

ERITREA

HEALTH SECTOR STRATEGIC

DEVELOPMENT PLAN

(HSSDP 2012 – 2016)

Mid-Term Review

3rd November – 19th November 2014

Final Report

Harare, 18.12.2014

TABLE OF CONTENTS

ACKNOWLEDGEMENTS	IV
ABBREVIATIONS AND ACRONYMS	V
ESSENTIAL INDICATORS: RESULTS AND TARGETS HSSDP 2012 - 2016	VIII
MAP OF ERITREA.....	XII
EXECUTIVE SUMMARY	XIII
Achievements	xiii
Challenges	xiv
Recommendations.....	xv
1. INTRODUCTION.....	1
1.1. Background to the 2014 Mid Term Review (MTR) of HSSDP.....	1
1.2. Objectives of the MTR 2014	1
1.3. Methodology of the MTR 2014	2
1.4. Limitations	2
1.5. Composition of the MTR Team.....	3
1.6. Structure of the report.....	3
2. BASIC HEALTH CARE PACKAGE (BHCP).....	4
2.1. Maternal, Neonatal and Child Health Care (MNCH) and Nutrition	4
2.1.1. Maternal Health and Safe Motherhood	4
2.1.2. Child Health and EPI	6
2.1.3. Nutrition	7
2.2. Prevention, Control and Management of Communicable Diseases	8
2.2.1. HIV/AIDS and STI	8
2.2.2. Tuberculosis	8
2.2.3. Malaria	9
2.2.4. Integrated Disease Surveillance and Response (IDSR)	10
2.3. Prevention and Control of Non-Communicable Diseases (NCD)	10
2.3.1. Major Chronic Diseases (MCD).....	10
2.3.2. Blindness and Trachoma Prevention	10

2.3.3. Injuries and accidents.....	11
2.3.4. Mental Health	11
2.3.5. Oro-Dental Health and ENT.....	11
2.4. Cross-Cutting Health Interventions	11
2.4.1. Environmental Health Unit.....	11
2.4.2. Health Promotion Division	11
2.4.3. Quality of Care.....	11
2.4.4. Supportive Supervision	12
2.4.5. Disaster Preparedness and Response	12
3. HOSPITAL, EMERGENCY AND INTEGRATED ESSENTIAL MEDICAL CARE	13
3.1. Hospital Services	13
3.2. Emergency Medical Care and Referral Network	13
4. ESSENTIAL HEALTH SYSTEMS AND GOVERNANCE	15
4.1. Human Resources for Health Development and Management.....	15
4.2. Procurement, Supply and Logistic Management	16
4.3. Medicines Administration / Regulation.....	17
4.4. Biomedical Engineering.....	19
4.5. Infrastructure Engineering	19
4.6. Laboratory and Diagnostic Services and Medical Imaging Services	20
4.7. Blood Transfusion Services.....	21
4.8. Legal Affairs and legal framework.....	22
4.9 GOVERNANCE & PRINCIPLES	23
4.10. Partnership arrangements (national and international)	23
5. SECTOR PLANNING, INFORMATION SYSTEMS, MONITORING & EVALUATION	24
5.1. Planning.....	24
5.2. Health Management and Information Systems (HMIS)	25
5.2.1. HMIS as part of the HSSDP	25
5.2.2. HIS resources.....	26
5.2.3. Indicators: data quality and sources	26
5.2.4. Data outputs and use	27

5.2.5. Recommendations	27
5.3. Sector Monitoring & Evaluation	27
5.3.1. M&E Objectives of the HSSDP	27
5.3.2. Recommendations	28
5.4. Health Research	28
6. HEALTH CARE FINANCING, FUNDING AND BUDGETING	30
6.1. HSSDP Financing	30
6.2. HSSDP Funding.....	32
6.3. HSSDP Budget	32
6.4. Recommendations for Health Care Financing and Funding:	33
ANNEXES	35
Annex 1: Terms of Reference for the MTR of HSSDP	35
Annex 2: Work program of the MTR team	40
Annex 3: List of people / institutions interviewed at National level.....	41
Annex 4: List of documents consulted	44
Annex 5: JANS Joint Assessment Tool, version 3, August 2013.....	46
Annex 6: Questionnaire for the MTR of the HSSDP in Eritrea, Nov 2014.	51

ACKNOWLEDGEMENTS

The MTR team would like to express its gratitude to the Minister of Health, Her Excellency, Ms Amina Nurhussien for her stewardship and authorization to undertake this Mid Term Review of the HSSDP. The conduct of a first review of such an important strategic document is always a challenging exercise. It shows vision and courage to have it done. The team hopes that our findings and recommendations will allow Her Excellency to continue the excellent work her Ministry is undertaking.

We also would like to thank His Excellency, the Minister of National Development, Dr Ghiorgis Teklemichael for the long and informative interview he granted to the team. His comments and advice during our interview have been greatly appreciated.

The MTR team wishes to acknowledge the strong and continuous support it received from senior management of the MOH, in particular the members of the Steering Committee that showed active interest in the day to day findings and observations of the team. In addition, our appreciation goes to the Policy and Planning Division that managed at very short notice to prepare our work program involving many interviews with almost all Units and Divisions within the four Departments of the MOH as well as the field visits. Members of the HSSDP Steering Committee that supported our work were:

Name	Role in Steering Committee	Position within MOH
Mr Berhane Ghebretensae	Chair	DG Department Medical Services
Dr Andebrehan Tesfazion	Member	A/DG Department of Public Health
Dr Mismay Ghebrehwot	Member	Advisor to the Minister
Mr Tewolde Yohannes	Secretary	Director of Policy and Planning
Mr Tsegai Berhane	Member	Head Planning Unit
Mr Semere Ghebrejorgis	Member	WHO, Health Systems

Special thanks are due to the Ministry of Finance (MOF) and the Board of Higher Education that were willing to receive the team members at very short notice.

We would like to express our appreciation to the many staff members within the central MOH that we interviewed and who gave their ideas and suggestions on the status of implementation of the HSSDP and the way forward in the coming years. We have been impressed with the openness and frankness with which they shared their thoughts.

Many thanks are also due to the medical directors and staff working in the various health institutions (Zoba Hospitals, Community Hospitals, Health Centres and Health Stations) of the 4 Zobas we have visited. We are very grateful for their time and effort in sharing ideas and giving suggestions to us.

Finally, in addition to the various UN Agencies we interviewed, special thanks are due to the World Health Organisation (WHO) for their continuous logistic and technical support to this MTR. Their advice and suggestions have been instrumental in compiling this report.

Asmara, 20 November 2014.

Dr Prosper Tumusiime, Team leader

Dr Jarl Chabot, Deputy team leader.

ABBREVIATIONS AND ACRONYMS

ACT	Artemesine Combined Therapy
ADR	Adverse Drug Reaction
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal care
ART	Anti Retroviral
BCC	Behaviour change communication
BF	Breast Feeding
BHCP	Basic Health Care Package
CAH	Child and Adolescent Health Unit
CDC	Communicable Diseases Control
CDR	Case Detection Rate
CH	Community Hospital
CHA	Community Health Agent
CS	Caesarean Section
CSW	Commercial Sex Workers
DHS	Demographic and Health Survey
DOTS	Directly Observed Treatment Short course
DST	Drug Susceptibility Testing
EDHS	Eritrea Demographic and Health Survey
EHP	Eritrea Health Package
ENASP	Eritrean National AIDS Strategic Plan
ENLM	Eritrean National List of Medicines
ENPC	Eritrean National Pharmaco-vigilance Centre
ENT	Ear, Nose and Throat
EPI	Expanded Program on Immunizations
FGM	Female Genital Mutilation
FP	Family Planning
GAVI	Global Alliance for Vaccines and Immunizations
GDP	Gross Domestic Product
GF	Global Fund
GOE	Government of Eritrea
HC	Health Centre
HCF	Health Care Financing
HF	Health Facility
HFA	Health Facility Assessment
HH	Households
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HRD	Human Resource Development
HRH	Human Resource for Health
HS	Health Station
HSSDP	Health Sector Strategic Development Plan
HW	Health Workers
IDSR	Integrated Disease Surveillance and Response
IHR	International Health Regulations
IMNCI	Integrated Management of Neonatal and Childhood Illnesses
IMR	Infant mortality rate
ITN	Insecticide Treated Nets
IVM	Integrated Vector Management
JANS	Joint Assessment of National Strategies

JICA	Japan International Cooperation Agency
LLITN	Long lasting Insecticide Treated Nets
LSS	Life Saving Skills
MA	Maekel zone
MCD	Major Chronic Diseases
MDR-TB	Multidrug-Resistant Tuberculosis
MMR	Maternal mortality ratio
MNCH	Maternal, Neonatal and Child Health Care
MND	Ministry of National Development
MNT	Maternal Neo-natal Tetanus
MOF	Ministry of Finance
MTR	Mid Term Review
MWH	Maternity Waiting Homes
NA	Not Available
NBTS	National Blood Transfusion Services
NCD	Non-Communicable diseases
NDP	National Drug Policy
NGO	Non-Governmental Organization
NHL	National Health Laboratory
NHP	National Health Policy
NID	National Immunisation Day
NMCP	National Malaria Control Program
NMFA	National Medicines and Food Administration
NNMR	Neo-natal Mortality Rate
NRH	National Referral Hospitals
NS	Not Stated
NSSS	National Sentinel Site Survey
NTCP	National TB Control Program
NTD	Neglected Tropical Diseases
ODA	Overseas Development Assistance
ODF	Open Defecation Free
OOP	Out Of Pocket
PAC	Post-Abortion Care
PCV	Pneumococcal Conjugated Vaccine
PHC	Primary Health Care
PLC	Private Limited Company
PLHA	People living with HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission
PMU	Project Management Unit
PR	Principle Recipient
PV	Pharmaco-vigilance
PW	Pregnant Women
RH	Reproductive Health
RHS	Reproductive Health Services
SBA	Skilled Birth Attendance
SC	Steering Committee
SPCF	Strategic Partnership Cooperation Framework
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infections
SZHMT	Sub-Zoba Health Management Team
TB	Tuberculosis
THE	Total Health Expenditure
TOR	Terms Of Reference
U5MR	Under-five mortality rate

UN	United Nations
UNDP	United Nations Development Programme
UNSD	United Nations Statistical Division
VHC	Village Health Committee
WHO	World Health Organization
ZHMT	Zoba Health Management Team
ZMO	Zoba Medical Officer

ESSENTIAL INDICATORS: RESULTS AND TARGETS HSSDP 2012 - 2016

INDICATORS	Baseline EDHS	EDHS	EPHS	Target	Result	Target	Result	Target	Result 1/2 yr	Target HSSDP
YEARS	1995	2002	2010	2012	2012	2013	2013	2014	2014	2016
BASIC HEALTH CARE PACKAGE (BHCP) / SERVICES										
A1. MNCH & Nutrition										
Estimated Population									3,600,000	
Life Expectancy	49		61			63				NS
IMR	72	48	42		37 WHO		36 WHO			20
U5MR	136	93	63		52 WHO		50 WHO			49
NNMR	25	24	23							NA
MMR	998	752	486				380WHO			350
Total Fertility Rate	6.1	4.8	4.8							NS
% mothers visiting ANC (first visit)	50	71	89		57.5		93		55.6	95
% of mothers making at least 4 ANC visits	NA	41	57		35.5		33.5		34.6	60
% deliveries attended by HW / SBA	NA	26	34		18,733 34		18,529 33		20,844 36	51
Nb / % mothers delivered by CS	0.8	3	2.8		1,421 7.6		1,281 6.9		1,383 6.6	14
% mothers / babies with postnatal care visit within 1 day at facility	NA	8	5		28		23		13	NA
CPR modern methods	8	8	8.4							17
FP first visit					10		11		9	NA
Prev. of FGM among girls adults / < 5 yrs	95	NA	83						23 (<5yr)	FGM Free villages
Prevalence of Teenage pregnancy (15-19 yrs)	19	14	11		NA		NA		NA	8
% public facilities providing B-EmNOC	NA	NA	NA				67			100
% Hospitals providing C-EmNOC	32	NA	48				60			90
A2. CHILD HEALTH										
Facility IMNCI coverage	NA	NA	44				100		100	100
Community IMNCI coverage	NA	NA	39				NA		NA	NS
Pneumonia <5 yrs Cases / Death									51,313 50	
Diarrhea <5 yrs Cases / Death									38,079 21	
% children < 1 yr with Penta 3	49 (DPT3)	83	91		82		74		NA	> 90
% children < 1 yr with Measles	36	84	84		77		75		NA	> 90
% children fully vaccinated					NS		NS		NS	NS

INDICATORS	Baseline EDHS	EDHS	EPHS	Target	Result	Target	Result	Target	Result 1/2 yr	Target HSSDP
YEARS	1995	2002	2010	2012	2012	2013	2013	2014	2014	2016
% new-born protected at birth from MNT	13	NA	26							> 90
A3. NUTRITION										
Prev < 5 stunted (Ht/A)	38	38	50				> 50%		58.4	< 25
Prev underweight in < 5 children (Wt/A)	44	40	39				> 50%		56.5	< 30
Prev of wasting in < 5 children (Wt/Ht)	16	13	15				15-20%		15.2	< 10
% mothers initiating BF within 1 hour	NA	NA	93						NA	80
% mothers with exclusive BF till 6 ms			53						NA	80
% < 5 supplemented Vit A every 6 ms	8	38	48						78	> 90
B. PREVENTION, CONTROL OF COMMUNICABLE DISEASES										
B1. HIV/AIDS										
Prev. of HIV/AIDS in general population.	1784 cases	2.4	0.93	1.2		1.1		1.0		<0.5%
HIV sero-prevalence rate among ANC PW 15-24 years (PMTCT)	NA	2.8	0.9						0.27	< 0.5
Number PW receiving testing and counseling services for HIV	NA		NA						33.400	170.000
Nb and % of adults / children with HIV infection receiving ART	NA		NA						7,306 74%	11.300
Nb of patients receiving treatment for STIs	NA		NA							6000
B2. TB										
Nbr / % of new smear positive TB case (CDR)	NA		46 (2010)						1,228	> 70%
% of smear positive TB Cured (Cure Rate)	NA		83 (2010)				81		88%	> 90%
Treatment Success Rate			84		89		90		NA	> 90%
Prev. MDR-TB cases detected in new and re-treatment cases	NA		33 (2011)						1.8% 19%	100
B3. Malaria										
Confirmed malaria cases	NA						17,616		10,340	
Nb Malaria Case fatalities at HF	NA						5		2	0.6
Nb patients receiving ACT treatment	NA									44.575
% HH in malarious areas owning ITNs	NA								32,846	100
% Women / Children sleeping under ITN		3 /	/ 28							NA

INDICATORS	Baseline EDHS	EDHS	EPHS	Target	Result	Target	Result	Target	Result 1/2 yr	Target HSSDP
YEARS	1995	2002	2010	2012	2012	2013	2013	2014	2014	2016
C.1. PREVENTION AND CONTROL OF NON-COMMUNIC. DISEASES (NCD)										
NCD + Malignancies									7,303	
Mental Health									2,921	
Eye disorders					55,677		83,907		40,820	
Oro-Dental + ENT									29,367	
Car accidents					354		625		617	
Blood Glucose 25+			7.8%							
Blood Pressure 25+			32.2							
Tobacco Use 15+			13%							
D. CROSS-CUTTING HEALTH PROGRAMMES										
D1. Hygiene & Environmental Health										
% Population with improved latrines	13	26								54
% HH using safe water storage	16	67								NA
Open Defecation Free villages (ODF 2,666)					243 9%		398 15%		489 18%	NS
D2. Quality of Care										
In-patient case fatality rate										
Proportion standardized Labs/level										
Bed Occupancy Rate					47.6%		38.1%			
Average Length of Stay (days)							4.1 days			
OPD attendance per person / yr (first visit)							2 M OPD = 15%			
Customer satisfaction index							72% (good)			
Hospitals with Emergency Unit										
III. BHCP / ESSENTIAL SYSTEMS										
A. Human Resources for Health										
Doctor to Population					1:22,875		1:20,348		1:18,041	
Doctors					153		172		194	
Nurse to Population					1:927		1:821		1:810	
Nurses					3,775		4,262		4,318	
Total staff to population					1:432 8101		1:397 8806		1:393 8896	
% HF staffed as per standard										

INDICATORS	Baseline EDHS	EDHS	EPHS	Target	Result	Target	Result	Target	Result 1/2 yr	Target HSSDP
YEARS	1995	2002	2010	2012	2012	2013	2013	2014	2014	2016
B. Pharmaceuticals Procurement, Supply and Logistic Mgmt										
Proportion of HF with no stock-out of key essential medicines						90%	45% of 14 tracer medicine not avail	95%		95%
Blood transfusion Services										
Blood Transfusion Readiness (HFA)			41%				47%			NS
IV. A. PLANNING AND BUDGETING										
No Zoba's with annual plans										
No Sub-Zoba's with annual plans										
B. HEALTH MGMT INFORMATION SYSTEM (HMIS)										
Percentage of Zones submitting complete reports to national level									95	100%
Percentage of Zones submitting timely reports to national level									95	> 90%
C. HEALTH RESEARCH										
A. HEALTH CARE FINANCING AND FUNDING*										
Per capita GOE expenditure on health (US\$) 1996	5 1996	6 2000	4 2005		6 2012					
GOE expenditure on health as % THE (%)	48.4	64.6	45.1		50.5					
Private sector expenditure on health as % THE (%)	51.6	35.4	54.9		49.5					
External resources spent on health as % of THE (%)	17.7	35.3	76.0		71.6					
Private HH OOP as % of private health expenditure (%)	100	100	100		100					
THE as % of GDP			4.5		2.7					

Sources: (Note: THE = Total Health Expenditure)

DHS 1995 and DHS 2002 and EPHS Eritrean Population and Health Survey 2010

HFA: Health Facility Assessment 2010

Semi-Annual Activity Report 2014

HCF figures generated using data from www.who.int/nha/country/ERI¹ and 2014 World Health Statistics

¹ Ministry of Health of Eritrea, National Health Financing Policy (Draft2), November 2007

MAP OF ERITREA



EXECUTIVE SUMMARY

Since independence in 1991, the Government of Eritrea has given priority to the provision of health care to its population. Initially this took the form of annual planning exercises at the various levels of the health care system. Later, as part of the National Development Goals of the country, the Ministry of Health produced its second National Health Policy (NHP) in March 2010. This important document defines a set of clear policy priorities that aim to (i) strengthen community based health services, (ii) bring facility-based services closer to the people; (iii) strengthen decentralised governance structures; (iv) improve efficiency and quality of care of hospital services and (v) strengthen health sector coordination to enable better participation of all actors whether public or private.

Based on the NHP, the MOH developed this first Health Sector Strategic Development Plan (HSSDP 2012-2016). It provides the guidance and priorities to move from policy to action and sets the overall objectives, strategies, outputs and targets that are to be attained. The HSSDP is implemented through Annual Operational Plans, specific for each level of service provision.

As part of the monitoring of the implementation of the HSSDP, a Mid Term Review (MTR) is important to take stock of progress against its objectives. In light of this the MOH decided to conduct a MTR in November 2014. The Ministry of Health through the WHO Country Office asked the Regional Office of the World Health Organisation (WHO) to provide technical support in organising this MTR. Thus, a team composed of national and international experts conducted this review over three weeks. They visited 4 of the 6 Zobas and went to all levels of the health care system, they interviewed staff from all major Departments, Divisions and Units of the MOH, reviewed available documents and had regular debriefing meetings with the national Steering Committee that provided oversight of their work. They also had the chance to interview other stakeholders in the sector, such as UN Agencies and other government departments.

At the end of their stay, the MOH organised a debriefing meeting in which all stakeholders participated. Still in-country, the MTR team submitted a draft report to the Steering Committee for their appreciation and comments. The most important findings and recommendations from that MTR report are summarised below.

Achievements

Eritrea has achieved many outstanding successes. It will likely achieve its targets for two of the three health related MDGs: MDG 4 by reducing its IMR from 72/1000 in 1995 to 42/1000 in 2010 (target 36); MDG 5 by reducing its Maternal Mortality from 998/100,000 in 1995 (DHS) to 486/100,000 in 2010 (target 350). It has already achieved MDG 6, by reducing the prevalence of HIV/AIDS from 2.47% in 2003 to 0.79% in 2011 (EPHS); bringing TB incidence and prevalence down to respectively 93/100,000 and 152/100,000 and TB mortality from 12/100,000 in 1990 to 4.7/100,000 in 2012. Malaria incidence has declined from 53 cases/100,000 in 1998 to 4.78 cases/100,000 in 2014, thus allowing the country to embark on the pre-elimination phase. There are also successes in other areas of service provision, such as the elimination of Polio and Neonatal Tetanus, reduction of Measles, reduction of Female Genital Mutilation and an EPI coverage for Penta and Measles, consistently more than 90%. Also in the area of hygiene and sanitation successes are reported with already 21% of the 2,666 rural villages in the country having been declared "Open Defecation Free". The MTR team expects that the use of many different types of CHA (for C-Nutrition, C-IMNCI, C-Malaria, C-TB etc) has contributed to this success. As a

consequence of these achievements, the relative burden of non-communicable diseases like diabetes, hypertension, cancers and injuries (road accidents) is increasing, leading to a 'double burden of disease'.

In the area of Health Systems Strengthening (HSS) the number of 'home-trained' doctors and nurses is increasing, slowly filling the gaps from the increase in infrastructure and the relatively modest attrition (0.6 and 4.1% respectively), the provision of drugs and consumables appear regular with relatively few incidences of 'out-of-stock' of essential drugs. Laboratory services exist in all regional hospitals, in 20 other hospitals and in 43 community hospitals/health centres. The National Blood Transfusion Services produce some 10,000 blood units per year, all from volunteers.

The establishment of a Policy and Planning division has added value to the planning in the sector. Guidelines have made planning and monitoring a regular feature at Zoba and Sub-zoba levels, with the development of annual action plans and quarterly monitoring sessions. Commitment at all levels is high. Health Management Information Systems (HMIS) shows timely routine data reporting (90%) and completeness (98%), but its reliability and use by other departments and programs of the MOH is limited. There is a comprehensive M&E framework for 2012-2016, linked with the HSSDP, providing targets, (but unfortunately baselines and results are not regularly recorded). MOH has a Research Agenda in place and some research applications have been submitted.

Financing the HSSDP shows some positive developments, like the introduction of modest cost recovery and limited private practice in the hospitals (with exemption mechanisms in place). There are signs of improved availability of funds and the annual (upfront) funding of the health sector by the MOF improves predictability. Given the extremely low resource base in which the health sector operates (estimated at US\$ 6 per person per year in 2012), its achievements in terms of improved health of its population are outstanding and a shining example for many countries on the continent.

Challenges

These many achievements do not imply that there are no challenges to address. In this executive summary we will just mention the most important ones. More detailed challenges have been mentioned in the respective chapters of this report.

