PD- ABP-482
94959

Eritrea Health and Population (EHP)

Project Number 661-0005

Project Identification Document (PID)

Revised DRAFT: April 28, 1994

TABLE OF CONTENTS

PID Facesheet 1
Table of Contents 2
List of Acronyms 3

I. Executive Summary 4

II. Program Factors 5
- A. Conformity with Recipient Country Program 5
- B. Relationship to USAID Strategy Statements 6
- C. Transition to Development Assistance 7
- D. Rationale for Project Approach 9

III. Project Background 10
- A. Health Sector Overview 10
- B. Health Sector Constraints 13
- C. GOE and Other Donor Activities in Health 16
- D. Experience with Similar Projects in Eritrea 18

IV. Proposed Project 19
- A. Goal and Purpose 19
- B. Expected Achievements and Impact 19
- C. Project Activities (Inputs) 21
- D. How the Project Will Work 23
- E. Illustrative Financial Plan 27
- F. Project Implementation Arrangements 27
- G. GOE and Mission Management 28
- H. Donor Coordination 28
- I. Monitoring and Evaluation 29

V. Design Strategy 32
- A. Further Analyses for PP 32
- B. Budget for Project Design 33
- C. Project Design Team 33
- D. Project Approval Schedule 33
- E. USAID Issues and Concerns 34

Annexes:
- A. Logical Framework Matrix
- B. Health Sector Concept Paper by Shepperd, et. al.
- C. Health Sector Financing Review by Larry Forgy
- D. Initial Environmental Examination
- E. SOW for Eritrea Health Sector Review
- F. SOW for Environmental Impact Assessment
- G. MOH Health Profile of Eritrea
- H. Selection of Focus Provinces
- I. SOW for Financial Capabilities Analysis

LIST OF ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
AIDSCAP	AIDS Control and Prevention Project
ARI	Acute Respiratory Infection
AVSC	Association for Voluntary Surgical Contraception
BASICS	Basic Support for Institutionalizing Child Survival
CA	Cooperating Agency
CRS	Catholic Relief Services
DHS	Demographic and Health Survey
ECS	Eritrean Catholic Secretariate
EPI	Expanded Program of Immunization
EPLF	Eritrean Peoples Liberation Front
EU	European Union
FP	Family Planning
FPAE	Family Planning Association of Eritrea
FY	Fiscal Year
GOE	Government of Eritrea
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
IEC	Information, Education, and Communication
IPPF	International Planned Parenthood Federation
ORS	Oral Rehydration Salts
ORT	Oral Rehydration Therapy
MCH	Maternal and Child Health
MOH	Ministry of Health
MSH	Management Sciences for Health
NGO	Non-Governmental Organization
PACD	Project Assistance Completion Date
PD&S	Program Development and Support
PH	Population and Health
PHC	Primary Health Care
PHN	Population, Health, and Nutrition
PID	Project Identification Document
PHC	Primary Health Care
PP	Project Paper
PSC	Personal Services Contractor
PVO	Private Voluntary Organization
REDSO/ESA	Regional Economic Development Services Office for East and Southern Africa
TA	Technical Assistance
TB	Tuberculosis
TAP	Technical Assistance Project
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USAID/W	USAID/Washington
WHO	World Health Organization

I. EXECUTIVE SUMMARY

Newly independent Eritrea (1993) is determined to reverse the devastating effects of a 30 year civil war. Government structures and policies have been established to create the necessary infrastructure and systems to sustain economic growth and development. Essential to Eritrea's larger economic development are the challenges within the health sector to raising the physical well-being and productivity of Eritrea's population.

The formidable challenges facing the Ministry of Health include high mortality and morbidity rates for women, infants, and children due to such preventable causes as diarrheal diseases, malaria, tuberculosis, tetanus, acute respiratory infections, closely spaced pregnancies, and early and late pregnancies. Contraceptive prevalence is less than one percent and the annual population growth rate exceeds three percent, which, if not reduced, will result in a doubling of Eritrea's population in 23 years.

The EHP project is a five year, $12 million project to increase the availability and utilization of basic health and family planning services, especially by the most vulnerable groups, Eritrean women of reproductive age (15-44 years), infants and children, while laying the necessary foundations for a sustainable health care delivery system. The project will focus both at the national and provincial levels of the health system. The four contiguous central provinces of Asmara, Akele Guzai, Hamasien, and Senhit have been selected as focus areas for project implementation for reasons described in detail in the text.

The project will achieve two major outputs: (1) a much strengthened public sector health delivery system capable of delivering basic health services; and (2) increased awareness of and utilization of basic health and population services, especially by women and children in the four focus provinces.

Project activities consist of (1) human resource development/capacity building, (2) planning and management information systems, (3) health education for Eritrea's population and (4) expansion of private sector and NGO roles in PH service delivery.

The project emphasizes sustainability planning and realistic financial management with a focus on paramedic (non-physician) delivery of basic health services. It is expected to serve as a catalyst to stimulate other donors to provide a critical mass of coordinated support for the health sector and, if successful, should provide the basis for a longer term sustainable investment in the Eritrean health sector.

II. PROGRAM FACTORS

A. Conformity with Recipient Country Program

To meet the formidable challenges of the health and population sector the MOH has developed a national health policy based on the principle of making primary health care available to all citizens. The policy emphasizes maternal and child well-being, a decentralized and integrated approach to services, and community involvement and support.

To accomplish this goal, the MOH has identified a number of priorities which include: 1) expansion of primary health care services to underserved populations, particularly those at greatest risk: women of reproductive age (15-44 years), children under five, and returning refugees of all ages; 2) functional restoration of health care facilities damaged or neglected by the war, and the refurbishing of health care training facilities and construction of student housing; 3) training of all types of health care providers, with particular priority given to the training of ex-combatants who already have health care experience; 4) control of communicable diseases (malaria, TB and HIV/AIDS); 5) strengthening of the management of health services; and 6) establishment of an effective health information system for health surveillance and management. The GOE/MOH has successfully translated these priorities into action plans and interventions, and is seeking donor assistance to implement its plans.

Acknowledging the negative health implications of high fertility and high annual population growth rate of over 3% (which, if not reduced, will result in a doubling of the population in 23 years), the GOE plans to expand population awareness and integrate family planning services into all levels of primary health care services. Based on the foundation laid by the Eritrean Peoples Liberation Front (EPLF) efforts in family planning during the war, and considering Eritrea's low contraceptive prevalence rate (less than 1%), this effort will involve extensive awareness raising, training of health care staff, provision of commodities and logistical support, and participation of both private and public sectors to increase usage of family planning services.

The proposed EHP project is consistent with the goals and priorities of the Eritrean Government and is specifically designed to help address most of these priorities through a series of interventions and activities which will help lay the necessary foundations for development of a sustainable health care delivery system.

B. Relationship to USAID Strategy Statements

The Eritrean strategy for health and population described above is very consistent with USAID worldwide and Africa Bureau

strategies for population, health and nutrition (PHN), child survival and economic growth.

By supporting Eritrea's health policy through human resource and both public and private institutional development in the health sector, the proposed EHP project will be in congruence with USAID's strategies in the areas of PHN, child survival, and economic growth. All three strategies call for a clearly focused effort in countries that demonstrate economic need; where the health conditions stand as a major impediment to economic development; where the potential for sustained impact is greatest; and where political commitment and will appear strong. The project is also consistent with USAID's draft Democracy and Governance Strategy in that it supports decentralization of decision making in the PH sector.

USAID's draft Population, Health and Nutrition Strategy emphasizes: the critical areas of the general health needs of infants and young children and the reproductive health needs of women and adolescents; the reduction of population growth rates to levels consistent with sustainable development; and the development of programs that are responsive and accountable to their consumers. The draft strategy stresses increased access, choice and quality of care, and particularly recognizes the synergies that exist in an integrated approach to the delivery of essential health services.

Then too, USAID's draft Child Survival Strategy for Africa underscores the strengthening of institutions and basic health systems which benefit not only child survival programs, but also family planning and preventive and curative health services. The strategy emphasizes support for efforts both to increase public demand for services and to encourage community involvement in health management and health financing at the local level.

