Appendix E.

Conclusion: In spite of efforts to improve existing services through NGO activities and the public sector RH/FP program, RH/FP services in Ethiopia are still characterized by inadequate facilities and service providers. RH/FP indicators depict a high fertility level, low CPR, high incidence of adolescent pregnancy, and unsafe abortion, as well as a rising prevalence of HIV and other STIs. Although a national population IEC strategy exists, IEC is weak due to lack of trained manpower, financing, materials, and equipment, and a shortage of IEC materials for specific target groups. This indicates the challenges and opportunities for increased demand and assistance for the private and the public sector.

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[5] (Margins were found to range from 30 percent to 60 percent through NGOs nationwide. CBRHAs can also earn commissions on successful referrals for IUDs and NORPLANT.)

FGAE and other Pathfinder-supported NGOs have done much to quickly raise demand for FP and to provide access to contraceptives. These efforts have increased demand for and actual use of family planning services in the private and public sectors. Moreover, the training and service delivery models developed by FGAE and other NGOs are very relevant to the needs of the public sector. The need to develop an effective IEC strategy and to expand IEC services and develop materials tailored to the situation and needs of adolescents is evident.

Recommendations:

4. **The potential for FGAE program expansion (static clinics, outreach sites, youth programs, etc.) should be explored during the next phase of the project with adequate resources allocated to support it.**

5. **FGAE should strengthen its IEC and counseling capacity by developing a target-oriented IEC strategy, training core IEC personnel, training staff in FP/RH counseling, and developing an IEC manual (guideline) for service providers. The provision of technical assistance and required funds for IEC should be considered and implemented.**

6. **Increased resources should be allocated to FGAE to strengthen and expand adolescent RH counseling and services in branches and to integrate adolescent reproductive health services in all static clinics, as well as to develop standards of practice of adolescent reproductive health counseling and services and training of adolescent health service providers. A peer promoters training manual/guideline including integration of life skill training should also be developed.**

7. **The potential for expanding other NGO programs (i.e., Marie Stopes International, Mekane Yesus, and Good Shepherd) needs to be explored, and if feasible commensurate resources allocated during the next phase of the project**.

8. **USAID/E should review the resources available to expand FP and related services in the public sector and allocate increased resources to strengthening this sector during the next project phase.**

5.4.2 Developing Systems for High-Quality Family Planning Services

The major project component, supported mainly through AVSC/FGAE's activity, was intended to support the introduction and expansion of quality clinic-based family planning services at seven FGAE sites, eight public sector sites, and up to three private practitioner sites. Developing

quality family planning services also includes developing quality assurance systems that include training curricula and protocols. To this end, Pathfinder's assistance to develop the Infection Prevention Manual, Clinical Standards of Practice, NCBRH Training Curriculum Protocol, and Supervision Checklist were important contributions to improving quality of care.

Technical assistance in the form of training and quality improvement was programmed for three additional NGO Consortium members: Marie Stopes International, Mekane Yesus, and Good Shepherd. The project also provided financial assistance for key equipment and supplies and for limited facility renovation; technical assistance in the supervision and management of these services; skills training in minilaparotomy under local anesthesia (ML/LA), vasectomy, and NORPLANT insertion and removal; training for facility-based staff in counseling for all contraceptive methods (including postabortion counseling); and infection prevention.

Public Sector Sites

Assistance to public sector institutions under ESHE's "quality-based family planning service" has included specialized equipment, ML/LA kits, accessory and expendable supplies, training of personnel, quality assurance monitoring, and supervision. Under the project and earlier support, a total of 27 physicians, 20 operating room nurses, and 65 counselors received ML/LA training. FGAE and AVSC provided ML/LA skills training and updates, technical support for COPE (Client-Operated, Provider-Efficient Service) introductions and follow-up, and supervision and monitoring of the quality of clinical family planning services. These organizations also provided financing for minor renovations and established dedicated space for clinical family planning services. The public sector program was confronted by problems and obstacles that limited its capacity to provide quality clinical contraceptive services. Two such important problems were high turnover of trained providers and frequent changes of administrators and managers.

Family Guidance Association of Ethiopia

Support to FGAE was intended to expand clinical services to six additional sites: Gondar, Bahir Dar, Awassa, Nazareth, Mekele, and Dessie. Gondar and Awassa were previously renovated with assistance from Pathfinder. Bahir Dar is scheduled for renovation under this subagreement. The other FGAE sites were to receive equipment, expendable supplies, and technical assistance. All six branch FGAE clinics are now providing NORPLANT services and four? Nazareth, Gondar, Bahir Dar, and Dessie? offer ML/LA. Awassa was scheduled to start providing ML/LA services in August 1997. Currently FGAE remains heavily dependent on two FGAE headquarters surgeons to perform ML/LA at the six newer sites. Important progress has been made in arranging for sessional doctors to perform ML/LA at all sites, except Awassa and Nazareth. FGAE clinics in Awasa, Bahir Dar, Gondar, Dessie, and Mekele have been renovated, equipped, and staffed with Pathfinder's assistance to provide ML/LA and NORPLANT services. In addition, the Nazareth and the Saris clinics are mainly supported (staff and supplies) by Pathfinder. NORPLANT training has mainly been supported by the MOH.

Other NGO Consortium Members

To date, the majority of AVSC-funded assistance used by COFAP members is in the form of skills training and updates in VSC and family planning counseling, NORPLANT insertion and removal (training and updates), infection prevention, and general FP technology. Technical assistance is to be provided according to the respective NGO's absorptive capacity for equipment and technical and management assistance provided through FGAE. Funding is available for expendable supplies and ML/LA and NORPLANT kits as these organizations develop the capacity to provide clinical services. AVSC funds are also available for technical assistance in the form of skills training, updates and refreshers, orientations related to clinical family planning, and other RH-related services (e.g., general FP technology, postabortion care, etc.).

Private Sector Sites

Initially, three private sites? St. Gabriel General Hospital, Bethel Women's Clinic, and Chapter 2 Polyclinic? were programmed to receive project support in the form of ML/LA and NORPLANT skills training and updates, and technical assistance including an introduction to COPE and other quality management tools, basic equipment, expendable supplies, and ML/LA kits. A major obstacle has been the absence of policy on donor support for the private sector.

Conclusion: In spite of considerable institutional, infrastructure, and procedural obstacles and delays faced by the public sector and problems faced by private providers including FGAE and COFAP, important progress has been made in expanding the availability of permanent and long-term family planning services in Ethiopia. FGAE has reported that the public sector hospitals that are designated to provide clinical contraceptive services (VSC) do not consider the service as one of their responsibilities. Therefore, the question of ownership of the project is an important issue that needs to be addressed if the problem is to be solved.

Future project focus should address problems of the public sector, which has served less than the expected number of permanent and long-term clients needs. The effort in this regard should address obstacles that limit the capacity of the public sector to provide increased quality clinical contraceptive services and address the question of responsibility and ownership of VSC services in the public sector.

Recommendation:

9. Future AVSC involvement to support the NGO and public sector should be assessed and reviewed to streamline and/or strengthen its future direction. Coordination of AVSC's activities in the NGO and public sectors need to be improved.

5.4.3 Developing a Comprehensive Monitoring and Evaluation System

One of the main strategies of the USAID/E-sponsored project is to develop a standard and comprehensive monitoring and evaluation system and incorporate it into the overall management of the project. The CAs, in consultation with COFAP and FHI as the lead agency, have developed an M&E system for COFAP and Pathfinder-supported NGOs. The M&E instruments developed include a Family Planning NGOs Assessment Form, Service Delivery Point (SDP) Assessment Form, Family Planning Client Exit Interview Form, Catchment Area Sample Survey Female Questionnaire, Catchment Area Sample Survey Male Questionnaire, Monthly Monitoring Form, and Public Sector Service Delivery Assessment.

These instruments are appropriate to the long-term objective of the project. Progress made in this effort includes (1) NGO and service delivery forms developed; (2) a baseline assessment of 6 NGOs and 20 SDPs completed; (3) a workshop organized to establish consensus on the need for a comprehensive and standardized M&E system; (4) a technical committee formed on the basis of the workshop recommendation; (5) a monitoring system for routine collection of service statistics established? daily activity register, clinic client card, and CBRH daily activity register; and (6) subagreements signed with FGAE, MSI-E, COFAP, and EECMY-SCS as part of the phase one activity to enable these organizations to implement a new standardized and comprehensive M&E system by putting in place additional personnel, equipment, and training.

Status of the initial effort to implement the M&E system stands at 6 NGO and 20 SDP baseline assessments made and the client exit interview process initiated in 3 FGAE sites in Addis Ababa, Awasa, and Nazareth, and in 3 MSI-E sites. A catchment area survey has been completed in EECMY-SCS, a new comprehensive and standardized system for routine collection of services statistics designed, and four subagreements of the M&E system executed.

Conclusions: The development and introduction of a new system for the collection of service statistics and the integration of an M&E system in NGO project management is a difficult task, particularly in a situation where technical capacity is lacking, and where immediate data needs may conflict with long-term institutional building efforts. Because of the difficulties COFAP members encounter in terms of the diversity in their programs and target beneficiaries and the lack of skilled manpower and training, the phased implementation strategy is appropriate.

Also, the process of M&E systems development and operationalization, involving FHI with a subcontract with an M&E team of Ethiopian experts drawn from the Demographic Training Center (DTC) at Addis Ababa University, is an important step toward M&E technical capability building and sustainability. When fully implemented, the system could be capable of generating relevant effect indicators (intermediate outcome indicators) that show the status in achieving the intended results of the program process and outputs including changes in contraceptive prevalence and proportion of eligible individuals or couples who are practicing contraception for

spacing or limiting of births at a given point of time in a defined catchment area of the service delivery outlets.

Recommendations:

10. **During phase two of the project implementation, additional funds should be made available to expand FHI's technical assistance to the public sector to develop a similar M&E system for the overall management of the public sector FP/RH services.**

11. **FHI activities should be expanded to undertake programmatic and operational research covering such areas as new approaches to expand FP/RH services through channels such as workplace and marketplace programs, male involvement in FP/RH activities, impact of IEC in creating awareness, changing attitudes and behavior, client willingness and ability to pay for services, and remuneration for community-based reproductive health services.**

5.4.4 Strengthening and Sustaining the Consortium of Family Planning

COFAP was established in July 1993 with assistance from Pathfinder. Since 1995, a significant effort has been made to build COFAP's institutional capacity to ensure effective coordination mechanisms and networking.

COFAP's organization has three components: a General Meeting, an Executive Committee, and a Secretariat. The General Meeting is composed of all members who meet annually to review NGO family planning activities in Ethiopia; adopt an annual plan of action; examine government NGO cooperation, relationship with donors, and collaboration among members; and examine and adopt the coordinating committee's report. The Executive Committee, five members elected by the General Meeting, meets on a regular basis to review program progress and to provide guidance to project staff and the Secretariat.

COFAP's primary objectives are (1) streamlining and strengthening RH/FP NGOs' service delivery and skills by identifying and mobilizing technical, financial, and other resources to benefit member NGOs; and (2) fostering dialogue among NGOs and with appropriate public sector agencies to create an enabling climate that increases demand for and acceptance, accessibility, and use of RH/FP services throughout Ethiopia. COFAP has established its secretariat and its membership has increased from 7 to 33.

COFAP's Accomplishments

The most important accomplishments implemented with funding from Pathfinder are as follows:

- COFAP has assisted the MOH in developing and standardizing the "National CBRH Curriculum," "Protocol and Supervision Manual," and "Clinical Standards and Practice and Infection Prevention Guidelines" to be used by both the public and private sectors. These have already been endorsed by the MOH and MOH staff. Regional Health Bureau officers and COFAP members were trained as a national and regional core team.

- COFAP has developed a "Clinic-Based Service Delivery Standard of Protocols and Infection Prevention Manual" for FP service in Ethiopia. This manual is currently under review by FHD/MOH. Detailed cost-recovery and sustainability master plans for selected COFAP-member NGOs were developed and are under review.

- With a view to building the institutional capacity of its members, COFAP organized and implemented a number of training programs for service providers and management staff. Many program and finance managers and clinical and community-based service providers have been trained.

- A considerable number of IEC materials (i.e., posters and leaflets) were reproduced and distributed to member organizations. Recently, in close collaboration with the Health Education Coordination and Health Learning Materials Production Center of the MOH, all the necessary groundwork for the preparation of RH/IEC in-service training materials for all cadres was undertaken. This process is to be followed by training of trainers (TOT) for all service providers of member agencies.

Conclusions: COFAP has demonstrated effective coordination and partnership between NGOs and the public sector and has helped to establish a strong link between the efforts of NGOs and national policies and strategies. COFAP has also established a mechanism for sharing resources and experiences.

Recommendations:

12. **Continued support should be given to COFAP by allocating increased resources to strengthen its FP program management, and through providing appropriate technical assistance to strengthen the institutional capacity of its members and expand the NGO's RH/FP service delivery network.**

13. **There must be continued effort to register COFAP with the appropriate government office in accordance with prevailing laws.**

5.5 RP2.2: Expanded Condom and Oral Contraceptive Social Marketing

This is an ongoing AIDS and FP project implemented by DKT International and Population Services International with support from USAID, the Netherlands, the Swedish International Development Authority (SIDA), the Overseas Development Administration (ODA), the Norwegian Agency for Development Cooperation (NORAD), WHO, and DKT. In August 1995, USAID and PSI signed a separate Cooperative Agreement under which DKT/PSI has continued to socially market its highly subsidized Hiwot Trust condom and to conduct innovative IEC activities throughout Ethiopia. During 1996 and 1997, activities expanded the sales of condoms and oral contraceptives under DKT/PSI's ESMP. To date, USAID has provided contraceptives through global field support funds. DKT/PSI is registered with the Ministry of Justice as DKT-Ethiopia.

Under the ESMP, DKT/PSI expanded the market for Hiwot Trust condoms by six million pieces over the 1996 level, with 30 million condoms socially marketed by the end of 1997. DKT/PSI also introduced 300,000 cycles of the new low-dose OC, Prudence Duofem. The volume of condoms socially marketed was 20 million in 1995 and 24 million in 1996. Progress in CSM of condoms and oral contraceptives has been quite satisfactory and is a key component of RP2. The shortfall is attributed to DKT/PSI's caution with respect to advertising contraceptives (as opposed to disease prevention products) prior to liberalization of the law. No consumer IEC or product advertising has been conducted on the pill, although DKT/PSI have planned to incorporate family planning into their target audience IEC program beginning January 1998.

By the end of 1997, condom outlets had increased by 1,000, ninety pharmacies and drug shops in Addis carried Prudence Duofem, and policy dialogue with the MOH and the NOP continues to promote policy and legal reform on issues that affect contraceptive social marketing. Oral contraceptives have already been included on the official LIDE, and efforts to include condoms on the essential supply list and to effect changes in FP legislation are underway.

Complementing their marketing activities, DKT/PSI also conducts an innovative IEC program to reach target audiences throughout Ethiopia. In 1997 alone, their six IEC teams have reached 230,000 persons to discuss basic health issues, AIDS, and condoms. Other IEC activities include radio programs, radio and television advertisements, and promotional materials. By the end of 1997, AIDS information and education reached 180,000 people, and 1,320 radio advertisements (110 per month) and 50 television spots promoting or advertising Hiwot Duofem have been completed.

Customers are informed of the availability of the Prudence product with the advice that interested consumers may consult their doctor. Registration of Prudence was granted in December 1996, about two years later than hoped. DKT/PSI is expanding its use of CBDAs (in addition to

pharmacies, drug vendors, and NGOs) to sell Prudence. DKT/PSI has also initiated provider training in several areas and, as noted, will incorporate family planning into their IEC activities beginning in January 1998.