In the area of service delivery, the main challenges are the low use of Skilled Birth Attendants (SBA), with figures varying between 35 - 55%, the Family Planning services that are available but hardly used (10%) and the very high EPHS 2010 figures for malnutrition (50% stunted and 39% underweight) that should have caused alarm in all nutrition-related sectors. The rising importance of the NCDs will have important consequences in all the other systems, like staff and training, drugs, equipment and laboratory services and finally also in the indicators for the NCDs and the allocation of financial resources.

In the area of systems strengthening, important challenges are shortages in technical and support staff; training in management of hospital heads; limited tools to monitor quality of care at the various levels; no standards and guidelines for the procurement of goods and services; absence of a Logistic Management Information System (LMIS); no operational budget for maintenance and an old medical equipment workshop that has limited tools and staff; absence of a health infrastructure development plan; no strategic plan to strengthen medical imaging, diagnostics and radiotherapy, and finally absence of an comprehensive Health Act.

In Planning and HMIS/M&E, the HSSDP does not have a comprehensive situational analysis that brings together all the major features of the sector and thus allows for priority setting and strategic choices. The current M&E framework has hardly been used by the MOH for monitoring the results in service delivery or systems strengthening. Up till now it does rely mainly of the information coming from the various programs, as there are gaps between the various data -sets and the link between HMIS and M&E has not yet been made. There appears significant data gaps in data collection and uncertainty about its reliability (denominator!).

With regard to financing and funding, the HSSDP shows only recurrent expenditure and no investment costs, nor details about spending per region or per area of intervention. Government funding is incremental, limiting the scope for funding of new priorities and interventions. With the general absence of data on Health Care Financing, it is difficult to draw firm conclusions regarding health financing direction for the country. The high Out Of Pocket Expenditure (OOP) could indicate high levels of catastrophic and unmet needs.

Recommendations

The main recommendations from this MTR have been summarised in the table below.

The findings of the MTR team do not suggest the need for revising the current HSSDP.

The short-term suggestions are meant for the enhancement of the implementation of the current HSSDP. The team therefore advises the MOH to consider these recommendations in the upcoming Annual Operational Plans (AOP 2015 and AOP 2016). At the same time, preparatory work should start on the long-term suggestions for the eventual inclusion in the next HSSDP.

Table 1. Summary of main recommendations for the short and longer-term

Recommendations for the short-term (within current HSSDP, to include in AOPs)	Recommendations for the long-term (to include in the strategies of the next HSSDP)
SERVICE DELIVERY	
Expand and improve the work of CHA. Continue to train many different type CHAs (C-Nutrition, C-FP)	Develop a Comprehensive Health Care package Align all program plans to the next HSSDP in terms of timeline, indicators / targets and budget
Accelerate construction of MWH, Expand B-EmONC and C-EmONC	Develop a new FP Policy with focus on spacing Improve Post-Abortion Care (PAC) services
Initiate Research on the three delays	Increase focus on Neo-Natal care.
Initiate Nutrition Prevention Program and strengthen coordination with other sectors	Participate in the development of a National Multi-sector Nutrition Program
HEALTH SYSTEMS	
Initiate a Quality of Care Improvement Strategy for the hospital sector	Develop a Systems Investment Plan, in which infrastructure, HRH, HIS are all included
Develop a health emergency plan for National and Regional levels	Conduct an Institutional review of the MOH and align its functions to the new HSSDP.
Undertake a MTR of the HRH Strategic Plan	Develop a new HRH Strategy; Address HRH attrition; explore non monetary retention schemes
Develop national standards for procurement of goods; Strengthen coordination between PMU and General Services Division	Initiate a Logistic Management Information System (LMIS)
Prepare accreditation of Quality Control Lab. Include Food in the new NMFA bill	Ensure accreditation of Quality Lab

Recommendations for the short-term (within current HSSDP, to include in AOPs)	Recommendations for the long-term (to include in the strategies of the next HSSDP)
Ensure funding for repair and maintenance. Update the workshop with adequate tools Extend survey on HF conditions and update HF Master list	Develop medical equipment policy and establish standard list of medical equipment Develop long-term national infrastructure development plan
Finalise Lab Strategic Policy and Plan (incl NHL)	Develop policy for imaging and diagnostic services
Develop Legislation for NBTS and strengthen open IT data system, aligned to HMIS	Review and update health sector legislation
PLANNING AND INFORMATION SYSTEMS	
Start working on Situational Assessment; Burden of Disease Assessment; STEPS survey; M&E revision; HH expenditure study, NHA, and Infrastructure Assessment.	Align HSSDP with NCD and all national programs Align Planning cycles from 2017 and align HSSDP to the post 2015 UHC Agenda
Initiate a web-based National Data Warehouse for HMIS, Review core set of indicators and develop a meta-data dictionary	Widen stakeholder participation in the HMIS / M&E development of HSSDP
Initiate Annual Review and Planning meetings with all partners	Increase non-MOH stakeholder involvement; Institutionalize decentralised data-analysis and use
Develop HMIS / M&E guidelines and a training plan for in-service training	Implement relevant DHIS-2 modules (GIS)
HEALTH CARE FINANCING	
Design evidence-base transition towards UHC	Develop a Health Care Financing Strategy
Accelerate generation of critical HF information: conduct NHA, do a costing study and a HH living conditions survey	Design progressive pre-payment scheme Involve CSO and FBO in identification of the poor and HH classification
Include key finance indicators in M&E framework	Explore opportunities for Public Private Partnership
Strengthen HCF stewardship in MOH	Improve coordination, harmonisation and alignment of health resources from all sources.

1. INTRODUCTION

1.1. Background to the 2014 Mid Term Review (MTR) of HSSDP

Since independence in 1991 the Government of Eritrea (GoE) has given priority to the provision of health care to its population. Initially, this took the form of annual planning exercises at the various levels of the health care system that addressed the challenge to restore the health of the people that had suffered from war related devastation of essential infrastructure, limited human resources and poor services.

Later, as part of the National Development Goals of the country, the Ministry of Health (MOH) produced its second National Health Policy (NHP) in March 2010. This important document sets a series of clear priorities that aim to (i) strengthen community based health services, (ii) bring facility-based services closer to the people; (iii) strengthen decentralised governance structures; (iv) improve efficiency and quality of care of hospital services and (v) strengthen health sector coordination to enable better participation of all actors whether public or private.

The National Health Policy mentions the following strategic development goals for the sector:

1. Significantly reduce the burden of early childhood illness and improve maternal and child health/development.
2. Control communicable diseases with an aim of reducing them to a non-public health problem.
3. Prevent, control and manage non-communicable diseases.
4. Strengthen cross cutting health programs.
5. Enhance efficiency, equity and quality of service delivery through health systems development.
6. Improve effectiveness of governance of the health system.
7. Introduce a health-financing scheme that protects people from catastrophic expenditures and ensures sustainability of the system.
8. Strengthen sector planning and monitoring capability.

It proposes a Basic Health Care Package (BHCP) that consists of three priority programs: (i) maternal and child health, (ii) control of communicable diseases and (iii) prevention, control and management of non-communicable diseases. These programs are complemented by cross-cutting interventions, being: (i) environmental health services, (ii) health education and promotion, (iii) integrated disease surveillance and response and (iv) disaster preparedness and response and strengthening of Essential Systems.

Based on the NHP, the MOH developed in 2010 a first draft of its Health Sector Strategic Development Plan (HSSDP), that was updated and completed in 2012 thus producing its first HSSDP 2012-2016. The HSSDP aims to implement the National Health Policy through the preparation of Annual Operational Plans, specific for each level of service provision. It provides the guidance and priorities to move from policy to action and sets the overall objectives, strategies, outputs and targets that are to be attained.

Over the last 20 years a lot of progress has been made: impressive reductions in infant, child and maternal mortality, success in the control of communicable diseases, such as HIV/AIDS, Malaria and Tuberculosis and an enormous expansion of the available health infrastructure at Zoba, Sub-Zoba and community levels. The MOH felt the need for a thorough review of the implementation of its HSSDP at mid-term, resulting in the current Mid Term Review (MTR) of the HSSDP.

1.2. Objectives of the MTR 2014

The Terms of Reference (TOR) of the Mid-Term Review (MTR) mentions (Annex 1) that the HSSDP needs to be monitored to ensure that it is still relevant and appropriate to the current context and that the implementation of its activities are proceeding as planned. It is also an opportunity to see how the management and governance of the HSSDP can be improved. More specifically, the TOR mentions the following objectives that are to guide the MTR:

The general objective of the MTR is to assess the implementation of the HSSDP in the first two and a half years of implementation in order to provide the implementers with the necessary information on progress made, challenges faced and lessons learnt to redirect the interventions in the remaining period of the plan. Specific objectives are:

1. To assess the overall progress of implementation of the HSSDP against key set targets during the first two and a half years;
2. To detect gaps, deficiencies and challenges (policy, strategy, institutional input and other implementation constraints) and identify areas for change or modification in planned intervention strategies;
3. To identify strengths and best practices of the plan that need to be further enhanced, opportunities to be seized and threats to be eliminated;
4. To propose tangible and feasible recommendations and adjustment ideas as the way forward to improve the progress of implementation of the current HSSDP as well as to inform the development of the next HSSDP;
5. To review the costing and financing component of the plan;
6. To serve as a learning exercise for the Policy and Planning Department to conduct similar evaluation exercise in the future and also to gain insight into future strategic plan development practices.

The TOR was discussed and adopted by the Steering Committee (SC), tasked to guide and supervise the work of the MTR team. Similarly, a detailed program for the work was adopted (Annex 2), that consisted of two teams undertaking field visits to two Zobas each in week 1 and interviews at central level during week 2. The last week was used for debriefing and consensus building around the main conclusions and recommendations of the MTR.

1.3. Methodology of the MTR 2014

The detailed TOR of the MTR (annex 1) provides a description of the methodology that was adopted by the review team:

1. Based on a pre-established questionnaire (Annex 6, endorsed by the Steering Committee), undertake key informant interviews and discussions with program officers, MOH staff and development partners at all levels of the service delivery system (see Annex 3, people interviewed);
2. Do in-depth analysis of available documents (Annex 4) such as the annual HMIS activity reports, program specific strategic plans, surveys, assessment and reports, etc.
3. Use the format of the Joint Assessment of National Strategies (JANS, Annex 5) to see its comprehensiveness, alignment with program specific strategic plans, the costing and the monitoring components and detect other strengths and weaknesses that the JANS would reveal;
4. Hold consultative and periodic progress update briefing meetings with the Steering Committee and consensus building workshops with all the stakeholders at the end of the review.

The MTR was conducted between the 3rd till the 19th of November 2014.

1.4. Limitations

This MTR acknowledges various limitations, the most important ones being:

- The methodology used for this MTR is extensive and demanding. With only four full time team members, together with temporary reinforcements in the important areas of Hospital Care and Health Financing / Budgets, the findings of the MTR team might not have been as detailed as desired.
- The relative short duration of the field visits (just 4 days), forced the team to meet only a limited number of Health Facilities in the four Zobas. The team was not able to visit the more remote areas, due to distance and time constraints. Such limitations might have biased our findings.
- Unfortunately, it was not possible to meet all the divisions and units we would have liked to meet. For example we have not met the Head of the Malaria program, Pharmacy division, Transport Unit and the Responsible for IDSR.
- Figures, as available from the various National and Program reports were not always consistent, due to incomplete reporting and other inaccuracies. A comprehensive list of data with baseline and targets for the annual action plan was not available. In addition, the team received the complete Monitoring Framework or Budget of HSSDP quite late. This limited a full review of the status of HSSDP implementation. This issue is discussed in more detail in the chapter on HMIS / M&E.

- There was only limited information available on the private and NGO sector. These limitations should be taken into account when reading the findings in this MTR report.

1.5. Composition of the MTR Team

Name	Organisation	Responsibility
Prosper Tumusiime	WHO	Team leader, Systems & Governance
Jarl Chabot	Free lance consultant	Service Delivery and programs
Arthur Brookes Heywood	Free lance consultant	HMIS and M&E
Harris Benito Koubemba Mona	WHO	Statistician, HMIS and M&E
Diane Muhongerwa	WHO	Economist
Humphrey Karamagi	WHO	Hospital Care & Health Financing
Mr Semere Gebregiorgis	WHO	Health Systems
Tewelde Yohannes	MOH, Director Policy & Planning	Organisation, field visit
Tsegai Berhane	Head Planning Unit	Organisation, field visit
Andeberhan Tewelde	Head M&E Unit	Field visit

All the members of the MTR team worked in their individual capacity and provided independent advice as mentioned in this report.

1.6. Structure of the report

In the first pages, this report provides an acknowledgements, a list with abbreviations and a summary table with essential indicators of the HSSDP that present the baselines (years 1995, 2002 and 2010), and the targets and results for the years 2012, 2013 and half 2014 with the available targets for HSSDP 2016, being the end of the HSSDP. While incomplete, the table still provides a good overview of what has been achieved.

After these first pages, the structure of the report follows closely the structure of the HSSDP. After this introduction, it starts in chapter two to discuss the Basic Health Care Package (BHCP) with all its priority interventions in the field of Maternal, Neo-Natal Child Health and Nutrition, Prevention, Control and Management of Communicable and Non-Communicable Diseases and the various Cross-cutting interventions.

After discussing the findings in Hospital services and Emergency care (chapter three), all the major Essential Health Systems, including Governance are presented and analysed in chapter four for their achievements, challenges and suggestions for improvements in the short and long-term.

In chapter five Planning, Health Information Systems (IS), Sector Monitoring & Evaluation and Research is discussed with a focus on indicators and what needs to be done to improve the various data sources. Finally, in chapter six the important topic of Health Care Financing and funding is presented, with details on financing, funding and budgeting and with a summary of the recommendations in that area.

Several Annexes will be found at the end of the report.

2. BASIC HEALTH CARE PACKAGE (BHCP)

The HSSDP introduced for the first time in 2010 the concept of the Basic Health Care Package (BHCP), consisting of a set of priority interventions that are meant to address the various challenges the sector is confronted with within the four core interventions: (i) Maternal and Child Health and Nutrition, (ii) Prevention, control and management of Communicable Diseases and of (iii) Non-Communicable Diseases. Together with (iv) Cross-cutting Interventions and the strengthening of the BHCP Essential Systems, the MOH expects to reduce morbidity and mortality in the country. While partly based on the six building blocks as defined by WHO, this conceptual framework is not yet clearly linked to a comprehensive situational analysis of the major health determinants within the epidemiological, political, socio-economic and organizational context prevailing in the country. According to the JANS guidelines (attributes), such an analysis is expected, using disaggregated data to describe progress towards achieving health sector policy objectives, such as • Universal coverage, to improve health equity • Service delivery, to make health systems people-centred • Public policies to promote and protect the health of communities, and • Leadership to improve competence and accountability of health authorities.

While the overall strategic objectives of the BHCP have been defined together with their strategic orientation from the National Health Policy (NHP), unfortunately, they are not always measurable, realistic and time-bound. Interventions of the BHCP, presented in the HSSDP do not systematically address the priorities of the sector in the context of access, equity, efficiency and quality for all population sub-groups, especially vulnerable people. The HSSDP does include a monitoring framework, but the most important objectives of the various programs are not always linked to measurable indicators or results for the relevant service delivery and systems related interventions.

The MTR team has tried to bring together in a systematic way the most important indicators for all interventions and systems as mentioned in this HSSDP, including the baselines of DHS 1995, DHS 2002, the EPHS 2010 and the targets versus results for 2012, 2013 and half of 2014 with the available targets for 2016, being the end of this HSSDP (Table 1. Essential indicators and targets HSSDP 2012-2016). The Table thus provides an overview of achievements and remaining challenges for the sector, looking at reliable baselines (for 1995, 2002 and 2010) and comparing them with the targets and results of the last 2,5 years (2012, 2013 and half 2014).

2.1. Maternal, Neonatal and Child Health Care (MNCH) and Nutrition

According to the HSSDP, the BHCP of the MNCH and Nutrition interventions consist of safe motherhood, ANC and PNC, adolescent and reproductive health, FP and prevention of unwanted pregnancies and STI, reduction of Female Genital cutting (FGM), reduction of domestic and sexual violence, IMNCI (both at facility and community levels), EPI and Nutrition interventions.

The HSSDP document mentions 8 specific objectives (p. 23), some of which with expected output figures, but others without a reference to baseline or targets (adolescent birth rate, unmet need FP, EmOC). The situational analysis on these interventions is quite limited and does not give the context in which services like adolescent RH, abortion or domestic and sexual violence are provided.

2.1.1. Maternal Health and Safe Motherhood

The Maternal Health Program (Safe Motherhood) has been very successful in reducing the Maternal Mortality Rate (MMR) from the extremely high 998/100,000 in 1995 (DHS) to 752/100,000 in 2002 (DHS) to 486/100,000 in 2010 (EPHS)², thus likely to reach its MDG target (being a 75% reduction in MMR since 1995) of 350/100,000

² The IMR and MMR figures in this report are based on population-based data (DHS and EPHS). Recent WHO figures from 2013 have not been included, as these have been produced based on a different methodology, making trends analysis less reliable.

even before 2016. Some of the contributing factors to reduce MMR, such as deliveries by SBA 35%, ANC first attendance, ranging between 56% and 90%, while the HFA gives 57% readiness to provide ANC (HFA 2013). These figures might have been influenced by the uncertainty of the total population in the country (uncertain denominator) and incomplete / unreliable HMIS figures. It is clear that the low MMR figure is a remarkable achievement, explained by the strong support from the Government, the good referral system and the increasing important role of the community health committees and the health promoters in the villages.

For the MOH this achievement is an extra stimulus to give even more priority to reduce the MMR further in the coming years, as the 350/100,000 is still far too high to be acceptable. Focus will be on: (i) expanding infrastructure (HS) to areas where there is limited access to services (define catchment area for each health facility), (ii) expand and strengthen the community health promoter (first delay) and the role of the VHC (Supervision); (iii) expand Maternity Waiting Homes (MWH) as a formal policy; (iv) improve transport for emergency cases; (v) increase the number of staff with Life Saving Skills (LSS); (vi) ensure that for every 500,000 population there are four facilities offering BEmOC and one Hospital providing CEmOC and (vii) use and review the Maternal Mortality Audits. With regard to Peri-Natal mortality, the team suggests to undertake a national review into this topic.

Currently, expanding availability of EmONC facilities is underway (including staffing and renovation) in several Community Hospitals, based on criteria like population density, distance from next referral level, transport availability and communication facilities. The MTR team suggests to include in the preparatory work for the next HSSDP the development of an Infrastructure Development Plan that defines realistically the functions of the various facilities (CH, HC and HS), the population with their catchment areas, the staffing norms, and the transport / referral possibilities (mountains, rivers). Several scenarios for the different Zobas have to be made that will include the expected costs and benefits.

With regard to **Gender**, little is mentioned in the HSSDP and thus little is reported within the reports available from MOH. But important developments have improved the gender situation in the country. With support from other Ministries and various women organisations, gender equality has improved (although a lot still needs to be done), discrimination on women in HIV/AIDS is reducing, MMR, FGM and Early Marriage all show substantial improvements. MOH should include a special section on its plans in gender when drafting the next HSSDP.

Family Planning and abortion

While Total Fertility Rate (TFR) has gone down since 1995 from 6.1 to 4.8 in 2002, it has remained stagnant at this level till now (EPHS, 2010). This is understandable, as up till recently Family Planning (FP) services have not been actively promoted in the country. Most commodities (condoms, oral contraceptives and Injectables like Depo) are available in about 77% of all (public) health facilities, but according to the Health Facility Assessment (HFA 2013) only 24% of staff has been trained to provide FP services. Perceptions that FP services imply to limit childbirth rather than promote spacing are reportedly widespread among health professionals and the population. The Family & Reproductive Health Unit intends to give a boost to FP services in the next HSSDP, (i) introducing Community-based distributors at village level, (ii) training nursing staff and health promoters in good FP practices and (iii) focusing its FP campaign on spacing (for 24-36 months), thus contributing to further reducing maternal mortality.

Abortion and Post Abortion Care (PAC)

According to the director of the Family & Community Health (FCH) Division, unsafe abortions take place quite frequently and implies a serious risk for the woman, as it is known to contribute substantially to MMR. In Eritrea, abortion is illegal, unless there are circumstances that allow an abortion to take place:

- The woman is less than 18 years old
- The person who made her pregnant is a family member
- The woman suffered rape
- The health of the woman is in danger (bleeding)

In these circumstance the doctor is authorised to do an abortion and Post-Abortion Care (PAC) is available in all the Zonal hospitals. The MOH intends to expand its FP program and thus hopes to help reduce the incidence of illegal abortions in the country. There is a clear need for research to ascertain the level of unsafe abortions and their impact on the current MMR figures.

Female Genital Mutilation (FGM)

FGM has not been well addressed in the HSSDP, while outstanding achievements have been made. Just some 10 years ago, FGM was still widely practiced in many (rural) parts of the country with a prevalence among adult women of 95%. Together with other Ministries and women organisations and through widespread sensitization campaigns, the FGM prevalence among children less than 15 years is now 32% and among children less than 5 years just 23%. The MOH intends for the next HSSDP to introduce a new FGM related indicator, being the % of FGM free villages. Some 20 villages will declare themselves FGM free before the end of the year.

The prevalence of **Fistula** in Eritrea is estimated at 0.34/1000. Recently a Fistula Hostel has been constructed (adjacent to Mendeferra Referral Hospital), where the complex Fistula cases receive the complex surgical care they need. Non-complicated cases are treated in the existing Obstetric departments. Since 2003 more than 1000 cases have received the required surgery.

2.1.2. Child Health and EPI

The Child Health Program and the Expanded Program on Immunizations (EPI) together have contributed substantially to the very successful reduction in Infant and Child Mortality. IMR was 72/1000 in 1995, 48/1000 in 2002 and 42/1000 in 2010 and is likely to reach the target of 20/1000 in 2016. Similar impressive figures can be presented for the U5MR, being 136/1000 in 1995, going down to 93/1000 in 2002, and 63/1000 in 2010. It seems the target for 2016 of 49/1000 is well within reach. While these impressive results can be partly credited to these two programs, there are many other contributing factors that need to be mentioned, such as the motivated and well trained staff, expansion of facilities (HS, HC), good linkages with the communities and adequate supervision.

The Child Health Program consists of i) Facility IMNCI by well trained health staff, (ii) Community IMNCI by the Community Health Agents (CHA) in the villages and (iii) by strengthening several health systems. Together they are a proven strategy for effective child survival that addresses the major causes of under-five morbidity and mortality (such as Diarrhoea, ARI and pneumonia, Malaria, Worm, Malnutrition, and poor Iron and Vit. A supplements). The Health Facility Assessment (HFA 2013) found that 87% of facilities offered child curative services and 90% offered growth monitoring. Diagnostic capacity was high (Malaria RDT 90%, Growth Charts 84%), guidelines were available almost everywhere and life-saving drugs (Amoxicillin and Co-Trimoxazole) were present in 89-92% of the facilities. No information was available on the work in the C-IMNCI or on the strengthening of the relevant systems. In the first half of 2014, the HMIS registered 50 child death for Pneumonia and 21 child death from Diarrhoea. Finally, it is important to mention that Neo-natal units have been established in hospitals across all Zobas.