USAID's draft Economic Growth Strategy recognizes the importance of investments in health as a means of strengthening the productive capacities of people, particularly the lesson that improved health can significantly contribute to a country's sustained economic growth performance.

Eritrea's PH policies are emerging very close to the above USAID PH policies and these policies enhance the potential to maximize the impact of donor assistance in the PH sector. With an epidemiological profile that places its health status among the worst in the world, the GOE has developed a progressive health policy to improve the health status of Eritreans. This policy parallels USAID's PHN and child survival strategies with similar emphasis on an integrated approach, development of institutional and technical capacity, and the achievement of sustained impact.

C. Transition to Development Assistance

USAID began emergency food assistance to Eritrea in 1984. Since

that time, food assistance has continued, and is expected to continue into the foreseeable future. In 1992, USAID placed a representative in Asmara to coordinate further food assistance and to conceptualize a development assistance program for Eritrea. USAID developed the Technical Assistance Project (TAP) in 1993 as a flexible means to assist the Eritrean public and private sectors to develop and adopt systems, technologies, and practices which were needed following independence.

As USAID's assistance to Eritrea continues to evolve from pure emergency food aid to a combined program of humanitarian and development assistance, USAID/W guidance to USAID/Eritrea has been to focus on one strategic objective, namely health/child survival. Furthermore, the Africa Bureau welcomed establishing the USAID/Eritrea program as an exception to the Small Country Program Strategy, for three compelling reasons: 1) the GOE's pervasive and positive pro-U.S. attitude; 2) the history of Eritrea's successful struggle for independence, and 3) the rather unique Eritrean characteristics of self-reliance, entrepreneurship, lack of corruption, fiscal responsibility, and emphasis on education.

The time to act is now. The GOE has reformed its health policies and articulated a clear vision very much in line with USAID's strategies for health and population. Given the positive policy environment and the strong GOE/MOH commitment, the EHP project has an immediate (and rare) opportunity to make a major contribution to strengthening Eritrea's health delivery system and lay the foundation for meaningful improvements in health status, particularly for the most vulnerable segments of the population: mothers and children. The project is expected to serve as a catalyst to stimulate other donors to provide a critical mass of coordinated support for the health sector.

D. Rationale for Project Approach

The approach which will be taken in the EHP project is a combination of (1) foundation building - both in the public and the private and NGO sectors - to aid in the development over the long term of a sustainable health delivery system capable of delivering essential services, and (2) a package of selected interventions which can begin having an impact on health status of the most vulnerable groups in the near term. There are a number of reasons for selecting this approach for USAID's first major health/population project in Eritrea. First of all, the lessons of the 1980s strongly suggest that **successful** health and family planning programs must strengthen the core set of management systems (e.g., financial controls and planning, management information, supervision, and training) that are critical to the effective delivery and sustainability of these services. The draft 1994 USAID Child Survival Strategy for Africa, states that the key approaches to implementation include:

> "a continued emphasis on successful focused interventions-immunizations, improved child nutrition, control of diarrhea disease, child spacing, malaria prevention and control, management of acute respiratory infections, and HIV/AIDS prevention and control. At the same time, and depending on countries' needs and USAID's comparative advantage, USAID will increasingly focus on support for strengthening of health systems, including essential drug supply, strategic planning and management, management information systems, supervision, quality assurance and training systems. These systems have typically been weak in Africa; strengthening them is a prerequisite to ensuring that the successes of child survival interventions are sustained".

Similarly, the 1994 USAID Strategy on Population, Health and Nutrition emphasizes the need to create and sustain local capacity:

> "An important overarching objective for USAID in the PHN sector is to build national institutional and technical capacities. This includes sustained support to private or public sector institutions, investments in human resources and developing technical capacities to develop and carry out programs".

Other approaches to supporting the Eritrean health sector were considered, from limiting support to one major intervention, (e.g., family planning) to supporting a small package of primary health care interventions for which USAID has a comparative advantage, to focusing entirely on training or upon strengthening the health delivery system. All of these approaches were ruled out principally on sustainability grounds. While focusing on one or a few interventions would be "easier" and might, in the short to near term, result in greater health impact, unless the core elements of the PH delivery system are considerably strengthened,

impact would be short-lived. Also, in a country with such limited resources it is easy for donor support focused on one or a few interventions to skew priorities and divert limited country resources to areas that may not have the greatest impact for the investment or provide the basis for a sustainable system. It is for this reason that the EHP project will support an integrated approach to service delivery and sustainability.

III. PROJECT BACKGROUND

A. Health Sector Overview

1. Health Status

Children and women in Eritrea experience very high mortality and morbidity rates resulting from the inter-related problems of under-development, including poverty, chronic malnutrition, low standard of living conditions, inadequate socio-economic infrastructure, unhealthy environment, low literacy, and lack of access to basic health services.

Although there are no reliable demographic or health statistics for the country, the GOE estimates infant mortality at about 135 per 1000 and the child mortality rate at 203 per 1000 live births. Based on a total fertility rate of 6.8 live births per woman, the overall maternal mortality rate is estimated at 710 maternal deaths per 100,000 live births, while the maternal mortality rate for rural areas (excluding Asmara) is estimated to be 799 per 100,000 -- one of the highest in the world. Use of family planning is less than one percent and fewer than five percent of women deliver at a health facility or under the care of trained personnel.

A significant proportion of Eritrean women have very early or very late pregnancies, placing them at special risk. Closely spaced pregnancies put stresses on both the health of women and of their children. Although there are no statistics for Eritrea, worldwide evidence shows that proper birth spacing and avoidance of early and late pregnancies can prevent a significant number of maternal and infant deaths. Proper spacing has also been shown to reduce the incidence of malnutrition among children under five years of age. There is evidence that Eritrean women who know about methods want to use contraceptives; indeed, there is a rapidly increasing demand in Asmara for depo-provera and an increasing use of other family planning methods. However, the number of complications from illegal and self-induced abortions which are seen in the hospitals indicate that most women still do not know about, have access to, or feel comfortable with contraception.

Child mortality is mainly due to diarrheal diseases; these account for 10.7% of all hospital admissions with a case fatality rate of 12.7%. Malaria contributes to 19.6% of hospital admissions with a case fatality rate of 7.4%. Acute respiratory infections (ARI) account for 44% of the causes of hospitalization, with a mortality rate of 3.2%. High case fatality rates also exist for meningitis, anemia and measles.

Eritrean children are not appropriately protected against vaccine preventable diseases. Only 24.9% of the under-five child population is fully immunized, 25.5% are vaccinated against

measles, 34.4% against tuberculosis, 30.7% against polio (OPV3) and 31.6% against diphtheria, pertussis and tetanus (DPT3).

Women of child bearing age are also very vulnerable. Particularly worrisome is the very low coverage (estimated at 9.2%) of women aged 15-44 years with tetanus toxoid (TT2). Maternal mortality, as recorded in hospitals and health centers, is mainly due to malaria, ARI and pregnancy complications (including those of illegal abortion). Although there are few records to corroborate it, there is widespread concern that many women are dying in childbirth and of other causes not captured by health statistics. Indeed, those who actually utilize the health services are in the minority.

A principal underlying cause of much of the mortality and morbidity in children and women is malnutrition. Eighty-five percent (85%) of Eritrea's population lives in economically depressed areas without even basic necessities, and incomes are extremely low (the estimated national per capita income is below $120 a year). Food insecurity is a chronic problem; despite improvements in agricultural practices and increased inputs, for example, badly timed rains and pests resulted in almost 90% crop loss in 1993. There is evidence of wide-spread malnutrition, both moderate and severe, in children under five years of age. Again, it must be pointed out that frequent, closely spaced pregnancies contribute to the nutritional problems of both infants and mothers.

The overall pattern of child morbidity and mortality is dominated by communicable diseases, associated with undernutrition. Respiratory infections in all their forms (upper respiratory tract infections, bronchitis, pneumonia) are the major causes of morbidity country-wide, followed by diarrheal diseases and malaria. Malaria, which is endemic in lowland Eritrea, is a leading cause of morbidity during the peak transmission period.

2. Health Services

Since liberation of the country in 1991, the GOE has been integrating two quite different health service systems: one which was developed by the EPLF in the liberated areas and one in the areas previously controlled by the Ethiopian government. The distinctive features of innovation and resourcefulness of the EPLF system have given the system an unusual vitality considering the devastated infrastructure and the dearth of resources of all types.