Conclusion: The EET has reviewed DKT/PSI's cooperative agreement, workplans, and progress reports and has found them to be consistent with ESHE's objectives. All government and NGO partners are highly satisfied with the results achieved through the DKT/PSI's activities and its innovative IEC programs to reach target audiences throughout Ethiopia. The staff composition is sufficient and cost effective and complies with the requirements of the current level of program activity.

5.6 RP2.3: Increased Knowledge of Modern Contraception among Reproductive Age Women

Progress in promoting increased knowledge of modern contraception among reproductive age women has been limited. Ongoing and planned activities intended to increase government capacity to deliver modern family planning services have had a limited impact. Pathfinder, through COFAP, has assisted the MOH in developing and standardizing the National CBRH curriculum, Protocol, Supervision Manual, and "Guidelines for Clinical Standards and Practices and Infection Prevention" for use both by public and private sector. These have already been endorsed by the MOH and MOH staff, and Regional Health Bureau officers and COFAP members were trained as a national and regional core team.

5.6.1 Recently Instituted Mechanisms

The implementation of the Johns Hopkins University/Population Communication Services (JHU/PCS) and the POLICY Project was initiated by USAID/E in 1996. However, the project activities planned between the NOP, JHU/PCS, and USAID have not been implemented and have been delayed considerably. The EET discussed this issue at length with the NOP Chief. This discussion revealed that the main reason for the lack of progress was the NOP's difficulty in starting project implementation before proper project appraisal and review. The NOP claims that it has been confronted with a take-it-or-leave-it situation, as opposed to a normal government project appraisal procedure, which the NOP is required to follow.

On the other hand, USAID/E claims that it has made it clear to the NOP that both the POLICY project and JHU/PCS activities are funded through field support resources and has had numerous discussion on the management and implementation of such funds in the past two years. Further, USAID/E claims that, together with the Bilateral Desk/MEDAC, it has actually tried to facilitate the request for the project appraisal and review for the JHU/PCS project. Discussion between JHU/PSI, Pathfinder, USAID/E, and the NOP on how to implement the IEC project has already

started and the NOP wishes to maintain the scope of the IEC project as per the previous agreement.

Progress in implementing the IEC activities under ESHE has been limited to COFAP's efforts and has resulted mainly in producing the IEC materials and implementing the previously described IEC activities undertaken by PSI/DKT. USAID/E had also provided two years of long-term technical assistance to NOP to support their effort in implementing the National Population Policy. The NOP is satisfied with the technical assistance provided to implement the objectives of the National Population Policy.

Conclusion: The POLICY project and JHU/PCS play a central role in meeting ESHE's objectives. In terms of achieving ESHE's objectives, the implication of the delay in implementing activities is serious because of the important role IEC plays in promoting national population policy implementation, which also contributes to the achievement of RP2's objectives. The EET urges the NOP and USAID/E to speed up the implementation of the projects. The data for the development of the performance indicators for RP2.3 will come from the Demographic Health Survey (DHS), scheduled for 1999, whose results may not be available before the year 2000. In view of this, the efforts underway to conduct knowledge, attitudes, and practices (KAP) surveys should be pursued and expanded to supplement the lack of data on the performance of RP2.3.

5.7 RP2.4: Increased Government Capacity to Deliver Modern FP Services

Activities related to capacity building include support to increase the capacity of central and regional health bureaus to play a strong advocacy role for population and FP, enhancement of the capacity by providing commodities and training, and support to strengthen the MOH's logistics management system. Activities related to policy include supporting change in FP legislation to allow the advertisement and wider distribution of contraceptives, supporting reforms to put OCs and condoms on the list of essential drugs and medical supplies, and supporting the development of operational policies that govern the provision of FP services.

5.7.1 Capacity-Building Activities

Progress in activities related to public sector capacity building has been limited due to Pathfinder's current mandate in Ethiopia, which is focused on assisting the NGO and private sectors. During the last two years, however, Pathfinder has been collaborating with the MOH in coordinating the NGO's Sector RH/FP program to ensure effectiveness and consistency of their activities with the National Health and Population Policies. The mechanisms of the TC have been instrumental in this coordination. Pathfinder has also supported the MOH in reviewing and updating the Community-Based RH Services, training curriculum and protocol, RH/FP Guidelines, Service Delivery Protocol, and Infection Prevention Guidelines.

The MOH, on the other hand, has officially requested that USAID/E assist in the finalization, printing, and distribution of the different protocols, guidelines, and training curricula, which have been updated. These activities are to be undertaken with technical assistance from Pathfinder to assist in training national and regional trainers in the use of the above mentioned materials; to review and update the MOH's RH/FP training master plan; and initiate innovative model CBD programs that will have marketplace, adolescent, and workplace components. Pathfinder has also been requested by Tigray Development Office, Tigray and Oromia Regional Offices of Population, and SNNPR Kefa and Zonal Labor Office to work jointly with them in planning, coordination, IEC, and policy initiatives. Discussion with the MOH/FHD and Pathfinder have indicated difficulties on the part of Pathfinder's mandate and with the resources allocated to its activities to respond to their demand.

The ongoing and planned activities expected to achieve this sub-RP2.4 have been limited to the activities previously discussed. Because of the requests submitted by the MOH/FHD and the various regional offices and particularly the effective collaboration already developed between the MOH and Pathfinder in coordinating RH/FP activities in the NGO sector, the scope of ESHE's project funding and activities should be to address the needs of the public sector.

Recommendation:

14. USAID/E should consider expanding Pathfinder's mandate into the public sector, as well as increasing the resources made available to Pathfinder to enable it to meet the current and future demands for assistance by the public sector (MOH, RHBs, and ROPs). In addition, USAID/E should consider expanding such assistance to a greater number of RHBs than ESHE is currently working in.

5.7.2 Policy Activities

Policies and strategies adopted by the GFDRE since 1995 have helped to create an enabling environment for initiatives in family planning promotion, as well as in the promotion of RH/FP programs in Ethiopia. However, in spite of the commendable accomplishments registered by COFAP and its members in expanding FP/RH services in the past two years, the environment for the NGOs has been circumvented by the fact that COFAP and its members had difficulty registering and importing commodities and equipment for their operations.

Article 35 of the Constitution of the GFDRE clearly recognizes broad legal rights to women and Subarticle 35.8 singles out the right of access to education and information on family planning and the capacity to benefit from family planning services to protect their good health and prevent hazards resulting from childbirth. On matters that concern reproductive health, Article 10 of the health policy spells out strategies that bear heavily on the development of RH programs in

Ethiopia.

The population policy seeks to harmonize the population growth rate and has explicit targets to reduce the TFR to 4 percent and increase the CPR to 44 percent by the year 2015. The relevant strategies, stipulated under MCH/FP programs, outline the strategies for promoting and implementing RH/FP programs in the country. With regard to women's reproductive health, the National Policy on Women reaffirms the rights of women to have easy access and information to modern and traditional FP methods.

In addition to the problems associated with COFAP's registration, there are some articles in the Penal Code that are inconsistent with the present thinking and practice in RH/FP and that require amendment of the pertinent articles in accordance with the GFDRE's policy. These include legal codes (Article 802 in particular) that could be interpreted as prohibiting advertisement of contraceptives. Although in practice these have not prevented recent activities in IEC FP campaigns and condom advertisements, they need to be amended. The legal requirements related to safety, and manufacturing, importation, and distribution of contraceptives have been facilitated by the recent inclusion of contraceptives in the official LIDE.

Conclusion: The overall goal of the GFDRE's population policy is to harmonize the population growth rate with the country's capacity to develop and use its natural resources. Specific population objectives and strategies focus on the provision to increase the availability of contraceptive methods, the accessibility to RH/FP services, and the quality of services offered; to strengthen IEC; improve method mix; increase contraceptive outlets; and initiate and strengthen quality of service for adolescents, etc. A review of the availability, accessibility, and use of FP services in Ethiopia indicates that, regardless of the approach used, the overall CPR in Ethiopia is very low even when compared to sub-Saharan African countries: Only 8 percent overall CPR (MOH 1997 estimate), an estimated population size of about 60 million, a 3 percent annual population growth rate, and a TFR of 7.0 in 1997.

The objective and activities under ESHE's FP/RH project activities implemented in the past two years have been to support national family planning activities with the aim of increasing the availability and demand for modern contraceptives as discussed in Section 5.4. The project has contributed to increased use of modern contraceptives in both urban/periurban and rural areas due largely to the success of CBD agents and the ECSM program. The EET is convinced that ESHE's interventions have been relevant and responsive to the GFDRE's needs and priorities in population and FP/RH program objectives. Government policies and strategies (health and population in particular) adopted since the start of ESHE have helped create an enabling environment for NGO and other private sector initiatives in RH/FP, as well as for the promotion of RH/FP programs. However, EET urges the GFDRE to expedite the COFAP registration with the appropriate government body.

IR2.4 is a newly formulated IR that does not yet have corresponding indicators. Such indicators

might include (1) increased use of modern contraceptives in public health facilities and (2) increases in the number of public health facilities offering FP services including commodities. This IR should be helped by the construction of new PPHC facilities (CHC's), increased FP IEC, and adequate supplies through stronger FP logistics management.

6. RP3: ENHANCED CAPACITY OF ETHIOPIAN SOCIETY TO EXPAND ACCESS TO AND USE OF STI/HIV/AIDS SERVICES IN RESPONSE TO THE EPIDEMIC

6.1 Background and Intended Results

It is widely believed that HIV infection in Ethiopia is spreading at an alarming rate and poses a serious health and socioeconomic threat to the nation. According to a September 1997 UNAIDS report, sentinel surveillance data indicate that between 10 and 27 percent of pregnant women in Addis Ababa are infected with HIV.[9] Sentinel surveillance data for 1992 to 1993 indicate a range of HIV prevalence rates: 11 to 13 percent at urban sites and 0 to 7 percent at rural sites. The MOH estimates that, nationally, adult HIV prevalence has increased from 3.2 percent in 1993 to 5.2 percent in 1996 (ref. 1996 AIDS in Ethiopia booklet).

Unfortunately, actual prevalence rates and their rate of increase over the past few years are difficult to measure or estimate because the national HIV/AIDS surveillance system has become essentially defunct. The National AIDS Control Program, which once constituted a MOH department of over 50 staff, has been practically dismantled. As a consequence of decentralization, this program is now constituted as the AIDS Control Unit (ACU)? with only three staff? within the Department of Epidemiology and AIDS. Meanwhile, the devolution of commensurate capacity to the regions is still at an early and incomplete stage. Revival of the country's surveillance system is a critical need to inform national- and regional-level policymakers, program managers, and the public of the true nature of the problem and to assess the success of efforts to combat the epidemic.

Heterosexual sex is the main mode of transmission in Ethiopia. Even at estimated adult prevalence levels of 5.2 percent, the epidemic represents a huge burden on society, which may indeed be increasing at an alarming rate. Significant progress has been made over the past several years to inform the people about HIV/AIDS and to encourage risk reduction behavior, including condom use. Awareness of HIV/AIDS and how it is spread is very high among the population (1996 PI baseline of 98 percent for youth aged 10 to 24), although perception of personal risk is much lower (1996 PI baseline of 20 percent). An excellent condom social marketing program has made condoms available at a low cost in nearly every part of Ethiopia.

USAID/E has provided support for AIDS prevention and control efforts since 1992 when the Ethiopia Support to AIDS Control Project (STAC) was initiated through the AIDS Control and Prevention Project (AIDSCAP). STAC was originally scheduled to end in December 1995; ESHE was designed, in part, to serve as a mechanism to continue and expand the strategies and activities already started under STAC.

According to the ESHE Project Paper (July 1995), ESHE's key components would continue to be those started under STAC: STD prevention and control (including procurement of drugs and supplies and construction of a warehouse through a grant to WHO), IEC, condom promotion, capacity building of public and private institutions, surveillance, and research. These would support ESHE's stated objective of "increased availability of HIV/AIDS prevention and control

services in focus areas."

The Project Paper envisaged continued funding of AIDSCAP under ESHE except that the condom social marketing component would be supported through a separate cooperative agreement with PSI. Through AIDSCAP and/or successor technical assistance mechanisms, ESHE would build on STAC's integrated focus site prevention strategy and programs at Awassa, Nazareth, Bahir Dar, and Mekele by expanding into surrounding communities (especially in SNNPR), developing linkages with family planning NGOs, and providing support to regional and zonal health bureaus.

The STAC project was evaluated in November 1995. One of the recommendations was an extension of STAC for a period beyond December 1995, explicitly to avoid disruption of USAID-supported AIDS activities and to provide a transition period during which USAID and the GFDRE could finalize plans for subsequent support under ESHE.

It was hoped that a seamless transition from STAC to ESHE would be achieved in FY96, and that during this transition period the following major activities would occur:

- PSI/DKT would continue its condom social marketing program under a separate cooperative agreement;
- A grant to WHO for STI/HIV/AIDS-related drugs, supplies, and construction would be executed; and
- The new ESHE component would be developed and initiated.

Although ESHE funds were used to extend the life of STAC, further programmatic evaluation of STAC is not within the terms of reference of this evaluation. However, the transition from STAC to ESHE is pertinent to this evaluation and is discussed further.

6.2 Extension of the STAC Project

ESHE unilateral funds totaling $448,771 were used for a delivery order to AIDSCAP to extend the life of STAC beyond its original December 1995 termination date through September 1996 (and subsequently through July 1997 under a no-cost extension). STAC was further extended through October 1997 with non-ESHE funds to allow time and support for the establishment of a successor NGO; but, most STAC programmatic activities effectively ended in July 1997. Support for strengthening STI case management and delivering behavior change-oriented IEC (especially for the youth) in the STAC focus areas needs to be resumed and expanded as soon as possible.

6.3 Condom Social Marketing

In August 1995, USAID and PSI signed a separate cooperative agreement, under which PSI/DKT has continued to socially market its highly subsidized Hiwot Trust condom and to conduct innovative IEC activities throughout Ethiopia. Under various projects, the PSI/DKT program has sold over 100 million condoms since 1990. Under ESHE, they have sold 51,175,889 (August 1995 through September 1997), with monthly sales generally increasing over time. This accounts for some 95 percent of all condoms distributed in the country.

Complementing their marketing activities, PSI/DKT conducts an innovative IEC program to reach target audiences throughout Ethiopia. In 1997 alone, their six IEC teams have reached 230,000 persons to discuss basic health issues, AIDS, and condoms. Other IEC activities include radio programs, radio and television advertisements, and promotional materials.

The PSI/DKT program (through ESHE) represents the most important contribution to Ethiopia's AIDS control program at the present time. However, much more needs to be done aside from condom distribution to help control the HIV/AIDS epidemic.

Although primarily considered an STI/HIV/AIDS intervention, condom social marketing is subsumed under ESHE's RP2, as part of the broader contraceptive social marketing effort. More information is provided on contraceptive social marketing targets and outputs (including condom sales) under RP2 in Chapter 5.

6.4 Support for STI/HIV/AIDS Supplies and Construction

Bilateral ESHE funds totaling $1.9 million were allocated to WHO for STI/HIV drugs, kits and supplies and for construction of a warehouse in Addis Ababa, as well as for an extension to the Regional Training Center (RTC) in Awassa. Based on positive earlier experience (during STAC), WHO was asked to procure the supplies and construction services through a grant mechanism (support for the Awassa RTC). Although the MOH submitted its drugs and supplies request in September 1996 (with the first consignment requested to arrive in February 1998), negotiations over the warehouse have continued. First, the MOH requested a $2 million three-block facility, far in excess of the $300,000 initially allocated by USAID. The MOH request was reduced to a one-block warehouse costing $400,000, but the proposed surface space exceeded USAID's limit of 10,000 square feet. This issue remains unresolved.