Adolescent & Youth Reproductive Health Services have been initiated recently in the country under the guidance of the Child and Adolescent Health Unit (CAH). Plans have been made to start in the North Red Sea Zoba to acquire experience. A standard package of Adolescent and Youth Reproductive Health Services has been defined, that includes a separate corner for AYRH Services. Collaboration and coordination is ensured with the Ministry of Education. No indicators and targets have yet been defined, but this will become part of the next phase of the HSSDP.

The Expanded Program on Immunisation (EPI) has achieved remarkable successes over the last years, maintaining a coverage for Penta 3 of 74% and for Measles of 75%. The 2013 Coverage survey showed a crude coverage of 94% of the U5 Children (= show card and history), while 99% appeared fully immunized in 2012 against 98% in 2009. The EPI Unit has already introduced ROTA Vaccine in 2014 and plans to start Measles/Rubella Vaccine in 2015 and Pneumococcal Conjugated Vaccine (PCV) at a later date. Polio National Immunisation Day (NID) is conducted nationally to prevent the spread of wild Polio virus. The available HMIS figures do not provide information on the coverage of children that are fully vaccinated or the coverage of Pregnant Women vaccinated for Maternal Neo-natal Tetanus (MNT). Financial support to the EPI Unit comes from GAVI for the new vaccines and from JICA for the cold chain and solar panels.

2.1.3. Nutrition

While most programs of the Family and Community Health (FCH) Division show good and sustained results, this is unfortunately not the case for the Nutrition program. The National Sentinel Site Survey (NSSS August 2013) shows disturbing figures of more than 50% stunting (Height for Age) and similar figures for underweight (Weight for Age) between 45 - 63%. Nutrition is a multi-sector problem. The MOH could play a very important and active role in addressing this distressing situation in close collaboration with the agricultural sector and with the MND. It could stimulate local food production and use of fish in the diets (more than the use of Unmix, Plumpy-Nut, F-75 and F-100, Resomal or BP5) to malnourished children. The indicators of the Community-Based Therapeutic Feeding program (CBTF) show good results (mortality just 1% and cure rate 83%), while the regular use of Weight Charts and providing adapted nutrition advice could be more highlighted. The elaboration of a National Nutrition Program (NNP) with involvement of all stakeholders and other Ministries seems a topmost priority. The MOH is working diligently with other sectors to implement an integrated nutrition strategy to reduce the high levels of (mal)nutrition. In addition, at HF level the charting of all children that visit the F-IMNCl on ONE Weight chart on the wall would be helpful to show the nutritional status of the catchment area of the facility. The promotion of food gardens in the compound of the health facilities could provide a welcome addition to enrich the daily food consumption by the population. In the various reporting formats, there is no mention of any Breast Feeding (BF) indicator (exclusive and within one hour). These should be included as well as children not gaining weight.

2.2. Prevention, Control and Management of Communicable Diseases

Time-wise the HSSDP **2012-2016** will be revised and renewed in the coming year (2015/16) with the objective to have a new (and better) HSSDP II ready with the suggestions of a JANS included and approved by Government by the end of 2016. Ideally, the various programs operating in the country should in that period develop their own Strategic Plans and in this way become fully aligned with the Sector Strategy. At the moment such alignment is not evident as the various specific disease programs (HIVAIDS, TB, Malaria and Neglected Tropical Diseases (NTD)) all have a time-frame going from 2015 till 2019, thus moving with three years difference. While objectives and strategies might be consistent between the programs and the HSSDP, issues like the monitoring framework and the budget elements are quite different and will be difficult to align. In discussion with the CDC Division, the welcome suggestion was made to ask the various disease programs to re-program their intervention in the year 2016, so that a joint start could be made with a common M&E framework and an aligned budget at the beginning of 2017.

2.2.1. HIV/AIDS and STI

The HIV Epidemic in Eritrea is characterized by a 'generalized' epidemic among the mainstream population, and a 'concentrated' epidemic among specific key populations at higher risk. Since the adoption of the first strategic plan in 1997, the national HIV prevalence has steadily declined. Four sentinel sero-prevalence surveys conducted among pregnant women attending ANC services since 2003 show that HIV prevalence decreased from 2.47 % in 2003 to 2.38 % in 2005, 1.33 % in 2007, 1.31% in 2009 and 0.79% in 2011. The results of the Eritrea Population and Health Survey 2010 (EPHS 2010) indicate that 0.93% of Eritrean adults age 15-49 are infected with HIV with variations in age, sex, residential area and Zoba (0.28% for the 15-24 age group). This consistent and steady decline in HIV prevalence triggered the following aim of the fourth Eritrean National AIDS Strategic Plan (ENASP IV, 2012-2016): "*Deliver maximum results towards universal access and zero new HIV infections, zero discrimination, zero AIDS-related deaths*". ENASP IV expects to realize a significant reduction of the national HIV prevalence in the general population from 0.93% (EPHS, 2010) to less than 0.5% in 2016.

In the first six months of 2014, a total of 36,750 pregnant women attended ANC, 33,400 of these women were tested for HIV through PMTCT and 91 of the women tested HIV positive, yielding a very low HIV positivity rate of 0.27%. These impressive figures do not disguise the fact that there are some 7300 HIV+ patients already on treatment and some 385 that started in the first half of 2014. Similarly, the HFA 2013 gives as readiness to provide HIV care and support services just 60%, the main reason being the availability of intravenous treatment for fungal infections just 40% and guidelines for palliative care 48%. Also the training of staff in the clinical management of HIV (70%) can be improved, while readiness to provide PMTCT services (just 60%) also needs special attention in the future.

The **latest STI study** conducted in 2011 showed syphilis prevalence of 0.49% in pregnant women, a decrease of 69% from that of 2003 which was 1.6%.

These overall positive figures indicate the need for a thorough change in the current approach, moving from a 'generalized' epidemic towards 'focused' epidemic, where specific attention is given to Commercial Sex Workers (CSW), Truck drivers and prison inmates. Given the substantial cost implications to sustain the current program, changes have to be made to reduce costs in BCC, in testing and other interventions, while maintaining the excellent work that is being done.

The start that has recently been made to integrate data collection in the overall HMIS and not rely anymore on the previous program specific data collection seems an important step in the right direction of more integration in the national health system.

2.2.2. Tuberculosis

The current National TB Control Program (NTCP) is based on the second TB Strategic Plan covering the period 2010-2015. The goal of the program is to accelerate progress in reducing TB-related morbidity and mortality towards reaching national, regional and global targets, including Universal Access and the Millennium Development Goals (MDGs). Since January 2014, the NTCP is implementing Phase II of the GF Round 10 grant. As this second phase of the grant is coming to an end next year, the staff has started to develop the next TB strategic Plan for the period 2015-2018 taking the post 2015 WHO Strategy into account.

In 2012 an external review was conducted by a WHO team of experts, who concluded:

1. The Eritrea TB Control Program has made significant progress on some key program performance indicators, especially treatment success rate for new smear positive TB cases which reached 88-89% in 2008 and 2009 before declining slightly to 84.3% for the 2010 treatment cohort.
2. Overall TB case notification rates have declined by an average 2% per year from 111.3 / 100,000 population in 2005 to 81.3 in 2011.
3. All Zobas have well-developed TB DOTS systems spanning referral hospitals, community hospitals, Health Centres, health stations and peer groups across the country.
4. TB laboratory services are gradually expanding to lower levels and are supplemented by initiatives to facilitate fixing of sputum slides at peripheral levels that are then forwarded to microscopy centres.
5. Proportion of TB patients tested for HIV is high and increasing.
6. There has been uninterrupted supply of first line and second line anti-TB medicines at all levels and a standardized recording and reporting system is being implemented across the country.
7. There is virtually universal facility coverage for DOTS, together with C-DOTS in many villages.

Finally, according to the 2012 WHO Global TB report, in 2011 the incidence of TB in Eritrea is 93/100,000, less than the global average of 125/100,000. Prevalence is 152/100,000 and TB mortality is reduced to 4.7/100,000 from 12/100,000 in 1990.

These positive achievements have continued in the last two years, resulting in (i) a total of 1,228 notified cases in the first quarters of 2014 (less than the 1,493 cases in the same period in 2013); (ii) a cure rate of 89.8%; and (iii) a treatment success rate of 99%.

Screening of TB patients for HIV increased substantially and reached 89%. ART uptake among TB-HIV co-infected patients reached around 50% from a mere 17% in 2013. In June 2011, a MDR / TB Centre was established in Merhano and Asmara. Between June 2011 and June 2014, 105 patients have been admitted for second line anti-TB treatment, 35 were confirmed cases. The prevalence of MDR-TB among new cases in Eritrea is 1.8% and among re-treatment 19%. The National Health Laboratory (NHL) has resumed culture and drug susceptibility testing (DST) since late 2013.

However, it is not time for complacency: The HFA shows several gaps in the available TB services, such as 70% of staff trained in TB control, 64% trained in HIV/TB co-infection, only 45% presence of TB guidelines and - most worrying - only 19% presence of All first line TB medication. Together the absence of these tracer guidelines bring the readiness score to provide TB services at 61.5%.

2.2.3. Malaria

The National Malaria Control Program (NMCP) was established in 1995 and has developed 3 Strategic Plans. It is currently finalising the Fourth Malaria Five Year Strategic Plan 2015-2019 (draft). A lot has been achieved over the last years, such as:

- The HF staff including Malaria Technicians and public health technicians (PHTs) at the sub-zonal level are responsible for the implementation and coordination of all malaria control activities. They are the supervisors of the Community Health Agents who are responsible for malaria control at the community level. A total of 4,067 CHA have been trained.
- Linkages for coordination and collaboration with other ministries, national associations and communities have been started, so that control activities are broadened and ownership is shared among all stakeholders.
- There are convincing indications that malaria incidence is sharply declining from 53.5 cases/1000 population at risk in 1998 to 4.78 cases/1000 population in 2012. However, small epidemics could be missed, hence the increase of sentinel sites from 26 in 2008 to 32 in 2014.

These achievements make the NMCP confident enough to subtitle their program "Moving towards Malaria Elimination", stating the following Goals and Objectives for 2014-2018:

Reduce incidence of malaria cases and deaths by 75 % from 2010 levels by 2018 and bring Test Positivity Rate below 5% required for pre-elimination by end of 2016.

Its objectives are:

1. By 2018, 100% of fever cases presenting to health providers shall be promptly tested for malaria, and 100% of the confirmed malaria cases treated according to national guidelines.

2. By 2018, 100% of population at risk of malaria should be covered by effective, appropriate and quality assured vector control methods.
3. By 2018, strengthen malaria surveillance system in light of pre-elimination; and detect and respond to 100% of malaria epidemics within two weeks of onset.
4. By 2018, increase proportion of people utilizing malaria control interventions by 50% from 2012 levels (ITN use, early treatment seeking behaviour, participation in source reduction).
5. Develop requisite capacity in program management at all levels in order to achieve malaria pre-elimination objectives

As the MTR team had no chance to meet with the Malaria Program managers, their challenges could not be recorded. From the 2013 HFA, the team noted several imperfections that the NMCP will need to address, such as only 65% readiness among the HF to provide Malaria services, guidelines and training for IPT 62% and availability of ITN just 59%. Also during the field visits, it became clear that the provision of ITN was many years ago and that new impregnated ITN were eagerly awaited.

2.2.4. Integrated Disease Surveillance and Response (IDSR)

The main task of the IDSR program is the surveillance of the priority communicable diseases. Weekly and monthly routine reports are sent from the facilities up to (Sub)Zoba and on to the national level. Priority diseases are reported to MOH while epidemics and suspected cases are investigated.

The most important regular activities are:

Polio and AFB Surveillance: Only South Red Sea achieved a Non-Polio detection rate of > 2/100,000 cases per population of < 15 years.

Measles Surveillance: Out of 77 suspected measles cases, only one was positive for Measles IgM and 26 were positive for Rubella.

Maternal Mortality Audits are also conducted by the unit, but its status could not be assessed.

MOH has a strong focus on NTD's, but its performance could not be verified.

2.3. Prevention and Control of Non-Communicable Diseases (NCD)

From the available statistics, it is clear that NCD are on the rise and rapidly changing the balance between CDC and NCD, partly due to the impressive results in the reduction of HIV and AIDS, TB, Malaria, Childhood diseases and EPI related morbidity.

However, the monitoring of the NCDs still leaves a lot to be desired. A comprehensive situational analysis should be made for the NCDs as a group to establish the priorities to be addressed, define baselines and targets and the indicators to be collected regularly within the HMIS. In this way the challenges in these NCDs in treatment and prevention (HR, resources and capacity building) can be addressed in a coordinated and cost effective way.

Below the most important features of the NCDs in the country are presented:

2.3.1. Major Chronic Diseases (MCD)

Among this group of NCDs, the most important are: (i) Cardio-vascular diseases , Chronic Respiratory diseases, Hypertension, Diabetes and the various Cancers. For all of them a survey has been done about the risk factors that will lead to these diseases, the most important being: smoking, excessive alcohol, little exercise and poor diet. Strategic Plans have been made and Prevention and Treatment of these diseases can be done within the country. Only Cancer patients have to go abroad, but not for long, as an Oncology Centre has been planned.

2.3.2. Blindness and Trachoma Prevention

A fully equipped Eye hospital exists in Asmara that can take care of all blindness related illnesses.

Trachoma is limited to a few pockets in the country where there is a high prevalence. Prevention has started with mass drug administration. In 5 of 7 sub-zobas, good results have been obtained and mass treatment will be repeated in the remaining sub-zobas. Finally, cataract surgery is undertaken with some 6000 already done out of the 8000 interventions planned for 2014.

2.3.3. Injuries and accidents

Injuries account for some 12% of all NCDs, being mainly road accidents, but also violence, burns and disabilities. Collaboration with Ministry of Transport and the Police exists. Together a Strategic Plan has been made that will be implemented in the coming years.

2.3.4. Mental Health

A KAP survey has been done that showed psycho-somatic disorders as the most common psychiatric ailment. Post Traumatic Stress has gone down over the last years. There still exist a lot of stigma related to these diseases. There is a psychiatric hospital in Asmara, but there is no national psychiatrist. A psychiatric Practitioner and other experienced staff have started the training of psychiatric nurses.

2.3.5. Oro-Dental Health and ENT

Attention for this NCD has started only 2 years ago. There is no Strategic Plan yet. WHO has been asked for support to set up a Dental unit (with one dentist in the country) and an ENT unit (with two ENT specialists in the country). Dental practitioners are providing the required care at the moment.

2.4. Cross-Cutting Health Interventions

2.4.1. Environmental Health Unit

The Environmental Health division, under the Department of Public Health, is composed of (i) Sanitation and Hygiene, (ii) Occupational Health and Safety, (iii) Vector and Epidemiological control and (iv) Quarantine and Inspection, the latter being reinforced by International Health Regulations (IHR), but not (yet) included in the HSSDP. Within the Organogram of the MOH, the IHR is part of the Quarantine and Inspection unit.

The latest policy of the environmental health was drafted in 1998 and is thus grossly outdated. The unit plans to develop a new updated policy that will guide its priorities and interventions under the next HSSDP. In the meantime, it has conducted in October 2012 a nationwide assessment of water, sanitation and hygiene facilities in the health facilities. The report mentions relevant figures on catchment areas, average daily number of visitors per type of HF, availability water and sanitation per HF etc.

Currently, its most important interventions are in the area of (rural) Community Led Sanitation (CLS), in which villages are triggered and sensitized to make latrines (of their own choice) and together make their village "Open Defecation Free (ODF)". Currently, already 554 rural villages have been declared ODF out of the 2,666 villages in the country (21%). The program intends to expand to the urban areas of Asmara and the Zoba capitals and awaits support from Urban Habitat (not represented in the country) through UNICEF. In addition other hygienic measure are promoted, such a hand washing, use of safe water (Wash promoters), ventilation in the cooking quarters and rising concerns around air- and water pollution (plastic).

2.4.2. Health Promotion Division

The aim of the division is to promote positive behaviour change for the improvement of people's health. There are three units under the Division that (i) develop IEC material and make informative programs on Radio and TV, (ii) conduct training at various levels and (iii) supervise the many activities by the health promoters and Health Agents / peer groups that operate in the communities under the supervision and guidance of the staff in the HC/HS.

The division is increasingly confronted by the double burden of disease, being the reducing infectious diseases and the increasing number of non-communicable diseases.

In Sept 2006, the division developed a Health Promotion Policy that it considers to be outdated.

In Nov 2011, a Strategic Plan 2012-2016 was developed that has recently been external reviewed. Based on these recommendations, it is expected that the division will develop a new Strategic Plan and also a new Health Promotion Policy that will take the changes in the morbidity pattern (NCDs) into account.

2.4.3. Quality of Care

The HSSDP aims at ensuring that the people of Eritrea get quality health services. A quality assurance and supervision unit was established in the Nursing Division and this unit undertakes supervision of health service delivery in hospitals, using quality assurance checklists at least twice a year at sub-national level and at least four times at central level. There is a training unit in the Nursing Division that builds capacity in this area.

Infection prevention and control is an important aspect of quality of care and checklists for infection prevention and control are used to monitor quality of care. However, the infection prevention and control guidelines are yet to be developed.

It is recommended that quality assurance be strengthened by extending the quality assurance teams beyond the nursing division. Consideration should be made for establishment of a national quality assurance program that brings together expertise from different disciplines and that has access to necessary resources and logistics to ensure regular continuous quality improvement.

2.4.4. Supportive Supervision

Support supervision is being provided at all levels using checklists. Two types of support supervision are being carried out, being focused supervision and integrated support supervision. For example, focused supportive supervision was conducted in first half of 2014 in selected hospitals of Zoba Semenawi Keih Bahri (Massawa, Maihimimet, and Afabet) and Gash Barka (Agordat, Barentu, Haikota, Tesenei and Goluj). The supervision of the lower health facilities is done by the Zoba medical team as well as by programs at Headquarters. After each supervision, a supervision form is filled, gaps are identified and actions recommended. Verbal and written feedback is provided by the supervising teams of each program and the recommended actions are reviewed at subsequent visits. However, the visits to the health facilities by the review team showed that some of the peripheral health facilities have not been supervised for periods of up to 5 months. There were also correctable errors and technical gaps that could easily have been handled by supervision visits.

Challenges to supervision revolved around shortage of transport, either due to limited availability of vehicles or in most cases shortage of fuel.

Given the importance of support supervision in improving the effectiveness and quality of health services, priority should be given to providing the Zobas with adequate transport and access to fuel to ensure regular supervision visits and follow-up.

2.4.5. Disaster Preparedness and Response

Initial work has recently started on disaster risk management with assistance from WHO. Through a network of hospitals, mass casualty preparedness has been enhanced with equipment for telephone and fax communication. The network of hospitals has been put on alert in case of mass casualty and where human resources and transport are not adequate, the transport and human resources from central level would be mobilized to support management of mass casualty. At the national level, arrangements are in place to mobilize helicopters where necessary. However, an emergency and preparedness plan is not yet developed. On the other hand, disease outbreak response arrangements including response teams and committees at all levels are in place. There are weekly IDSR reports sent to Zoba and HMIS at central level for early detection of any abnormal occurrence of diseases or sign of a disease outbreak. For malaria, threshold incidence is monitored and reported.

The Ministry of Health should continue to work on the disaster risk management and finalize development of the emergency preparedness and response plan.

3. HOSPITAL, EMERGENCY and INTEGRATED ESSENTIAL MEDICAL CARE

3.1. Hospital Services

There is a network of 28 hospitals (27 public and 1 private), comprising of 5 national referral hospitals, 6 Zoba regional referral hospitals, 4 first contact hospitals and 13 community hospitals. The regional and national referral hospitals have specialist doctors. They offer a variety of specialized services. The table below shows the kind of services offered at the different referral hospitals:

Table 2. National Hospitals with their specializations

Name of Hospital	Services Provided
Orotta Tertiary Referral Hospital	Surgery, internal medicine, Obstetrics & Gynaecology, Paediatrics; Cardiac surgery; dialysis; ENT; Physiotherapy; Emergency care; Intensive Care
Halibet Hospital	Orthopaedic surgery; burns centre; surgery; internal medicine; emergency care
St Mary Hospital	Psychiatric health services
Berhan Aini Hospital	Ophthalmic (eye) services
Hazhaz Hospital	Merhano TB MDR Hospital - Treatment center for multiple drug resistant TB patients and General hospital services

Although the HSSDP aims at introducing private wings in hospitals, this has not yet happened. Rather, for the last 2 to 3 years private practice has been introduced in public health facilities. The private practice starts after 5pm in public hospitals. It is reported that the current private practice in public health facilities tends to compromise quality of care in the hospitals. The private practice is now managed by a separate office headed by a general manager and is legally recognized as a Private Limited Company (PLC).

One of the challenges for hospital services is management. Many people heading the hospitals have got some sort of management training albeit not hospital administration training. At the national referral hospitals, reported challenges include shortage of health workers and supporting staff, including lack of technicians like electricians and plumbers, worn out x-ray, autoclave machines in Halibet hospital, long waiting list for operation in Orotta hospital and problems of sanitation and cleanliness of Orotta hospital in general and the department of paediatrics in particular. As for the regional referral hospitals, reported challenges include shortage of water supply in Mendeferra and Hazhaz hospitals, limited wards, inadequate pharmacy store, absence of incinerator in Hazhaz hospital, shortage of laundry machines in Barentu and Ghindae hospitals, non-functional blood chemistry analyzer machines in Mendeferra and Keren hospitals, old x-ray machines in Halibet, Keren and Mendeferra hospital, worn out autoclave machines in Halibet hospital, and shortage of transportation means in Ghindae, Keren and Hazhaz hospitals.

On the other hand, a list of basic emergency diagnostic equipment for national and regional referral hospitals has been prepared and distributed to all. An assessment of emergency services was also conducted in six regional referral hospitals as part of a process to have a base line document of the status of emergency services in health facilities. Furthermore, a draft document with definition of functions of various levels of health care delivery has been developed, and circulated for comments and amendments to be finalized after a consensus building workshop. A draft policy guideline and strategic plan on patient safety has also been developed.

3.2. Emergency Medical Care and Referral Network

The emergency health services are aimed at ensuring effective emergency services in all hospitals with appropriate capacity of health professionals in trauma care. It requires strengthened pre-hospital and hospital emergency services delivery capacity based on standardized medical and surgical emergency care services in hospitals and lower health facilities.

Originally the MOH did not have a medical emergency services unit but has one now. Emergency units have been established in all hospitals headed by a medical doctor and in some health centres. They are equipped with human resources and diagnostic equipment. Obstetric emergency persons, trained in life saving skills and Caesarean section surgery, are increasingly found in these health facilities. Technical guidelines and training materials have been developed and training has been cascaded to zobas.

A list of basic emergency diagnostic equipment for national referral hospitals has been prepared and submitted to the project management unit for procurement and an assessment of emergency services conducted in seven regional referral hospitals as part of the process to have a base line document of the status of emergency services in health facilities. In addition, training was conducted in Zoba Debub and Gash Barka and for ICU and emergency services staff in Orotta hospital on emergency services. In preparation for the upgrading of emergency services in health facilities, infrastructure assessment was conducted in Massawa, AdiKeih, and AdiQuala hospitals.