The national health policy is based on the principles of primary health care and the GOE is firmly committed to making basic health services available to all Eritreans. The MOH gives special attention to underserved populations (those in isolated rural areas, pastoralists, and previously marginalized groups) and vulnerable groups (especially women, children, the disabled and the displaced). This emphasis on equity has resulted in the

concentration of resources and greatest attention toward rehabilitation/reconstruction in the rural areas and in the lowlands.

The health service structure is pyramidal; it begins at the community level with Community Health Agents and Traditional Birth Attendants, continues to the health station level (serving about ten villages), then to the health center (district level), then to the nine provincial hospitals and then up to the national referral hospitals. The system is structured so that referrals are made from the lower to the next higher level, so as to screen out and deal with all health problems at the lowest possible level of the health structure. This is especially important for Eritrea considering the very limited numbers of health professionals currently in the country. Adherence to the referral structure is also important to preclude unnecessary pressure on the referral hospitals. As a consequence, the responsibility for dealing with the bulk of the health problems falls on the nurses and health assistants who are located at the health stations and health centers in the small towns and villages. Many of these workers have devoted their lives to the independence struggle and have continued to work without pay since liberation and formal independence. They have begun to be demobilized; this process will continue for the next three years.

Overall, the country's health infrastructure is in very poor condition. Health care facilities were destroyed or damaged during the 30 year war or were abandoned. For an estimated population of 3.1 million there are 15 hospitals, 35 health centers and 113 health stations. Forty percent of the existing facilities are below the expected standard. The hospital bed/population ratio is 1/1082. Overall, the country has one medical doctor for a population of 26,956, one nurse for 13,000, one health assistant for about 10,000 and one laboratory technician for 61,403. These ratios are among the worst in the world.

Diagnostic facilities are extremely limited. Among the existing hospitals, only half can provide complete x-ray services and only a third even have a functioning laundry. Health centers and stations are even less well equipped. Health facilities also suffer from a shortage of drugs and medical supplies. Seventy percent of health centers and health stations consume their annual drug supply within 9 months or less, with none available the remainder of the year.

B. Health Sector Constraints

The most visible constraint to delivery of health services in Eritrea is that of the severely damaged and deteriorated infrastructure. Almost all health facilities were either

destroyed or damaged during the war or have been neglected for decades and require serious rehabilitation. The lack of adequate facilities has severely limited access to services and has compromised the quality of services provided. It is estimated that there are over 1800 villages in Eritrea and presently only 18% of these have reasonable access to services.

The GOE and donors have begun a crash program of construction and rehabilitation of facilities, emphasizing health stations and centers in the rural areas. There are plans to construct or rehabilitate 13 hospitals, 42 health centers and 74 health stations over the next several years. Donor funding has been secured and work begun on 20 of these projects. Others have been undertaken by the MOH and/or the regional and local authorities. The lack of facilities (and difficulty of transport) in some rural areas has prevented the conduct of some basic programs, such as the Expanded Program of Immunization (EPI).

Although Eritrea has an asset in its pool of highly motivated and experienced health personnel, there are also serious personnel shortages which hamper the delivery of services at all levels and in all areas. The country does not have the number of staff required for service delivery and many of the existing staff need additional training. To meet the goals of the Ministry, there will need to be an intensive effort at human resource development - training at all levels and at all stages: new recruits as well as upgrading of current staff. There are particularly acute needs for laboratory and pharmacy technicians for health stations and centers, for training of additional community health workers, and for family planning providers. The current training facilities are inadequate. The Nursing School is crowded and has had little new equipment or reference materials in decades. The Health Assistant School is dilapidated and has no dormitory facilities at all. This is no training institution for laboratory or pharmacy workers, and there is lack of resources for training village health workers.

Related to the infrastructural constraints is that of lack of transport. The shortage of vehicles of all types has restricted the mobility of health workers as well as of clients. Much of Eritrea is mountainous and roads are ungraded and unpaved, requiring four wheel drive vehicles to reach many areas. However, most health stations have no access to motorized vehicles at all and even many health centers have no vehicles. Some provincial hospitals have only one or two vehicles. This constrains all outreach programs, such as EPI, and contributes to the lack of essential drugs and supplies in the health facilities. The travel time to the nearest health facility can reach up to three days in some isolated areas; in such circumstances conditions like obstructed child birth mean almost certain death before reaching the health clinic.

The referral system is not fully functional and the breakdown in the system results in inefficient service delivery, especially at

the tertiary level. The maternity ward at the central referral hospital, for instance, is currently the only site for assisted deliveries in the Asmara area and consequently is so crowded and busy with normal deliveries that quality of care for complications may be compromised. If the health centers are able to handle normal deliveries (as planned), then the hospital can focus properly on the referral cases. An effective referral system will only be possible when there are adequate facilities, staff, equipment and supplies at the community, health station, and health center levels.

The lack of minimal equipment and supplies and the inconsistent and inadequate supply of drugs also impede good quality of care. This can be improved through the installation of the proper equipment at each facility and the improvement of the national system for procurement of drugs and supplies as well as the logistics system for distribution. Laboratory services, in particular, must be improved through the provision of the equipment and supplies required for the necessary services at each level (as well as through the proper training of lab technicians, discussed above).

Another constraint to effective delivery of services is the lack of demographic and health information in the country. Eritrea has never had a census (although the independence referendum registration has provided some information) nor any sort of national health or nutritional survey. Although the service records in health institutions are of good quality, there is only the beginning of any sort of health information system and virtually no analysis which can be used for planning and policy making, either at the national or regional level. USAID plans to support a Demographic and Health Survey in 1994 in order to provide some baseline data in these areas. The MOH has also identified the lack of a comprehensive health management information system as a constraint to planning and has set a high priority on the development of such a system.

To effectively administer the national health system, the MOH needs more skilled personnel. Capacities to set policy, plan, manage, monitor and evaluate should be strengthened at both national and provincial levels, through additional training of current MOH staff and recruitment of additional staff. This is especially critical at the provincial level to operationalize the GOE's decentralization policy. Currently, although the staff has a wealth of experience in medical areas and valuable experience in on-the-ground service delivery, there is little formal training or experience in operations management or strategic planning. More efficient functioning of the Ministry itself will lead to better policy making and implementation.

A real challenge over the next few years will be health financing. The GOE has few resources and a very small total budget. The economy of Eritrea has good recovery potential but recurrent droughts (as in 1993) may threaten this recovery. The

extreme poverty in most of the country precludes much cost recovery at this time and it is unclear, even if donors help with facilities and equipment now, how the GOE will meet recurrent costs. This will be complicated by the need to pay salaries to the demobilized EPLF health workers (48% of the MOH staff) who currently are unpaid. The maintenance of the new facilities, planned expansion of services, and provision of salaries to former fighters currently working as unpaid health workers is estimated to require a doubling of the current health budget. The MOH is developing approaches to deal with these issues but needs assistance in evaluating alternative approaches to implementing health financing schemes.

Tied to this finance issue is the almost complete monopoly of the public sector in provision of health services. A small number of local NGOs (all church-based except the Planned Parenthood Association of Eritrea) do provide some health services but the role of the non-governmental and private sectors in service delivery is very limited. The GOE has recognized the important role that the private sector can play and also encourages increased NGO participation. Strengthening of both groups could have a very positive impact on health service delivery and could shift some of the burden from the public sector, thereby contributing to greater sustainability. NGOs which are already in the field could significantly increase their activities if their own planning and management capabilities were strengthened.

Many of Eritrea's health problems can be ameliorated through preventive measures, appropriate health care, and adequate information on the part of the population. Due to low literacy and limited communications media, much basic health, nutrition, and family planning information is not available to many citizens. Public health, nutrition, and family planning education programs play a very important role in improving health status and should be supported through assistance for a wide variety of Information, Education, and Communication (IEC) activities. In family planning in particular, there is much misinformation to be overcome at every level.