At the same time, the parties agreed to proceed with the procurement of the drugs and construction of the Awassa training center extension. The $1.4 million that was obligated by the signing of the Project Agreement in 1995 was committed in July 1997 through a Modified Acquisition and Assistance Request Document (MAARD). Above the $1.4 million obligated funds (approximately $1,270,000 for drugs and $130,000 for the Awassa RTC construction), the obligation stipulated that an additional $500,000 could be obligated subsequently to cover the planned warehouse construction. Unfortunately, USAID and WHO procedures took another two

months to finalize the grant agreement; it was finally signed by the WHO representative and sent to Geneva on September 12, 1997. At that time, USAID was requested to establish a Letter of Credit, as stipulated in Attachment A of the MAARD. Because of administrative oversight, USAID had not yet completed this final, necessary administrative step as of early December 1997, thereby preventing WHO from initiating the procurement of drugs. USAID/E's Contracts Office indicates that it has now sent all necessary documents and instructions to USAID/Washington's Office of Financial Management and expects the WHO grant to be executed and implemented without further delay.

It is estimated that the lead-time between order and delivery will be at least four months, making it unlikely that the first consignment of drugs will reach Ethiopia before May 1998.

This same grant procurement process (including the Letter of Credit) worked smoothly on two prior occasions to support STAC, so it is difficult to understand why that experience could not be replicated. Although USAID and the MOH agreed on using WHO to procure supplies and contract for construction, the parties' failure to do so on schedule has drawn increased attention from the MOH to the cost? 13 percent fee? of WHO's procurement services. The MOH is understandably questioning both USAID's and WHO's performance in implementing the supplies and construction grant in a timely and cost-effective manner.

Given the multiple steps and relatively high cost associated with accessing WHO's procurement services, in future, the option of granting funds to Pharmid (or using some other mechanism) to procure pharmaceutical supplies should be explored and considered. Such consideration would have to be taken realistically and innovatively in view of USAID's legal restrictions on procuring pharmaceuticals. It might be possible to "swap" with other donors the purchase of pharmaceuticals for support of equal value in another area, such as training.

Recommendation:

15. The Health, Population and Nutrition (HPN) Office within USAID/E should work with its Contracts Office and with USAID/W's Office of Financial Management to ensure issuance of the Letter of Credit and with WHO to ensure quick action on placing the order once the Letter of Credit is received.

With respect to the warehouse, which the MOH/ACU still expects to receive through ESHE, the options appear to be as follows: (1) obtain the MOH agreement for building a smaller warehouse (under 10,000 square feet), (2) use the available funds to renovate an existing building rather than to finance new construction, or (3) drop the warehouse altogether and negotiate with the MOH for alternative use of the available funds. WHO's representative believes that the third course of action is the only realistic option, but this should be a matter for discussion first between USAID and the MOH, both of which still consider the warehouse issue unresolved.

Recommendation:

16. **The Health, Population and Nutrition Office within USAID/E should immediately clarify the status of the warehouse with the MOH/ACU and negotiate the best option available. Either option 1 (construction of a smaller warehouse) or 2 (renovation of existing space) would be preferable to dropping the warehouse altogether.**

A government network was also agreed upon but is awaiting finalization of the National AIDS Policy. With USAID/E leadership, this is an important contribution to donor coordination in Ethiopia.

6.5 RP3 Planning Document

Constraints beyond USAID/E's control on the speed and completion of this process, especially as it relates to design of the ESHE component, included the absence of an official national policy on HIV/AIDS and of strong donor and multisectoral coordination. Although promulgation of the National AIDS Policy is still pending (and has been made an NPA tranche three conditionality), the Ethiopian Framework of Objectives (EFO) represents a national, multisectoral consensus on priorities which, within the HSDP framework, serves to guide organizations, including USAID, involved in AIDS prevention and mitigation.

The current ESHE RP3 results matrix and monitoring plan appear to be consistent with the EFO and the draft National AIDS Policy. It is also consistent with USAID/E's Strategic Objective 2. Within these frameworks, USAID/E has recently developed its draft RP3 Planning Document (October 9, 1997). Overall, these plans are consistent with and supportive of the HSDP, with RP3's strong emphasis on improving the technical quality of STI/HIV/AIDS service provision and IEC. However, as with other ESHE components, support would be focused and limited both geographically and programmatically. Therefore, ESHE's contribution to the HSDP would have to be considered in relation to other inputs.

Despite important achievements in broadening participation and building consensus on STI/HIV/AIDS objectives, the specific details of USAID/E's proposed support and activities under RP3 remain unclear to the MOH/ACU. This includes planned interventions and arrangements for technical assistance to be supported under ESHE. Although USAID/E briefed the MOH/ACU on overall contents of the proposed RP3 in October 1997, the planning document apparently could not be disseminated pending final sign-off within USAID/E. Also, the direct linkage between the contents of the planning document and the consensus reached on the EFO (through the three participatory workshops) may be more clear to USAID than to the MOH.

Recommendation:

17. USAID/E should intensify consultation and joint planning with the ACU (and with other GFDRE offices as appropriate) as soon as possible to further develop or revise RP3 plans collaboratively. USAID/E should consider the possibility and appropriateness of sharing a clearly marked "draft" copy of the unapproved RP3 Planning Document with the ACU and other partners to solicit early formal comment and participation. Likewise, the ACU and other partners should give adequate priority to completing this process to help avoid further delays. This will ensure GFDRE ownership. Such consultations would also be a good opportunity to consider the recommendations of this evaluation that relate to the RP3 plans.

The head of the ACU expressed regret that ESHE had been unable to simply fund AIDSCAP to continue and expand STAC activities without disruption. This may suggest the need for greater attention on USAID/E's part to explain to its partners in government how USAID operates, including issues related to central projects and project assistance completion dates. In any case, ESHE's current plans to build on STAC activities (including the four STAC focus sites plus Addis Ababa) seem consistent with the MOH's wishes, although it is hoping for the greatest possible geographic expansion of USAID-supported activities.

The RP3 Results Matrix and Performance Monitoring Plan have been developed for implementation in FY98, with targets set for 1999 and beyond. Therefore, there are no earlier targets and actual performance-to-date data to present or compare under RP3. As noted, condom social marketing targets and performance are discussed in Chapter 5 under RP2's contraceptive social marketing component.

6.6 RP3 Design

Recommendations for consolidating and modifying RP3 sub-intermediate results, and reducing the number of corresponding PIs, are provided at the end of this chapter. These changes are aimed at promoting integration of HIV/AIDS activities and support with other areas of ESHE and at reducing somewhat the monitoring burden. They would not substantially change the content of HIV/AIDS activities (as reflected in the RP3 Planning Document), except for the possible addition of a research support component.

Over time, the nature and mechanisms of USAID support in the health sector may evolve in accordance with the HSDP and with improved and audited GFDRE financial management capacity. In the shorter term, however, building on support begun under STAC (for improved STI control and youth-oriented IEC in focus areas) would be beneficial, consistent with the current ESHE project, and, as noted, supportive of the HSDP.

In addition to providing support for increased STI and IEC capacity and services in focus areas, ESHE should consider creating a programmatic research component, centered in the ACU and designed to assist policymakers and program managers to better design or assess STI/HIV/AIDS interventions. Although this area of activity does not appear to score high on the EFO, it may be implicit in the objectives relating to policy, strategy, and guidelines development; lobbying; and management. Moreover, the ACU identified this area as one of their greatest areas of need. Careful assessment would be needed of available technical capacity and interest in the medical, social science, and other academic communities to conduct relevant research in a timely and competent manner if a mechanism for awarding and coordinating research project grants could be established within the ACU. Such an assessment was not possible within the time and scope of this evaluation.

Recommendation:

18. ESHE should, as currently planned, build on earlier USAID/E support for increased capacity and services for STI case management and youth-oriented IEC in focus areas of the country. In addition, inclusion in RP3 of an STI/HIV/AIDS applied research component should be considered by the appropriate ESHE partners.

Although support for improved national surveillance was also part of the earlier AIDSCAP/STAC project and remains a critical need, efforts by UNAIDS and WHO are already underway to address the technical assistance needs in this area by placing a biostatistician in the ACU. Additional support is likely to be required at central and regional levels; ESHE inputs for training, workshops, materials, and supplies have been mentioned in the RP3 Planning Document.

Recommendation:

19. As currently planned, the ESHE RP3 SOW and budget should include mechanisms for providing material and financial support to revive the national HIV surveillance system and to support surveillance capacity in the SNNPR. To help meet this critical need, special attention should be given to close coordination with UNAIDS and WHO to support and/or complement their involvement, particularly with respect to the planned placement by UNAIDS of a biostatistician within the ACU.

6.7 Procurement and Implementation of the New STI/HIV/AIDS Component

To expedite approval and implementation of RP3, USAID/E, the MOH, and other partners need to work closely to finalize detailed plans and to agree on an appropriate procurement mechanism. The ESHE Steering Committee (ESC) will need to endorse the content of and mechanism for accessing needed technical assistance (e.g., direct competitive procurement versus a buy-in to a central USAID contract). Depending on decisions on a "Beyond BASICS" contractor, the ESC may also have to decide whether STI/HIV/AIDS technical assistance should fall under the same or a separate contract. To initiate the new HIV/AIDS component by the end of FY98, fairly urgent and concerted action is required by USAID/E and its ESHE partners.

Recommendation:

20. In consultation with ESHE partners, USAID/E should proceed immediately to develop the RP3 objectives, SOW, and time line for the new STI/HIV/AIDS component and its corresponding procurement mechanism. The EET does not make a recommendation regarding the most appropriate mechanism for procuring technical assistance except that the relative time required under various options should be considered. All efforts to expedite implementation of RP3 should be made by all ESHE partners, under guidance of the ESC.

6.8 Suggested Modifications Under RP3

RP3 fits well into the SOs and, moreover, conveys the need for multisectoral involvement. The performance indicator for IR3? increased number of NGO facilities that use a systematic approach to HIV/AIDS interventions? is adequate, but the definition of "systematic" and its measurement needs to be more specific. A revised performance indicator might read, "Increased number of *public and NGO health care facilities* using a systematic approach to STI/HIV/AIDS interventions *including treatment, counseling, and control procedures, including those related to better reproductive health*."

Sub-IR 3.2 reads, "Increased capacity of, access to, and use of public and private sectors for delivery of quality STI/HIV/AIDS services." The EET recommends the following changes for IR3.2: Increased capacity of, access to, and use of the public and private sectors for delivery of *effective, comprehensive management of STI.*

The present sub-IR3.3 regarding increased community involvement in the SNNPR should shift to IR4 to consolidate activities and measures in the SNNPR and to emphasize the need for integration of STI/HIV/AIDS within PPHC.

"Increased STI/HIV/AIDS services focused at youth, especially girls" is the current sub-IR3.4. The EET proposes the following changes for sub-IR3.4: Increased *awareness and reduced risk behavior for STI/HIV/AIDS prevention among the youth aged 10 to 24, especially among young females*. Appropriate performance indicators are recommended as follows:

- Decreased percentage of target population(s) reporting multiple or non-regular sex partners.
- Increased percentage of target population(s) reporting regular condom use with non-regular sex partners.
- Increased number of public and private institutions in focus areas providing effective and comprehensive STI case management.
- Decreased reporting of STI incidence among sexually active young males.

The EET proposes consideration of a programmatic research component to be added as follows: *Increased capacity and conduct of relevant research on STI/HIV/AIDS-related topics*. The appropriate performance indicator would read as follows: Increased number of STI/HIV/AIDS-relevant studies conducted and disseminated.

7. RP4: INCREASED USE OF INTEGRATED RURAL PRIMARY AND PREVENTIVE HEALTH CARE DELIVERY IN THE SNNPR

7.1 Intended Results and Background

The objective of ESHE's RP4 is to "increase the use of integrated rural PPHC services in the SNNPR." The main contractor is BASICS, a USAID centrally-funded child survival project scheduled to end in September 1998. However, some of the individual results under IR4 are ESHE and USAID's direct responsibility. BASICS was involved in some of the predesign (baseline survey and information gathering) and design work for ESHE. As ESHE developed, USAID/E wished to bring the SNNPR project more in line with ESHE's overall goal, "Improve the Health Status of Ethiopians and Begin to Reduce Population Growth." Accordingly, BASICS was asked to work with Pathfinder in the SNNPR to begin to integrate family planning into its child survival project.

After several workplan revisions, the means of achieving the project's central goal of improving the health status of women and children has come to be expressed as follows: (1) expand access to health services, (2) improve the quality of services, (3) change individual health-related behavior, and (4) develop community support for health prevention and health care. Another way to describe and differentiate project objectives is in the language of IR4: Enhance regional government's capacity of service delivery (at several levels: regional, zonal, and woreda), and revitalize community health service. BASICS, under the ESHE project, works in four focus zones, five woredas, and five focus communities within the woredas. It also works with the RHB and NGOs. In spite of limited geographic areas of project implementation, BASICS's work in systems strengthening and capacity building at the central, regional capital and RHB level ensures that the project has a certain amount of region-wide impact.

7.2 Environment for Project Implementation

ESHE's systems strengthening activities in the SNNPR were originally conceived under a seven-year time frame. The technical and managerial support needed to implement the project was assigned to BASICS, but under a shorter time frame partially in response to the GFDRE's concerns on transferring project management to counterpart institutions after the first three years. The initial BASICS workplan was in effect a compression of a general seven-year plan into the current two and one-half year contract period. The latter plan had to be revised at length to more realistically reflect logistical and other project implementation constraints.

A set of problems has further constrained BASICS's ability to fulfill its workplan in the remaining time. First, BASICS's implementation was delayed considerably because of initial disagreement over the choice of the chief of party (COP) and the health planner. The BASICS contract was signed in March 1996, but the COP arrived only in January 1997, and the health planner in February 1997. Nevertheless, BASICS carried out a number of activities by using consultants and local staff. All scheduled activities are said to have been completed during this time. On the government side, there were also several delays in crucial approvals, due in some cases to the GFDRE's disagreement with the design of some key project components (e.g., the plan for BASICS to be able to provide subgrants to NGOs).

7.3 BASICS's Approach to Project Implementation

BASICS's approach to project implementation is to develop the RHB's capacity and to strengthen health systems by developing human resources, relevant health strategies with counterparts, and information-based planning; improving logistics; and equipping the RHB and health facilities when necessary. BASICS complements such strengthening of the formal system with work at the community level to raise demand for appropriate service and to promote health in several ways apart from service utilization. At all levels, the project approach focuses on longer-term capacity building and sustainability rather than on short-term gains.

There has been a careful process of interactive planning in the SNNPR at all levels, involving all players at the region, zone, woreda, and village levels. One measure of this process has been the formation of committees at all levels. A sense of project? or new initiatives? ownership seems to have been achieved by involving a wide range of people in a sustained process, as well as by having day-to-day interaction related to all phases of project implementation. A sense of responsibility for a specific range of activities is engendered during periodic planning meetings when responsibility is assigned. This sense of responsibility is developed further during follow-up implementation. Project work at the community level explores new participatory approaches aimed at improving the awareness, capacity, and self-reliance of communities to address their own health needs.

7.4 Regional Government and ESHE

At the September 1997 meeting of the Technical Working Group, the RHB asked if it could receive some sort of tranche paid directly to the region if ESHE's conditionalities are met. This issue appears to have arisen because USAID's Basic Education System Overhaul project (BESO) pays what is called a Regional Incentive Fund (RIF) to the Regional Council when conditionalities in the education sector are met.

USAID agreed to consider the request; however, it was not clear at the time of the request if the RIF is part of what the central government deducts from the regional education or health budget, making the overall budget for the region the same with or without the RIF. The RHB might actually have more control over the amount in question if it were not in the form of a RIF, because it could only be spent with USAID's agreement. However, this consideration seems to be offset by the enhanced sense of project ownership that should result from providing a RIF for health.

Recommendation:

21. The Regional Health Bureau in the SNNPR should receive a Regional Incentive Fund as it meets conditionalities specified by ESHE.