The referral network is in place following the three-tier health care delivery systems in the country, namely the primary level (186 health stations, 53 health centres and 13 community hospitals) where community hospitals act as first referral centres, the secondary level (zoba regional referral hospitals and the first contact hospitals) where regional referral hospitals are second level referral centres, and the tertiary level with the national referral hospitals. Health services referral policy, guidelines and protocols have been developed to guide the referral services to ensure continuum of care. However, the policy, guidelines and protocols were found only at the Zoba medical office and had not reached the sub-zobas and lower health facilities.

An assessment of the status of the emergency units in health facilities should be undertaken to identify the gaps in necessary requirements to make them fully functional. The costs for these requirements should be budgeted for in the remaining years of HSSDP. The Zobas should embark on the dissemination of the referral policy, guidelines and protocols to enable appropriate application.

4. ESSENTIAL HEALTH SYSTEMS AND GOVERNANCE

4.1. Human Resources for Health Development and Management

The Human Resources for Health strategic plan (2012–2016) was developed and has been implemented but is yet to be reviewed. Human resources for health are recognized as pillars but despite regular production and recruitment of new health workers, the staffing norms are not yet met, especially for specialists at hospital level, including surgeons, radiologists, internists, etc. The Ministry of Health until now does not have a health economist, an essential expertise for planning and health financing, despite being planned for. Opportunity should be explored for schools abroad that offer sandwich courses in this area. With 4 schools for Associate Nurses, the primary level standards are almost met, but the secondary and tertiary levels still have a gap. Forty-eight expatriates were hired to reduce the gap. The trend in increase of health workers as suggested by the table below, may pose challenges in reaching the targets for 2016.

Table 3. HR Development 2011-2014

Profession	2011	2012	2013	2014 (first half)	Target by 2016 ³
Medical Doctors	136	153	172	194	215
Nurses	916	982	1107	1103	1700
Bsc Nursing	164	256	288	265	
Ass/Nurses	2373	2537	2867	2950	3161
Laboratory staff	280	335	376	366	664
Pharmacy staff	202	235	282	306	389
Imaging	70	80	84	95	189
Public health	97	122	136	173	
Anesthetists	30	29	41	36	181
Dental therapists	64	83	102	103	129
Ophthalmic officers	18	18	17	17	93
Others	157	120	138	111	
Total Professional staff	4507	4950	5610	5719	
Administrative staff	3166	3151	3196	3177	
Grand Total	7673	8101	8806	8896	

The policy for upgrading and or downgrading of Health Centres to community hospitals or health stations has human resource implications that need to be taken into account. It is important that the implementation of this policy should be based on objective criteria and that the upgrading or downgrading should be planned over time, based on the availability of the required resources.

Training of health professionals

An important cross-cutting issue that is not really presented in the HSSDP is the training of health staff. Through the Board of Higher Education and its Bureau of Health Education and International Relations, the Ministry of Education is responsible for the quality of the training of medical doctors, paramedical staff and continuous education. Two institutions are involved:

1. The Orotta School of Medicine for training of medical doctors
2. The Asmara College of Health Sciences, that provides Degree and Diploma courses through:
 - School of Nursing (nursing with specialisations in mental health, Midwifery, Anaesthetics and Ophthalmology),
 - School of Allied Health Professions (Optometry, Laboratory, Physiotherapy, Radiology and Dental health specialisation),
 - School of Pharmacy and
 - School of Public Health.

³. Estimated numbers based on the Human Resource for Health Strategic Plan 2012 - 2016

Although most of the training institutions are under the Board for Higher Education, there is good collaboration with the Ministry of Health, given that it is the basic consumer of the graduates. There are quarterly meetings between the Ministry of Health and the training institutions where information on the sector needs are discussed. The College of Health Sciences expressed interest to strengthen and expand the dialogue and communication with the MOH/HRD, as it would like to (i) receive feedback on the performance of its students in their daily work situation (part of their internal quality control system) and (ii) be part of the discussions on new developments and priorities in the health sector, such as the change from Communicable towards Non-Communicable diseases, as this has obviously important implications for the curriculum of the students.

The Board receives support from various agencies, such as UNDP, JICA, Finland and the African Development Bank (AfDB). Orotta School of Medicine receives Technical Assistance from Cuba and Gezira University, while the College receives assistance from Bologna and Khartoum University. It also sends promising candidates to outside universities for Masters and PhD studies, for example to Cape Town (Health Economics) and China (psychiatry)

In consultation with the MOH (HRD Division), these schools are responsible for the development of the curriculum, the textbooks, equipment and the necessary faculty to provide all these disciplines. In total there are some 2000 students currently trained in the College, while last year 377 graduated in the various Degree and Diploma courses. In most cases, the production of the training institutions is less than the needs of the Ministry of Health and the situation is aggravated by the high attrition of health staff, varying between 0.6% for doctors, 4.1% for nurses with an overall attrition rate of 17.9% for all cadres by mid-2014 (SAR 2014).

Furthermore, the training institutions may not be able to produce certain categories of health professionals. In the latter case, the Ministry mobilizes resources, particularly from health programs, to train these health professionals through the continuing education program and if need be in institutions outside the country. For example, 23 nurses are at Dundee University for training at Masters Level and about 150 nurses have been trained for first degree with Dundee University through long distance education, using Ministry of Health budget. Furthermore, there is a broader Advisory Board for all workers (not only health) where 3 to 4 Ministers, including that of Health, meet to discuss human resources issues.

The role of health workers at community level has become more and more important. However, apart from the associate Nurses whose training is community oriented, there has not been much guidance for the community health agents (CHAs). There is need to consider developing guidelines on training of such CHA and to also decide on whether to use multiple specialized CHAs or integrated CHAs.

As regards regulation of the health professionals, there still are no professional councils. Ministry of Health has been acting as the regulatory body but steps are underway to establish the professional councils. For example, the Government of Eritrea is negotiating with the Government of Sudan to help in establishing the Physicians' council.

Recognizing and nurturing talent are key to strengthening the human resource capacity. Ministry of Health is building in-roads in this area. For example, the Ministry has established a policy whereby after 5 years, the Associate Nurses, subject to passing an exam, are eligible to upgrade to Diploma level. This approach should be extended to other areas, including policy and management.

A mid-term review of the human resources for health plan should urgently be undertaken. Furthermore, human resource implications for the upgrading and downgrading health centres should be taken into account while developing criteria for decision of which health centres to upgrade and determination of the plan for the upgrade. This work should be linked to on-going work on defining the health care delivery levels.

4.2. Procurement, Supply and Logistic Management

There are two types of procurements, namely local and external procurements. The local procurements are handled by the General Services Unit under the Department of Administration and Finance, while external procurements are handled by the Project Management Unit (PMU). However, the bids for all these

procurements are reviewed by the Bids Committee in which General Services Unit is represented. Although the Director General in charge of the Administration and Finance department under which the general service division belongs heads the bidding and procurement committees in which the PMU also participates, better coordination between the PMU and the General services division is required when it comes to the issue of procurement. The General Services unit has not issued standards for the different categories of goods for procurement, which could lead to procurement of diverse types of goods of the same category. This is particularly important for non-medical and transport equipment that may require spares and maintenance. The procurement follows the Guidelines for procurement and administration and guidance of finance, all of 1994. There are no specific guidelines from the Ministry of Health. With regard to transport, most of the procurements for vehicles are external and tend to be done through the Program Management Units (PMU) of the externally funded programs as vehicle purchase is often from external funds. However, there is one local company where vehicle purchase can be done through General Services as long as this is GOE funding.

Communication rests mainly on use of the ERITEL fixed telephones as well as mobile phones. Only nine High Frequency radios were last procured years ago and none in the recent past.

Currently goods and supplies are stored in 3 different places but a new single store is in the process of being built. The stocks are managed using stock cards and an electronic stock control system which is updated on daily basis. Programs and other users can obtain the status of their stocks upon request, if they are linked to this database, they could access the database from their offices.

The General Services unit has shortage of storekeepers and drivers and also does not have expertise of a logistician. The existing staff could benefit from training in logistics management.

For transport, the unit has only two trucks (Isuzu and Hino). The General Services unit does not distribute supplies to the zobas, rather the zobas come to Asmara to collect their supplies. It is only occasionally where zobas are unable to collect their supplies that the unit distributes goods to zobas.

Whereas the unit is supposed to undertake supervision to the zoba stores at least twice a year, this is not done on a regular basis. The unit reported having carried out training of the zoba in stores management twice in the last 2 years.

Inventory of fixed assets is carried out twice a year and after each inventory the database is updated. There have been no audits on fixed assets in the last 2 years. As regards disposal of assets, the Ministry of Health requests the Ministry of Finance for boarding-off of old assets but the revenue from the disposal of these assets is remitted to Ministry of Finance.

At times partners also do undertake procurements on behalf of the Ministry of Health. For example, UNICEF procures vaccines. However, for such procurements, the Ministry of Health and the Ministry of National Development sign an agreement with the partner before the procurement is done.

The capacity of the General Services Division should be strengthened with relevant procurement and logistics expertise and the current procurement system be reviewed to ensure appropriate coordination for local and external procurements.

Consideration should be made of acquiring logistics management information systems that allows programs and other clients to access database of the stocks of goods and supplies.

4.3. Medicines Administration / Regulation

The National Medicines and Food Administration (NMFA) is a body of the Ministry of Health that regulates the quality of pharmaceuticals and medical supplies in the country to ensure that the public has access to quality, safe, efficacious and affordable pharmaceuticals and medical supplies. It is guided by the Eritrea National Medicines Policy (2010) and the Eritrea National Pharmaco-vigilance Policy (2014). In the last decade, one local medicines manufacturing plant has been engaged in producing essential medicines. It is a joint venture between the Government of Eritrea and a Jordanian company. To-date 45 products have been registered and it is reported to cover up to 45% of the Ministry of Health demands. There are a few private importers. Although

the NMFA was supposed to also regulate foods, this has not started yet as this needs to be supported by a law that has not yet been developed.

Regarding regulation, NMFA, in addition to the policies mentioned above, is also guided by the Proclamation to control drugs, cosmetics and sanitary items (1993). The Eritrean National List of Medicines (ENLM), as well as the product registration guidelines are currently being updated.

In October 2003, the Eritrean National Pharmacovigilance Centre (ENPC) was established at the then, Department of Regulatory Services. After the Pharmacovigilance (PV) Establishment Workshop, Eritrea applied for membership of the WHO Programme and was admitted as an Associate Member in December 2003. Promotion of the activities of the PV system was however poor and the period 2003 up to early 2012 saw virtually no activity with only 46 adverse drug reaction (ADR) reports being made in the 9 year period. In 2012, the NMFA, with full support of the Ministry of Health, strengthened the Eritrean Pharmacovigilance system through capacity building and provision of the necessary infrastructure and in the same year, Eritrea was admitted as 107th full member country of the WHO Programme for International Drug Monitoring Centre. Following this achievement, the ENPC strategically began to sensitize health professionals through the institution of Medicines and Therapeutics Committees (MTCs) at eligible health facilities. To sustain the program, the Ministry of Health developed a National Pharmacovigilance Policy in 2014 in which the National Medicines and Therapeutic Committee became the National Pharmacovigilance Advisory Committee.

The National Pharmacovigilance Centre has worked successfully on detection, monitoring and reporting of Adverse Drug Reactions (ADRs) in the last two years, resulting in the centre being ranked among the top four African countries in reporting adverse drug reactions and completeness of the reports submitted to the Global data base. (*Ref. Uppsala Report Apr. 2014*). The ultimate goal of Pharmacovigilance, however, is not only to collect adverse drug reactions rather it should generate signals, assess benefits and risks of medicines based on local data collected, develop risk minimization plans and initiate regulatory actions. In spite of the success cited above, the Pharmacovigilance centre lacks professionals who can understand, manage, analyze and communicate drug safety data.

The NMFA has a quality control laboratory that was established in 1997 but has not been internationally accredited. To accredit the laboratory will require updating of the laboratory, including its infrastructure and human resource capacity, a process that could take 3 to 4 years. Currently, the NMFA has only 21 technical staff for its 6 units. Among the 21 staff members, one has an M.Sc degree, 14 have B. Pharm degrees, 2 have B.Sc Chemistry degrees, 1 has CLS degree, whilst 3 have Diplomas in Pharmaceutical Technology. On the other hand the NMFA needs expertise in areas that include Pharmaco-vigilance, Pharmaco-epidemiology, Clinical trials, Drug Regulation, Pharmaceutical analysis and Toxicology.

It was encouraging to note that samples from new shipments as well as samples from the health facilities and retail outlets are regularly submitted to the quality control laboratory for analysis. Out of 300 to 450 products tested each year, only 2 to 3 failed last year. The products that fail are withdrawn. Some samples that cannot be tested in-country are sent to the external accredited laboratories but it is very expensive. Unfortunately, the Quality Control laboratory is reported to have a weak documentation system and the quality management manual is not in place.

A national drug survey is planned but the results of the recent health facility assessment (2013) show that on average, 55% of the 14 tracer medicines⁴ were available on the day of assessment.

Over the remaining years of the HSSDP and in the subsequent strategic plan, accreditation of the quality control laboratory should be given priority. Preparations should also be made for the drafting of the necessary bill to allow NMFA take on the food aspect. Furthermore, the Ministry of Health should strengthen the human resource capacity of NMFA and in that regard should mobilize resources to support further training at MSc and PhD levels for the staff on a sustainable basis as well as for short courses and in-service training. "Twinning" opportunities with other national regulatory agencies in Africa and beyond should be explored to enable NMFA and ENPC staff appropriate south to south exchange and attachment.

⁴ Salbutamol inhaler, Diazepam, Glibenclamide, Omeprazole, Amitriptyline, Captopril, Atenolol, Simvastatin, Paracetamol suspension, Diclofenac, Amoxicillin, Co-trimoxazole suspension, Ciproflaxin and Ceftriaxone injection

4.4. Biomedical Engineering

The Biomedical Engineering Division comprises two units. These include the Medical Engineering Unit and the Medical Equipment Procurement and Training Unit. The Division has a total of 47 staff members of whom only 16 are skilled and semi-skilled technicians. The division does not have a vehicle of its own, rather it depends on the MOH vehicle pool and the operational budget from domestic sources is not adequate making it difficult for the division to respond efficiently and timely to the needs of the zobas and health facilities for maintenance and repair of equipment.

The medical equipment is not standardized. Whereas requests of medical equipment procurement go through the Biomedical Engineering division, which advises on specifications prior to sending the request to Pharmecor. Sometimes the zobas or health facilities make their requests directly with Pharmecor without liaising first with the Biomedical Engineering division. This results in many different types of equipment from different sources, making the repairs, maintenance and availability of spare parts very difficult. The opportunity to procure larger numbers of medical equipment and their spares from the same sources tends to be missed. Although efforts had started on developing a standard medical equipment list with appropriate specifications, up till now none exists.

The medical equipment workshop is old and requires upgrading of tools. There are regional workshops in Mendefera and Massawa but the capacity of the technicians is very low.

There is no medical equipment policy in place and yet this would have guided procurement, maintenance and repair of medical equipment.

The hi-tech equipment pose a bigger challenge as there are no medical technicians in the MOH that are trained to repair and maintain them. There is need to either send the technicians abroad for training or arranging to have someone from abroad come and train them in-country.

Critical issues for enhancing the function of Biomedical Engineering include 1) development of a medical equipment policy; 2) establishment of a standard medical equipment list; 3) strengthening the human resource capacity; 4) adequate funding for repair, maintenance and supervision; 5) assuring transport for the Division; and 6) updating the workshop with relevant tools.

4.5. Infrastructure Engineering

An effort has been made to expand the physical infrastructure over the years since the beginning of the HSSDP implementation. Current data shows there are 28 hospitals, 56 health centres and 256 health stations and clinics. The policy of the MOH regarding health facilities is to simplify referral by focusing more on health stations and the community hospitals at the lower level with eventual elimination of health centres. While work is nearing completion regarding the definition of the health facility levels with their rationale, the guidelines, protocol and policy for health services referral are already in place, though the referral system still needs improvement.

The Engineering Infrastructure Unit has a manager, 4 Civil engineers, 2 construction technologists (joined in 2013), 2 persons with vocational certificates (survey and bills of quantity), 2 secretaries. They have no driver as they depend on the transport unit for transport requirements. The increase in capacity has been the 2 persons that joined in 2013. At each zoba, there are engineering /infrastructure units under the Local Administration that cater for all public sectors. The Ministry of Health has introduced focal points for infrastructure at zoba medical offices, starting with Northern Red Sea and Anseba, who work with the Local Administration Infrastructure units.

A health infrastructure development plan is not yet in place although there is an itemized budget for the period of the HSSDP. The health facility database is reported to be with HMIS but only in numbers and not by physical status. However, survey of health facility conditions has been carried out in the Northern Red Sea zoba by the Local Administration infrastructure unit.

Work on developing the master plan for the Orotta Hospital Complex and Ministry of Health Headquarters has started with discussions with Ministry of Public Works on the site plan. However, while waiting for approval of the site plan, some constructions have proceeded at Orotta Hospital. The site plan drafts are discussed with Ministry of Public Works before having been discussed in Ministry of Health. It would facilitate the process to have agreement within the Ministry of Health first before presenting the plans to Ministry of Public Works for approval.

It was reported that 6 hospitals have built incinerators in 2014. While hospitals use incinerators for waste management, the health stations use pits with burning method. Most hospitals were reported to have water tanks, save for those where the tanks have broken down, like in Dekemhare Community Hospital. Details are available in the 2012 inventory report by the Environmental Health Unit

The infrastructure standards are provided by the Clinical Services Unit and designed by the Ministry of Health Infrastructure Unit. No violation of these standards was cited. During construction of health facilities there is strict supervision by the engineers starting from the foundation stage.

While the budgets for maintenance of the referral hospitals and infrastructure of Ministry of Health Headquarters are obtained from Ministry of Finance through the Ministry of Health, those for the lower health facilities are obtained by the zobas from the Ministry of Finance.

The main challenges for the infrastructure unit are access to health facilities in the mountainous areas in the northern and eastern parts of the country, availability of transport, adequacy of office space and capacity building through specialized training of staff.

The Ministry needs to develop a national health infrastructure development plan to guide investment into infrastructure; Standardization of medical equipment is encouraged to facilitate maintenance and ensure availability of spares; the survey on health facility conditions should be extended to all the zobas and a database updated continuously.

4.6. Laboratory and Diagnostic Services and Medical Imaging Services

There are 5 levels of laboratories, constituting 1 National Health Laboratory (NHL); 2 National Referral Hospital Laboratories; 6 Zoba Regional Hospital Laboratories; 20 hospital laboratories; and 43 community hospital laboratories. In the HSSDP, there is only one National Health Laboratory under the office of the minister responsible for the provision of high standard of health laboratory services. The NHL also works as a reference and teaching laboratory and gives supportive service to other laboratories and public health programs.. Originally there was no unit which took responsibility to control the activities of all laboratories. However, because of increasing laboratory and other diagnostic problems in the peripheral areas, a unit was established under the clinical service to coordinate their activities and solve their problem with the NHL. A policy and strategic plan have been drafted for laboratory services that requires consensus across the relevant laboratory stakeholders. The policy also needs to be comprehensive enough to capture the laboratory needs both at the periphery and at the national levels, including the role of the NHL, as a national reference laboratory.

The National Health Laboratory develops operational plans annually and some standard operational procedures (SOPs) have been developed, particularly under health programs like for tuberculosis and malaria. Equally, quality assurance guidelines were developed for these programs. Examples include the AFB microscopy external quality assessment (2014), malaria in-country proficiency tests done every 3 months. The Zoba Referral hospital laboratories are responsible for quality assurance of the laboratory services in lower health facilities. External quality control has been a challenge as some specimens had to be sent abroad with delayed or sometime no feedback. Fortunately, the supra-national laboratory in Australia, whose external control function had been interrupted following queries to be responded to by the Ministry of Health, has recently been re-established. They have also released the software for laboratory information system relieving the NHL from having to send the data abroad to be incorporated into the database. Automated chemistry machines are being introduced in hospitals for the latter to participate in the laboratory quality control. So far, Barentu and Mendefera hospitals have received the machines; one for Keren hospital is expected. On the other hand,

smaller chemistry analyzers have been installed at NHL and will be installed in other hospitals after training at the end of November 2014. Recently, training on the coulter machines was provided.

The human resources capacity at NHL consists of 50 technical staff of whom 23 are clinical laboratory scientists (BA holders) and the rest are medical laboratory technicians. Recently NHL received additional staff (4 clinical laboratory scientists and 1 medical laboratory technician) but there is increasing attrition. There is also 4 staff doing a Masters degree in Sudan.

The human resources capacity at NHL consists of 23 technical staff, including clinical laboratory scientists (BA holders), medical laboratory technicians. Recently NHL received additional staff (4 clinical laboratory scientists and 1 medical laboratory technician) but there is increasing attrition. There are also 4 staff doing a Masters degree in Sudan.

Although the NHL participates in research, they do not initiate research. The research supported is mainly health program and academic research. The NHL currently does not conduct innovative research designed to guide new laboratory procedures, methods and protocols.

There exists an imaging and diagnostic unit but no policy or strategic plan has been developed yet. The imaging technology still uses X-ray films, but there is intention to go digital. However, attention to the imaging services by the MoH is gaining momentum. New MRI and CT scan gadgets have been purchased (replacing the older ones) and are offering full time services. Experts from abroad have been hired and are currently giving in-service training to staff with regard to operationalization of high technology equipment. Furthermore, the school of allied health professions is producing radiology technicians.

There are no radiotherapy services in the country and patients requiring radiotherapy are referred abroad for treatment. However, people are being trained in radiotherapy and the country awaits permission to acquire the radiotherapy equipment. Meanwhile the construction of the relevant physical infrastructure is on-going. It is planned to be in place before end of the HSSDP.

It is recommended that the overlaps in mandate between the NHL and the Clinical Services Unit be ironed-out as soon as possible and the policy and strategic plan for national laboratory services be urgently reviewed and finalized to facilitate smooth operations and performance of laboratory services.

4.7. Blood Transfusion Services

The country has a National Blood Transfusion Policy of 2011 that guides the work of the National Blood Transfusion Services (NBTS) in Eritrea with its goal of ensuring safety and adequacy of blood and blood products for all patients in all medical services in the country. The policy is being operationalised through a 5-year strategic plan for the National Blood Transfusion Services, 2012 – 2016. According to the NBTS strategic plan, apart from the national blood transfusion centre, the plan was to decentralize the services to the Regions (Zobas). Thus far, there is one Regional Blood Transfusion centre at Gash-Barka, established mid-2014 but plans to expand to the other Regions will depend on the lessons learnt with the one at Gash-Barka. This arrangement is meant to ensure that quality is not compromised. As such, the Regional Blood Transfusion center at Gash-Barka is seen as a satellite branch of the National Blood Transfusion Centre. The centre at National level supervises the Regional centre 2 to 3 times a year. The staff at the Regional centre includes 3 Associate Nurses in the donor clinic and 2 to 3 staff in the laboratory section. At the hospital level, there are blood banks where refrigerators and standby generators are necessary prerequisites.