Of special concern is the very low level of knowledge about and use of family planning by Eritrean couples. This is partly a result of lack of information but also because of the lack of services. UNICEF has stated that birth spacing is the single most powerful child survival intervention and it is well proven that birth spacing is critical for reducing maternal mortality. The MOH has adopted family planning as an integral part of the primary health care program. Yet public sector family planning services are weak; providers need more training; the method mix is limited; and many health staff are not fully aware of the health benefits of family planning. NGO services and IEC activities are also very limited. Both sectors should be strengthened through awareness raising, training, and support for commodities and logistics systems.

In a related area, many policy makers and health providers have low awareness of the demographic phenomenon occurring in the country. There are some notions that, having lost so many people in the war, there is a need for rapid replacement. However, it is estimated that the annual population growth rate is currently over 3%, implying a doubling of the population by the year 2017. The implications of this growth for employment and for service provision must be taken into account by planners and the positive role which family planning can play in reducing growth rates emphasized.

Both the EPLF health personnel and many of the Eritreans working under the Ethiopian health system during the war have basically been isolated from the rest of the world for decades. Consequently, many health personnel and policy makers have not been exposed to global developments in health and family planning and are only now able to learn about the experiences of other countries. Greater exposure to other experiences could strengthen the health system by bringing in new ideas. For example, learning about the decentralization policies and practices in other countries could widen the options under consideration for implementation of decentralization in Eritrea. Also, exposure to the population and family planning programs in nearby Muslim countries such as Yemen could change the attitude held by many in Eritrea that family planning is not accepted by Muslims.

C. GOE and Other Donor Activities in Health

Since 1991, the MOH has focused on both expansion and improvement of health services - particularly primary care. EPLF health workers at all levels have been deployed throughout the country in health stations and centers and have been working without salaries alongside the paid civilian workers. Consequently, almost two thirds of the MOH budget has been able to go towards the purchase of drugs, supplies, and equipment, and for the rehabilitation of damaged health facilities and the construction of new ones. A number of NGOs and bilateral donors have contributed to this effort, often guided by the GOE in selection of focus regions. Those bilateral and international donors involved in such infrastructure development include: the Italians, the EU, and UNICEF (partially through a USAID grant for three provinces). NGOs (particularly religious groups) have played an important role as well. Those involved in construction/rehabilitation are: Norwegian Red Cross, the Evangelical Church, Lutheran World Federation, various Catholic orders (Orsolini Sisters, Caritas Padova, etc), Kap Anamur (German), International Committee of the Red Cross (orthopedic workshop), and the Eritrean Catholic Secretariat, which is also very active in other sectors.

The Ministry of Health has also emphasized human resource development and is in the midst of developing a comprehensive training plan. In 1993, two classes of EPLF field-trained health

workers were enrolled in a one year upgrading program in the Nursing School so that they could be formally credentialed and take assignments as certified nurses once demobilized. This program will continue for another two years until over 700 nurses have graduated. At that point, the regular program of nursing training will recommence. Plans for similar upgrading and credentialing of other levels of field-trained health workers are underway. Other recent training programs have included PHC management for regional coordinators (UNICEF supported), training of malaria workers (WHO supported), and the participation of a small number of health personnel in short courses or one year courses abroad. Donors and agencies supporting training include: UNICEF, WHO, Norwegian Church Aid, Christian Outreach, Save the Children (UK), and Redd Barna. The Israelis and Australians have provided scholarships to their health training institutions.

Health interventions, such as EPI, malaria control, ORT, AIDS control, as well as family planning, have made slow headway in the country, partly due to shortages of supplies and lack of facilities and trained staff. Major donors and NGOs involved in strengthening these programs (and PHC in general) are: UNICEF, Save the Children (UK), and the Italians. The Australians are interested in contributing to a national AIDS laboratory. In family planning, the lack of support for the Family Planning Association of Eritrea (FPAE) from the International Planned Parenthood Federation (IPPF) from 1991 until 1994 and the delay of support from the United Nations Population Fund (UNFPA) has seriously impeded the program. The Unitarian Universalist Committee provided salary support and some other resources to the FPAE in 1992/3 and the GOE Department of Social Affairs provided a loan. Otherwise, the FPAE would have been forced to close altogether. The Ministry of Health family planning program has received little support as well, although MOH is expecting assistance from UNFPA in the very near future in the form of a one year grant for contraceptives and limited IEC activities. The Hollows Foundation of Australia has supported the construction and operation of an interocular lens factory in Asmara.

In terms of support for planning and administration (in the MOH), Save the Children (UK) has provided a health planner who works in the MOH and UNICEF has supported a number of planning seminars. The head of the MOH Planning Section attended a short course at Harvard in 1993. His participation was organized by the Eritrean Medical Association in North America and funded partially by the Unitarian Universalists.

A number of donors have contributed drugs and/or medical supplies to the MOH in an ad hoc manner - Qatar, Saudi Arabia, Denmark - but have no ongoing programs of support.

There are a number of mission run clinics in the country. The Eritrean Catholic Secretariate has the largest number (24 clinics). There is also a Cheshire Clinic for handicapped

children. Llamba, a US-based NGO, has just begun an ophthalmology program in Eritrea.

There is only partial information available on the level of donor resources going to the health sector in Eritrea. However, in 1993, nine-tenths of the annual health budget of 265 million Birr was for capital expenditures -- the equivalent of $40 million. Over the past two years, it is estimated that donors have contributed $30 million, mainly for construction, vehicles, equipment and supplies.

D. Experience with Similar Projects in Eritrea

USAID has recently provided a grant of $2.3 million to UNICEF for the rehabilitation of the PHC program and delivery of EPI in Barka, Sahel, and Dankalia provinces. This project is only just beginning, so it is too early to comment on its implementation. Most donor assistance in the health sector has been either through emergency programs or on a small scale; there is little experience with large projects thus far. Among the donors and organizations working in the sector, however, there is widespread appreciation of the dedication and organizational abilities of the health cadres, especially at the provincial and district level. Construction and rehabilitation projects have been proceeding efficiently and without wastage, most with significant community participation. The thirst for training and upgrading of skills among health personnel is impressive. Assistance has been used effectively and corruption is virtually nonexistent. One concern of donors has been the shortage of personnel and the fledgling administrative capacity in the Ministry.

IV. PROPOSED PROJECT

A. Project Goal and Purpose

Goal: **To improve the health status of Eritreans, particularly women and children.**

Purpose: **To increase the availability and utilization of essential health care services, especially by Eritrean women and children in four target provinces.**

B. Expected Achievements and Impact

Eritrea is in transition from emergency reconstruction to a

development mode. Accordingly, most development projects over the next few years will focus on foundation building (training, infrastructure, systems building and strengthening) in the various sectors. The EHP project will provide leadership in the transition from emergency to development assistance in the health and population sectors.

As a consequence of the current state of the sector, and considering the constraints which must be overcome, it would be unrealistic to expect a dramatic impact on health status of the country's population to occur by project end. It is expected, however, that very positive trends will be in evidence with declining maternal, infant, and child morbidity and mortality and increasing utilization of contraceptives and family planning services.

The project will aim to achieve two major outputs: (1) a much strengthened public sector health delivery system at the national level capable of delivering basic health and population services, and (2) increased awareness of and access to basic health and population services, especially by women and children in four focus provinces.

1. Strengthened Public Health Delivery System Capable of Delivering Basic Health and Population Services

Although by the end of the project it is not expected that Eritrea will have developed a sustainable nationwide health delivery system, it is expected that the system will be significantly strengthened administratively, managerially, operationally and financially and possess a greater capability to provide at least the most basic health services to the majority of the population. The following activities will be implemented with this particular objective in mind:

1) A nationwide health management information system will be developed and implemented. This system will be a combination management information and disease surveillance which will allow for better and more rational strategic planning and management of health delivery, including procurement and distribution of essential commodities. It is expected that this HMIS will be tested initially in the four targeted provinces prior to expansion nationwide before the end of the project.

2) Appropriate health financing (cost recovery, resource mobilization) schemes will be developed and tested in the target provinces for later replication throughout the country.

3) The number of trained health personnel will be increased at all levels of the health system, including at the community level, to make possible the delivery of basic health services to the population on a daily basis. Emphasis will be placed initially on upgrading the skills of ex-combatant health personnel to fill vacancies in the health structure.