Another important issue from the RHB perspective is the central GFDRE's practice of offsetting the amount of foreign donor assistance to the RHB's annual health budget allocation. It has not been clear in the past whether the amount of donor assistance includes expensive foreign technical assistance. In fact, it does not. Therefore, there is no recommendation from the EET except to repeat the need for improved communication between all ESHE participants and stakeholders.

The RHB is satisfied with its scope and BASICS's accomplishments in the SNNPR, despite the late start-up. The RHB fully supports BASICS's systems strengthening, capacity-building approach. It does not believe that there has been more emphasis on quickly reaching targets directly related to child survival. According to the RHB head, "just going for the numbers would not leave anything behind." With the current approach, there is "a good foundation" and BASICS and the RHB developed the project workplan and the systems approach jointly. However, the BASICS approach would not be sustainable beyond the life of the BASICS contract.

The RHB also fully supports BASICS's community-level project initiatives. It feels that these initiatives may be replicable by the regional government, although there needs to be "objective assessments" (operations research) to examine models of local financing, incentives for CHWs, and other initiatives being piloted. The RHB commented that much of BASICS's community work has been "resource-intensive" in the early phases, but that expansion of these activities to elsewhere in the region need not be, once viable approaches are found and local staff are trained and gain practical experience in such work. The EET agrees (see Community Health Initiatives in Section 7.67).

Recommendation:

22. There needs to be operations research to better determine how much external input is needed to mobilize a community in ways that improve health. The RHB needs to know better how to replicate the community-based work that has been pioneered in BASICS's focus communities.

7.5 Project Management Issues

There is a Regional Steering Committee in the SNNPR for BASICS's activities. Its members include the chairman of the Social Sector of the Regional Council, as well as officials from regional finance, the Regional Planning Bureau, disaster prevention, and other divisions. After an initial meeting to form this body, there has been only one additional meeting, in May 1997. However, there are regular meetings between BASICS and RHB staff at various levels. RHB leadership assured the EET that they plan, implement, and evaluate everything with BASICS. They were well-informed, engaged, and interested in all aspects of BASICS's activities.

Although BASICS/SNNPR maintains close contact and good relations with the RHB, the central MOH seems removed from project activities in the South. Quarterly project progress reports and annual reports are sent to BASICS/Central, which forwards the reports to the MOH (three copies for the Planning and Project Department) and to MEDAC (three copies). However, there has been little response or feedback from the MOH, and it is not known if BASICS's reports are passed on to relevant staff at the MOH (e.g., staff of the family planning, drugs, and finance divisions).

It is not clear how closely the MOH wants to, or should, follow activities in the South in light of the current policy of decentralization and regional autonomy. But given the issue of questionable central GFDRE support for a post-September 1998 contract and the importance of BASICS's activities as a pilot or test case for new policies and program initiatives, the MOH, as well as MEDAC and the PM's Office, should be better informed and play a more active role in monitoring project activities in the southern region.

It appears that in the original ESHE plan, there was supposed to be a project manager attached directly to the central MOH to supervise, liaise, and keep the MOH fully informed. Although this is part of the COP's responsibilities, a stronger, more direct link between the project in the SNNPR and central government is needed.

Recommendation:

23. The MOH, as well as MEDAC and the PMO, need to be better informed and play a more active role in monitoring project activities in the southern region. There needs to be a more participatory and responsive monitoring system, perhaps including assigning a representative of a post-September 1998 contractor to the MOH. USAID should be a partner in planning and developing such a system, after which monitoring primarily should involve relevant branches of the MOH and the project contractor in the SNNPR.

7.6 BASICS's Activities

7.6.1 Strengthening Regional Government

In fulfilling the sub-IRs under RP4, "Regional Government's Capacity of Service Delivery Enhanced," BASICS has engaged in a variety of capacity-building activities with all levels of regional government designed to achieve a number of sub-results? improved planning and management, increased regional training capacity, increased resources and improved use; improved ability and quality of services in health facilities; and improved logistics. BASICS has felt it essential to help the RHB make realistic plans and decisions related to health care based on collection and analysis of all pertinent information. One concrete result of this is expected to be the region's enhanced ability to justify requests for health budget allocations from MEDAC. The RHB should also be better able to rationally allocate its resources throughout its own system. For these reasons, BASICS has put considerable emphasis on capacity building in management and training.

BASICS's own planning began with a pre-ESHE national survey ("Report of a Health System Baseline Survey," 1995), a November 1996 baseline health facility and quality of care assessment, and an early 1997 comprehensive baseline needs assessment survey in the SNNPR. The RHB has been able to see how the latter studies formed the basis for the development and implementation of both central, regional, and community initiatives in the SNNPR.

BASICS has provided training in general health management, TOT, HMIS, and quality of care (QOC) and supervision. It has also developed a regional training curriculum and provided necessary training materials including books and journals, and it provided a librarian to help organize training materials at the region's four health professional training centers. In addition, BASICS is developing several technical manuals for RHB use and it has also developed a computerized health resources and activities management database to facilitate information-based planning.

7.6.2 Training of Trainers

Each region in Ethiopia has an RTC. BASICS has conducted various TOT sessions at the RTC in Awassa. One TOT session last year on community health approaches was deemed sufficiently useful and the government asked that TOT staff from other regions receive the same training. The model is for trained trainers to disseminate the training from the RTC to the zonal and lower levels. NGO representatives working in the region have also been both trainers and trainees in these BASICS workshops. Additionally, BASICS has conducted TOT training in technical aspects of child survival and reproductive health. The Michigan population fellow attached to BASICS and a consultant from the FGAE were among the trainers.

In a December 2, 1997, interview with the Ethiopian Herald, the head of the RHB in the SNNPR commented on his region achieving improved health professional-population ratios because of the contribution of the region's four health professional in-service training centers. These centers have all been supported by BASICS.

According to the Project Year (PY) 5 Timeline, the following training activities were planned for 1997:

- Develop PPHC/MCH materials and lesson plans,
- Train RTC and zonal staff as trainers on facility-based integrated MCH topics,
- Develop community health agent refresher training lesson plans and a manual, and
- Provide limited on-the-job computer training for regional MOH staff.

Key achievements in training are summarized in the following table.

Table 3

BASICS's Key Achievements in Training

Indicator/ Results	**# of Trainers at RTC/Health Professional Training Institution/Zone Trained in Integrated PPHC**	**# of SNNPR Health Workers Trained in PPHC Topics in Last 12 Months**	**# of CHAs in Focus Communities Who Have Received Refresher Training in the Last 12 Months.**
Unit of Measurement	Number of TOT sessions	Number trained/total number of health workers in the formal health system	Number of CHAs
Source	BASICS project reports	Zonal reports, regional management database	BASICS project reports
Dec. 1997	30	Over 600	10 (in 4 communities)

Some training is ahead of schedule, such as refresher training for community health agents,

which was scheduled for 1998. These achievements can also be assessed against the following expected end-of-project results:

- Teaching materials in key maternal and child health topics adapted, produced, and available for continued use by trainers, trainees, and institutional staff;
- Training of zonal trainers in the use of new materials and methods; and
- In-service training of woreda and facility staff by zonal trainers in the SNNPR.

7.6.3 Health Management Information Systems

The 1995 baseline survey, as well as the needs assessment in the SNNPR, showed that HMIS was weak throughout the nation. Reporting was "highly erratic," a standard set of record-keeping tools was lacking, HMIS forms were long and cumbersome, and it was not clear how health data were used at higher levels for planning and decision making. Planning seems to have been informal, ad hoc, and conducted in-house with "little coordination among departments or between management and service delivery levels" (BASICS, 1995:6).

Accordingly, BASICS/SNNPR and RHB counterparts have developed a more workable information-based system of health planning. BASICS first helped establish a regional task force to assess the current HMIS system. Then, BASICS, in conjunction with counterparts, developed a two-page simplified form, adding questions about health center (HC) management, including QOC and PPHC issues. The forms will be used primarily to improve health center (PHC Unit) management; the data collected at present simply goes up the chain of command and is of no particular use at the HC.

The new HMIS form and system is being piloted in 10 woredas. The reaction thus far is positive, in fact the woredas involved would like to substitute the new form for the old one. There is no national or regional computerized HMIS system. The new system allows BASICS to periodically monitor key behaviors in focus woredas. BASICS has also compiled woreda health profiles, and designed a regional management database and supervision tools.

According to the PY5 Timeline, the following training activities were planned for 1997:

- Development of a pilot HMIS in 10 woredas,
- Procurement of radio equipment, and
- Importation of radio equipment.

Relevant end-of-project (EOP) results are as follows:

- Health profiles are established in five focus woredas and explicitly used, along with other sources of information, for annual planning.

- The pilot HMIS is tested and evaluated in 10 woredas. A decision is made on an extension.

- A computerized management database is set up at the regional level.

- A core regional management training team is ready to train zonal and woreda managers using lesson plans developed by the project.

- The *Rural Health Facility Management Manual* series is distributed.

7.6.4 Operations Research Studies

The following studies have been completed or are in progress: a study of antenatal care; a retrospective study of shigella dysentery; an evaluation of various levels of training (TOT, management training, MCH, EPI, etc.); a quality of care study that examines supervision, client satisfaction, waiting time for service, rational use of drugs, etc.; and a focus group study of barriers to contraceptive acceptance. The methodology and instruments including focus group topic guides seem appropriate. In total, five OR studies were planned for 1997; five were begun and one was completed. Two or three are planned for 1998.

7.6.5 Improved Logistics

An ESHE assumption is that devoting more drug supply GFDRE resources to the purchase of essential drugs and medical supplies will improve the health units and therefore improve attendance. With improved attendance, more Ethiopians can be reached with PPHC services.

ESHE has bought 33 vehicles and given 31 to the SNNPR public sector. There is little vehicle maintenance capability in the region; therefore, Save the Children/UK and Oxfam have submitted to ESHE a $300,000 proposal to build a garage, provide TA, and develop a mobile repair unit. The RHB is considering this request. A transport survey will be conducted in early 1998 by a joint transport operation in Addis, and supported by BASICS. The transport survey will be regionwide and will assess the condition of all vehicles.

To better ensure that there are supplies of essential drugs and medical equipment, BASICS is cooperating with UNFPA in developing a USAID-funded regional drug supply warehouse in Awassa; BASICS has been defining technical specifications. BASICS will provide equipment for the maintenance workshop to be located in the building, and it will support the definition of the

regional maintenance strategy and training of maintenance technicians and users.

One performance indicator, the proportion of health facilities with functioning cold chain refrigerators, has improved from 89 percent to 95 percent at the early 1997 baseline. BASICS' contribution has been capacity building and systems strengthening rather than provision of refrigerators. It has helped the RHB develop a relevant strategy and has trained personnel.

A medical equipment specialist arrived in Awassa on December 1, 1997, and soon after a workshop was held with participants from zones throughout the region. A follow-up zonal workshop was held that month in Hosaana and a survey was initiated by zonal and woreda staff in collaboration with the RHB, Ethiopia Science and Technology, and BASICS. Work began on a computerized database template by a local software development specialist for the development of an RHB database that will include medical equipment, transportation, furniture, and personnel.

According to the PY5 Timeline, the following activities related to logistics were planned for 1997:

- A review of current equipment standards and maintenance procedures,
- A workshop for equipment survey,
- An equipment survey in all health facilities, and
- An adaptation of the equipment module of the regional database.

The expected EOP results are as follows:

- Regional personnel are trained in medical supplies warehouse management;
- Warehouse management guidelines are developed; and
- The regional maintenance workshop is equipped and functional, the regional maintenance strategy is developed, and the maintenance visit schedule is followed.

7.6.6 Health Care Finance Reform

Health care finance reform is part of the HSDP and a conditionality of the ESHE program. The ESHE project in the southern region is, or should be, a laboratory for piloting such reforms in the Ethiopian context.

Fees for medicines and health services are extremely low throughout Ethiopia. They have not changed with inflation, and moreover there are many complex exemptions by disease category and ability to pay. To develop a sustainable health care system, fees need to be increased and? as a conditionality of ESHE? retained within the health sector and by the unit that collected them.

HCF reform is an initiative that must fit with other elements of the HSDP. BASICS consultant Dan Kraushaar, who is based at REDSO/Nairobi, came to Ethiopia in January 1997 to review the MOH's HSDP draft document for USAID/E, then returned in March to participate in a donor pledging meeting where this document was presented and discussed. Both trips were funded through REDSO. The consultant returned in October-November to participate full time in the World Bank/Donor/MOH identification mission, which reviewed the regional and national HSDP. This trip was financed through BASICS's Delivery Order #20 funds. BASICS/Addis staff participated in one of the regional workshops where the SNNPR presented its plan, and in the summary workshop (November 4th and 6th).

While HCF initiatives are being developed at the central level, BASICS is exploring community financing schemes that will be tested in focus communities in the SNNPR. They will include such approaches as costing of local labor inputs and establishment of community health funds. BASICS plans to provide technical advice to communities to establish revolving drug funds and to support community health workers.

There is also a pilot HCF scheme in the SNNPR funded by Irish Aid. This program has rehabilitated a number of CHPs and it has trained CHWs to provide at least curative services in these facilities. The CHWs are paid 60 birr a month from revolving funds that come from profits made on the sale of basic medicines, such as chloroquine, paracetamol, aspirin, and ORS.

According to the PY5 Timeline, the following HCF reform activities were planned for 1997:

- ? Support to joint World Bank/donor country visits for HSDP in health financing and budgeting,
- ? Assistance with monitoring of NPA financial conditionalities,
- ? Follow-up on civil service reform process (links between capital and recurrent budgets), and
- ? Promotion and dissemination of information on HCF strategies.

7.6.7 Community Health Initiatives

In fulfilling the sub-IR under RP4, "community health service revitalized," BASICS works in five focus communities in four SNNPR woredas. In communities, BASICS's work beyond the

formal health care system is meant to complement the work it does strengthening this system. BASICS's goal is to improve the awareness, capacity, and self-reliance of communities to address their own health needs, rather than being mere passive consumers of health services. BASICS's activities and objectives include efforts to achieve the following:

- Improve links between local communities and the nearest health facility;
- Improve community participation in health matters, develop a sense of personal and group responsibility for health, and a sense of ownership of health services;
- Promote health behavior change at the community level;
- Develop a more effective integrated service delivery system;
- Create greater demand for health services;
- Assist in limited renovation and refurbishment of health facilities;
- Explore improved, sustainable HC financing, including community mobilization of manpower and finances, cost recovery from limited curative and preventive services, and effective use of recovered revenues; and
- "Dissuade adverse traditional practices" such as female genital mutilation and inappropriate injection practices (not in fact "traditional").

Under the HSDP, to facilitate supervision the five satellite community health clinics attached to each public health center will be 5 to 10 km from the nucleus health center. As the government has relinquished responsibility for community health posts and health stations (part of the six-tier system) and because of the concentration of CHCs within a small radius of the health centers, there seems to still be a need for CHPs or at least CHWs to provide some basic medicines and serve needs at the village level. Moreover, community-level initiatives complement BASICS's work with the formal health system.

Although it will not support CHPs, the RHB seems in aggreement with communities developing and maintaining their own CHPs, as is beginning in BASICS's focus communities. The RHB seems to recognize that CHPs and CHWs can provide limited curative services and a great number of preventive services at the local level, improving knowledge and health behavior and raising demand for appropriate services at government health units. In other words, although CHPs are not part of the new four-tier system, they may be very important in terms of improving PPHC. Furthermore, communities may be willing to support them.