Currently, the capacity for blood production is 10,000 blood units per year. It has passed the target in the HSSDP of 8,000 per year. However, the strategic plan of the NBTS estimates the yearly blood needs to range between 12,000 and 15,000 units. The voluntary donors have increased to 92% of the blood donors and it continues to increase. The increase has been attributed to the emphasis on sensitization and creation of awareness, which have yielded establishment of voluntary blood donors' associations which have been formally registered and are meant to work independently. Recruitment of blood donors is one of the main activities of the NBTS.

Quality of blood is of high priority. All blood is tested and no blood is released to the hospitals without testing for HIV, Hepatitis B and C and syphilis. Both internal and external quality assurance are undertaken. On an annual basis, external quality control to ensure that the NBTS remains ISO 9001:2008 certified is done in collaboration with South African Laboratories. The internal control is effected through development and application of standard operating procedures, responding to clients' complaints and document control. Quality control for serology is done three times a year and haematology once a month. New auto-machines (Abbott) for screening blood, using infection markers were introduced in 2013, but due to lack of reagents, the screening has returned to manual.

Blood wastage was reported only in terms of expiring blood at hospital level. NBTS ensures that all blood types are always available at the hospitals and there seems to be less demand for blood groups A and B, resulting in these two blood groups tending to expire in the blood banks. However, the NBTS has developed a method that has increased the shelf-life of blood to 42 days instead of the original 21 days.

The NBTS has met a number of challenges. They include staff shortages, inadequate logistics, lack of an appropriate sensitization strategy, weak legislation for NBTS and limited skills in health education, lack of appropriate means for discarding of blood and blood products, closed IT data system (DELPHI) and limited support for commemoration of World Blood Donor's day. The quality management unit originally had 3 staff and now only has 1 person; there is only 1 mobile unit and a total of 3 vehicles (2 vans and 1 Landcruiser) of which the vans have a sitting capacity of 10 to 12 people whereas a mobile unit requires up to 16 persons, resulting in the use of two vans for each mobile; there is a pending need to undertake a KAP study to inform a blood communications strategy; the centre does not have an incinerator for discarding blood and blood products and currently depends on burning method; the capacity to train in communication is inadequate and may require a special training of trainers that may require external expertise; the current IT data system is controlled from Egypt and every time a problem is encountered it requires to get an expert from Egypt to address the issue. The system does not link with the HMIS; although there have been at least 2 research proposals submitted, none has been approved or supported.

The NBTS needs support with adequate human resources, particularly for quality assurance and an appropriate bigger van for the mobile unit, as this may eventually cut costs. As quality assurance is very important the Ministry should ensure that the necessary funds to register for external quality control are available. It is advisable to conduct a KAP study to inform the communications strategy for blood transfusion. While efforts should be made to identify the trainers for training the trainers on communication, an alternative to the current closed IT data systems should be sought to eliminate dependence on external expertise and reduce unnecessary costs, as well as align the blood data system to the HMIS. Research should be encouraged and may require support for proposal development in line with the National Health Research agenda.

4.8. Legal Affairs and legal framework

The Legal Affairs office has been in existence since 2005 and is a one-person office with a qualified lawyer. The functions of the office include provision of legal advice to the Minister of Health, representation of the Ministry of Health on legal matters in court, review of policies and policy guidelines to ensure they are in line with the national laws of Eritrea, facilitation of enforcement of the law and creation of awareness of the law among the zobas and the MOH. There is no National Health Act or Regulation but there are several proclamations on control of drugs, cosmetics and sanitary items, tobacco control, control of private practice and control of female genital mutilation (FGM). Although it was reported that at the moment the health issues are well covered by the civil and penal codes and hence there has not been need for a National Health Act, there is an intention in the future to develop a National Health Act as more and more health issues demand legal attention.

The legal office collaborates with the Ministry of Justice. When there is need for amendments of the civil and penal codes, the MOH is given opportunity to table health legal needs for consideration. Equally, as in the case of the breastfeeding substitute Bill, draft bills are prepared by the Ministry of Health after multi-sectoral consultation and submitted to the Ministry of Justice. However, this is on ad-hoc basis and there are no institutionalized fora for engagement with the Ministry of Justice.

The Legal office, however, has limited expertise in medico-legal issues. It has not developed a strategic plan nor does it have annual operational plan. Although the work of the legal office is mostly demand driven, a plan would facilitate the proper implementations of its functions.

The Ministry of Health should consider developing a national Health Act to take care of all the health issues and build capacity for medico-legal law.

4.9 GOVERNANCE & PRINCIPLES

The services are organized in a three-tier basis with the primary level constituting the health stations, health centres and community hospitals, while the secondary level constitutes the Zoba regional hospitals and first contact hospitals (sub-zoba) and the tertiary level with national referral hospitals. The overall policy and national guidance is provided by the Ministry of Health (refer to MOH Organogram) that has 4 departments (Medical Services; Public Health; Planning, Policy and Human Resource Development, and Administration and Finance) and advisory services to the Minister (Legal, Health). Other structures reporting to office of the Minister include National Medicines and Food administration, Internal Audit, National Health Laboratory, Information Technology and HMIS, Parastatal organizations and Public Relations. At the lower level, there are 6 zonal medical offices at the regions and sub-zoba (district) offices. Over the past few years the MoH has established functional management structures across all levels from zoba to the community. Thus Zoba , Subzoba, Hospital ,and Kebabi Health Management Teams and Committees have been instituted and guidelines for their functionality developed.

The Ministry of Health initiated the national health policy (2010) and has the lead role and responsibility for the implementation of the HSSDP (2012 – 2016). It also coordinates all the stakeholders for the implementation of the strategic plan. However, apart from the national health policy and the HSSDP, there are multiple policies and strategic plans for the different programs. Some of these strategic plans are not aligned to the HSSDP, especially in the time periods. Some programs have had to develop strategic plans to satisfy the requirements by the funding programs like Global Fund for AIDS, Tuberculosis and Malaria. However, there are key areas like health financing (only draft policy) that to-date do not have guiding policies and strategies.

Efforts should be made to align the various program strategies to the subsequent HSSDP and appropriate policies should be developed where needed like for health financing.

4.10. Partnership arrangements (national and international)

Although the dissemination of the HSSDP amongst stakeholders, including development partners, was not wide, the strategic plan was used to inform the development of the partners' programs, for example the UNICEF country Program 2013 – 2016. For the UN Agencies, the Strategic Partnership Cooperation Framework (SPCF) 2013 - 2016 formed the umbrella for the development of UN country program based on individual Agency mandate and areas of advantage. Within this framework, UN Agencies work with the Ministry of Health departments in technical working groups and specific plan outcomes. Furthermore, there is a platform that brings the UN Agencies together with the Government of Eritrea through the Ministry of National Development. Through this platform, there is supposed to be a mid-year review and end of year review of performance of the SPCF. However, this has not regularly taken place and for example the end of 2013 review was held in June 2014. Although these meetings are meant to address high level strategic issues, they have tended to address operational issues, despite prior preparations in bilateral meetings between Ministry of Health and the development partners. It was revealed that even between development partners, coordination remains weak and at the moment there is no platform or forum where all the actors in the health sector discuss regularly.

The HSSDP could be used in the future to harmonize the planning not only of the MOH but also of the other stakeholders. This will strengthen the planning, monitoring and evaluation of the sector interventions. For this to happen the HSSDP should be disseminated widely so as to allow all stakeholders to understand its content and thrust as a guide to the work they undertake to contribute to its implementation. For to bring together all partners, Ministry of Health and relevant Government departments would enhance the partnership and maximize synergy. The MOH should put in place mechanisms for regular annual planning and for sector review involving all the stakeholders.

5. SECTOR PLANNING, INFORMATION SYSTEMS, MONITORING & EVALUATION

5.1. Planning

The integrated planning system of the MOH is designed to replace the previous process of program-focused planning. Two years ago, MOH established a division of Policy and Planning (P&P) with two skilled planners that have made enormous progress in this short time. They have managed to establish a functional system of continuous preparation for planning cycles at Zoba and sub-Zoba level. A planning template has been developed and training has started all over the country

Results achieved from 1991 to 2012 in service delivery and systems development, even without national strategic planning, are most impressive. Now that a systematic planning process has been introduced down to facility level, it is certain that even more progress will be made through a focus on high impact, low cost solutions to priority problems.

The Health Sector Strategic Development Plan (HSSDP) was first developed in 2010 and revised in 2012 to end in 2016. The HSSDP is the product of collective efforts of key departments of the MOH, with references that include the National Health Policy, program strategic plans and international documents. Program specific strategic and action plans were used as the basis for the document which was finalized after consultation meetings and comments by all MoH departments. The HSSDP for the first time combines all the program specific strategic plans into one overall package.

There is a high level of political commitment to the HSSDP, with a spirit of "health in all policies" in place to allow successful implementation. Cabinet-level political discussion and formal endorsement of the strategy and budget by the Ministry of National Development have occurred. This political commitment is shown by provisions for maintaining sustainability and substantial government financing of the plan.

There is a limited problem analysis of each section with an initial analysis of health determinants, within the local epidemiological, political, socio-economic and organizational context. There is an analysis of health sector responses that attempts to identify local priority problems and areas for improvement. This needs to be expanded to a full situation analysis in future HSSDPs.

The HSSDP sets out goals, policies, objectives, interventions and expected results that contribute to improving health outcomes and equity. These address health priorities, access and health outcomes across all population sub-groups. In future these should be expanded to better address equity, efficiency, quality and financing health services and create incentives to improve efficiency and quality in service delivery.

Approaches are relevant to the priority needs identified, but are weak in analysis of effectiveness and efficiency. The organization of service delivery is defined in operational plans but the strategy does not clarify the roles and responsibilities of service providers or the resources required. The implementation and management arrangements and systems for implementing and managing the programmes in the national strategy need to be further elaborated. Current logistics information and management system constraints are described, and actions are proposed to resolve constraints, but most have not (yet) been implemented.

Key system issues that impact on human resource capacity development and technical sustainability are identified and addressed. The plans are based on implementation capacity, though they do not actively identify ways to increase efficiency. Plans for emergency health needs in line with the International Health Regulations, assessment of risks and proposed mitigation strategies are not included in HSSDP.

Existing institutional capacity is identified as the biggest obstacle to implement the strategy and there are far reaching plans to develop the capacity required. Human resource needs are identified, including staffing levels, skills mix, distribution, training, supervision, pay and incentives. Weaknesses in key systems and capacity for planning and budgeting, technical and managerial supervision and maintenance are identified and plans are made for improvements. The plan does not describe technical assistance requirements for implementation.

There is a participatory process within MOH to develop operational plans, though roles and responsibilities of implementing partners are not clearly described in the HSSDP. There is minimum input planned from civil

society, private providers and development partners. There is no mechanism to ensure their input into future strategy development and planning.

The National strategy is weak on resource allocation and does not clearly describe how resources will be deployed to achieve outcomes and improve equity, or how resources will be allocated to Zoba level and non-state actors. There are no criteria for allocation.

Some of the challenges of the current HSSDP include (i) a weak situation analysis, lacking analysis and quality data; (ii) a M&E framework that is not integrated; (iii) targets that have been set without linkage to empirical data; and (iv) a HSSDP that is not clearly linked to a budget. It seems the HSSDP is more of a collation of existing disease and system programs rather than a strategic look at overall health challenges and programs needed to address them.

Annual Operational Plans are developed by national programs, (sub) Zoba levels and facilities. Most of those seen were linked to resources, approved by the relevant authority and cover most relevant activities. These action plans are well known and locally owned, widely disseminated and displayed on facility and office walls. Their implementation is a source of pride to program, (sub) Zoba and facility managers. All programs and Zobas have started a consultative planning process with regular review meetings. Unfortunately, key stakeholders outside MOH were sometimes left of these meetings.

The overall operational planning system tends to be top-down, rather than bottom-up as proposed by MND. Plans are often made without reference to data and targets are set without references to base lines or reflection on real local priorities. This will hopefully improve as planning skills become more developed at lower levels. Longer term strategic plans for zonal and program levels are not yet developed at sub-national level.

Basic monitoring and evaluation tools are in use and decision support software exists, though it is used by only a limited number of staff. Planning, monitoring and evaluation guidelines have been developed, and should be packaged into a user friendly manual and widely disseminated. Feedback of the results of M&E to implementers and health managers is being strengthened and a system is planned to institutionalise discussions about data at all levels. The feedback system will ensure that regular analysis reports targeted at specific stakeholders are prepared, supervision uses routine HMIS data before, during and after supervision and that the action plans are linked to daily activities.

Recommendations

1. Continue and strengthen the existing process of inclusive and transparent planning that has been started, with increased stakeholder involvement at all levels.
2. Strengthen the planning system by developing guidelines for each level that define roles and responsibilities, empower bottom-up planning capacity, encourage the use of appropriate planning tools and promote regular communication about achievements of targets and bottlenecks.
3. Align planning cycles of programs to ensure that all plans are aligned to HSSDP
4. Strengthen Planning capacity and skill mix at all levels through appointing dedicated planning staff, revising job descriptions and providing regular in service training, feedback and supervision
5. Improve use of data in planning by ensuring availability of quality data from both routine HMIS and surveys in user friendly format
6. Ensure that future HSSDP better address equity, efficiency, quality and financing of health services and create incentives to improve efficiency and quality in service delivery. They should also address implementation and management arrangements and systems

5.2. Health Management and Information Systems (HMIS)

5.2.1. HMIS as part of the HSSDP

The Health Management Information System (HMIS) was set up in 1997 and a comprehensive HIS assessment using the Health Metric Network framework was conducted in 2007 and another in 2014. These form the basis of the current MoH strategies to maximize the strengths of HMIS.

The HMIS unit is within the Information Technology Division, set up directly under the Minister of Health, with defined authority, roles, responsibilities and functions and there is a HIS policy (2011) and a strategic plan (2009). All programs see the need for a strong HMIS, but feel that the current HMIS is not able to adequately support health service planning, implementations, supervision, monitoring, evaluation and decision making. In spite of this, the HMIS has been able to produce annual activity reports on a continuous basis and to avail HMIS guidelines for data collection and collation from all facilities across the board.

The key strategy in the HSSDP to strengthen the HMIS is:

“Establish a web based Health Data Repository that consolidates health data from all sources and creates a platform for sharing of health data and other relevant data for decision-making”.

This will be done using the DHIS2 platform. When this is in place, all the major programs have agreed to use this system and create a single, unified HMIS. Using this web-based technology will need improved internet access, but once it is established, any facility or individual with internet access and a secure password will be able to enter and/or access data according to defined privileges. The provision of the data warehouse, combined with improved internet and strengthened ICT infrastructure will allow the HMIS to provide accurate, relevant, complete, and timely health information for decision makers, implementers and other HMIS data users.

Feedback is currently limited to semi-annual and annual reports. Establishment of the data warehouse will mean dramatic improvements in HMIS data sharing and utilisation by Zobas and programs. Computer dashboards and tailored reports will allow all health workers to interact with the “data pipeline” and participate meaningfully in the analysis and interpretation of data. Data use in planning, supervision and monitoring will be greatly facilitated.

5.2.2. HIS resources

A HIS strategic plan was developed in 2009 and the HIS policy in 2011. The national committee to monitor and coordinate the HIS exists, but needs to be strengthened. The National Statistical Office (NSO) works closely with MoH to coordinate population surveys and has initiated a vital registration system. Unfortunately, Eritrea has not yet undertaken a full population census.

HMIS staff is available at all levels but they have also other responsibilities, are inadequate in number and often have weak skills. The basic supplies and forms are available for data collection to function. Training programs are planned, using a combination of hands-on in-service training, distance learning and formal courses. Staff at all levels is expected to receive more training on computers and data use.

5.2.3. Indicators: data quality and sources

There is an extensive list of 136 indicators in the M&E results framework that cover the 7 key programs and support systems. These indicators need to be revised as planned, particularly now that HIV/AIDS, TB and Malaria are planning to use the HMIS.

Routine data is timely (90%) and facility reporting is complete (98%). The proposed data quality assurance system will monitor data completeness within reports and ensure that routine data results correspond well to survey data. The data warehouse will have the capacity to identify outliers and provide electronic approaches to data quality assurance. The biggest problem with data quality in Eritrea is that there has never been a census, so all denominator related data are of uncertain quality.

HMIS uses two different data sources:

Population based sources: As mentioned above, a census has never been undertaken and population data for denominators come from different sources, thus giving different results. The official population in 2014 is 3.5 million (NSO) though other estimates are up to 6.1 million (UNSD). Vital Registration is weak outside Asmara with unknown coverage. Population surveys by NSO are the basis for all data at the moment. These are the Demographic and health Survey (DHS) done in 1995 and 2002 and the Eritrean Population Health Survey (EPHS) undertaken in 2010, with plans for another in 2015.

Facility based sources: Patient Records are collected at all facilities on individual patient records, tally sheets and registers. The data collection and reporting system is fine, with a good notifiable disease system reporting from all levels of the system and epidemics dealt with at Zoba level.

Resource records are weak. There is no master facility list and no GPS coordinates of facilities. While maps and GIS are used to display some health service data, systems, staff and services are not mapped. Financial and human resource data, equipment and supplies are not integrated into the HMIS.

There are currently various databases for human resources, logistics and other systems but these are not interoperable. Implementation of the data warehouse will require that all existing computer systems become interoperable with it. A metadata dictionary is planned that will provide definitions of data elements, indicators, collection methods, periodicity, geographical designations and analysis techniques to be used. Written procedures for data management need to be revised for the data warehouse and incorporated into HMIS guidelines

5.2.4. Data outputs and use

Health services information is currently used in most annual planning processes, with graphs and maps widely used to display information at offices and health facilities. Semi-annual and annual bulletins are published and an internal annual health sector review is performed. Plans are underway to involve program managers in improving HMIS data quality to ensure that it is good enough for use in health service management, monitoring and evaluation. Feedback is seen as important and will be strengthened by use of dashboards and standardised reports in DHIS2 that will be made widely available to data users and external stakeholders.

5.2.5. Recommendations

Short term:

1. Revitalise the HIS Steering Committee to coordinate HMIS revision and implementation process and mobilize the necessary resources
2. Set up the Data warehouse for HMIS at national level and pilot DHIS2 in two Zobas with existing internet connections. Import all existing data into the warehouse and ensure quality by using relevant tools and dashboards.
3. Review indicators to develop a core set that adequately covers the requirements of the HSSDP M&E framework, key systems and the needs of programs for the post-2015 agenda. Develop a meta-data dictionary for these indicators and data elements.
4. Involve program and subsystem managers in strengthening the HMIS, encouraging them to review indicators, develop dashboards, analyse and interpret data and use information for decision making.
5. Develop and implement a HMIS training plan for all levels, with the Asmara College of Health Sciences (or as part of the continuing education program). This plan should include in-service training on computer skills, data analysis and use, as well as longer term certificate, diploma and degree programs.

Long Term:

6. Revise the indicator set in the light of the post-2015 agenda, the systems approach, the reduction in infectious diseases and the increase in NCD.
7. Increase numbers and skills of HMIS staff at all levels. Review job descriptions of non-HMIS staff to ensure that they actively participate in key HMIS functions.
8. Incrementally implement existing DHIS2 modules such as GIS, mobile phone reporting, mortality and discharge reporting using ICD10 diagnosis, tracker for case-based reporting and logistics management
9. Review data management guidelines, the HIS Strategic Plan, HIS Policy and other key documents in light of new developments.
10. Advocate for the organisation of a national Census to bring coherence in the HMIS reporting

5.3. Sector Monitoring & Evaluation

5.3.1. M&E Objectives of the HSSDP

The MOH plan for monitoring and evaluation (M&E) is basically sound, reflects the HSSDP and includes core indicators, many sources of information, methods and responsibilities for data collection.

There is a comprehensive M&E framework for 2012-2016 that guides implementation of the HSSDP and reflects most goals and objectives of the national strategy. For each of the programs and systems it provides the

baseline and the annual targets. Unfortunately, the Planning Division and the M&E unit have not been able to include the results of implementing the various plans and programs into the M&E framework. Hence for the moment this important document has not been able to fulfil the role that was originally designed for it, being the monitoring of the performance of the sector.

The purpose of the M&E plan is to ensure achievement of HSSDP objectives, justify the implementation budget and provide a framework for sector accountability. The M&E framework selects a number of strategic national performance indicators to be regularly measured, and sets targets for them. A larger set of indicators is used at the Zoba and sub-Zoba levels.

The objectives of M&E are to provide decision makers at all levels with evidence-based data for planning and program management, to strengthen sector performance based on HSSDP indicators, to undertake ongoing monitoring of progress and sector performance and evaluation of programs plans.

Strategies are basically sound and consist of (i) selecting performance indicators to measure progress and performance; (ii) Regular performance review meetings, quarterly at Zoba and MOH; (iii) In depth thematic assessment; (iv) Annual sector performance report and stakeholder performance review meeting (v) A sector mid-term review; (vi) Development of guidelines for monitoring, supervision

Many of these strategies have been initiated. The set of indicators has been selected, though they have to be streamlined and operationalised, MoH and (sub) Zobas hold regular review meetings and annual reports are being produced; The MTR is currently being conducted.

However plans for management of the M&E system, data collection and analysis and quality assurance are not mentioned. There are still major problems with quality of data, dissemination of results and participation of non-MoH stakeholders.

Regular assessments of progress and performance are proposed as a basis for policy dialogue and performance review. There is a plan for periodic MOH performance reviews and processes to feed back the findings into decision making and action. Plans for a multi-partner review mechanism to allow joint assessment of sector and program performance need to be further developed. There is a need to institutionalize discussions about data and its use at each level, using a cyclical approach that focuses on different topics at least quarterly and discusses them in detail

5.3.2. Recommendations

1. Implement planned M&E strategies with an emphasis on improving data quality and dissemination, with full involvement of programs and partners
2. Clarify roles and responsibilities of MOH programs and (sub) Zoba staff, particularly with regard to data analysis, interpretation and dissemination
3. Develop guidelines and Standard Operational Procedures (SOP) for monitoring and evaluation that specify data sources and collection methods and flow between levels; data analysis and synthesis methods and quality assurance; feedback, information dissemination and communication mechanisms
4. Institutionalise use of routine HMIS data for M&E during program management, performance assessment and supportive supervision
5. Promote regular discussions about M&E data at each level using a cyclical approach that focuses on a different topic but covers all topics in a cycle.
6. Improve M&E skills of health workers (particularly program and (sub) Zoba managers) by (continuous) in-service training and supervision.

5.4. Health Research

MOH has developed a health research policy and policy guideline that serves as a guide for strengthening this key component of systems development. The objectives include:

- Strengthen Basic and Applied/Operational research capacity at all levels to promote evidence-based disease prevention, health promotion and treatment;
- Stimulate generation of new knowledge, new facts, ways and means, their correct interpretations and practical applications;
- Discover new or improved ways of applying the existing knowledge
- Stimulate reaching practical solutions or decision by decision makers;

- Enhance efficiency and effectiveness of the health system as part of socio-economic development

Achievements

A mechanism for coordination and dissemination of research findings has been established with a national resource centre established and in use. Mechanisms have been established that ensure health research is relevant and complies with set standards.