4) The capacity of the central ministry, the health ministries of the target provinces, and the NGOs supported under the project will be developed or enhanced so that they will be able to carry out effective health education activities, particularly in family planning, malaria, and ORT. Some assistance will also be provided for the production of appropriate IEC materials and training, with special attention given to the populations of the focus provinces.

5) Limited reconstruction/rehabilitation of essential health facilities will be undertaken in the target provinces to provide the basis for outreach services in underserved areas.

2. Increased Access to and Utilization of Basic Health and Population Services, especially by women and children in the four focus provinces

Increased access to and utilization of basic health services will be achieved by bringing these services closer to the populations which need them, particularly the most vulnerable groups of women and children in the four focus provinces. Basic health services, as defined here, include EPI, ORT, family planning (including pre- and post-natal care), AIDS control, nutrition, ARI, malaria, and TB management. However, the EHP project will not take responsibility for all these areas. UNICEF will be providing support for EPI and nutrition activities as well as procuring essential drugs for ARI, TB, and malaria control, while Australian AID is providing support for AIDS awareness. The EHP project will therefore concentrate its efforts on the delivery of

family planning, ORT and EPI. It will attempt to bring about increased access to and utilization of the these basic health services in the following ways:

A) increase the role of the private and NGO sectors in the delivery of basic health and family planning services and commodities by

- supporting NGOs to expand service delivery activities in underserved areas;
- promoting greater involvement of the private sector health providers in the delivery of essential preventive services; and
- supporting development of a social marketing program for essential health commodities and contraceptives.

B) ensuring that commodities required for the basic health services supported by the EHP project, including contraceptives, are readily available in adequate supply at all levels of the public health system, NGO clinics supported by the project, and through the social marketing program.

C. Project Activities (Inputs)

At the national level, the project will support the following four activities:

1) Human Resource Development/Capacity Building

The training of nurses, health assistants, midwives and laboratory technicians at the training facilities in Asmara, and training of community health workers (CHWs) in the provinces. Assistance will be provided to upgrade and expand the training facilities, update curricula, and provide essential supporting materials, books, and equipment. Emphasis initially will be on training ex-combatant health personnel to fill immediate vacancies in the health system.

2) National Planning and Management Information System

The development of a greater capacity to plan programs, deal with health financing issues, and institute adequate financial budgeting. Also, assistance to develop a national health management information system, to include training of staff at all levels in the collection and use of information for disease surveillance and effective day-to-day management of the health system.

3) Health Education/Information, Education, Communications

The development of a capability for health education activities in family planning, and other targeted child survival interventions through training of Eritrean personnel and provision of appropriate technical assistance. Assistance would also be provided for the production of IEC materials and for conducting national awareness campaigns for family planning and other targeted interventions.

4) Private Sector and NGO Roles

The expansion of the role of the NGO and private sectors in health and family planning service delivery in all provinces of Eritrea through an NGO grants program and the development of a social marketing program for contraceptives and other essential health commodities.

Development of decentralized capacity is considered essential. Therefore, in addition to the above national level efforts which will affect all of the provinces of Eritrea, the EHP project will concentrate resources at the provincial level in the four contiguous central provinces of Akele Guzai, Hamasien, Senhit, and Asmara. These provinces were selected for four principal reasons: (1) they are the optimal place in Eritrea to model improved systems for expansion to the rest of the country, (2) they are provinces which have received less donor support, (3) they are in critical need of improved services, and (4) their location, contiguous to Asmara, will facilitate proper USAID oversight and management of project activities. (see Annex I for more detailed explanation of the provincial selection criteria).

Illustrative activities which the project will support in the four focus provinces include the following:

1) the rehabilitation of a number of health stations, especially in those areas considered the most underserved.

2) assistance in the development of appropriate health financing schemes, the capability for effective planning and administration of the health system at provincial level, and appropriate research activities which could lead to more effective management and delivery of health services at the provincial level.

3) provision of essential health commodities and contraceptives needed to ensure adequate supplies at all levels in the target provinces, including NGOs working in the provinces and the social marketing program.

It is expected that, with the exception of the support for facilities and commodities, much of what will be done at the level of the target provinces will be replicated by the GOE or other donors in other provinces once it is proved successful.

The EHP project will be available to provide information and facilitate donor coordination in this respect.

D. How the Project Will Work

1. Overview

The project will be managed by a prime contractor or Cooperating Agency(s)(see Section IV.F). During the first year of the project, assessments will be conducted in most areas for which sufficient information is still not available for developing detailed strategies and action plans for major activities. These action plans will identify the specific kinds of TA and other inputs, as well as the timing of inputs which will be required for project implementation. The prime contractor/CA(s) will then prepare an annual workplan(s) which will consolidate all input requirements for the year and will gain approval for the plan from MOH and USAID/Eritrea. This plan will specify the sources of all inputs (TA, commodity support, training), from the prime contractor/CA(s). The workplan will also contain a detailed budget broken down by input category and specific activity.

2. Support at the National Level

Although the MOH strongly supports the decentralization of health service management to the provincial level, the central ministry will retain certain responsibilities and authorities for the program at the national level for some time to come (it is expected to take time for the provinces to develop the necessary management capacity). While USAID/Eritrea will work with the other major donors in the health sector to assure complementarity in their support for the national program, this project will provide the technical assistance, training, commodities, equipment and local cost support for the following key areas:

a. Human Resource Development/Capacity Building

The training of new health staff and the upgrading of the skills of those already in the system are key to the effective delivery of quality services. As the Eritrean health system is already severely understaffed at all levels, filling of new positions is also crucial if access to services is to be enhanced. The project will build upon the training which is already being provided at the various health provider training facilities in Asmara, but TA will be provided to upgrade the curricula ensuring that it reflects the latest information and methodologies available. Where necessary, these curricula will be strengthened with the addition of specific components on topics currently not covered fully, such as family planning, AIDS prevention, and post-abortion counselling. The project will also provide TA for such activities as training of trainers, support for in-service training workshops to update providers already trained, and other support to ensure that health providers at all levels are adequately trained in the essential interventions.

The project also will provide some support for the rehabilitation and refurbishment of the national training facilities in Asmara in order to facilitate improved and training of additional health staff. An engineering assessment will be done of the exact rehabilitation requirements at the Nursing School, the Health Assistant School, the Midwifery School and the Central Medical Laboratory. The rehabilitation will be done by the Ministry of Health through a local contractor(s) on a reimbursable basis.

b. Development of National Planning and Health Management Information System

Currently, there is a system which secures a flow of health statistics up the health system from health station to the center. This system, however, is principally intended to report services provided and commodities utilized. Due to the lack of transport and the shortage of personnel, the system often operates haphazardly. It also does not provide the information required at the different levels for adequate management of the system. The project will provide TA for conducting an assessment of the current system, helping the MOH at central, provincial and sub-provincial levels to determine what information they really need for disease surveillance and management of the system, and then developing a streamlined HMIS which is appropriate for Eritrea's health system at its current state of development. It is expected that once a new HMIS is designed it will be tested out in the four focus provinces before being implemented nationwide.

c. Development of Enhanced Health Education Capability

The project will provide TA to conduct a needs assessment during the first year of the project of the health education area, especially with regard to family planning and other targeted primary health care interventions. Based upon this assessment, the MOH will be assisted to prepare a national communications strategy and action plan. This plan will identify training needs for each of the interventions and determine what health education supporting materials are required for the different levels of the health delivery system. The project will provide support for the preparation of appropriate IEC materials and messages based on research findings. All curricula for the training of health providers at all levels of the system will be modified to include sections on health education in order to develop the skills considered necessary for each particular level, for example, counselling skills in family planning for health assistants located at health stations.

The project will also support awareness raising in population and family planning as well as health issues among policy makers, opinion leaders and special groups such as journalists, women's groups, and the Medical Association. This will be done in

coordination with UNFPA programs as they are developed.

d. Increased Involvement of the Private Sector and NGOs in Family Planning and Health Service Delivery

Non-governmental organization (NGO) involvement in health and family planning will be strengthened through provision of funding, technical assistance, training, and commodities. An NGO grants program will be established, with a committee (USAID, MOH, and possibly other donors) to review NGO proposals for support. The committee will set basic criteria for NGO projects, emphasizing outreach programs in underserved areas which will have specific benefits for women's and children's health. For instance, the Family Planning Association of Eritrea can be provided technical assistance in the design and production of IEC materials for use in its outreach campaigns in new areas. A grant could be given to FPAE for such activities and subgrants made to other NGOs interested in expanding their activities to include family planning. Another local NGO, the Eritrean Catholic Secretariat, has 24 clinics but no outreach programs at this time. The ECS "partner", Catholic Relief Services would like to provide assistance to ECS in this area and could be given a grant to support ECS staff training and the development of outreach capabilities.