According to the PY5 Timeline, the following activities related to focus communities were

planned for 1997:

- Assist with the rehabilitation of selected health posts and water supply systems;
- Conduct assessments with appropriate government staff;
- Mobilize local communities;
- Provide industrial materials;
- Facilitate linkages between communities and formal health services;
- Conduct assessments with relevant government staff;
- Support the development of local income-generating activities;
- Facilitate local nutrition groups to develop demonstration gardens or child-feeding centers.
- Explore the possibility of local traditional birth attendants (TBA) and women's groups to use and produce "Disposable Delivery Kits;"
- Provide TA for the development of drug revolving funds;
- Develop health education materials for key emphasis behaviors; and
- Conduct small workshops with zonal and woreda health staff, RTC, local health workers, CHWs, TBAs, and community groups.

Achievements

BASICS assisted communities in rehabilitating three health posts, working on spring protection, repairing a hand waterpump, and developing a health center roof catchment system. Furthermore, BASICS provided industrial materials such as cement, paint, and nails, while the community provided local materials and labor.

BASICS has developed a proposal to form nutrition groups in at least three communities in early 1998.

The possibility of local TBAs and women's groups using disposable delivery kits (DDK) was delayed and is now scheduled for 1998.

The development of health education materials (interactive materials) began in September 1997 with a workshop involving participants from the RHB and RTC, and zonal and woreda staff, as well as CHAs. Pretesting of the materials (stories on key emphasis behaviors, such as ANC, exclusive breastfeeding, and immunization) identified by the communities began in October and will continue until March 1998. Each community will develop and refine the stories through focus groups. Alternative channels of communication involving schools, churches, community leaders, rural drug vendors, CHAs, and TBAs will also be explored in the following months.

To develop linkages between communities and health facilities, BASICS has made special efforts to involve RHB, zonal, and woreda health staff in each planning stage, each committee, activity, and workshop. BASICS has also tried to link communities and their demand for services, with such entities as a water resources department and family guidance association.

Table 4

Achievements Linked to Key Indicators in the Five Focus Woredas

Indicator/Result	Health Facilities Providing PPHC Service (inc. ANC and FP) (%)	Facilities Receiving $1 Supervision Visit Every 6 Months, Using Integrated Supervision Checklist (#)	Women (15-45) Who Had Vaccine Card Checked (%)*	Children (<5) Who Had Vaccine Card Checked (%)*	Children (<5) Whose Weight Was Plotted on Growth Chart (%)*	Children (<5) with Diarrhoea Treated As Appropriate (%)*	Children Whose Mother Was Given Correct Advice on How to Administer Oral Medication (%)*
Dec. 1997	In process	10 of n=33	25%**	25%**	25%**	65%**	45%**

*From observation of a sick child visit

** latest data from 10/96. Awaiting next survey

Table 5

Achievements Linked to Key Indicators in the Five Focus Villages

Indicator/Result	Children 12-23 Months Who Received Measles Vaccine (%)	Infants 0-6 Months Exclusively Breastfed (%)	Caretakers Who Can Identify Signs for Seeking Care When a Child Is Sick (%)	Caretakers of Children Who Have Received Health Education from a CHW in the Last 3 Months (%)	Focus Communities with a Functioning Health Committee (%)	Women Who Made $2 ANC Visits for Last Pregnancy (%)	Children Sick in Last 2 weeks Who Sought Care From Trained Health Provider (%)
Unit of Measure	Household	Household	Household	Household	# Comm.	Household	Household
To Dec. 1997	25%*	35%*	78%*	Ongoing	100%	23%*	42%*
1998 Target	75%	50%	90%	50%	100%		

*From Feb. 1997 survey. Next survey May 1998.

These indicator achievements can also be assessed against the following expected EOP results in focus woredas:

- Supervisory checklists used regularly by supervisors in the focus woredas;
- Improved case management in maternal and child care and family planning;
- Selected health centers and health posts are better equipped to provide PPHC services;
- Regional Quality of Care strategy is developed; and
- IMCI is implemented on a pilot basis in selected SNNPR sites. Lessons learned for replication.

Also, achievements can be assessed against the following expected EOP results in focus villages:

- Five communities have improved health services and health-related awareness, with stronger links with the institutional system;
- Training and health education materials for CHAs and communities are developed and ready to be used;
- CHAs in five communities are trained to deliver integrated PHC services;
- A method for participatory community needs assessment is developed; and
- Preliminary evaluation of strategies are developed for working with communities.

BASICS's community work has been time-consuming for several reasons that are important even if they are hard to document: (1) bottom-up, participatory planning simply takes more time than the former top-down, PHC-by-decree; (2) government staff is unfamiliar with the new participatory approach and needs time to learn it; (3) the project faces suspicions held over from reactions to the old system; (4) people may have become passive and dependant due to external relief in recent years; (5) neither the RHB nor USAID initially supported BASICS's efforts to rehabilitate CHPs, which was considered a very high-priority need by community leaders.

In spite of problems and constraints, BASICS staff, local counterparts, and village leaders have gone through a participatory planning process whereby village leaders identify their health-related needs by priority. This has led to identification of the needs to rehabilitate a community health post and a potable water system as priorities. Also, former or potential community health assistants (CHA, or the more universal designation CHW) have been identified. BASICS has

trained or given a refresher course in child survival and family planning to a number of CHWs.

Incentives for community-based health workers, or those that visit local communities in both rural and urban areas, is a complex issue that transcends the BASICS project because (1) CHWs or CBD agents are central to the ESHE activities of both Pathfinder (along with its various local NGOs) and BASICS; (2) currently, Pathfinder is following one incentive policy (cash incentive) while BASICS is following another (non-cash incentive); (3) this issue absorbs much of the time BASICS's staff and government counterparts spend in focus communities; (4) this issue relates to complex, still-to-be-resolved issues surrounding health care finance reform; (5) this issue sheds light on the future of public and private sector health services; (6) this issue is central to sustainability; and (7) this issue has plagued health and family planning programs throughout Africa and other developing countries for decades, and there is still no consensus on what kind of incentives, if any, CHWs should receive.

In BASICS's five focus villages, CHWs work without cash incentives of any kind. The nearest health center may provide free health services and drugs (representing at present very small amounts of money) for the CHW and his family, as a government-provided incentive. BASICS is experimenting with non-cash community incentive schemes for CHWs. In at least one village near Alaba, the local health committee has told the project that it will find some way to induce CHWs to work, but it has yet to come up with a clear plan, and the PA chairman (also on the Health Committee) told the team that the incentive would not involve cash or salary.

USAID/Washington's position appears to be that since poor countries cannot sustain any sort of cash stipend for CHWs, there is no reason to support such programs at all, even for limited periods. BASICS for the most part seems to support this view. However, Ethiopia may present a special case. Ethiopia is rare among African countries in that in the HSDP, it plans to provide salaries for both CHWs and trained TBAs who will be attached to CHCs. That is, it plans to provide salaries to facility-based but not community-based CHWs. (BASICS-trained CHWs might therefore become salaried workers at CHCs.)

Moreover, Pathfinder is paying its integrated CBD agents (called CBRHAs) who work in the same areas as CHWs. CHWs are aware of this and naturally wonder why some community health agents are paid and others are not. This, along with the HSDP, are both strong arguments for piloting some sort of cash incentives for CHWs in Ethiopia, although this should not be considered until a post-September 1998 contract is in place. It would not make sense to begin something that might not continue beyond a few months (and the timetable for the RHB hiring CHWs to work at peripheral health facilities is uncertain).

The value of having two models of community-based health and family planning workers under the same ESHE project, and sometimes even working in the same areas, is that it provides an unusual opportunity for operations research to determined the relative cost-effectiveness and sustainability of the two approaches. A variety of economic, social, cultural, geographic, and

other relevant variables can be held constant where the two models are being implemented side by side.

Recommendation:

24. There needs to be operations research to determine the comparative cost-effectiveness and sustainability of three or more types of CHWs (CHWs working on sales commission in the SNNPR under Irish Aid, CHWs working without cash incentives in BASICS's focus communities, and two to three models of CBD agents working with Pathfinder-supported NGOs). A closely related question is the degree to which the CHW/CBDA should serve in a preventive or curative role. There should be a thorough review of pertinent published and unpublished literature on African CHWs as part of this research.

7.6.8 Project Implementation

Project implementation in the SNNPR has involved a large number of short-term consultants. Some of these consultancies were beyond what BASICS/Ethiopia requested, but many were requested by BASICS/Ethiopia to help in project and program implementation. BASICS management justifies this by saying that some activities, including those related to training, HMIS, and research, require an intense two- to three-week concentration of time and energy, and regular long-term staff cannot take time away from their regular activities, even if they possess some of the necessary skills. Moreover, BASICS/Global by design and mandate is a TA-intensive central project; it can be argued that providing a great deal of short-term TA is one of its strengths. Still, USAID and the GFDRE disagreed with BASICS's planned level of short-term TA in the final revision of BASICS's workplan.

Local NGOs and Donors in the SNNPR

The GFDRE did not agree with the ESHE design plan for BASICS to be able to extend its activities and, therefore, its impact by giving subgrants to NGOs. However, BASICS is working cooperatively with AFRICARE and World Vision, sharing experiences and methodologies as requested in their SOW to coordinate activities.

Responding to the USAID/JICA Common Agenda, JICA has expressed willingness to buy health equipment and improve facilities with which BASICS is working. BASICS has been active in brokering this cooperation between unilateral donors. The USAID/JICA Common Agenda is one example of USAID's efforts to leverage other donor support to the health sector.

Commodities

The GFDRE changed its policy of exempting goods donated to the government from taxes on imported goods. Earlier in the project, vehicles, books, and other imports entered Ethiopia this way. However, with the change of policy, substantial taxes have been levied on medical equipment, computers, and other commodities. Many of these items now sit in warehouses while the GFDRE and USAID negotiate. Meanwhile, project implementation is constrained by lack of supplies and equipment.

7.6.9 Monitoring and Evaluation

BASICS's evaluation is based on baseline and follow-up surveys, while monitoring is based on data gathered through newly inaugurated systems. A baseline health facility quality of care assessment was conducted during the last quarter of 1996 in 19 health facilities from the focus woredas, along with its regional, zonal, and woreda counterparts. The assessment focused on providers' behavior when the children visited the health facilities. Selected behaviors were incorporated into a supervisory checklist used during supervisory visits made with woreda supervisors. A supervision results database will allow periodic monitoring of key behaviors in the focus woredas during FY98. A repeat quality of care assessment scheduled for May 1998 will provide estimates of changes in providers' behaviors at the end of the project.

A community assessment and planning process survey conducted in the five focus communities in February 1997 provided baseline information on the prevalence of selected key emphasis behaviors by caretakers and others in the community. The assessment process will be repeated in May 1998 and is expected to show indications of changes in key behaviors linked to support to the community workplan and to the development of health education activities.

Monitoring of the health budget and expenditures both at national and SNNPR levels, conducted by BASICS and USAID, will provide the information needed to assess the completion of NPA conditionalities; monitoring of conditionalities is formally conducted by USAID/E.

7.6.10 Performance Indicators for RP4

Partly as a result of the September 1997 consultancy and recommendations (Patterson et. al.), a planning exercise was conducted in October 1997 during which a revised set of performance indicators was agreed upon by USAID and BASICS.

Neither central nor regional government was represented at this event, which seems unfortunate, especially since the RHB has a stake in and agrees with BASICS's systems-strengthening approach in the SNNPR. Subsequent to the agreement, USAID is said to have added at least one

performance indicator that holds BASICS responsible for outcomes dependant upon the GFDRE (parliament) passing health care finance reform legislation. Such an outcome is beyond the control of BASICS, USAID, and perhaps the government branches that are ESHE partners.

Most performance indicators for the project involve increased use of health facilities. Such increases could result from improved transportation and physical infrastructure, increased coverage, improved drug supplies, and other factors unattributable to project impact. However, the team was pleased to note the addition of two performance indicators of a different nature that involve measures of changed knowledge and behavior in focus communities.

Some of the most important, sustainable, and lasting project contributions may be those that are hardest to measure, and are, in fact, not among the project's performance indicators. In discussing the sustainability of BASICS's activities, a nurse in the Alaba health center answered by describing how he himself became a convert to the participatory, bottom-up approach while working with BASICS staff in community mobilization. He observed:

> My thinking was changed. We can't just tell the villagers what they need, what is good for them. We need to listen to them and plan with them.

7.7 Conclusions

7.7.1 Progress Under Sub-Intermediate Result 4.1: Regional Government's Capacity for Service Delivery Enhanced

BASICS has made commendable progress in meeting results under Sub-IR4.1, including improving planning and management, increasing regional training capacity, improving availability and quality of services in health facilities, and improving logistics. Yet, it must be remembered that all achievements have been accomplished in the past 15 months and that most are in progress. Some key planned activities related to systems strengthening and capacity building have not yet taken place. Those planned for 1998 may be constrained by inadequate time and human resources because of required project-closing activities and possibly loss of BASICS staff.

7.7.2 Progress Under Sub-Intermediate Result 4.2: Community Health Service Revitalized

The BASICS project in the southern region is piloting some valuable initiatives at the community level, something the GFDRE and the RHB are committed to but need guidance on. As the 1995 baseline survey notes, there have been a number of past initiatives to emphasize primary health care and to improve access of the rural population to appropriate health care.

At present, the GFDRE seems committed to approaches endorsed by WHO, UNICEF, and USAID (participatory planning, self-reliance, community mobilization, sale of commodities, and retention of profits and local financing), but it lacks experience in such approaches. BASICS and other foreign groups for the most part lack adequate experience in implementing the desired approach in Ethiopian settings. Therefore, experimental and pilot initiatives are needed.

There has been progress in all areas listed under Sub-Result 4.2.1 (Delivery of Essential PPHC Package at Community Level), namely: (1) rehabilitate community health posts and village water supplies, and support outreach activities; (2) evaluate and develop training and IEC materials for CHWs; and (3) improve health awareness and PPHC practices in the communities. Accomplishments in the second area has been most recent: two BASICS consultants came in October (this information is not in the "Annual Report," which covers the period from October 1996 through September 1997) and worked with community health committees and CHWs to develop IEC approaches appropriate to the needs (including low literacy levels) of villages in the SNNPR.

USAID and others have raised questions about the sustainability of community-based project initiatives. One question concerns the amount of external input that would be needed to mobilize a community in ways that improve health. A related question concerns the amount of time, manpower, and perhaps financial resources that would be needed to have an effect.

In its early work, BASICS held week-long meetings to gain the trust and confidence of people in a focus community. Through a participatory planning process, village leaders identified their health-related needs by priority. This process often led to identified needs to rehabilitate a community health post and a potable water system. These exercises were necessary to achieve the desired results and to gain a community's confidence.

There is also a need for regular outsider-community meetings and for actions to follow up on agreements. Otherwise, outside animators are "back to square one." Clearly there needs to be not only careful, comparative analysis of BASICS's experience on community activities, but also operations research to answer questions related to the sustainability of the project, and those related to incentives for CHWs. Of relevance to this project may be the experience of Food for the Hungry, which built or rehabilitated a number of health posts in the Alaba woreda but apparently did no participatory planning and did not develop an incentive for CHWs. When the project ended, everything stopped.

7.7.3 The Capacity of the Regional Health Bureau to Assume Sole Project Responsibility by the End of the BASICS Contract

Several activity areas require more time than is available through September 1998. Among these areas are health care financing reform and revitalization of community health services, as well as promotion of PPHC and behavior change in focus communities. These project areas involve developing, testing, and adapting new models that in turn must be proven useful and sustainable, and then must become institutionalized.

The resulting models should be institutionalized regionally, not only in focus zones, woredas, and communities. Development and testing of these models cannot be rushed for fear that nonviable models be developed or good models discontinued because they are inadequately tested. If unforeseen problems arise, which is quite likely, then expatriate TA with experience from other countries in health care financing reform and community-level health services and behavior change will be needed to help resolve these problems and to fine-tune the models in use.