Health research priorities are identified and documented⁵ along with policy and policy guidelines, ethical and legal frameworks governing health research. Resources and funding mechanism for operational health research have been mobilized and training on relevant areas of research and research methodologies has been conducted. As a consequence several research activities have been conducted (see research agenda for Eritrea)

Recommendations

1. Disseminate the priority health research agenda widely
2. Identify potential researchers, strengthen their research capacity and facilitate access to research support and funding
3. Identify funding sources for research into priority areas and make these easily available.
4. Encourage research on the topics outlined in this report.
5. Move health information towards knowledge management that can support strategic planning and decision-making.

⁵ Priority Health Research Agenda (2013-2017), MOH 2013

6. HEALTH CARE FINANCING, FUNDING AND BUDGETING

Eritrea, like many developing countries, is confronted with the challenges of how to reconcile the objective of improving financial accessibility to health care and equity in the health system on one hand, and the need to mobilize domestic resources for improving the financial viability of health services on the other hand.

In 1996, a first health financing policy was developed, and revised in 1998, in order to cover various aspects of interest including the cost sharing through levying of user fees. This version of the health financing policy was again revised in 2007, in order to have a more comprehensive policy incorporating a deeper consideration of the key health financing functions: revenue collection mechanisms, revenue pooling and risk management, and resource allocation and purchasing.

Improving the health status of Eritrean people was also one of the priorities in the National Health Policy (NHP) developed in 2010 by the Ministry of Health. This was emphasized through the three objectives of the NHP related to health financing, namely: “1) Ensure that quality health services are available, accessible and affordable to all the people in the country; 2) Introduce a health financing scheme that protects the people from catastrophic expenditures and ensures sustainability of the system; and 3) Implement the concept of hospital autonomy.”

Based on this background, the current Health Sector Strategic Development Plan (HSSDP 2012-2016), has extensively integrated specific strategic orientations in issues of health care financing and funding.

The implementation of the related health financing interventions have benefited from the following opportunities. The strong political commitment of the Government of Eritrea to Health of the population as a foundation for a conducive policy environment.

Performance of a health financing system depends among others on (i) its capacity for equitable and efficient revenue generation; (ii) the extent to which financial risk is spread between the healthy and the sick, and the rich and the poor; (iii) extent to which the poor are subsidized; (iv) efficient purchasing of health inputs and services; and (v) the prevailing macroeconomic situation (e.g. economic growth, unemployment, size of the informal sector compared to the formal sector, governance, etc.)

Health Financing goals are integrated in the HSSDP 2012-16: to raise sufficient financial resources to fund the plan, whilst ensuring equity and efficiency in resource mobilization, allocation and utilization during the plan period.

6.1. HSSDP Financing

The Government of Eritrea’s concern in the health financing is the financial sustainability of health care financing, given the current situation where:

- Existing revenue collection faces the problems of low investment in health; heavy reliance on out-of-pocket expenditures; low household capacity to pay due to widespread poverty; high unemployment; low economic growth; limited fiscal (budgetary) space; double burden of communicable and non-communicable diseases; high but declining population growth rates and erratic disbursement of donor funds.
- The health financing goals of improving equity in the use of quality services are compromised in the existing revenue collection mechanisms. People need to access care without it becoming a catastrophic expenditure.

Achievements:

According to the different reports produced on health financing and consultations conducted with the MOH, MOF, MND, and Partners, the key achievements noticed are summarized as follows:

- The cost recovery through the levying of nominal registration fees at the primary level and user fees at the secondary and tertiary level has been introduced. These fees are low to limit financial impact on clients and staggered based on level of care (lowest at primary care, and higher for hospitals)
- There are reported institutional arrangements to ensure the user charges collected are contributing to improvements in service quality. These include ensuring some of the funds collected are used at the facility of collection, and inclusion of some quality indicators for monitoring effects of use of these funds.

- Public hospitals and some selected other facilities have now already begun or are in the process of beginning private or for-profit sections of health care along with the public sector, for the past three years. The funds collected directly contribute to improvements in operations at the facility, with the potential of up to 40% of the funds collected being used for this.
- There are exemption mechanisms in place to limit the financial burden of health care on the poorest, and selected groups such as those with some chronic diseases like HIV/AIDS and Diabetes
- Strong commitment to ensure access to health services and access to free education including education in health sciences.

Table 4. Estimated Health Care Financing (HCF) key indicators:

Indicator	Value, by year				Comments / remarks
	1996	2000	2005	2012	
Per capita general government expenditure on health at average exchange rate (US\$)	5	6	4	6	Increased back to pre-2000 level following reduction in 2000 - 2010
General government expenditure on health as % of Total Health Expenditure (%)	48.4	64.6	45.1	50.5	Increasing trend, improving sustainability of health financing
Private sector expenditure on health as % of Total Health Expenditure (%)	51.6	35.4	54.9	49.5	Reducing trend, improving sustainability of health financing
External resources spent on health as % of Total Health Expenditure (%)	17.7	35.3	76.0	71.6	High expenditure is from non-local sources
Private households out of pocket payment as % of private health expenditure (%)	100	100	100	100	Out of pocket still contributing all private health expenditure, sustaining inequities in health financing
Total Health Expenditure as % of GDP		4.5		2.7	Potential for increasing health expenditure

Generated, using data from www.who.int/nha/country/ERI⁶ and 2014 World Health Statistics

Challenges:

In spite of the above achievements, the MOH has a few challenges hampering progress in health financing:

- There are still missed opportunities to make pay those who can actually pay: the MOH is fully aware that even the free services targeted to the poor are captured by the rich, who use them more than the poor;
- There is potential for disincentives in the identification of poor population and related burden on the local administration (Eligibility for exemptions on poverty is on the basis the provision of poverty certificate from the local government with the understanding that the local administration that issues the poverty certificate will be responsible for paying for the services provided to the poor);
- There is insufficient evidence generated to inform any decision-making in health care financing priorities. The three health financing studies planned in the HSSDP have not yet been conducted, and there is no indication whether they will be implemented before the end of the HSSDP period. These are: 1) Assessment of health care expenditure patterns; 2) Assessment of a range of financing options such as social or private health insurance; 3) Assessment of the impact and ways of improving the effectiveness and efficiency of the just begun private or for-profit section in public hospitals.
- The shortage of skilled staff in Health Economics is hampering appropriate planning and implementation of Health Financing Strategies for HSSDP, and development and implementation of Health Financing policy.
- Presumed high levels of catastrophic expenditure and unmet needs, especially for the poor households. High out-of-pocket expenditures with still developing exemption mechanisms exist;
- Some inefficiencies were noticed in the use of resources. These include parallel financial management systems; wastage in resources and duplications in resource allocation due to a weak coordination among the health sector stakeholders; duplications in data collection caused by parallel data systems; existence of many database systems that are not interoperable; unnecessary spending on some medicines; some inappropriate use and maintenance of medical equipment; wastage in some health products; some health entities with low utilization rates of available resources (low bed occupancy rates)
- Funding projections were found in different MOH specific programs, including domestic and international funding sources, but no harmonized or consolidated national budgetary framework was found. Likewise, the strategy does not provide any mechanism for spending priorities in the assumption that the strategy will be not fully financed.

⁶ Ministry of Health of Eritrea, National Health Financing Policy (Draft2), November 2007

6.2. HSSDP Funding

The funding sources of the HSSDP implementation are grouped into 1) Government source 2) Funding from multilateral (UN, GF, and GAVI) and bilateral partners. The government funding is in the form of annual budgets allocated by the Ministry of Finance. The financial support from the partners is managed through the MOH. The MOH uses a Project Management Unit (PMU), which is directly answerable to Minister of Health to coordinate the management of the Global Fund and GAVI Projects, and direct requests and reports with the sub-recipients. The sub-recipients at central level are ministries (health; education; labour) and civil society. At decentralized Zoba level, there are PMUs in each one of the six Zobas, managing the projects funds.

Achievements:

There are overall signs of improved availability of health funds:

- Overall government expenditure on health is increasing, in average terms. Donor funding has increased (e.g. from Global Fund). Household funding has also increased due to the introduction of the cost recovery.
- The health sector funding from the government is done annually only in one transfer at the beginning of the year. This is valid for all levels including at zoba level, and it succeeds a systematic planning process where the planning unit in MOH coordinate the process and accompany zobas in this process, in order to improve zobas plans and budgets.
- During the implementation of this HSSDP, the semi-private service in public hospitals was introduced, and is considered by the authority as satisfactory with the expectations of substantial indirect contribution to the financing of health services.

Challenges:

In spite of the increase in funding, there are some challenges:

- The current funding structure has potential for accentuating financial inequities. Out of pocket (OOP) payments are still high (49.5% of THE).
- Government spending on health is still low – way below WHO expectations (44 US\$ per capita) and the Abuja targets (15% of general government budget) for a country health spending.
- The plan of the MOH to consider moving towards cost recovery at a higher percentage of the costs of care in the context of social insurance systems rather than through price increase within the current system is not yet implemented.
- Weak coordination of funding from the health sector stakeholders, including funds from international organizations and bilateral agencies, government entities.
- No harmonised financial management system established yet. Multiple systems for disbursement, procurement and financial data management lead to problems of duplications and unnecessary transaction costs.
- Health care financing indicators are not included in the current national M&E framework.

6.3. HSSDP Budget

Achievements:

- There is a good financial planning due to provision of full annual budgets at the beginning of the year. This enables implementation units to confidently plan for activities without delays due to possible funding flow challenges
- Capacity building provided to central and decentralized levels in planning / costing of health interventions.

Challenges:

- There is still a de-link between the planning and budgeting processes. The funds allocated for health are not based on evidence based baselines and targets, which is made worse by the once a year transfer process that limits capacity to adjust to situation on the ground.
- The HSSDP has a budget, but no clear indication of an expenditure framework, nor the explanation of costing estimates and methods used to come up with the budget.
- The HSSDP budget, in its annex 2, has only the recurrent budget component. It does not reflect any capital budget.
- There are insufficient skills in costing health interventions

6.4. Recommendations for Health Care Financing and Funding:

For the current HSSDP:

The strategic focus in the current HSSDP is to build the information and evidence base around health financing, to provide appropriate guidance towards a comprehensive health financing strategy that will facilitate attainment of the 3 health financing goals of resource adequacy, efficiency and equity in sustainable financing of health services. The sector needs to focus on initiating the following interventions:

- A review of the existing exemption mechanisms in terms of their support to equity goals is needed. These will explore the ability to redesign them innovative mechanisms that focus on (i) increasing community awareness and involvement in the exemption mechanisms, (ii) issuance of exemption certificates prior to, not during a health event; (iii) strengthening administrative capacity for monitoring, supervising, interpreting and applying exemptions; (iv) exploring additional financing to facilities based on levels of exemptions; (v) strengthened political support for exemptions; and other approaches
- Have a comprehensive institutional analysis to define acceptable transition process towards universal health insurance which is evidence based and relevant to the country's socio-economic-cultural and political status that ensures care is accessed based on need, not ability to pay.
- The country should accelerate generation of evidence on health financing targets and indicators. Key assessments that need to be initiated include a National Health Account (NHA), health services costing study (e.g. costing of NCDs, and other emerging priorities), household health expenditure and utilization survey, sector allocative and technical efficiency studies, and a Household Living Conditions Survey. These would build the evidence base relating to key health expenditure trends and distribution in the country, and so guide the health financing targets.
- Put in place communication and advocacy mechanisms to raise internally and externally the awareness of health financing achievements of Eritrea, in view to initiate strategies to mobilise more financial resources for health. At present, Eritrea is recognized as spending the least globally on health, while it is also one of the only ones that has achieved health MDGs. There is clearly a message that needs communicating from this achievements
- The health sector national M&E framework should include the key health sector financing indicators, in order to ensure monitoring of the health financing strategies implementation in a more systematic and cost-effective way, through routine HIS data collection.
- There is a need to urgently strengthen the health financing stewardship from the Ministry of Health. This includes include a Health Financing position in the planning department, and other staffing needed in order to guide the process of elaboration of required health financing policy and strategies development and costing, implementation, monitoring, and reviews.

Based on this information, the country can conduct a comprehensive health financing assessment that would generate clear recommendations that it needs to implement in the short, medium and long term.

For the next HSSDP

The overall focus in the next HSSDP should be on putting in place an evidence based policy and strategic approach to moving towards attainment of its health financing goals. Such goals relate to sustainably assuring resource adequacy, in a manner that is efficient and equitable. This would detail out:

- Overall costs of provision of the health services as defined in the next strategic plan – macro (e.g. at sector level) and micro (e.g. by facility) costing
- Clear health financing goals relating to (i) sustainable resource adequacy, (ii) allocative and technical efficiency; and (iii) equity / fairness in financing for health services
- Key targets the sector will need to work towards, relating the resource generation, risk pooling, and purchasing of health services
- Description of the institutional arrangements the country needs to have, relating to the different means of managing finances. These means include (i) direct purchasing; (ii) social and private health insurance; (iii) direct provision; and (iv) contracting
- Definition of targets for resources to be raised from different sources of financing. These sources include (i) Government; (ii) donors; (iii) households

It is recommended the country design a comprehensive process to put in place a progressive prepayment mechanism in form of social health insurance as one of the institutional arrangements to manage health resources in a manner that is efficient, equitable and financially sustainable.

In addition to this, the health financing policy and strategy would:

- Propose mechanisms to better involve the civil society and community based organizations take an active role in the identification of the poor and the classification of households according to their socio-economic status.
- Define a strong sensitization and awareness strategy could be designed in order to ensure the community understanding and acceptance at each one of the steps of the design and introduction of a health insurance.
- Explore opportunities for Public Private Partnership and private institutions contribution to the health care financing.
- Adopt measures to address the inefficiencies in the use of resources at different levels in order to ensure efficient use of existing resources.
- Improve coordination, harmonisation and alignment of health resources from all sources; and integration of a harmonized monitoring and evaluation system based on institutional requirements rather than individual partner project.

Annex 1: Terms of Reference for the MTR of HSSDP

I. Introduction:

The National Health Policy (NHP) envisages the improvement of health status, general well-being, productivity and quality of life of the Eritrean people through the provision of quality promotive, preventive, curative and rehabilitative services. In order to make this vision a reality, the first HSSDP 2012 – 2016 has been developed and put into action for the last two and a half years.

Thus, half way the implementation, in 2014, is the time for evaluating the progress of implementation of the plan, assessment of the plan document itself and for drawing lessons learnt from this process that could feed ammunition for improvement in the second half of the plan time period. In other words, this undertaking referred to as mid-term review (MTR) is timely and important not only in identifying weaknesses and threats to the current implementation efforts but also in harnessing the current strengths and opportunities in order to accelerate implementation of the strategic plan during the remaining half of the term.

The Health Sector Strategic Development Plan (HSSDP) needs to be monitored to ensure that it is still relevant and appropriate to the current context and that the implementation of its activities are proceeding as planned. It is also an opportunity to see how the management and governance of the HSSDP can be improved; how resources can be utilized effectively and how timely decisions have been made to resolve any constraints and /or problems that are encountered during its implementation.

Therefore, the mid-term review is expected to assess the relevance of the activities, the progress made, the problems encountered and the experiences gained in the process of implementing the HSSDP. The review will use the detailed programmatic indicators & targets of HSSDP and the IHP compact. The review will assess findings, conclusions and recommendations of any previous reviews and sector performance reports, as well as various program reviews and progress reports; and recent studies or surveys and relevant documents in the health sector of Eritrea. The review will provide information on the progress of the sector plan, achievements obtained so far, constraints and/or challenges encountered and solutions provided for all of the HSSDP's eight strategic policy goals⁷. Also of interest will be to identify best lessons learned and experiences gained and forward recommendations on the overall performance of the program.

In order to make appropriate use of the mid-term review findings, WHO will provide technical support to the Ministry of Health to address any required modifications to guide the implementation of the remaining period of HSSDP. The findings will also be used to initiate the preparation for the development of the next HSSDP, which preparation should start in 2015 to allow adequate time to adhere to standards of developing a sound national health sector plan.

To this end a Steering Committee composed of high level MoH staff, chaired by the DG of the Medical Services Department have been formulated and entrusted with the task of providing oversight, guidance and leadership for the successful accomplishment of the whole process.

II. Objectives of the midterm review:

General objective:

The aim of the mid-term review (MTR) is to assess the implementation of the HSSDP in the first two and a half years of implementation in order to provide the implementers with the necessary information on the progress made, challenges faced and lessons learnt to redirect the interventions in the remaining period of the plan and to inform the next HSSDP.

⁷ Significantly reduce the burden of early childhood illness and improve maternal and child health/development; Control communicable diseases with an aim of reducing them to a non-public health problem; Prevent, control and manage non-communicable diseases; Strengthen cross cutting health interventions; Enhance efficiency, equity and quality of service delivery through health systems development; Improve effectiveness of governance of the health system; Introduce more effective and efficient health-financing scheme, as economic and purchasing capacity of the population improves; and Strengthen sector planning, monitoring and evaluation capability.

Specific objectives:

7. To assess the overall progress of implementation of the HSSDP against key set targets during the first two and a half years;
8. To detect gaps, deficiencies and challenges (policy, strategy, institutional input and other implementation constraints) and identify areas for change or modification in planned intervention strategies;
9. To identify strengths and best practices of the plan that need to be further enhanced, opportunities to be seized and threats to be eliminated;
10. To propose tangible and feasible recommendations and adjustment ideas as the way forward to improve the progress of implementation of the current HSSDP as well as to inform the development of the next HSSDP;
11. To review the costing and financing component of the plan;
12. To serve as a learning exercise for the Policy and Planning Department to conduct similar evaluation exercise in the future and also to gain insight into future strategic plan development practices.

III. Expected outcomes:

The final outcome of the whole Review Process will be a Main Report, which captures:

1. The strengths and weaknesses of the health system in the national policy context (democratization & decentralization, development of preventive & promotive health service, and other policy focuses) to proceed with the implementation of the HSSDP.
2. The level of progress made in achieving targets during HSSDP period
3. The main challenges of the implementation process of HSSDP key initiatives in the context of its main strategic objectives and strategic results and the MDGs
4. Identification of best practices and lessons learnt and major implementation problems,
5. Conclusion on achievements to determine whether HSSDP is on track or needs any adjustments in management and governance and implementation including recommendations on useful measures that will help to improve the implementation of HSSDP in the remaining period of time.
6. Recommendations on the way to develop the Health sector policies and strategies after 2016 (The HSSDP goes up to 2016) as well as the development of the next 5-year phase of health sector development strategy.

IV. Specific issues to be addressed:

The review should also assess the status of HSSDP monitoring indicators and present additional information on implementation progress and challenges.

Significantly reduce the burden of early childhood illness and improve maternal and child health/development

- Infant and child mortality
- maternal health
- malnutrition in children U5
- Access to Adolescent friendly services and information in schools and health facilities
- unwanted pregnancy and abortion, FGM
- Nutrition

Control communicable diseases with an aim of reducing them to a non-public health problem.

- HIV-AIDS prevalence
- access to treatment for HIV/AIDS
- incidence of malaria and other major diseases
- other communicable disease prevalence
- emerging and re-emerging disease epidemic occurrence
- communicable disease mortality
- communicable disease surveillance (IDS&R)

Prevent, control and manage non-communicable diseases.

- morbidity, disability and premature mortality from chronic non communicable diseases
- healthcare services based on primary health care principles that target persons with NCDs and strengthen preventive, control and curative measures

Strengthen cross cutting health interventions

- Environmental Health Services
- Health Promotion and Education
- Quality of Care
- Support Supervision
- Disaster Preparedness and Response

- Occupational Health

Enhance efficiency, equity and quality of service delivery through health systems development

- Human resources for health development
- Pharmaceuticals Procurement, Supply and Logistics Management
- Biomedical Engineering
- National Medicines Administration/ Regulation
- Procurement and Supplies Management System
- Infrastructure Engineering
- Laboratory and diagnostic services
- Medical imaging services
- Blood transfusion services
- Legal Affairs
- Basic health package delivery, including Hospital Services, Emergency Medical Care and Integrated Essential Medical Care

Improve effectiveness of governance of the health system

- Organization of health services and the National Health System
- Policy environment
- Legal frameworks
- Decentralization
- Coordination
- Partnerships

Introduce more effective and efficient health-financing scheme, as economic and purchasing capacity of the population improves.

- Health Care Financing
- HSSDP Funding
- HSSDP Budget

Strengthen sector planning, monitoring and evaluation capability

- Planning and budgeting
- Health Management Information System
- Sector Monitoring and Evaluation
- Health Research

V. Methodology of the NHSSP mid-term review:

5. An in-depth analysis of available documents such as the annual HMIS activity reports, program specific strategic plans, surveys, assessment and reports, etc.
6. Key informant interviews and discussions with program officers, MoH relevant officers and development partners;
7. Conduct of the Joint Assessment of National Strategies (JANS) of the plan document to see its comprehensiveness, alignment with program specific strategic plans, the costing component and consistency of targets with the integrated M&E framework and other strengths and weaknesses the JANS would reveal;
8. Hold consultative and periodic progress update briefing meetings with the Steering Committee and consensus building workshops with all the stakeholders.

The team leader will work with the Steering committee of the MoH for the preparation of the review.

The consultancy team is expected to:

- Propose an approach to be followed, including for data collection procedure and analysis etc.
- Develop guidelines and tools for data collection, summarization, organization and analysis in consultation with Steering Committee. The tools should be commented by Steering Committee to ensure that the review is appropriate.
- Collect data by conducting document review; interview with governmental, civil society organizations, UN Agencies and other partners implementing partners in the Zobas and sub-Zobas and other relevant stakeholders in the health sector development program; and visit health service areas.
- Organize and analyze data and write report based on the TOR.

Data will be collected through:

a) Review of relevant documents:

- HSSDP 2012 – 2016
- Eritrea Health Policy (2012)
- Periodic health reports at all levels (MoH, Zoba and sub-Zobas)
- Annual health sector and program reports
- Reports of the previous reviews and assessments
- Demographic Health Surveys (DHS) or Multi- coverage indicator Survey (MICS), if there is any recent surveys
- Other relevant policy documents (sub-sector policies, decentralization, etc.)
- Other relevant and recent studies on the health sector of Eritrea.

b) Semi-structured interviews/discussions with:

- Members of the Steering Committee and other MoH relevant committees
- MoH staff of the relevant directorates and agencies
- MoF, MoE and other relevant ministries (Eritrea to advise)
- Staff of health facilities at National, Zoba and sub-Zoba levels
- Staff of Zoba and sub-Zoba Health Offices
- Officials at administration offices at Zoba and sub-Zoba levels
- Community members/beneficiary assessment.
- Non-public sector partners in health
- Community and Religious Leaders at National and Regional levels
- Representatives of development partners proactive in the health sector
- Professional Associations (Public Health Association, Medical and other professional associations, etc.)
- Institutions of Higher Learning (School of Medicine, School of Public Health, Nurses and other professional training institutions)

c) Questionnaires

(providing qualitative information) that address the HSSDP Strategic themes, Strategic objectives and Strategic results.