The private sector is weak in Eritrea as a result of decades of a controlled economy. However, the private pharmacies in the major cities are an important provider of drugs (and health advice) as well as contraceptives. Private practice of physicians is allowed but there are few practitioners. As more medically trained Eritreans return from abroad, this is expected to change. This project will assist in strengthening the private sector services (including factory clinics) through support for workshops and short courses in MCH and FP for private practitioners and perhaps, pharmacy staff. The project will work closely with the Eritrean Medical Association in Eritrea and the US to organize such programs. The project will also provide for an assessment of the potential for social marketing of some drugs and contraceptives and, if it seems feasible, support for the development of a social marketing program.

3. Support at the Provincial Level

Much of what will be done at the provincial level will either support or will reflect what is being done at the national level. In fact, it is expected that many of the systems improvements, such as development of the HMIS, will first be implemented in one or more of the focus provinces prior to being implemented nationwide.

a. Rehabilitation of Health Facilities

An assessment will be made of the specific requirements for

rehabilitation of facilities in underserved areas of the target provinces and a work plan developed based on both local needs and staffing capabilities. The rehabilitation will be carried out by local firms under contract to the MOH.

b. Provision of Essential Health Care Commodities

An assessment of current and projected commodity needs and a review of other donor support in this area will determine the level and types of essential health commodities to be provided in the project. With the exception of contraceptives, all commodities to be provided to the facilities in the target provinces (vaccines, ORS) will be procured by UNICEF in order to ensure uniformity. USAID will probably fund only a portion of the required commodities in the focus provinces and will support MOH coordination with other donors to ensure supply of the remainder. UNFPA has agreed to provide contraceptives to the MOH for the next year but further programming is unclear at this time. USAID will endeavor to provide contraceptives to fill the gap between UNFPA supplies and regional (even national -- considering the current low utilization rate) requirements.

E. Illustrative Financial Plan

USAID/Eritrea and the PID design team have prepared a preliminary estimate of the costs for accomplishing the activities described above. A summary by basic categories of costs is as follows. During the PP design (see Section V below) the project costs will be estimated in detail.

Category	Thousands of Dollars
1. Rehabilitation/Construction	1,000
2. Commodities and Equipment	1,500
3. TA (for 4-7 below)	1,500
4. Training	2,000
5. Health Education\IEC	500
6. Research	500
7. NGO/Social Marketing/Private Sector	1,000
8. Demographic and Health Survey	600
9. Project Management (Contractor)	3,000
10. Evaluation and Audit	400
TOTAL	12,000

The project is planned to be authorized and Project Agreement signed during August, 1994. Initial year funding in FY 94 is planned at $5.5 million. The remainder of the project funding would be added during FY 95 - FY 98. The Project Assistance Completion Date (PACD) for the project will be December 31, 1999.

F. Project Implementation Arrangements

The project grant will finance either a competitively-selected U.S. institutional contractor or will finance one or two buy-ins to large umbrella-type cooperative agreements/contracts. Following initial discussions with UNICEF, which is already implementing a USAID grant-funded health activity in three provinces, it is possible that the facility rehabilitation and construction component of the project would be done through an additional grant to UNICEF.

Regardless of which of the former two implementation arrangements is selected, the contractor/CAs would have principal responsibility for the day-to-day implementation of the project, and for identifying and obtaining the technical assistance from

other CAs, which would be required in the implementation of the various components of the project. These contractors or CAs would also be able to directly fund and oversee specific activities of the project, such as the NGO grants program.

A third option would be to issue a series of buy-ins to individual CAs for different components of the project. This option is not considered viable with the current limited manpower of USAID/Eritrea, as it would be much more management intensive.

All three approaches have advantages and disadvantages. The single institutional contractor would mean that USAID/Eritrea would have fewer entities with which it would have to deal, i.e., the contractor and possibly UNICEF. At the same time, the selection of such a contractor would take up to one year before actual project implementation could begin.

If it is possible to do buy-ins to large projects/CAs, the time before implementation could begin would be considerably shortened to around three months, but the number of organizations with which the Mission would have to deal would obviously be more and a suitable arrangement would have to be worked out to ensure a coordinated approach to their management and implementation of the project. A determination of which approach the project will take will be made during the PP stage.

G. GOE and Mission Management

The Minister of Health will be the principal counterpart for project implementation. He or his representative will chair the quarterly project strategy meetings to which all concerned donors and implementing agencies and organizations will be invited, as well as the smaller monthly project implementation meetings at which the bottlenecks and "nuts and bolts" problems will be discussed and resolved. The Minister has committed to organize all necessary additional counterparts in the MOH to ensure smooth progress of the project.

Considering the very limited staffing of USAID/Asmara, most of the management of the project will be handled by the prime contractor/CAs. The Mission will be principally responsible for providing oversight of the prime contractor/CAs.

H. Donor Coordination

USAID/Eritrea has initiated dialogue with other donors in the health sector and has involved a number of them, including UNICEF, in the design of the EHP project. Many donors are currently shifting from ad hoc emergency assistance to development of longer term projects and are just now in the process of formulating their programs. This state of donor assistance programs presents an excellent opportunity for USAID to work with these donors and the GOE to develop a cohesive and

coordinated set of sector development activities. The EHP project is likely to be the first major bilateral activity of its kind in Eritrea and, judging from interest already shown by other donors, it appears that it will lead to even greater donor investment in the sector.

USAID and UNICEF have discussed their willingness to provide support for MOH donor coordination activities and will be pursuing this with the Ministry.

I. Monitoring and Evaluation

Overview

Given the differences in the components of the EHP project (construction, training, logistical support, IEC, HMIS support, TA, national and provincial level activities), effective monitoring and evaluation will require a variety of data to be collected to achieve the following objectives: 1) to record the performance of the various project components; 2) to generate information which can be used for better decision making by the project managers; and 3) to strengthen the capacity of counterparts both at the central and provincial levels in data collection and analysis. The prime contractor/CA(s) will have principal responsibility for the coordination of project monitoring and evaluation activities, and will monitor progress towards national and provincial level project objectives. Data collection and analysis will be performed by technical consultants supervised by the prime contractor/CA(s), but working closely and collaboratively with Mission staff, Eritrean counterparts and implementing organizations. In addition, the prime contractor/CA(s) will have access to data generated by special efforts outside the project, such as the Demographic and Health Survey (DHS) scheduled for 1994 under the USAID/Eritrea Technical Assistance Project (TAP).

Project Baseline

Accurate baseline data are virtually non-existent. Therefore, these data will be generated during the first year of the project. The principal activity scheduled is the nationwide DHS, which will take place in 1994. Once these data are available, the targets against which project impact will be measured will be determined, refined or modified as needed.

Monitoring

Monitoring activities can be grouped into two categories: 1) those which will be used to track progress of national level components of the project; and 2) those which will be used to track progress of project activities in the focus provinces down to the health station and community levels. Principal activities in each category are as follows:

National Level Monitoring

- annual assessments will be made by the prime contractor(s) of the progress achieved on each of the national level components of the project;
- periodic reports will be produced by those organizations responsible for implementation of specific national level activities;
- technical assistance will be provided to develop a more effective health management information system (for both the national level and the provincial level) from which disease prevalence and service utilization data will be continually obtained;
- national level statistics produced by the MOH HMIS will be used to track the overall utilization of health services; technical assistance will be provided at the center and provincial levels to improve the collection of health statistics nationwide as well as their analysis and utilization by managers and decision makers.