According to EET interviews with the RHB head and two deputies, the RHB would like to see project activities increasingly handed over to the government. Yet, it does not feel ready to take over BASICS's activities, which by expiration of the BASICS contract, will have been implemented for less than two years. The RHB mentioned that new, participatory approaches to community health are still "resource-intensive"? meaning beyond what the RHB would be able to do? but that this may be because these approaches are still exploratory. Once models for animating and working with local communities are discovered and refined, the RHB ought to be able to replicate such community-level work in other zones and woredas.

At the time of the EET's interview, the RHB felt that continuing with BASICS would be the best option after the current contract expires.

The EET believes that expatriate TA ought to be continued beyond September 1998. Progress has been limited by the late project start-up and by other factors previously mentioned. For gains to be sustained and for the capacity of the region to operate new systems and procedures, a new USAID contract for TA will be needed for perhaps two additional years. Such TA should continue to follow BASICS's current approach of systems strengthening and capacity building, involving government counterparts in every phase of project planning, implementation, and evaluation. There should be a phased, continuous handover of responsibility from the project to the RHB during the life of the successor ESHE project in the SNNPR.

Recommendation:

25. There should be continued long-term technical assistance to the RHB after September 1998. Such TA should continue to follow BASICS's current

approach of systems strengthening and capacity building, involving government counterparts in every phase of project planning, implementation, and evaluation. There should be a phased, continuous handover of responsibility from the project to RHB during the life of the successor ESHE project in the SNNPR.

The RHB would like to see project activities expand to the whole region. In fact, a good deal of project support at the central (i.e., the RHB and RTC) level has strengthened the health system of the whole region.

Recommendation:

26. After the first year of the post-September 1998 project continuation, there should be a phased expansion into more zones and woredas in the SNNPR. The Regional Steering Committee, in consultation with ESHE's national entities, should be primarily responsible for identifying and establishing the number of new zones and woredas.

Given that the BASICS contract will expire in September 1998 and there will be shifts of emphasis within ESHE since the BASICS contract was designed. USAID/E should begin developing a post-BASICS contract.

BASICS has made a good start in building the capacity of regional government counterparts and in working with local communities. The RHB in the SNNPR would like to build on this momentum and good working relationship rather than starting over with new expatriate TA. Specifically, the RHB believes that the best option for a post-September 1998 TA would be to continue with BASICS. The RHB noted that there is a good relationship between the RHB and the project and that "it would take 6 to 12 months for any new foreign team to become fully functional."

On the other hand, BASICS's global mandate and expertise is in child survival; this mandate does not include reproductive health (family planning and STI/HIV/AIDS). BASICS also lacks the adequate mandate and experience in the type of policies and legislative reform called for in the ESHE NPA conditionalities. Looking to a post-1998 contract, the needs of the GFDRE, ESHE, and USAID might be better served with a different contractor or grantee. Furthermore, a mechanism other than a centrally-funded project might also better serve ESHE's needs. USAID and ESHE would save money if ESHE worked through a mission-initiated contract or grant. Moreover, there would be more mission and steering committee control using such a mechanism.

As a centrally-funded contract, BASICS has been able to draw upon a pool of technical assistance through a relatively easy contracting mechanism. On the other hand, there are large overhead costs and there may be differences in the agendas and mandates of BASICS/Global and

BASICS in a particular country. For example, there has been some tension between BASICS/SNNPR staff and BASICS/Global over the latter initiating unrequested technical consultancies in the core areas of BASICS/Global, namely integrated management of child illness (IMCI), sustainable immunization, behavior change, nutrition, and private sector participation.

Overall, the disadvantages of continuing with a centrally-funded child survival contractor outweigh the advantages. A new contractor does not necessarily preclude the continuation of incumbent staff under a different contract or grant mechanism. Retention of at least some incumbent staff under a different mechanism would speak of the RHB's concern about having to start over with new expatriate TA.

Recommendation:

27. A mechanism other than a centrally-funded project and a contractor other than one focused exclusively on child survival would better serve the needs of the ESHE project. USAID/Ethiopia should develop objectives and a scope of work for a new contract or grant for the ESHE project. It should proceed immediately to avoid a hiatus between BASICS's expiration and the beginning of successor technical assistance.

Further Integration of PPHC

An HIV/AIDS component was part of the original ESHE design, but this component is said to have been dropped before the BASICS contract was finalized. As discussed in the previous section, STI/HIV/AIDS should be integrated with child survival and family planning as part of PPHC in the SNNPR. Some of the mechanisms for integration at all levels (RHB, zone, woreda, and village) are already in place. Moreover, there is compatibility and overlap between the messages, behaviors, technologies, and target audiences involved in child survival, family planning, and STI/HIV/AIDS. Therefore, there are potential synergies, cost savings, and mutual reinforcements that could be created if the three programs are integrated with one another.

Recommendation:

28. STI/HIV/AIDS should be integrated as planned with child survival and family planning as part of PPHC in the SNNPR.

7.8 Suggested Modifications

With regard to IR4, "Increased use of integrated rural PPHC in the SNNPR," this wording implies PPHC facility use only and does not capture project efforts that include improved health-related behaviors, as well as community participation in and mobilization for health. (Comments and recommendations on RP4 are based on the October 1997 revisions to the Performance Monitoring Plan).

Because the impact of the project is not restricted to rural areas and populations, the EET recommends deleting the word "rural" and modifying this RP to read: "Improved, integrated PPHC in the SNNPR."

The EET further recommends some modifications in the critical assumptions:
Assumption 6 should read: "Private sector health services increase during LOP."
In addition, a new critical assumption should be added: "The institution of cost recovery and implementation of user fees will not constrain use of health services."

The phrasing of RP4.1 is acceptable, however RP4.2, "community health services revitalized" does not capture the range of project activities. This language should read: "community health service and behavior enhanced."

The phrasing of all sub-IR's under IR4 is acceptable. However, some PIs under IR4 measure impact at the regional level, whereas project interventions thus far occur only in focus zones, woredas, and villages. USAID/E should clarify these PIs in view of the present and future scope of the ESHE project. For the present, the level of impact measurement for all PIs should be consistent.

Overall, there are opportunities to consolidate IRs, to make them more specific, and to reduce the number of PIs without compromising the effective management of the project. Consolidation of the IRs would also facilitate monitoring and assessing performance.

8. PROJECT MANAGEMENT

8.1 ESHE Steering Committee

Through a series of three bimonthly meetings (March 31, 1997, May 29, 1997, and September 4, 1997), a critical mechanism for the collaborative management of ESHE has been established. With the final approval and adoption of its terms of reference (TOR) at the meeting on September 4, 1997, the ESHE Steering Committee (ESC) was formally constituted, along with its subordinate ESHE Technical Working Group (ETWG).

Although the initial meetings served to review NPA conditionality and other pressing issues, several organizational questions had to be settled, notably (1) separate versus combined program and project committees, (2) representation on the ESC, and (3) formal TOR.

The ESHE Program and Project Amplified Descriptions are somewhat unclear with respect to whether separate steering and coordinating committees were originally envisaged. In any event, although USAID/E favored a separate Program Steering Committee to focus on the policy reform process, the initial committee members decided that one combined program and project committee would be more practical in terms of resources (available staff and time, especially at the MOH and MEDAC). Likewise, committee members decided that only one technical working group would be constituted to support the ESC.

The formal signatories to the ESHE agreement were MEEC (succeeded by MEDAC), the MOH, and USAID. Other key partners represented on the ESC, as finally constituted, are the Ministry of Finance, the SNNPR, and the NOP. The ETWG's membership parallels that of the ESC (with the addition of BASICS from the donor side), but at a more technical level.

The main issue regarding ESC membership considered during the initial meetings was that of PMO participation. With the transfer of the NOP from the PMO to MEDAC, the PMO is not directly represented.

USAID felt that PMO representation would be beneficial to ensure high-level support for ESC decisions and to ensure good coordination between ESHE and the governing HSDP framework (since the PMO Social Services Department has taken the lead in development of the HSDP). The MOH (which chairs the ESC) argued that it represents the government on health issues and that, with additional representation by the "macro" ministries (MEDAC and Finance), direct PMO membership on the ESC would not be necessary or appropriate. The committee accepted the MOH's view, but its disadvantages may outweigh its advantages. Whatever the final outcome on this issue, good communication between the ESC and the PMO is essential and it is appropriate for the chair of the ESC to ensure such communication.

The ESHE Amplified Project Description states that the prime minister's Office of Social Services will be involved in program and project management and coordination. Indeed, during the course of this evaluation, the PMO reiterated its need to be kept closely informed. However, it indicated that it would not demand to have direct membership on the ESC.

Although the ESC's initial meetings and the finalization of its TOR (including membership) were seriously delayed (following the signing of the bilateral agreement in 1995), it is now formally constituted and functioning. Formal TOR were developed and finalized by an ad hoc working group, reflecting the decisions on the combination of committees and representation. The TOR were adopted by the ESC at its third meeting on September 4, 1997. The ETWG has worked well to support and guide the ESC. It drafted the ESC terms of reference, formulated tranche three NPA conditionalities, reviewed the BASICS workplan, and reviewed the latest ESHE project amendment. It plans to meet soon to consider the recommendations of this evaluation, reallocating funds under the ESHE contingency line and possibly introducing a regional incentive fund for SNNPR.

Under the TOR, the ESC will meet every six months or sooner as needed; the ETWG will meet quarterly or sooner as needed.

The EET respects the MOH's position as the lead implementing agency for ESHE, but it also notes the important involvement and authority of the PMO in health sector matters, including its strong role in coordinating the development and implementation of the HSDP. Moreover, involving the PMO in ESHE program and project deliberations may serve to avoid unexpected delays or concerns at the highest levels.

Recommendations:

29. To ensure consistent and appropriate government support, the ESC should establish formal mechanisms so that there is adequate and timely liaison and communication with the PMO. This communication might take the form of a written aide-mémoire immediately following each ESC meeting or an in-person briefing of the PMO by a designated ESC member. The success of such measures should be reviewed and, if not satisfactory, the issue of direct PMO representation on the ESC should be reconsidered.

30. The ESC and ETWG meetings should be held on schedule, full participation of the membership obtained, and careful records of its decisions and responsibility for follow-up actions promptly recorded and disseminated by the chairman of the ESC.

8.2 Communication and Coordination

A program and project as large and as complex as ESHE needs corresponding managerial resources and skills at all levels? USAID/E; GFDRE departments; CAs; and regional, zonal, and woreda bureaus. To function properly, management needs established operating procedures, clear and defined reporting responsibilities, and functional communication channels. There must be well-established monitoring procedures and controls, including financial ones.

It appears that there are several weaknesses in ESHE's current management system that could, unless rectified, lessen the impact of the project and make the achievement of objectives more difficult. There was in some cases less-than-optimal coordination and communication in reviewing project workplans and informing partners in the GFDRE or CAs satisfactorily of project performance and events. Therefore, it was difficult for partners to discuss and agree to any necessary countermeasures or modifications, and particularly for GFDRE partners to feel a sense of close involvement in the project. An example of this was the major change in the project workplan made by the USAID/E Mission after the planning meeting in Debre Zeit in August 1996, apparently without close consultation with GFDRE partner agencies.

In some part, this lack of communication and coordination between all partners may be due to insufficient staff resources at USAID/E; however, the EET learns that steps are underway to rectify this situation.

Management of the project's central-level activities may be hampered and somewhat isolated by the fact that there is as yet no CA adviser actually situated in any government department, such as the Ministry of Health, although one major ESHE component is the strengthening of managerial capacity and skills in that ministry. This managerial isolation may have contributed to misunderstandings and negative attitudes toward the project in some central government circles, giving rise to complaints regarding lack of transparency and communication.

Recommendation:

31. The ESC and ETWG meetings should be used as formal mechanisms for informing all partners on ESHE's progress and for discussing and planning modifications and changes. These meetings should however be backed up by regular and frequent communications on a more informal basis. It is essential that the present feeling of non-participation in the project's progress at the Ministry of Health and other government agencies be overcome.

8.3 Logistics

The success of ESHE and the GFDRE's program to improve use of PPHC facilities depends to a considerable extent on proper management of essential supplies and logistics. Even if donated, quantities of essential drugs, medical disposables, and family planning commodities that are imported or produced locally must be viewed as precious; they must absorb much foreign exchange and cannot be wasted. PPHC depends to a large extent on these items being available at all times in health facilities, otherwise patients will not come to these facilities.

Whereas supplies to the public sector may be seen as adequate, it appears from reports received (MOH) and from observations in the field (SNNPR regional and woreda stores) that sound inventory control and storage systems may be lacking in some cases. For example, supplies received or procured from donations appear to not be well coordinated with those procured or supplied through regular systems. This lack of coordination leads to excess stocking in some cases and less-than-optimal use of funds.

Closer coordination is needed between the Pharmacy and Family Health Departments at the MOH, RHBs, and Pharmid. Management at regional, zonal, and woreda warehouses appear to lack good inventory control systems, storage, and restocking procedures, which could lead to waste or stockouts.

Recommendation:

32. Although logistics training is included in ESHE's SNNPR focus area component, attention should be given to identifying needs and planning possible training support at the central level. In particular, attention should be given to concerned departments at the Ministry of Health, in areas such as forecasting of needs, distribution, and inventory control of essential drugs and family planning commodities.

8.4 Other Concerns

Performance Indicators

The project appears to be burdened with too many performance indicators. For example, there are currently 25 PIs under RP4 alone and 13 under RP3. Close project monitoring is essential; however, this quantity of PIs takes management time and energy away from important planning and implementation activities. The PIs should be condensed. Suggestions for improvement have been made in the chapter relating to the Strategic Objective.

Overseas Training

The cost and benefit of overseas training under ESHE may be compromised by the lack of returning participant trainees (three short-term participants have so far failed to return). More effective mechanisms to ensure the return of participants should be studied by project management, including choice of training location, positive incentives, and closer assessment of personal factors affecting the likelihood of return.

Import Duties and Taxes

With regard to import duties and taxes, project activities and supplies may be compromised by heavy and unplanned import duties and taxes. ESHE project management, both USAID/E and government counterparts, should work closely with government departments to ensure compliance with previously-agreed-upon, duty-free status agreements. ESC should take the lead in resolving such situations. With regard to FP supplies, this appears to be critical and requires firm action. There are very few countries in which donated supplies of essential medical commodities are subject to stringent taxes.

Changes in Key Government Personnel

The effective management of the project may be adversely affected by the numerous and frequent changes of key technical personnel in government departments.

The development of management information systems at central and regional levels may help to mitigate the consequences of personnel changes; however, the negative consequences of a high turnover of government personnel, particularly those with training and skills related to ESHE, should not be underestimated.

9. REVIEW OF ESHE FINANCIAL ALLOCATIONS AND EXPENDITURES

The EET spent considerable time and effort working with the USAID Mission and ESHE's implementing agencies to compile this financial review to determine where funds have been allocated and spent as of September 30, 1997.

The term "allocated" or "allocation" means funds placed with an implementing agency or into a specific activity. "Expended" means funds actually spent, including the accrued expenditures as of September 30, 1997.

Table 6 breaks down ESHE funding by non-project assistance (NPA) ($30 million), bilateral project ($26.5 million), and unilateral project ($13.5 million). The table does not disaggregate the implementing agencies' expenses, because this information was not available.

Table 6

Information concerning the breakdown of expenditures by funds spent in Ethiopia versus funds spent in support of the implementing agencies' headquarters (U.S. costs) can be obtained by asking each implementing agency to provide such a cost breakdown. This exercise could be coordinated by the USAID Mission if the government so wishes. The financial table does not include global field support resources projected at $35 million over LOP, the analysis of which was beyond the scope of this evaluation.

9.1 Conclusions

By the end September 1997, only 11 percent of bilateral and 20 percent of unilateral funds had been spent. This is not surprising given ESHE's slow start up. Significant underspending has occurred in USAID's technical assistance line item in the bilateral budget. This is directly related to the slow start up of the BASICS contract and has resulted in USAID having a balance of $2.6 million with which to program technical assistance over the next five years.