VI. Deliverables:

1. An initial workplan subject to approval and consent of the Steering Committee
2. Periodic oral briefings to the Steering Committee
3. Draft document outlining the main results of the mid-term review (MTR) incorporating the JANS attributes
4. Debriefing meeting for the MoH officials on the results of the review and JANS
5. Consensus building workshop on all review results
6. Final reviewed and updated HSSDP document (*Suggest that this will be done after the review but not part of the review*)

VII: Reporting and Dissemination of Results:

The Team Leader will present the draft mid-term review report to Steering Committee. The report and any other comments as may be deemed necessary will be distributed to all stakeholders (Government agencies, donors, etc.) and will be presented at the National Stakeholders' Consultation/debriefing meeting for discussion and input. Following the review, the review team will incorporate the inputs and submit a finalized report to the Steering Committee for final approval (*2 weeks post review*).

VIII. Team Leader:

The Team Leader shall be a senior specialist in any of the public health fields related to the ToR of this review. He/She will be selected by the MoH Steering Committee and will:-

- Be accountable to MoH Steering Committee, chaired by the DG/Medical Services;
- Be responsible for the preparation of the overall review program in consultation with the Steering committee
- Have overall responsibility for the day-to-day direction of the review
- Finalize, in collaboration with the Steering Committee and the review team members, the instruments / questionnaires;
- Identify and discuss any issues/problems with the Steering Committee;
- Maintain regular contact with team members in the field
- Be responsible for the consolidation and analysis of inputs from team members to produce a coherent report.
- Be responsible for the quality of the report as stipulated by the ToR of the HSSDP mid-term review.
- Consider feedback from the draft report and be responsible for the finalization of the report

IX. The Team Members:

In general, the team will be of two types:

- 1) Team that develops the design and data collection instrument, analyze data and write the report

2) Team that will participate in the field work

The review team will consist of two teams to cover at least 4 Zobas. For the members of the teams, as much as possible, preference will be given to specialists already familiar with the HSSDP in order to maintain continuity and to the extent possible. The composition of each sub-team will have appropriate mix of national, international, Government and donor personnel. There will also be representative professionals in the teams from other sectors like Ministry of Education, Agriculture, Water, Information, Finance & Economic Development and Disaster Prevention & Preparedness Agency.

In order to strengthen the teams with professionals of sub-national planning & implementation experiences and perform in-depth analysis of health service delivery system, staff from Zoba health offices will be included in the teams but they will be assigned in different regions other than their respective work place.

Professional mix will consist of at least:

1. Public Health professionals (depending on availability in country) majority from outside the Ministry of Health but some from MOH (including agencies) with working experience in:
 - Planning/ Health Systems (?3) at least one with strong sub-national planning experience
 - Maternal Health (?2)
 - Child Health (?2)
 - Disease control (emphasis on Malaria) (?1)
 - Disease control (emphasis on HIV/AIDS and TB) (?1)
 - Community based Health care delivery (?3)
 - One Public Nutrition Expert
 - One Environmental Health Expert
 - One Health Economist
 - One Pharmacist/Procurement specialist with health system and drug supply management experience
 - One regulatory expert
2. Health professionals from selected Zoba health offices (?#)
3. Representatives from other sectors who had direct or indirect relationship with the health sector (?#)

Based on the specific tasks assigned by the team leader, a team member is expected to successfully complete the following tasks depending on his/her areas of assignment:

- Each team member shares the duties and responsibilities specified for the review;
- Each member of the team is accountable to the team leader;
- Assess the progress in HSSDP implementation by reviewing and analyzing documents, interviewing appropriate institutions and making site visits;
- Collect information required for the review.
- The review teams will report on their findings on each of the components, as specified in this ToR. The report of the mid-term review of HSSDP will thus be composed of chapters for these components as will be outlined by the Team leader.
- Perform other relevant duties assigned by the team leader.

Assessment Approach:

The assessment approach will constitute review of available documents, including reports, surveys and studies. In addition, the review team will hold interviews with key stakeholders in the MOH, Development Partners and other stakeholders at central level. This will be supplemented with field visits to at least 4 zobas, including visits to health facilities at zoba and sub-zoba level

IX. BUDGET:

The total budget required to conduct the review will be covered by WCO Eritrea and WHO/Geneva.

Annex 2: Work program of the MTR team

DATE & HOUR	ACTIVITY	ACTIVITY
Week 1: Field Visits		
Sunday 02.11	Arrival international team members in Asmara	
Monday, 03.11	Meeting with Steering Committee (SC,) and with national team members. Adoption of work program, Questionnaire and receive background documents	
Tuesday, 04.11	Present and discuss tools with Steering Committee for approval. Decide on composition of Expanded Team (incl programs and partners) and finalise the program	
Wednesday, 05.11	Team 1 visits Zoba North Red Sea (Massawa) Departure:	Team 2 visits Zoba Ansaba (Karen) Departure: Sleep in Serena Hotel
Thursday, 06.11	Visits to Sub-Zobas, Health facilities and Hospitals	Visits to Sub-Zobas, Health facilities and Hospitals in Serena Hotel or back to Asmara
Friday, 07.11	Team 1 visits Zoba Debub (Mendefera)	Team 2 visits Zoba Maekel (Asmara)
Saturday 08.11	Visits to Sub-Zobas, Health facilities and Hosp	Visits to Sub-Zobas, Health facilities and Hosp
Sunday, 09.11	Internal review of findings from field visits. Writing	Internal review of findings from field visits. Writing
Week 2: Interviews at central level		
	Team 1: Prosper Tumusiime, Arthur Heywood, Mr Semere (WHO), Mr Andeberhan Tewolde (MOH/M&E), (Diane Muhongerwa, economist)	Team 2: Jarl Chabot, Benito Koubemba, Mr Tewolde Yohannes (MOH/Planning), Mr Tzeggai Berhane (MOH/Planning), (Humphrey Karamagi).
Monday, 10.11	08.00-09.30 DG Policy and Planning and HRD Dept 10.00-11.00 SC Debriefing Field Visits 11.00-12.00 HMIS and M&E Units (+ ICT) 14.00-15.30 MND 15.30-17.30 HRD Division (training)	
Tuesday, 11.11	08.00-09.30 General Services (Procurement) 10.00-11.30 DG Admin & Finance / Budget 11.30-12.30 Biomedical Engineering 14.00-15.30 UNICEF 16.00-17.00 Steering Committee	08.00-09.30 Family and Community Health (Div) 10.00-11.30 Nutrition and EPI 11.30- 12.30 Environmental Health (Div) 14.00-15.30 UNFPA 16.00-17.00 Steering Committee
Wednesday, 12.11	08.00-09.30 Nat Health Lab (NHL) 10.00-11.00 Blood Transfusion 11.00-12.00 Legal Advisor 14.00-17.30 Team members start writing	08.00-09.00 CDC HIV/AIDS/STI 09.00-10.00 CDC TB 11.00-12.00 DG PH and Non CDC 14.00-17.30 Team members start writing
Thursday, 13.11	08.00-09.00 DG Medical Services and 08.00-09.30 Diane visit to MEducation/Finance 09.00-10.00 Dir Health Care Service Delivery incl. Emergency Serv + Disaster Prep) + Nursing 11.30-12.30 National Medicine Food Administration 14.30-15.30 Engineering unit (infrastructure) 15.30-16.30 Transport Office	08.00-09.30 IDSR 09.30-10.00 UNDP 10.00-12.00 PMU 14.00-15.30 Board of Higher Educ 16.00-17.00 Dean College of H Sciences
Friday, 14.11	08.00-10.00 WHO (all relevant departments) 10.30-11.30 Health Promotion and Education 10.30-11.30 Chair of the Faith Based Organisations (Umbrella FBO) 11.30-12.30 NSO (Arthur + Benito) 15.00-16.00 Ministry of Finance	
Saturday, 15.11	04.10 Arrival Dr Karamagi Whole day: Work on text and power point presentation	
Sunday, 16.11	03.05 Departure Diane Muhongerwa to Rwanda	
Sunday 16.11	09.00 Team meeting to discuss ppt and 14.00 Submit draft text of MTR report to JC 16.00 Invitation Yohannes for Coffee Ceremony at his home	
Week 3: Debriefing		
Monday, 17.11	10.00 Team meeting to discuss the draft report 15.00 First debriefing of results (ppt) with Steering Committee	
Tuesday, 18.11	11.00 Finalise power point for presentation on Wednesday 18.00 Finalise the first draft of the report	
Wednesday, 19.11	09.00 Finalise interviews and loose ends of the report 15.00 Broad Stakeholder Debriefing Meeting (ppt) with Zonas and Programs. 18.00 Submission of first draft	
Thursday, 20.11	Departure TL at 04.10 to Cairo	

Annex 3: List of people / institutions interviewed at National level

NATIONAL LEVEL INTERVIEWS		
INSTITUTION / DEPARTMENT	NAMES OF PEOPLE INTERVIEWED	POSITION
HE Minister of National Development	Dr. Ghiorgis Tekle	Minister of Nat Development
HE Minister of Health	Dr Amina Nurhussien	Minister of Health
DG Department Medical Services	Mr Berhane Ghebretensae	Chair Steering Committee
DG Department of Public Health	Dr Andat Tesfazion	Member and acting chair
Advisor to the Minister	Dr Mismay Ghebrehwet	Member SC
Director of Policy and Planning	Mr Tewelde Yohannes	Secretary SC
Head Planning Unit	Mr Tsegai Berhane	Member SC
WHO, Health Systems	Mr Semere Ghebregiorgis	Member SC
Dept of Planning / M&E Unit	Mr AndeBerhan Tewelde	Head M&E Unit
Office of the Minister / HMIS	Mr Emmanuel Kifle	Head HMIS Unit
Dept Policy and Planning / HRD	Dr Berhane Debru	Acting DG HR Division
Dept Public Health / MNCH	Dr Berhane Haile	Head Fam & Community Hlth Div
	Efrem Zerai	Reproductive Health
	Tesfagaber	Child and Adolescent Health
	Amleset Hagos	Nutrition
	Tekie Abraha	Environmental Health
Dept Public Health	Dr. Andat Tesfazion	Acting DG PH / Head NCD
Dept Public Health / Disease Control	Dr Berhane Araya	Director CDC / HIV-AIDS
	Dr. Ratwa Tekle	CDC / TB Program Manager
	Mr Selam Mihreteab	CDC / Malaria
National Blood Transfusion Services	Mr Mekonnen Tesfagiorgis	NBTS
	Mr Solomon Eyob	NBTS
	Ms Menghisteab Andemichael	NBTS
	Mr Tewolde Gebregiorgis	NBTS
	Ms Selamawit Nemariam	NBTS
	Mr Senoit Tesfazhghi	NBTS
MOH Office	Mr Mehari Woldu	Legal Advisor to the Minister
MOH/ Dept Medical Services	Mr Berhane Ghebretensae	DG Medical Services
	Dr Goitom Mebrahtu	Director Med Services
	Sr Terhas Mehreteab	Director Nursing Division
	Mr Hailemariam Andemariam	Manager of Infrastructure
MOH / PMU	Dr Eyob Tekle	Director PMU
MOH / National Health Lab	Mr Asmerom Seyoum	Acting Head NHL
MOH/Health Promotion	Mr Gabremichael Tesfasghi	Head Health Promotion
Dept Medicines and Food admin	Mr Iyassu Bahta	Director Nat Med and Food Admin
Board of Higher Education	Dr. Zemenfes	Director
Asmara College of Health Sciences	Prof Berhane Girmay	Dean College of H Sciences
MOH, Finance Division	Mr. Assemehay Yebio	Director of Finance

NATIONAL LEVEL INTERVIEWS			
INSTITUTION / DEPARTMENT	NAMES OF PEOPLE INTERVIEWED	POSITION	
UNDP	Ms Christine N. Umutoni	UN Resident Coordinator	
	Mr Habte M. Gebregziabher	Program Analyst	
UNICEF	Dr Suleiman Braimoh	Representative UNICEF	
	Mr Youssouf Koita	Nutrition manager	
	Mr Hadish Tesfanaithe	Nutrition Officer	
	Ms Yodit Hiruy	Health Specialist	
UNFPA	Dan Odallo	Representative UNFPA	
	Mrs Yordanos Mahari	Program Officer	
	Mr Kahasse	Associate Program Officer	
	Mrs Yodir Gebrai	Finance officer	
	Tsehai Afeworki	Gender specialist	
World Health Organisation WHO	Dr Abdulmumini Usman	WR	
	Mr Semere Gebregiorgis	WHO Health Systems	
	Dr Assefash Zehaie	MNCH and ATM	
	Mr Tzeggai Kidanemariam	EPI Officer	
	Ms Zaid Gebremeskel	HR Officer	
	Ms Azmera Gebreselassie	Data manager	
	Mr Esayas Ande	WHO Operation Officer	
(SUB-)ZOPA LEVEL INTERVIEWS			
INSTITUTION / DEPARTMENT	NAMES OF PEOPLE INTERVIEWED	POSITION	
Zoba of Anseba / Karen Hospital	Dr Kasete Solomon	Medical Officer in charge	
	Ato Tzeggai	Head of Planning	
	Staff of all services present		
Community Hospital Elabereth	Alazar Haile	Nurse in charge	
Health Station Halibmental (mission)		Sister in Charge	
Health Station Glass (mission)	Elsa (Ursula Sisters)	Sister in charge	
Community Hospital Hagaz		Nurse in charge	
Health Station Dorotai	Mohammed Usman	Nurse in charge	
Community Hospital Aditokelezan	Samuel	Nurse in charge	
Zoba Maekel / Asmara	Dr Tesfay Solomon	Medical Officer in charge	
	Staff of all services present / Dr Gregorius	Head SRH unit	
	Health Station Embaderho	Bereket Yohannes	Nurse in Charge
		Askalu Hadege	CHA / Health Promotor
		Yohannes Yemane	CHA / Health Promotor
	Community Hospital Bet-Mekae (Villagio)	Dr Tseghereda Mehari	Medical Director, Pediatrician
		Sister Mnet Welday	Matron-Nurse
	Zemichael Gebremedhin	Administrator	
Health Centre Semenawi Asmara	Abrehet Yemane	Nurse in Charge	
Zoba North Red Sea / Massawa			
	Zoba NRS	Dr. Yohanes Tekeste	Zonal Medical Director
		Solomon Kelifa	Head, Family and community health (PHC)
	Eyob Woldeyesus	Head, Admin. & Finance	

	Hakiseyor Kibrom	Head, HIV/STI program
	Huruy Asfaha	Head, Environmental Health (Quarantine & Inspection)
	Weldeyesus Belay	Head, Planning unit
	Belay Habte	Head, TB and Leprosy
	Birhane Alemseged	Head, Health promotion
	Zedingl Asgedom	Head, Malaria program
Foro Health Centre	Mr. Menges Tewelde	Head, Foro Health Center
	Tsega Araya	Pharmacy dispenser
Hirgigo Health Statuion	Arefaine Ogba	Head, Hirgigo Health station
	Kedija Ahmed	Health Assistant
	Wezenet gebrekidan	Health Assistant
Amatere Health Centre	Mr. Semere	Head, Amtere MCH
Ghindae Referral Hospital	Dr. Dawit	Hospital Director
Zoba Debub / Mendefera	Yemane Haile	Medical Director
	Esseyas Araya	Head, Admin & Finance
	Isak Tekle	Head, Medical services
	Sr. Beletesh Gebreab	Head, Health promotion unit
	Sr. Lemelem Habte	Head, TB & Leprosy program
	Mohamed salih	Head, Environmental Health
	Abraha Weldeselasia	Head, Malaria unit
	Freminatos Misgina	Head, Zonal Pharmacy store
	Asefaw Negasi	Head, HIV/STI program
	Sr. Maeza kelati	Head, FCH
Dekemhare Community Hospital	Dr. Bernandos Bahta	Medical Director
Mendefera Referral Hospital	Dr. Amanuel Mihreteab	Director,
Debarwa Health Centre	Ghebrehiwet	Director, Debarwa HC
Shiketi health station	Semere	Head,

Annex 4: List of documents consulted

Author / Year	Title
DHS 2002	Eritrea, 2002 Demographic and Health Survey, key findings
MOH Sept. 2005	Human Resources Strategy for the health sector in Eritrea 2006-2010
MOH Nov 2007	National Health Financing Policy Eritrea, draft 2
MOH Nov 2007	Health Care financing and funding (draft) with National Health Care Financing Policy (power point)
MOH, 2007	National Medicines Policy
MOH, March 2010	National Health Policy
MOH, Nov 2011	Health Sector Strategic Development Plan (HSSDP, 2012 - 2016)
MOH, Oct 2012	Second National Integrated Monitoring and Evaluation Framework 2012-2016
MOH / GF, 2013	Health Facility Assessment (HFA), Report 2013
NSO et al, Aug 2013	Eritrea Population and Health Survey 2010
MOH, May 2012	Annual Health Service Activity Report 2012 by HMIS Unit
MOH, May 2013	Annual Health Service Activity Report 2013 by HMIS Unit
MOH, 2013	Priority Health Research Agenda, 2013-2017
MOH, 2014	Semi Annual Report 2014
MOH, April 2014	Annual Health Services Activity Report for the year 2013
MOH, Aug 2014	Definitions / functions of various levels of health care service delivery in Eritrea
MOH, Oct. 2014	Consultancy report on Assessment of the Health Information System (HIS) for Eritrea by Mugagga Malimbo (with power point) (Word and Adobe)
MOH, undated	National Referral System, Guidelines and Protocols
MOH, Undated	Zoba - health facility distribution (power point of all 6 Zobas)
PPD, 2012	Description of Annual Plan of action and Implementation Reporting Format Annual Plan of action. Format Annual Report 2012/2013 with the Planning Cycle
MOH, 2013	Priority Health Research Agenda 2013-2017
MOH/FCH 2013	Family and Community Health Annual report 2013 with power point
MOH, July 2012	Fourth Eritrea National Strategic Plan on HIV and AIDS / STI (ENASP IV) 2012-2016; "Towards Universal Access and the Three Zeros".
MOH, NMCP, undated	Malaria Annual Report 2011
MOH, NMCP, undated	Malaria Annual Report 2013 (Draft)
MOH, NMCP undated	Malaria Annual Report (Dec 2011 till Nov 2012)
MOH, NMCP Dec 09	Malaria Five Year Strategic Plan 2010-2014
MOH, NMCP Mar 14	Malaria Five Year Strategic Plan 2015-2019 (draft)
MOH, Sept 2006	National Health Promotions Policy (draft)
MOH, Nov 2011	National Health Promotion Strategic Plan 2012-2016
MOH, Oct 2014	MTR of the National Health Promotion Strategic Plan 2012-2016
MOH, XX	Eritrea National Medicines Policy
MOH, 2014	Eritrea National Pharmaco-vigilance Policy
UNDAF-GOE Nov 2012	Strategic Partnership Cooperation Framework (SPCF 2013-2016):

Author / Year	Title
	Driving Towards MDGs
Sebhatu et al, 2007	Determining the burden of TB in Eritrea, a new approach
WHO Afro, May 2012	Eritrea TB Control Program, external review report, May 2012
MOH. Oct. 2014	TB, M&E Framework
WHO, undated	Country Cooperation Strategy 2009 -2013
WHO, undated	Eritrea Country Cooperation Strategy 2009-2013
WHO, undated	Eritrea, Health Profile (2 page)
WHO Reg Office 2010	Eritrea, Factsheets of Health Statistics 2010
WHO 2012	Eritrea, Malaria Profile
WHO 2012	Eritrea, NCD Profile
WHO, June 2013	Assessment of the situation of the National Health Laboratory Services in Eritrea, June 2013.
WHO, 2014	International Health Regulation (IHR) with Eritrea Plan of Action 2013-14 and Progress of Implementation of IHR at national level (powerpoint)
WHO, Oct 2014	Global Reference List of Core Indicators (Geneva)
WHO, Oct 2014	Global Reference List of 100 Core Health Indicators (version 4)
UNFPA, 2012	Eritrea, Countdown to 2015 for MNCH
UNFPA 2014	Eritrea, country achievement and highlights for 2014 (power point)
UNICEF, Feb. 2013	Country Program Document 2013 - 2016
UNICEF, 2013	Annual Report 2013, Eritrea
WB, undated	Eritrea Poverty Assessment EFY
ODI - DP, 2011	Progress in Health in Eritrea



Joint Assessment of National Health Strategies and Plans

Joint Assessment Tool

Version 3, August 2013

For further information and additional documents on Joint Assessment, go to:
<http://www.internationalhealthpartnership.net/en/home>

The Joint Assessment Tool

Introduction to the joint assessment of national health strategies and plans

Joint assessment is a shared approach to assessing the strengths and weaknesses of a national strategy¹, which is accepted by multiple stakeholders, and can be used as the basis for technical and financial support. Joint assessment is not a new idea, but there are several reasons for renewed interest in the approach. There is strong consensus that sustainable development requires harmonized support to national processes. In health, the increased number of international actors in recent years has led to a resurgence of efforts to coordinate resource use and get more partners to support a single national health strategy. The presumed benefits of joint assessment include enhanced quality of national strategies and greater partner confidence in those strategies, thereby securing more predictable and better aligned funding. The inclusion of multiple partners in a joint assessment is also expected to reduce transaction costs associated with separate assessment processes.

An IHP+ inter-agency working group² developed this joint assessment tool, and its associated guidelines. These were reviewed by seven countries³ and endorsed by IHP+ partners at a steering group (SuRG) meeting in 2009 as ready for testing. In 2010, the tool was applied in several countries as part of the national health planning process⁴. The tool has also been used for the assessment of program strategies, and for other reviews of national plans⁵. Based on the lessons learned from these early applications of the tool, this version was developed under the oversight of a multi-agency group.

How to use this tool, and its companion guidelines

The joint assessment tool is deliberately generic - it sets out the essential 'ingredients' of any sound national strategy but, given the diversity of country circumstances, it does not prescribe what those elements should contain. It can be used to assess an overall national health strategy or specific sub-sectoral and multi-sectoral strategies. It examines the strengths and weaknesses of five sets of attributes considered the foundation of any 'good' and comprehensive national strategy:

- **Situation analysis and programming:** clarity and relevance of strategies, based on sound situation analysis
- The **process** through which national plans and strategies have been developed
- *Costs and budgetary framework for the strategy*
- **Implementation and management arrangements**
- **Monitoring, evaluation and review mechanisms**

It is not assumed that all the attributes will be detailed in the strategy or plan document itself – some aspects may be covered in other policy, strategy and operational documents. Assessment of a national health strategy includes a review of the strategy itself, and its alignment with national development frameworks; related multi-sectoral and sub-sectoral / disease specific strategies; monitoring and evaluation plan and budgetary processes. This means an assessment requires review of a portfolio of documents, not one single document.

The way a joint assessment is carried out will be unique to each country, but based on some key principles: it will be country demand driven; be country led and build on existing processes; include an independent element, and engage civil society and other relevant stakeholders. The output is not a yes/no recommendation for funding. It will give an assessment of the strengths and weaknesses of the national strategy, and gives recommendations. Findings can be discussed by national stakeholders and partners and may be used to revise the strategy.