Focus Province Level Monitoring

- special studies and operations research activities will be conducted on particular aspects of service delivery to identify the most efficient and cost-effective interventions for providing essential services;
- the prime contractor(s) will provide continuous feedback on the impact indicators to the Mission and GOE counterparts to improve prospective planning and prioritize interventions;
- the prime contractor/CA(s), along with a Mission representative, as available, will pay frequent visits to the focus regions for firsthand field observation of activities;
- detailed data from the various activities within each project component will be collected and analyzed annually by special TA organized and funded by the prime contractor/CA(s);

- provincial level statistics, generated from the community through provincial hospital levels in the HMIS, will be used to track the performance of the service delivery levels within the target provinces.

Evaluation

- **Mid-term** - A mid-term progress evaluation will be conducted using outside consultants/TA in year three of the project. This evaluation will consist of a review of all data available from periodic reports, site visits, evaluation and assessment reports for the various components of the project, and if possible, short term focused surveys conducted during the evaluation period. It will also evaluate the performance of the prime contractor/CA(s) in managing the implementation of the project.

- **Final** - A second DHS will be conducted at the beginning of year five and will be funded through the project. The preliminary DHS findings will form part of the final impact evaluation which will be conducted at the end of year five. The final impact evaluation will also include assessments or evaluations of the major components of the project, including the overall performance of the prime contractor/CA(s).

V. DESIGN STRATEGY

A. Further Analyses for the Project Paper

Considerable analyses have been performed and are reflected in this PID and in the following three Annexes:

-- Health Sector Concept Paper by Shepperd, et. al.
-- Health Sector Financing Review by Larry Forgy
-- MOH Health Profile of Eritrea

These documents cover, in adequate detail, the health problems, constraints, and needs in Eritrea. However, final design of a USAID Health and Child Survival project will require additional information about certain key dimensions of the health sector. The following analytical studies will fill these information gaps:

Institutional Capabilities and Needs Assessment. Includes other donors, PVO/NGO activities, private sector involvement in the health sector, MOH organization and functions review, training needs assessment, management information system, physical facilities review, medical supplies and equipment, logistics review, and geographic focus areas review.

Economic and Financial Analysis. The economic analysis includes a comparison of the costs and the benefits of the GOE's proposed programs in health and family planning. The financial analysis examines both the financial needs of the GOE health and family planning programs and of the USAID funded EHP project.

Social and Gender Analysis. Will focus on the project's socio-cultural feasibility and expected people level impact. Project effects on all stakeholder groups will be examined.

Environmental Impact Assessment. Includes an engineering assessment of the rehabilitation and construction planned under the project and preparation the Environmental Impact Assessment for the EHP project.

Financial Capabilities Analysis. Review of MOF and MOH financial controls and accounting systems.

Scopes of Work for the above analyses are included in Annexes E, F, and I of this PID.

B. Budget for Project Design

The above described studies will be funded as follows:

Eritrea Health Sector Review (Annex E) Includes: Institutional Capabilities and Needs Assessment, Economic and Financial Analysis, and Social and Gender Analysis.	Amount	Source
	$142,000	BASICS
Environmental Impact Assessment (Annex F)	$ 30,000	PD&S
Financial Capabilities Analysis (Annex I)	$ 30,000	PD&S
TOTAL	$202,000	

C. Project Design Team

In addition to USAID/Eritrea Mission staff, the project design team will include two REDSO/ESA health and population officers, one REDSO/ESA project development officer, and two members of the Health Sector Review team (see Annex E).

D. Project Approval Schedule

REDSO/ESA PID Review	April 1 - 30, 1994
REDSO/ESA Concurrence Cable	May 5, 1994
Contracts Executed for PP Studies	May 6, 1994
PP Studies Begin in Eritrea	May 10, 1994
AID/W Review	May 16, 1994
PP Design Team Arrives Asmara	June 7, 1994
PP Studies Completed (latest)	June 15, 1994
PP Design Team Departs Asmara Leaving draft PP with Mission	June 17, 1994
REDSO/ESA PP Review	June 29, 1994
REDSO/ESA PP Concurrence Cable (assumes PP approval is delegated to the field)	July 7, 1994
PP Approved and Project Authorized	July 14, 1994
Project Agreement Signed	July 21, 1994

E. USAID Issues and Concerns

1. Sustainability

With Eritrea at the beginning of its rebuilding stage, it is critical that the government carefully examine the sustainability implications of new policies and programs. Donors, particularly in their first substantial development assistance efforts, must also assess the sustainability implications of their foreign assistance investments to ensure that investments support sustainable strategies and do not result in programs that will never by sustainable given the resource constraints in Eritrea. In addition, there is the danger that unwise donor investments could divert limited country resources to areas that may not have the most impact for birr invested. USAID has taken this responsibility seriously and has developed a program that will address several key issues affecting the potential for sustainability. The Health and Population project deals with the financial as well as the institutional, capacity building and systems strengthening aspects of sustainability.

A. Organizational/Institutional Sustainability

Organizational/institutional sustainability refers to the capacity of the health delivery system (both public and private) to manage and deliver quality health services beyond the life of the project. There is a strong linkage between quality of health services and the consumer's willingness to pay.

1. Capacity Building

Tom Bossert in his "Sustainability and Health Services" treatise and the 1993 CCCD Sustainability Evaluation both recommend that manpower training is the foundation for sustainability of services. The project will focus its manpower training on health providers who deliver basic primary health care services to the majority of the people in rural areas. Health assistants and nurses are the backbone of the primary health care system in Eritrea. They deliver basic services, such as EPI, case management of ARI, diarrhea, malnutrition at the health stations and clinics and will be the trainers and supervisors of community-based health agents and TBAs.

2. Systems Strengthening

The new draft Africa Child Survival Strategy for the 1990s emphasizes the need for systems strengthening for achievement of long-term sustainability. Without these systems in place and operating efficiently, the functioning of services at the periphery are in jeopardy. The project will assist the MOH with improving its logistics and health management information systems, two areas where USAID has a comparative advantage.

B. Financial Sustainability

1. Public Sector

The Ministry of Health is well aware of the costs of expanding and upgrading the health delivery system. However, with the damage and neglect caused by the war, there is a critical need to rehabilitate and construct a number of basic primary health care facilities that will be the backbone of the PHC system. The number and location of these facilities appear reasonable. There is also a critical shortage of salaried-civilian staff to operate these facilities. Unpaid fighters are currently playing a key role filling in the manpower needs currently in many facilities along with the limited MOH paid employees. These health centers and stations will be the critical points of training and supervision of the community-based health workers. Lessons of experience throughout the world have indicated that a community-based system needs geographically-close linkages to the formal health system and MOH staff. The question is then how will this very basic primary health care system be supported with a MOH budget that is expending less than $1.20 dollars per person. (The World Bank in Better Health for Africa strategy is recommending $7.00 per capita as a minimum cost to support a package of basic services for an individual.)

The MOH has been studying various resource mobilization strategies including a health insurance scheme for public and private sector employees and cost recovery strategies based on user fees. These strategies have been presented to the GOE for consideration and adoption. In terms of support for community-based health workers and TBAs, the MOH has indicated that communities will have to support them with either in-kind contributions or birr but that they would not be part of the official MOH employee ranks. However, the present economic conditions with an 80% crop loss make it very difficult for both individuals and communities to contribute resources in most areas throughout Eritrea.

It is only realistic to assume that the next five years will be a rehabilitation and recovery period for the country. Short term strategies for the Ministry include putting in place a low-cost system of health care delivery based on community ownership and capacity to deliver minimum services and a small but solid PHC infrastructure based on strategically-placed health centers and stations, staffed by trained health assistants and nurses. Given the very limited budget of the MOH, donor support will be needed to support construction and equipment costs as well as essential commodities such as vaccines and pharmaceutical. In the short term additional budget support may be necessary to support the transition from free fighter services to additional paid-MOH staff.

The project during the next five years will assist the government to develop and test alternative resource mobilization schemes in the four provinces. These strategies will focus on the potential use of resources from the community levels as well as individual contributions. In these provinces it is anticipated that cost recovery schemes based on user fees will be operational by the

third year of the project. By this time, communities will also be responsible by mandate of provincial assemblies to support community based health workers and TBAs. In turn, MOH will be responsible for training and supervising these workers as well as providing a small supply of drugs. This three to four year timeframe is necessary to ensure that the quality of services has been improved to the point where people and communities see and appreciate the value of services and will be willing to pay. Thus all health financing strategies must be closely linked to quality improvements in services and IEC to increase in demand.