In addition, funds allocated for the procurement of STD drugs, warehouse construction, and the grant to WHO for construction have not been spent pending USAID's finalizing details on the size of warehouse construction and establishing letters of credit to WHO.

In addition, there are substantial unprogrammed funds still residing in the training, commodity, local support, and contingency line items (bilateral project), which represent an opportunity for future joint planning and programming with the MOH.

The unilateral project budget is also underspent. In view of the end date of the BASICS contract in September 1998, it is unlikely that these funds can be fully programmed and spent. Spending patterns of other agencies such as PSI and Pathfinder appear more reasonable and on target.

Apart from the contingency line item, only one line item contains significant funds for new activities. The EET understands that these funds will be used, in part, for future STI/HIV/AIDS activities.

This review of ESHE allocations and expenditures is a first step in addressing the government's criticism of a lack of transparency between USAID and the MOH and MEDAC over where funds have been allocated and what has been spent by whom.

Recommendation:

33. USAID/E and the MOH should meet semiannually to review in detail allocation and expenditure data on this large and complex project. In addition, the government should be substantially involved in discussions to program the funds available for future years' activities, especially the "Beyond BASICS" technical assistance and new STI/HIV/AIDS program component.

APPENDIX A

Scope of Work

MID TERM EVALUATION OF THE
ESSENTIAL SERVICES FOR HEALTH IN ETHIOPIA (ESHE)
PROGRAM (663-0016), PROJECT (663-0017)

ARTICLE I. BACKGROUND:

Ethiopia's health status is among the poorest in the world. Government figures indicate that between 38-47 percent of the population have access to health facilities. However, available resources are maldistributed both on a geographic and level of care basis, government facilities are under-utilized, and health services seriously under-funded. There are insufficient and appropriately trained health staff. The limited personnel are under-utilized and there are frequent shortages of essential drugs and supplies. Furthermore, with a total fertility rate of about 7.0, Ethiopia's population could exceed 100 million by the year 2015. Infant mortality is estimated at 110/1000 live births and child mortality is estimated at 170/1000. Major causes of morbidity and mortality include diarrhea, acute respiratory tract infection, vaccine preventable diseases, malaria and malnutrition. By the year 2000, over 2 million Ethiopians could be infected with HIV/AIDS.

The Government of the Federal Democratic Republic of Ethiopia (GFDRE) has shown commitment to improving and re-orientating health services. GFDRE policies emphasize the importance of achieving wide access to a basic package of quality primary health care services, emphasizing preventive, promotive and basic curative services via a decentralized system of governance. In December 1996, the GFDRE launched its Health Sector Development Program (HSDP). The first five year phase, which has a twenty year horizon, concentrates on providing health sector improvements and expansion of health facilities in order to achieve universal access to essential primary health care services within the next two decades. The focus will be on communicable diseases, common nutritional disorders and on environmental health and hygiene. Improving the quality of reproductive health care, immunization, and the treatment of basic

infectious diseases such as respiratory tract infections and tuberculosis, and the control of epidemic diseases such as malaria and diarrhea, and the control of sexually transmitted diseases, including HIV/AIDS, will receive special attention.

ESSENTIAL SERVICES FOR HEALTH IN ETHIOPIA (ESHE) PROGRAM/PROJECT

USAID/Ethiopia's program has the goal of "*Peace, prosperity and physical well being for the majority of Ethiopians,* ? and a sub-goal of *"Smaller, healthier and better educated families."* In direct response to issues of health in Ethiopia, the Mission has one Strategic Objective, namely, *"Increased use of primary and preventive health care services*," which integrates rural health care, family planning and STI/HIV/AIDS prevention and control.

USAID believes that rebuilding an efficient and sustainable health system over the long term is the key to health sector development in Ethiopia. To support this Strategic Objective, USAID/Ethiopia signed a seven-year $70 million Essential Services for Health in Ethiopia (ESHE) Program/Project with the Government of Ethiopia on 11 August 1995 as an initial investment in the health sector. Of the total planned USAID contribution of $70 million, $26.5 million is for project support to the government and $30 million is for non-project assistance, for a total of $56.5 million in bilateral assistance. The remaining $13.5 million will be provided through unilateral support to NGOs. Approximately an additional $30 million is channeled through Global Field Support.

Components of ESHE include:

? Program support for the implementation of national policies which will increase resources dedicated to the health sector and assist in the implementation of a revised health care financing strategy.

? Project/Program support for promotion of effective family planning (FP) nationwide through the liberalization of family planning legislation, expanded social marketing of contraceptives and increased Non-Governmental Organizations (NGO) FP outreach supported through the NGO Family Planning Consortium - COFAP.

? Project/Program support for HIV/AIDS prevention and control in focus areas includes condom promotion, better treatment of sexually transmitted diseases, and expansion of AIDS education to promote safer sexual practices.

? Focussed Project support for general system strengthening of primary and preventive health care services in the Southern Nations Nationalities & People's Region (SNNPR).

? Project assistance for vehicles, contraceptives/condoms, equipment and supplies, capacity building, training and technical assistance.

ESHE is designed such that four intermediate results are expected to lead to the SO. These are grouped for management purposes into "Results Packages" with activities that are implemented through various mechanisms.

Intermediate Result 2.1: Increased resources dedicated to the health sector, particularly primary and preventive health care.

Intermediate Result 2.2: Increased aacces to and demand for modern contraceptive services in focus areas

Intermediate Result 2.3: Enhanced capacity of Ethiopian society to expand access to and use of STI/HIV/AIDS services in response to the epidemic.

Intermediate Result 2.4: Increased use of integrated rural primary and preventive health care (PPHC) services in Southern Nations and Nationalities People's Region (SNNPR).

Five Cooperating Agencies (CAs) are currently working in Ethiopia: Pathfinder International, BASICS, Family Health International (FHI), Association for Voluntary and Safe Contraception (AVSC), and Population Services International (PSI). A matrix of the primary CAs working in Ethiopia, a description of the Intermediate Results they are responsible for and their activities is found in Attachment A. Key implementation mechanisms supporting the SO will be expiring in the next one to two years.

The ESHE Steering Committee, therefore, decided that a mid-term evaluation of the SO at the end of 1997 would be essential to determining how best to proceed with the remaining years of the program/projects in order to achieve the best results possible.

ARTICLE II. OBJECTIVES OF THE CONSULTANCY

This consultancy is an comprehensive evaluation of the ESHE Program (No. 663-0016), ESHE Project (No. 663-0017), activities supported with unilateral funds, and Global Field Resources. The general objective of the consultancy is to provide guidance on how best to proceed with the implementation of ESHE so as to achieve USAID/E?s Strategic Objective #2 ?Increased Use of PPHC Services? over the next five years. The evaluation will consider *inter alia* progress towards achieving the SO; effectiveness of implementation mechanisms; effectiveness of Project/Program management (including participation by partners and beneficiaries); as well as, responsiveness to a changing environment and government priorities for the health sector. Weakness, strengths and opportunities will be identified as a basis for providing recommendations for future action. The evaluation will also review the ESHE results framework and the development hypothesis to identify implementation gaps and provide suggestions on whether the approach adopted to achieving the SO requires reconsideration.

The evaluation is expected to provide recommendations (if necessary) regarding modifications to the ESHE results framework; suggest improvements to Project/Program management to ensure responsiveness to a changing environment and enhance participation among partners; options for implementation mechanisms should be suggested; and, comment made on the impact to date and progress towards achieving the SO. Since the evaluation will look at the performance of all actors associated with implementing and managing the program (USAID, GFDRE and Cooperating Agencies), an external evaluation was considered most appropriate.

ARTICLE III. SCOPE OF WORK

An external evaluation team will conduct a results oriented evaluation and respond in a written report to all the points and questions included in this scope of work. The external team will be supported by the managers and implementing agencies of the Program and projects at every level who will serve as resource persons to the evaluation.

Following are illustrative questions and issues:

1) **Essential Services for Health in Ethiopia (ESHE) Results Framework**: Review the validity of the original results framework (which includes the development hypothesis, assumptions, performance monitoring plan etc.). Suggest a course of action for addressing the implications of failed assumptions, inappropriate indicators and

particularly if there is a need to adjust the results framework. (This will require considering progress under each Results Package - Item 2 below).

a. How have government policies and strategies changed since the design and start up of ESHE? How has the pace of implementation of government policies/strategies affected ESHE's performance? [e.g. enabling environment for NGOs and other private sector initiatives; decentralization]

b. Does the SO statement adequately capture the results of the activities under ESHE and is it appropriate in terms of contributing to the overall goal of the Mission (healthier and smaller families). Do the indicators for the SO appropriately measures results?

c. Are the IRs well stated and defined? Do they appropriately imply that their achievement will necessarily impact on the SO? If not, what changes to the results framework is necessary to achieve the SO or alternatively, is there a need to reconsider the scope of the SO? Conversely, does the SO as stated indicate the achievement of the IRs? Are the indicators appropriate to measure results?

d. Are assumptions still valid and how have they affected overall impact?

e. What changes, if any, should be considered by USAID/E to the results framework to improve the possibility of achieving the SO?

2) **Progress towards Impact:** Examine progress made to date towards achieving each Intermediate Result. Review actual versus planned progress toward achieving the ESHE purpose; what outputs were achieved and what activities/conditions were implemented? Identify flexibility in approach and new opportunities taken as well as problems and delays. Consider national versus focus region impact. Provide recommendations as to whether to increase activities in those areas which are demonstrating greater success.

a. What results have been achieved collectively by the program/project to increase the use of primary and preventive

health care services in the focus areas and nationally?

b. How well do the activities undertaken respond to the SO and its intermediate results. Have the expected outputs been achieved in a timely manner? (e.g. Has long-term training promoted the achievement of sub-IRs?)

c. What have been the successes and problems encountered during Program/project implementation? What were the causes and how have these been addressed?

d. Should the focus areas be maintained as they are or should they be expanded or reduced?

e. Should those activities demonstrating better results be expanded; and conversely, how should those activities which are lagging seriously behind schedule be dealt with?

3) **Response to GFDRE's Health Sector Initiatives:** Review USAID/Ethiopia's interventions to assess conformity with GFRDE's plans, in particular with regard to the Health Sector Investment Program (SIP). Assess the program/project's contribution to the reform process. Review and comment on various possible modalities for supporting health sector reforms, particularly those requiring intervention at the regional level, other than the focus region.

a. How could the Mission better support the government's Health Sector Development Program (SIP)? How would this potential support fit within the ESHE Results Framework?

b. Are ESHE's interventions responsive to GFDRE needs and priorities in general?

c. What can be done within the current framework to strengthen policy implementation nationwide?

4) **Non-Project Assistance:** Determine whether Conditions Precedent (CPs) to disbursement of Tranches 1 and 2 of NPA resources have been effective in furthering the SO; assess whether the present mechanism for development, negotiation and implementation of CPs ensure a national impact.

a. What has been the process leading to policy/budgetary reform within Ethiopia and what have been the causes for delay? Given the influence of decentralization on how policy is implemented, is it realistic to measure the impact of the NPA at the national level?

b. How can USAID best participate in the process for negotiation and implementation of conditionality?

c. How effective is the NPA in making significant contributions to the SO? What approach is recommended to make the most out of the NPA under ESHE?

d. Has the NPA created any disincentives for any of the key players in the sector?

e. How has project assistance helped achieve conditionalities and what project support should be provided to assist in the achievement of the conditionalities?

6) **CA Performance:** Review the role and performance of each of the Cooperating Agencies (BASICS, Pathfinder, AVSC[10], FHI, and PSI).

a. Have the CAs' workplans been consistent with ESHE's objectives? To what extent have workplans been implemented in a timely fashion? [e.g. Has technical assistance (TA), short-term training, delivery of commodities been provided in a timely and cost-effective manner?]

b. Has the CA's staff composition, duties and level of effort been sufficient to comply with program/project's requirements?

c. To what extent have CA's contributed towards improving capacity and institutional strengthening in both the public and private arenas they are working in? (e.g. BASICS technical assistance to the RHB/SNNPR and Pathfinders assistance to COFAP). Do the recipients of such TA show any signs of improving productivity or quality in their service provision?

d. What has been the performance of the CA's from the perspective of government and NGO partners, including their degree of satisfaction with and results achieved through the technical assistance received, and participation in program/project

committees?

e. What financial management and reporting systems do CA'S have in place and are these sufficient for Mission management requirements? Are interventions by CA's cost-effective?

f. To what extent are CA's monitoring systems adequate for assessing performance and measuring impact? Has reporting on results by CA's been sufficient for Mission management requirements?

g. To what degree have CA's under the various Results Packages integrated STI/HIV/AIDS prevention activities into their programs?

h. To what extent have the CA's coordinated, planned jointly, and communicated activities and results to appropriate government counterparts and between themselves? Is there scope for such coordination to integrate activities across Results Packages?

i. Is there a need to consider shifting grant fund levels among CA's? Can direct allocations to government institutions be considered as CA activities are phased out?

7) **Recently instituted Mechanisms:** Recently, projects such as JHU/PCS and the Policy Project have been/are being initiated. While their progress to date cannot be fully evaluated, given that activities have in some part only just started, assess whether the expected results can be achieved or whether there are alternatives that should be considered.

a. What have been the implications, in terms of achieving ESHE's results, of delay in starting these activities?

b. Are there alternative mechanisms for implementing such activities that would reduce the management burden, be more cost-effective and yield similar/better results?

8) **Participation:** Assess participatory process in planning for and implementation of ESHE activities and provide recommendations for improved participation in a decentralized system.

a. How effectively has the government (at all levels) participated in the implementation of ESHE both in planning, implementation and follow-up of activities? Have appropriate government counterparts been identified during implementation of activities?

b. Have significant problems arisen and if so, are there better ways of engaging the government? Has implementation of ESHE been responsive to felt needs and how have differences been reconciled while keeping within the ESHE Results Framework?

c. What are the mechanisms that have been set to ensure effective participation by partners (government, CA's and mission)? How effective are the ESHE (Central and Regional) Steering Committee, the ESHE Working Group(s), and the Family Planning Technical Committee? Is there scope for improvement of such mechanisms?

d. How effectively have concerns of beneficiaries been included in workplans and activities?

e. Are there any partners that should have been involved, not included?

9) **Institutional Sustainability:** Assess what progress has been achieved under the program/project in terms of institutional sustainability. What is the likelihood of services being continued beyond the life of the program/project?

a. To what degree are the partners (including indigenous NGOS and government institutions) dependent on USAID financial assistance to continue providing services support by the project, including the purchase of contraceptives and IEC materials? What is the perspective for lessening this dependency, if any, by the end of the program/project? Include recommendations for increasing institutional sustainability if needed.

b. To what degree are the partners fulfilling the roles envisioned for them under the program/project? Are these roles still valid given changing circumstances since the launching of the program/project?

10) **USAID Program/project Management:** Assess program/project management within USAID. Assess USAID's relationship with its partners. Determine whether management of Results Packages are effectively carried out. Determine effectiveness of planning for and financial management of the program/project.

a. How could USAID better manage the program/project so as to maximize results over the remaining Life of project/program?

b. How has Strategic Objective Team #2 (SOT#2) coordination and communications been with core and virtual team members? How well has the Mission fostered partnerships with the government and NGOs working in the sector?

c. Has USAID/W and USAID/E provided timely and appropriate commodities; e.g., contraceptives? Has the procurement process been managed efficiently?

d. How has the availability of funds under the program/project affected the delivery of project assistance? For example, what has been the effect of the delay in getting HIV/AIDS RP in place?

e. Has USAID/E coordinated with other cooperating agencies, contractors and field support as required? How has USAID/E performed in terms of providing guidance to the CA's?

f. Could the Results Packages or their teams be reconfigured to allow better management of the program/projects? For instance, should RP#2 and RP#3 be combined into one Reproductive Health RP?

g. How can USAID correct any problems identified?