2. Private Sector

A) NGOs

There is a limited number of NGOS working in the health sector including the Catholic Secretariat that is operating 24 health clinics. In total NGOs are supporting 31 health stations. A number of other PVOs including AFRICARE and World Vision are establishing their first health projects in Eritrea. AFRICARE has applied for a Washington child survival grant from FHA. There is also an IPPF affiliate, the Family Planning Association of Eritrea that will provide an excellent basis for the provision of family planning information and training to both public sector and private sector groups. In order to increase coverage and access of health and family planning services, NGOS can play an important role in expanding and complementing the public sector.

The project will facilitate the establishment of public and private partnerships to provide increased coverage, access and quality of services. The Catholic Secretariat has entered into their first agreement with the government to construct and equip a health center that will be staffed by MOH employees. In another case, the Catholic Secretariat will employ government-trained staff but will pay the salaries. The project will assist with the identification of these types of partnerships and provide technical assistance and funding to assist with the implementation. Under the project technical assistance will be available to assist PVOS develop and test out resource mobilization strategies so that their programs too can be implemented on a sustainable basis.

B) For-Profit

Private sector participation in the provision of health services and inputs (drugs and commodities) is also critical for achieving sustainability. The private sector can augment the resources and services of the public sector. While the GOE has indicated support for private sector participation, an enabling legal framework is lacking. There are still licensing, registration,

and regulatory impediments that seriously discourage private sector involvement.

The MOH is well aware of the inherent costs of maintaining an increasing number of facilities and support for a growing number of staff, and has considered a number of financing alternatives. The MOH has submitted a proposal to the GOE for a health insurance scheme for public and private sector employees. In addition, they have proposed a scheme of user fees for all medical facilities. The goal is to eventually remove subsidies for health services in Eritrea. Given the general economic condition at this time, health insurance and user fees will have to be further developed and phased in gradually.

Project support will be provided to assist the MOH in this endeavor, as well as develop other health care financing schemes for all levels, national and provincial, and to pilot test the schemes in the targeted provinces. The project will also promote development of the private sector health system (NGO component), which, by its nature, will enhance the sustainability of the health sector. It is expected that during the 5 year life of project, revenues will be generated which should be able to finance an increasing proportion of the MOH operating expenses at the various levels.

Pre-Project Paper analyses should examine and assess feasible project targets for early indicators of sustainability that can be achieved through this project, such as percentage increases in MOH budget, implementation of user fees, and other measures. In addition, thorough analyses, which include a review of current MOH proposed policies regarding health care financing and health insurance, and a preliminary plan of health care financing schemes, should be completed prior to Project Paper design.

2. Strategic Planning within the MOH

The MOH has developed a detailed action plan, with multiple components: training, facilities reconstruction and refurbishing, commodities and more. While comprehensive in nature, the plan does not coherently link the inputs into a long term strategy, nor does it provide a strategic plan for coordinating the inputs. For example, the current plan for building health stations and health centers by districts and sub-provinces consists of a standardized allocation per unit and may not reflect the unique characteristics or populations of each area. Further, the plan for training ex-combatants and others in all areas of health delivery does not appear to describe the placement of graduates after training has ended. These plans may need to be re-examined considering other factors such as population density, catchment area, community priorities, needs, and more.

The plans will need to adequately describe the sequencing of health facilities construction, and training and placement of

health services providers at the different levels. At present, it is difficult to know whether the planned resources are adequate to meet current and future needs, at both national and provincial levels.

Strategic planning at all levels is fundamental to implementation of the MOH's decentralization plan, so that managers can continually assess and determine future needs. The project can assist the MOH to develop the capacity for strategic planning through a combination of technical assistance and strategic planning workshops. Areas for coverage should include establishing criteria for determining requirements in the areas of training, facilities, and commodities. The PP design team should analyze the requirements in this area and describe the technical assistance needs.

3. Reconstruction/Refurbishing of Health Care Facilities

An unfortunate outcome of the 30 year civil war was severely damaged and neglected health care delivery and training facilities. While in recent years, USAID has tended to move away from reconstruction, there are several compelling reasons to provide project assistance to Eritrea in this area. Perhaps the most convincing rationale for support for reconstruction, refurbishing, and in limited cases, new construction, is that lack of facilities is one of the most significant constraints to laying the foundation for a health system infrastructure. The upgrading of existing health infrastructure and the expansion of that infrastructure into underserved areas of the country are vital for the success and sustainability of Eritrea's PHC program. Static sites are essential for reaching the populations in the rural and outlying areas through both outreach activities and the launching of EPI campaigns. Clearly, without this project component, access to health services will be seriously constrained. Other donors, such as UNICEF, also recognize the importance of construction as an essential project component and have indicated a willingness, with USAID financial support, to assume responsibility for this.

Funding for continued maintenance becomes an important policy concern in order to sustain these facilities once they have been reconstructed and refurbished. The MOH and donors will need to collaborate to seek solutions to this problem in the medium and long term. The EHP project can serve as a catalyst in bringing together donors, the MOH, and the community to develop strategies for dealing with this issue.

ANNEX H

SELECTION OF FOCUS PROVINCES

There are four principal reasons for selecting the provinces of Akele Guzai, Hamasien, Senhit and Asmara for initial provincial level systems improvements under the project.

First, the outlying provinces are now being served by a number of donor development efforts. USAID, through a grant to UNICEF, is already supporting an expanded program of immunization and rehabilitation of the primary health care program in the three provinces of Sahel, Barka, and Dankalia. In addition, over this next year, USAID may be providing additional support in the Barka, Sahel, and Gash Setit provinces to deal with the health problems of returning refugees (not yet finalized). Africare has a proposal to support and strengthen the primary health care program in the province of Dankalia, including upgrading the health center in Galelo and establishing a new health station at Bada. This activity might be supported by USAID assistance from USAID/W. Gash Setit province is being assisted by Save the Children (UK) and Lutheran World Federation, while Seraie will be a focus province for UNICEF. Semhar province has received support from the Norwegian Red Cross to reconstruct the Masawa hospital and Norwegian Church Aid has provided support for Semhar's primary health care program.

Second, the four central provinces are in critical need of improved health services. Because the central provinces have been considered better served with health services they have been afforded a lower priority for donor assistance in the health sector. Nevertheless, according to MOH statistics, the combined populations of the selected provinces account for almost half of Eritrea's population and are characterized by an extremely high population to health facility ratio (31,933 per functioning MOH health station and 95,800 per functioning MOH health center, compared with 43,720 per health station and 89,833 per health center for the other six provinces of the country). Of the 74 new health stations and 32 health centers which the GOE wants to construct in all ten provinces over the next several years, 27 of the former and 13 of the latter are scheduled to be built in these four provinces. With respect to staffing, excluding the national referral hospital in Asmara, these four provinces also are more underserved than the rest of the country. For example, only 24% of the specialists, 43% of the nurses, 31% of the lab technicians and 40% of administrative staff are found in these four provinces, although approximately 47% of the population is resident there.

Third, the central provinces are the optimal place to model an improved and integrated health system for expansion to the rest of the country, while at the same time reaching the largest number of people with at least minimal health and family planning services. The fact that these central provinces are more densely

settled has traditionally meant that their populations have had more real access to health services because greater numbers are in closer proximity to health facilities and the transport infrastructure in these areas is more developed. The outlying provinces not only have sparser populations, but also large components of their populations are nomadic, further reducing the population reach of static health facilities.

It is fully recognized that the health needs of the populations of the outlying provinces are, in some ways, greater, especially with regard to having access to health services. However, from the standpoint of building foundations for a sustainable health delivery system, while at the same time starting to have a positive impact on health status, it is obviously far better to focus the efforts of the project on those geographic areas and populations where this can most readily be done.

The principal beneficiaries of this project are women of reproductive age (aged 15-44) and children under age 5. The four selected provinces account for around 48% of Eritrea's population of both groups.

Fourth, from the standpoint of EHP project management, the selection of provinces contiguous to Asmara will facilitate proper oversight and management of project activities, especially that of health station rehabilitation and construction. Also, the development of replicable models in such areas as health care financing (e.g., user fee retention schemes), and the strengthening of decentralized provincial health planning and administration will also be more easily supported and managed due to greater accessibility.