11) **Donor Coordination**: There are many donors providing assistance to Ethiopia. In order to maximize the efficacy of donor assistance and avoid duplication of effort, coordination is necessary. In addition, the GFRDE, in line with their Sectoral Investment Program, has requested coordination of donor inputs.

How has USAID/E promoted donor coordination? Have benefits to the sector been a result of this role? Are there additional opportunities and challenges in this respect?

12) **Gender:** In general terms, the evaluation team should analyze whether or not the project has addressed gender issues and how successful it has been in this regard.

a. Is the program/project helping women to improve their access to primary and preventive health care including reproductive health services?

b. To what extent has the choice of activities taken into account gender relationships and their implications for achievement of results? Has operational research contributed towards this?

c. Do indicators provide gender dis-aggregated information on achievement of results?

13) **Monitoring and Evaluation:** Examine the effectiveness of the Monitoring and Evaluation (M&E) systems developed at all levels. Assess progress toward developing a system for collecting the required information?

a. Have implementors as well as USAID/E established reasonable monitoring and evaluation systems to gather the information/data needed to monitor progress and impact indicators?

b. What is the effect of delay in carrying out a DHS in Ethiopia? Are there adequate alternatives in place for the interim? Is national data available for effective M&E; what has been the effect of decentralization?

c. Is there effective collaboration among various actors in the health sector that ensures accessibility of information for M&E purposes?

14) **Lessons Learned and Opportunities:** Address lessons learned from the program/project to date. Assess whether there are areas of intervention that USAID would have a comparative advantage should we choose to support them.

Which lessons learned can be used for the remaining life program/project and in future USAID program/project/activity design?

15) **Future Implementation Mechanisms:** Given status of program/project implementation and the approaching completion of various existing CA's mechanisms, determine options for future implementation.

a. Should the project continue with existing mechanisms? If so, in what manner?

b. Are there more effective (in terms of cost and management requirements)

alternatives for continuing support to the sector?

c. Is there scope for expanding activities under existing mechanisms? For example, what are the implications of undertaking the promotion of reproductive health services in the public sector through Pathfinder?

d. What actions are necessary to ensure continuation of activities if a change in mechanisms is recommended and/or required as a result of changes in Agency procurement and GFDRE concerns?

ARTICLE IV. LEVEL OF EFFORT, TEAM COMPOSITION AND TIMING

It is anticipated that the consultancy will be for six weeks (one week preparation and four weeks in country, one additional week to complete the document), beginning November 2, 1997 and ending December 19th, 1997. The contractor will be authorized to work a six-day week. Travel expenses and other communications costs incurred during the course of duty are authorized.

The external team will consist of five people: an expatriate team leader and three specialists and an Ethiopian health professional external to any of the program/project components who can give an unbiased assessment of ESHE and has good knowledge of the Ethiopian health sector. The team leader should be a senior professional with a minimum of 10 years field experience in Africa. He/she must have USAID management and evaluation experience and preferably be familiar with re-engineering concepts. Good interpersonal and writing skills are essential. The remaining members of the team should have a minimum of at least 5-10 years professional experience with at least 5 years field experience in Africa. USAID experience is preferable and they should also have experience in project evaluation. The following areas of expertise should be covered within the team composition: reproductive health, child survival, project development expertise, health policy and health sector reform and familiarity with NPA . At least one of the team members should have experience with institutional development and sustainability of governmental and non-governmental agencies. The Ethiopian health professional should have a minimum of 10 years public health experience. Experience in both the public and NGO sectors is desirable. Good English skills are essential.

ARTICLE V. REPORTING REQUIREMENTS/DELIVERABLES

The evaluation team will work closely with the USAID/Ethiopia Evaluation Coordinator and those designated by the other partners involved with the program/project. USAID/E/HPN Office and the designated government counterpart will provide the team with a draft list of initial meetings with relevant persons prior to their arrival in-country and the HPN office will assist in setting up these meetings prior to the team's arrival. Further meetings will be set up at the team's request. The team is expected to review all relevant program documents and other background materials prior to arrival in-country. These will be

provided by the USAID/E/HPN office.

It is suggested that team divide into two groups and spend an estimated 5 - 10 days in the field. These trips will be finalized during the preliminary week of the team's preparation before their in-country arrival. USAID/E/HPN Office will facilitate arrangements for field trips together with government counterparts and appropriate CA's.

At least two days prior to the conclusion of the evaluation, the team will give a presentation and distribute a draft report to the appropriate USAID/E and government representatives and be willing to discuss the evaluation findings and recommendations. The evaluation team shall incorporate any questions or issues raised at the review meeting into the draft report.

The contractor shall then prepare the final draft report within four weeks after the evaluation ends. USAID/Ethiopia will remit both the Mission's comments and those of the GFDRE within two weeks after receipt of the draft. Twenty (20) copies (including a copy of a diskette in a standard wordprocessing format) of the final complete document will be provided to USAID/Ethiopia within two weeks of receipt of the final comments.

The final report shall include the following:

1) An executive summary no more than ten (10) pages in length;

2) The body of the report should be approximately fifty (50) pages in length (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.
   e. Any other documents considered relevant to this evaluation.

ARTICLE VII. METHOD OF PAYMENT

The contracting Officer, USAID/Ethiopia, will determine the type of contract to be negotiated. The method of payment will depend on the type of contract negotiated between the Contracting Officer and the Contractor.

APPENDIX B

Bibliography

Barbiero, Victor, July 27, 1995. Action Memorandum for the Director, USAID/Ethiopia.

BASICS, October 1997. BASICS's Highlights.

Bertrand, Magnani, and Rutenborg, September 1996. Evaluating family planning programs, outcome, effect, and impact.

Bhacttacharyya, Karabi, Paul Freund, Wondimu Amde, Dergie Teshome, BASICS, 1997. Community demand study for the essential health services for health in Ethiopia project.

CDIE/PME, June 20, 1997, Strategic planning and performance measurement workshop.

Cobb, Laurel K., Eliot J.Putman, n.d. POPTECH Technical Assistance to USAID Missions on Result Frameworks-A POPTECH Reengineering Tool.

DKT/PSI Ethiopia, March 22, 1996. Cooperative agreement 663-0017-00-A-5009-00, Ethiopian marketing program (ESMP) annual work plan: FY 1996.

Family Guidance Association of Ethiopia, Research and Evaluation Unit, October 1997. Expansion of family planning services: A project review No. 11.

FHI, February 1996. FHI subagreement, improvement and expansion of FP service in Ethiopia. FGAE No. 9440-2GTZ, February 4,1997. Minutes of HPN Technical Donor Group Meeting.

HPNO, Stover, Carina, November 11, 1997. ESHE Non-project assistance memorandum.

Krushaar, Daniel, October 19-November 8, 1997. Management Sciences health in assuring financial sustainability-Ethiopia health identification mission.

Leinen, Gary, Mark Robbins, November 23-27, 1997. Thoughts and Observations.

Pathfinder, International (FHI), AVSC International, and Family Health International (FHI), n.d. Project proposal for improvement and expansion of family planning services in the NGO and private sector in Ethiopia.

POPTECH, March 1993. Population Technical Assistance Project Overview and Factors Affecting Program Performance, USAID/Ethiopia FY-99 results review and resources request.

POPTECH, June 1996. Consultant Guidelines.

Robbins, Mark, November 28, 1997. Thoughts and Obsevations.

The Federal Democratic Republic of Ethiopia/Ministry of Finance, November 18, 1997. Social Sector Review III.

UNFPA, April 14, 1997. Contraceptive requirements and logistics management needs, Action plan for Ethiopia 1997-2000.

USAID/Dominican Republic, February 1997. Strategic plan FY 1997-2002, USAID/Ethiopia, March 1997. FY 1999 results review and resources request.

USAID/Ethiopia, March 31, 1997. Minutes of ESHE steering committee meeting.

USAID/Ethiopia, March 27, 1997. Issues and position for USAID/Ethiopia regarding ESHE program steering committee meeting.

USAID/Ethiopia, May 29, 1997. Issues and position for USAID/E regarding ESHE program steering committee meeting.

USAID/Indonesia, n.d. Program objective tree.

USAID/Uganda, n.d. FY 1997 Action plan/Budget planning document.

USAID/Ethiopia, n.d. Amplified program description essential services for health in Ethiopia (ESHE) program.

USAID/Ethiopia, n.d. USAID in Ethiopia.

USAID/E, August 11, 1995. Action memorandum for the Director, "USAID".

USAID/E, August 11, 1995. Sector program grant agreement for ESHE between the Transitional government of Ethiopia (the "Grantee") and the United States through "USAID".

USAID/Ethiopia, August, 19, 1997. Summary notes of meeting held at ILRI, Debrezeit August 12-14,1997.

Woods, Mellisa, BASICS/Ethiopia, November 1997. Women's health in Ethiopia.

World Bank Resident Mission, July 30, August 1, 6, and 8, 1997. Minutes of donor meeting to

identify consultants for the different components of HSDP mission.

APPENDIX C

List of Contacts

AFRICARE
Haile Wubeneh, Acting Country Representative, Health Manager

BASICS
Logan E. Brenzel, Health Care Financing Advisor
Vincent J. David, Chief of Party/Health Policy Advisor
Paul J. Freund, Deputy Chief of Party
Admassu G. Michael, Program Liaison & Training Officer
Sjoerd Postma, Primary Health Care Planner/Manger

ETHIOPIAN RED CROSS
Alemnesh Kassaye, Deputy Head of Medico-Social Services
Afework Teshome, HIV/AIDS Prevention Coordinator

FGAE
Teka Feyera, Executive Director

ISAPSO
Fekerte Belete, IEC Manager
Beletu Mengistu, Director

JOINT TRANSPORT
George Fenton, Program Manager

MARIE-STOPES INTERNATIONAL-ETHIOPIA (MSIE)
Getachew Bekele, Country Director

MEDAC
Admassu Abebe, Head, Bilateral Cooperation Department
Mekbib Tilahun, Expert, Bilateral Cooperation Department
Eshete Yilma, Acting Team Leader, Human Resources and Social Affairs

MINISTRY OF EDUCATION
Yohannes Godana, Head, Senior Expert, School Health Education
Setotaw Yimam, Head of Physical Education and Co-curricular Programs Panel

MINISTRY OF FINANCE

Asrat Kelemework, Head of Budget Department

MINISTRY OF HEALTH
Abdulatif Abas, Head, PPD
Million Admassie, Senior Expert, PPD
Kassie Gebremariam, Head, Health and Training Department
Abebe Geist, Planning & Budgeting Team Leader, PPD
Yohannes Kebede, Acting Head, Health Services & Training Department
Berhanu Legesse, Team Leader,Projects, PPD
Abadi Mesfin, Administration & Finance
Tadesse Molla, Head, Epidemiology & AIDS Department
Hailu Negassa, Head, ACU
Yohannes Tadesse, Acting Head, FHD
Mengesha Yadeta, Expert, ACU
Amsale Yilma, Expert, ACU
Mr. Mohammed, pharmacist, Pharmacy Dept

NATIONAL OFFICE OF POPULATION
Genet Mengistu, Head, Women & Youth Affairs Dept.
Negussie Teffara, Head

PATHFINDER, AVSC, FHI
Emebet Admassu, PI
Kathy Colson, Program Manager, AVSC (Nairobi, Kenya)
Assefa Hailemariam, FHI Project Coordinator
Elizabeth Lule, Africa Regional Vice-President, PI(Nairobi,Kenya)
Kebede Mamo, Program Officer, PI
Tewodros Melesse, Country Representative, PI
Girma Seifu, Finance and Administration Officer, PI,
Michael Welsh, Senior Representative, FHI (Nairobi, Kenya)

PHARMACEUTICAL & MEDICAL SUPPLIES IMPORT AND WHOLESALE ENTERPRISE
Girma Bedasso, General Manager

PRIME MINISTER'S OFFICE
Bezuneh Fetene, Health Expert, Social Affairs Bureau
Mazengia Makonen, Head of Social Affairs Bureau

PSI/DKT
Goshu Abebe, Program Director
Duncan O. Earle, Country Representative

Teshome Wakene, IEC Manager

UNAIDS
Klint M. Nyamuryekunge, Country Program Advisor

UNFPA
Linda Devers, Country Representative
Abate Gudunffa, Program Officer

USAID
Roman Asseffa, Office of Financial Management
David Eckerson, Acting Director
Laketch Mikael, RP#1 Team Leader
Hana Nekatebeb, RP#4 Team Leader
Carina L. Stover, Chief, Office of Health, Population and Nutrition
Ayana Yeneabat, STD/AIDS Coordinator, HPN & RP#3 Team Leader
Wuleta Wbetemariam, RP#2 Team Leader

WHO
Wedoson C.Mwambazi, WHO Representative and Chief of Mission

AMAHARA REGIONAL STATE
Aweke Abate, Youth Counselor, FGAE
Mr. Aimro, CBDA, Kebele # 9, West Gojam Zone
Daneal Argaw, Head Health Programs Department, Amhara Regional Health Bureau
Mr. Asman, Nurse (STD Coordinator), Gondar Health Center
Ms. Asamer, CBDA, Kebele # 16, North Gondar Zone
Gebre Asmenew, Team Leader, Amahara Regional Health Bureau
Yewbdar Ayalew, Principal of Ewket Fana Elementary & Junior Secondary School
Fekadu Chala, NW Regional Office Coordinator, FGAE
Gultenesh Chekole, CBDA, Ambezo Peasant Association, North Gondar Zone
Edeglign Fenta Aynalem, Principal of Tana Haik Community Secondary School
Nibrat Getnet, CBDA, Kebele # 12, West Gojjam Zone
Tadele Hailu, Youth Coordinator, FGAE
Zinabu Kebede, Nurse in Charge & CBD Coordinator, Gondar Clinic, FGAE
Maryie Kefyalew, Principal of Ghion Secondary School
Maru Mesfin, Head, North Gondar Zonal Health Department
Mr. Melkam, CBDA, Kossye Peasant Association, North Gondar Zone
Dr. Sisay, Head, Gondar Health Center
Argaw Tagele, CBDA, Kebele # 2, West Gojjam Zone
Mr. Tilahun, Chairman, Kebele # 9, West Gojjam Zone Youth FLE Peer Promoters (Several)

SNNRP
Genet Amare, CBRHAS
Mengistu Asnake, PPHC Coordinator (BASICS staff)
Alemayehu Ayele, Yirgalem Health Center
Abu Awoel, Alaba Woreda Health Center Nurse
Punto Awoel, CBRHAS
Hamdino Bama, Chair person Ashoka Kebele, Alaba
Amare Bedada, Awassa FGAE, Head of Regional Office
Kebete Belala, TBA
Mulugeta Betre, PPHC Coordinator (BASICS staff)
Estifanos Biru, Head of Regional Health Bureau (RHP)
Bessamo Deka, Head, Health Services and Training
Mamo Diramo, Daleword Health Officer
Zeleke Forsido, FP-CBD Project KAT Zone Coordinator
Engdayehu Hailu, Alaba Woreda Office Head
Samuael Heramo, FP- CBD Kata Zone Project Manager
Hirpa Kurkura,CHA, Kunche Kebele,Alaba
Mohammed Ribato, CHA, Ashoka Kebele, Alaba
Sahelemariam, Acting Disease Prevention and Control Dept.
Melaku Samuael, Head, Sidama Zonal Dept.
Beyene Sora, Wicho Health Post Agent
Degafe Tsegaye, FGEA Aposto, Clinic Nurse, Yirgalem
Million Tumato, Awassa Health Center
Testamariam W. Senbet, ROP, Head
Abebe Wontamo, FP-CBD Alaba Woreda Supervisor
Melissa Woods, Population Fellow, Reproductive Health