¹ The term 'national strategy' is used here to include the various types of health plans and differing terminology used in countries, including health sector strategic plans, national health plans etc.

² A full list of agencies and institutions involved can be found at the end of this document.

³ Multi-stakeholder consultations held in: Burundi, Ethiopia, Ghana, Mali, Tajikistan, Viet Nam and Zambia.

⁴ Countries that used the JANS tool in 2010 include Bangladesh, Ethiopia, Ghana, Nepal, Uganda, Vietnam and Zambia.

⁵ The Global Fund used the tool in its first learning wave of national strategy applications for HIV/AIDS, TB and malaria. GAVI commissioned 26 country desk reviews of national strategies and related documents, using the JANS tool.

The Joint Assessment Tool

JOINT ASSESSMENT ATTRIBUTES AND CRITERIA

Attributes	No.	Characteristics of the Attributes
1. SITUATION ANALYSIS AND PROGRAMMING Clarity and relevance of priorities and strategies selected, based on a sound situation analysis		
Attribute 1: National strategy is based on a sound situation and response analysis of the context (including political, social, cultural, gender, epidemiological, legal, governance, and institutional issues).	1.1	The situation analysis is based on a comprehensive and participatory analysis of health determinants and health outcome trends within the epidemiological, political, socio-economic and organizational context prevailing in the country.
	1.2	The analysis uses disaggregated data to describe progress towards achieving health sector policy objectives in line with primary health care • Universal coverage, to improve health equity • Service delivery, to make health systems people-centred • Public policies to promote and protect the health of communities • Leadership to improve competence and accountability of health authorities.
	1.3	Analysis of past and current health sector responses and health financing arrangements identifies priority problems and areas for improvement
Attribute 2: National strategy sets out clear priorities, goals, policies, objectives, interventions, and expected results, that contribute to improving health outcomes and equity, and to meeting national and global commitments.	1.4	Objectives are clearly defined, measurable, realistic and time-bound.
	1.5	Goals, objectives and interventions address health priorities, access, equity, efficiency, and quality and health outcomes across all population sub-groups, especially vulnerable groups. This includes plans for financing health services that identify how funds will be raised; address financial barriers to access; minimise risks of impoverishment due to health care; and create incentives from improved efficiency
Attribute 3: Planned interventions are feasible, locally appropriate, equitable and based on evidence and good practice, including consideration of effectiveness, efficiency and sustainability.	1.6	Planned approaches and interventions are based upon analysis of effectiveness and efficiency, and are relevant to the priority needs identified. The approaches to and pace of scale up look feasible considering past experience on implementation capacity, and identify ways to increase efficiency.
	1.7	The plan identifies and addresses key systems issues that impact on equity, efficiency and sustainability, including financial, human resource, and technical sustainability
	1.8	Contingency plans for emergency health needs (natural disasters and emerging/re-emerging diseases), in line with the International Health Regulations, are included in plans at all levels
Attribute 4: An assessment of risks and proposed mitigation strategies are present and credible.	1.9	Risk analyses include potential obstacles to successful implementation. Mitigation strategies identify how these risks are being addressed.
2. PROCESS Soundness and inclusiveness of development and endorsement processes for the national strategy		
Attribute 5: Multi-stakeholder involvement in development of the national strategy and operational plans and multi-stakeholder endorsement of the final national strategy.	2.1	A transparent mechanism exists which ensures the lead of the government and meaningful participation of all stakeholders, so they can provide input systematically into strategy development and annual operational planning. Stakeholders include national and local government institutions; public representatives; civil society; private health care providers; and development partners.
Attribute 6: There are indications of a high level of political commitment to the national strategy.	2.2	Relevant sectoral and multi-sectoral policies and legislation, under the spirit of "health in all policies", are in place to allow successful implementation.
	2.3	The strategy notes challenges to implementing the needed regulatory and legislative framework and has approaches to overcome enforcement
	2.4	Political commitment is shown by provision for maintaining or, where relevant, increasing government's financing of the national strategy.
	2.5	High-level (e.g. national assembly) political discussion, and formal endorsement of the national health strategy and budget is planned, as appropriate to national

Attribute 7: The national strategy is consistent with relevant higher- and/or lower-level strategies, financing frameworks and plans.	2.6	The national health strategy, disease specific programmes and other sub-strategies are consistent with each other and with overarching national development
	2.7	In federal and decentralized health systems, there is an effective mechanism to ensure sub- national plans address main national-level goals and targets.
3. COSTS AND BUDGETARY FRAMEWORK FOR THE STRATEGY Soundness and feasibility		
Attribute 8: The national strategy has an expenditure framework that includes a comprehensive budget /costing of the programme areas covered by the national strategy.	3.1	The strategy is accompanied by a sound expenditure framework with a costed plan that links to the budget. It includes recurrent and investment financing requirements to implement the strategy, including costs of human resources, medicines, decentralized management, infrastructure and social protection mechanisms. When appropriate, the framework includes costs for activities and stakeholders beyond the public health sector.
	3.2	Cost estimates are clearly explained, justified as realistic, and based on economically sound methods.
Attribute 9: The strategy has a realistic budgetary framework and funding projections. If the strategy is not fully financed, there are mechanisms to ensure prioritisation in line with overall objectives of the strategy,	3.3	Funding projections include all sources of finance, specify financial pledges from key domestic and international funding sources (including lending), and consider uncertainties and risks.
	3.4	Funding projections are realistic in the light of economic conditions, medium term expenditure plans, and fiscal space constraints.
	3.5	If the level of funding is unclear or there is a gap, then the priorities for spending are spelt out with the consequences for results (either by showing the plans and targets under high, low, and most likely funding scenarios, or by explaining the process for determining spending priorities).
4. IMPLEMENTATION AND MANAGEMENT Soundness of arrangements and systems for implementing and managing the programmes contained in the national strategy		
Attribute 10: Operational plans are regularly developed through a participatory process and detail how national strategy objectives will be achieved.	4.1	Roles and responsibilities of implementing partners are described. If there are new policies or approaches planned, responsibility for moving them forward to implementation is defined.
	4.2	There are mechanisms for ensuring that sub-sector operational plans – such as district plans, disease program plans and plans for agencies and autonomous institutions – are related and linked to the strategic priorities in the national health strategy.
Attribute 11: National strategy describes how resources will be deployed to achieve outcomes and improve equity, including how resources will be allocated to sub-national level and non-state actors.	4.3	The organization of service delivery is defined and the strategy identifies the roles and responsibilities of service providers and resources they require.
	4.4	Plans have transparent criteria for allocation of resources (human resources, commodities, funding) across programmes and to sub-national levels and non-state actors (where appropriate), that will help to increase equity and efficiency.
	4.5	Current logistics information and management system constraints are described, and credible actions are proposed to resolve constraints.
Attribute 12: The adequacy of existing institutional capacity to implement the strategy has been assessed and there are plans to develop the capacity required.	4.6	Human resource (management and capacity) needs are identified, including staffing levels, skills mix, distribution, training, supervision, pay and incentives.
	4.7	Key systems are in place, and properly resourced, or there are plans for the improvements needed. This includes systems and capacity for planning and budgeting; technical and managerial supervision; and maintenance.
	4.8	Strategy describes approaches to meet technical assistance requirements for its implementation.
	4.9	Financial management system meets national and international standards, and produces reports appropriate for decision-making, oversight and analysis. Strengths and weaknesses in financial management systems, capacity, and practices in the sector are identified, drawing on other studies. Action plans to strengthen PFM address fiduciary risks, are feasible within a reasonable timeframe and are fully

<p>Attribute 13: Financial management and procurement arrangements are appropriate, compliant, and accountable. Action plans to improve public financial management (PFM) and procurement address weaknesses identified in the strategy and in other diagnostic work.</p>	4.10	Procurement systems meet national and international standards. Areas requiring strengthening have been identified, drawing on other studies, and there is a realistic plan to address these.
	4.11	Reasonable assurance is provided by independent internal and external audits and by parliamentary oversight. Audits include assessment of value for money. Mechanisms for following up audit findings are in place and functional.
	4.12	It is clear how funds and other resources will reach the intended beneficiaries, including modalities for channelling and reporting on external funds. There are systematic mechanisms to ensure timely disbursements, efficient flow of funds and to resolve bottlenecks. In decentralized health systems, this includes effective sub-national fund flow processes and financial oversight.
<p>Attribute 14: Governance, accountability, management and coordination mechanisms for implementation are specified.</p>	4.13	Internal and multi-stakeholder external governance arrangements exist that specify management, oversight, coordination, and reporting mechanisms for national strategy implementation.
	4.14	Description of national policies relating to governance, accountability, oversight, enforcement and reporting mechanisms within the Ministry and relevant departments. Plans demonstrate how past issues on accountability and governance will be addressed, to fully comply with national regulations and international good practice.
<p>5. MONITORING, EVALUATION AND REVIEW Soundness of review and evaluation mechanisms and how their results are used</p>		
<p>Attribute 15: The plan for monitoring and evaluation (M&E) is sound, reflects the strategy and includes core indicators; sources of information; methods and responsibilities for data collection, management, analysis and quality assurance.</p>	5.1	There is a comprehensive framework that guides the M&E work, which reflects the goals and objectives of the national strategy.
	5.2	There is a balanced and core set of indicators and targets to measure progress, equity and performance.
	5.3	The M&E plan specifies data sources and collection methods, identifies and addresses data gaps and defines information flows.
	5.4	Data analysis and synthesis is specified and data quality issues are anticipated and addressed.
	5.5	Data dissemination and communication is effective and regular, including analytical reports for performance reviews and data sharing.
	5.6	Roles and responsibilities in M&E are clearly defined, with a mechanism for coordination and plans for strengthening capacity. .
<p>Attribute 16: There is a plan for joint periodic performance reviews and processes to feed back the findings into decision making and action.</p>	5.7	There is a multi-partner review mechanism that inputs systematically into assessing sector or programme performance against annual and long term goals
	5.8	Regular assessments of progress and performance are used as a basis for policy dialogue and performance review.
	5.9	There are processes for identifying corrective measures and translating these into action, including mechanisms to provide feedback to sub-national levels and to adjust financial allocations.

Annex 6: Questionnaire for the MTR of the HSSDP in Eritrea, Nov 2014.

I. BASIC HEALTH CARE PACKAGE (BHCP)

National level (Tertiary) (HSSP, pages 22-40)

2.1. MNCH (SRH, IMNCI, EPI, FP, FGM, Adolescent Health, Fistula, Cancer) and Nutrition (BF, Micronutrients)

The statistics on the MNCH program show enormous progress.

Q1. In what specific areas has progress been made. What have been the factors that contributed to the success.

Q2. Where progress (against baseline or targets) was not achieved, what have been the main constraints and challenges that stood in the way.

Q3. Nationally progress on proportion of deliveries attended by skilled attendance have been stagnant. What do you think are the main factors that contributed to this and what action need to be taken immediately and in the long run?

Q4. In the Semi-annual report no mention is made on FP, FGM, Adolescent Health or Cancer. Can you tell us more about what achievements and constraints you are facing.

Q5. What is the status of implementation of integrated management of child illnesses (IMNCI) for common childhood illnesses

Q6. There is still a lot of malnutrition of children 1-5 reported. Please tell us your plans in this field.

Q7. Are there any best practices or Lessons Learned that you would like to share.

Q8. What are the main challenges you face to implement the HSSDP in the last two years.

Q9. What is your recommendation for the two remaining years of HSSDP and for the next HSSDP

2.2. Prevention, Control and Mgmt of **Communicable Diseases** (CDC) (ARI, CDD, STI, HIV/AIDS, TB, Malaria)

A lot of impressive work in the area of CDC has been undertaken. What are currently the top 3 CDC that are having an impact on the health status of the population. Have sector priorities been changes as a consequence.

2.3. Prevention, Control and Mgmt of **Non-Communicable Diseases** (NCD) (Diabetes, Mental, Oral, Eyes, Injuries) (Tobacco, Alcohol, physical, nutrition, specific education)

Has any comprehensive inventory of the major NCD been made? What are the three / five most important ones in terms of morbidity and mortality for the country. What specific interventions have been put in place.

2.4. **Cross-cutting** health interventions (p. 34 ff)

2.4.1. Environmental Health (excreta & waste disposal, safe food, hygiene, IAP, risk factors, ODF, WaSH)

2.4.2. Health Promotion and Education

2.4.3. Quality of Care (standards, guidelines, regulation,

2.4.4. Support Supervision

2.4.5. Rehabilitative Health Care (p. 38) (disability, deafness, blindness, CBR)

2.4.6. Disaster Preparedness and Response with IDS&R (p. 39 and p. 31)

2.4.7. Occupational Health (p. 40)

Q1. For each of these areas, questions are about progress made, problems encountered, lessons learned and plans for the remaining period of HSSDP.

On disaster preparedness:

Q1. Is there capacity and systems to detect health systems emergencies? Yes/No

Describe the strength and weaknesses

Q2. What is the state of preparedness and the response plan, human resources, drugs and medical supplies and other resources) to respond to these emergencies

I.2. Zoba level (Secondary)

Q1. In what areas has progress been made. What have been the factors that contributed to the success

Q2. Where progress (against baseline or targets) was not achieved, what have been the main constraints and challenges that stood in the way.

Q3. Nationally progress on proportion of deliveries attended by skilled attendance have been stagnant. What do you think are the main factors that contributed to this and what action need to be taken immediately and in the long run?

Q4. What is the status of implementation of integrated management of child illnesses (IMNCI) for common childhood illnesses in your Zoba

Q5. Are there adequate and timely supply of drugs and supplies at Zoba level?

Q6. How do you describe the support you get from national levels (supervision, guidelines)

Q7. What are the main challenges you face to implement the HSSDP in the last two years.

Q8. What is your recommendation for the two remaining years of HSSDP and for the next HSSDP

Q9. Are there any best practices or Lessons Learned that you would like to share with other Zobas.

I.3. Sub-Zoba level (Primary = HS/HC + CHosp)

Q1. In what areas has progress been made. What have been the factors that contributed to the success

Q2. Where progress (against baseline or targets) was not achieved, what have been the main constraints and challenges that stood in the way.

Q3. Nationally progress on proportion of deliveries attended by skilled attendance have been stagnant. What do you think are the main factors that contributed to this and what action need to be taken immediately and in the long run?

Q4. What is the status of implementation of integrated management of child illnesses (IMNCI) for common childhood illnesses in your Zoba

Q5. Are there adequate and timely supply of drugs and supplies at Zoba level?

Q6. How do you describe the support you get from national levels (supervision, guidelines)

Q7. What are the main challenges you face to implement the HSSDP in the last two years.

Q8. What is your recommendation for the two remaining years of HSSDP and for the next HSSDP

Q9. Are there any best practices or Lessons Learned that you would like to share with other Zobas.

I.4. Community level (CBHS)

II: HOSPITALS, EMERGENCY AND ESSENTIAL MEDICAL CARE

Hospitals:

- Organization and management
 - Hospital management committee
 - Other specialized committees (finance, welfare, etc.)
- What plans exist?
 - Strategic plan
 - Operational plan
- Hospital financing
 - Budget (budgeted amount in previous FY, proportion of budget received)
 - Sources of funding (central funds, own generated funds, private wings, etc.)
 - Financial management & financial reporting)
- Training functions
- Supervision of lower health facilities
- Hospital efficiency
 - Average length of stay
 - Bed occupancy rate

Emergency Medical Care:

- Existence of accident and emergency unit in health facilities (adequate HR, space, equipment)
- Transport and communication (functional and well-equipped ambulance and VHF radio or other means of communication)
- Staff trained in emergency care/response

III. ESSENTIAL HEALTH SYSTEMS AND GOVERNANCE

III.1. National level (Tertiary)

A. Systems (p. 45 - 57)

Human Resources for Health (HRH)

What strategies have been taken to increase availability of HR? What challenges are being faced?

How is in-service training coordinated and managed?

Do you have a problem of high turnover of HR? If so what strategies have been employed to address this?

What role are the professional bodies playing?

Management at all levels is critical. How is this being strengthened?

Procurement, Supply and Logistic Mgmt (p. 46-48 and p. 50)

Have there been any challenges in availability of pharmaceuticals and medical supplies and equipment?

How are the needs determined?

What arrangements have been put in place to strengthen preventive maintenance of equipment and transport? Is

there any relevant policy in place? If so what is the status of implementation?

Does the Ministry have a computerized logistics management information system? What is the status?

Biomedical Engineering (p. 48)

What is the status of the Biomedical Engineering unit (its strength, functions, funding)?

Are there challenges with availability of spare parts for medical and transport equipment?

What is the status of maintenance workshops at Referral Hospitals?

Has the standard medical equipment list been established for each health service level?

Medicines Administration and Regulation (p. 49/50)

What is the status of drugs laws and regulations?

Are there any challenges with drug quality control? Is the quality of the drug quality control laboratory in place and fully functional?

Is there a mechanism to review/revise regulations on medicines and medical supplies?

How are traditional medicines regulated?

Transportation and Communication (not included in the text)

How is transport and communication managed at various levels of health services delivery?

Infrastructure Engineering

Is there national guidance on development of health infrastructure? If yes, are there any challenges adhering to the guidance?

Is there a long-term health infrastructure plan in place?

Is the health facility database available and up-to-date? How is it maintained?

Are there hard to reach populations that do not have access to health services in walking distance? If so, what plans are in place to address this?

Laboratory, Diagnostic services and Medical imaging

Is there clear distinction of roles between central laboratories and peripheral laboratories? How are these linked?

Is there a laboratory and other diagnostic strategic plan? If yes, what is the status?

Are there any challenges faced with laboratory quality assurance?

What is the availability of imaging and radiotherapy in health facilities?

Blood transfusion services

What is the capacity and status of the Eritrea National Blood Transfusion services (storage, distribution, quality, types of blood products)?

To what extent have the blood transfusion services been decentralized?
Does the available blood meet the blood requirements?

Legal Affairs / legal framework

What is the status of the legal affairs office?

Are there established mechanisms for revision and amendments of laws and regulations? How often are the laws reviewed?

What is the link between the legal affairs office and the Ministry of Justice and that of Internal Affairs? Are there challenges with enforcement of the laws and regulations?

B. Governance and Guiding Principles (pages 14-20)

Organisation of services (levels of care, referrals and community involvement)

Are the levels of care currently clearly defined? Are their functions established and do they have the resources to effectively carry out their functions? Any challenges?

How is the role of the community captured in the organization of health services and what is the perceived level of community involvement in health service planning and management?

Policy environment and priorities (UHC, equity, comprehensiveness, intersectoral)

Does the current policy and strategic plan fully embrace tenets for moving towards universal health coverage? Do they need any adjustments?

Is the current basic health care package comprehensive?

To what extent are the other government and non-government sectors involved in plan and management of health and health-related services?

Partnership arrangements (national and international)

What partnership arrangements and structures are in place? How could they be strengthened?

Coordination and Decentralisation

As the steward for health, Ministry of Health coordinates and directs health sector efforts. What are the current coordination fora for health both at national and zoba and sub-zoba levels?

To what extent have health service functions been decentralized? Are there any challenges with decentralization in the health sector? Are the lower levels able to locally raise funding? Do they have the mandate to take financial and HR decisions?

Health Standards and Regulation / Accreditation

Are there national health standards in place? How often are they reviewed? What mechanisms are there to ensure the standards are adhered to? Is there any service accreditation system?

III.2. Zoba level (Secondary)

III.3. Sub-Zoba level (Primary = HS/HC + CHosp)

III.4. Community level (CBHS)

IV. SECTOR PLANNING, MONITORING AND EVALUATION

IV.1. National level (Tertiary) (p. 58 - 64)

Sector Planning and budgeting

1. How do you develop annual plans? Please describe the process, particularly how information is used in the process?

2. What are strengths and weaknesses of the current planning system (its process, bottlenecks analysis and high impact focus)

3. Did you receive adequate guidelines, training, orientations, etc mentoring and technical support during this process? Yes _____ No _____

4. What is the level of involvement of various stakeholders in this planning process?
5. What is the ICT based support you receive to carry out planning and monitoring functions?
6. Are there vertical plans (parallel plans) that you are requested to prepare by partners?
7. If yes, Please specify partners that requested to develop a vertical program plan
8. How aligned is the your plan to other planning and budgeting formats? Is there additional work burden to meet different planning formats?

9. What do you think should be done to further strengthen the planning process?

Health Management Information Systems (HMIS)

Please describe how the HMIS plan has been developed?

What are its successes and challenges in terms of meeting the quality and timeliness of objective?

Has it achieved its targets? If not, why not?

How are targets of the HSSDP being decided. Are they annual and are they used to monitor implementation, please describe and give examples

How far is the HMIS system owned, managed and implemented?,

- Is there overall acceptance by all programs within government
If not, what are its limitations and what can be done to address these limitations to ensure that all the programs feel part and part of the information system?
- Is there a plan to revise the indicators list after 5 years?
- Are there other information systems being built within the health sector (IFMIS, HRIS, LMIS etc) and also to meet the information requirements of donors and other agencies? If yes
 - , what is the strategy for interface among these different systems
 - What mechanisms are in place for these systems to speak with each other?
 - Are cross cutting indicators being generated and used?

- Is there evidence of feedback reports being sent down the levels to improve use of information for action?
- Does HMIS produce the information that it is expected to generate?
 - Does it provide quality evidence at all levels of the systems for all who need it (including dissemination/sharing timely information)?
 - What is missing and what can be done to improve it?
- Is there a strategy and mechanism to coordinating national surveys, census and research?
 - How far has it been implemented and adhered to?
 - How far is HIS managed comprehensively (including use and support to population based data)?
 - What are the mechanisms and degree of functionality?
 - What is the progress of setting up civil and vital registration system?
 - What is the role of MOH and use of the outputs?
- Is adequate capacity for data warehouse, utilization and dissemination at national and Zoba levels?
- Is the standard for staffing health information technicians and infrastructure and equipment requirement met? If not, what were the major challenges and what can be done to address them.

Sector Monitoring and Evaluation

- How is the M&E information generated through the routine information system used in decision making?
- Is there a written M&E plan?
 - To what degree is this plan implemented?
- How is the M&E information generated through the routine information system used in decision making?
 - Planning?
 - Resource allocation
 - Results based financing?
 - Others
- Which indicators are used for monitoring?
 - How are these indicators selected?
 - When were they last reviewed?
- Who participates in the monitoring process?
- How are the results of the monitoring process used?
- Do you ever receive feedback from monitoring done at higher levels

Health Research

Has any health research been done in the past year ? If yes

Who performed the research?

What has been done locally with the results of the research?

How were the results of the research disseminated?

IV.2. Zoba level (Secondary)

Have you been involved in the development of annual Zoba based plan? Do you have your own annual plan? If yes who is involved in the development of the plan?

NGO working with YOU? In what way?

- Sub-Zoba health workers?
- Community Health Agents?
- Any government administration, please specify

10. Did you receive adequate guidelines, training, orientations, etc mentoring and technical support during this process from the National level ?Yes _____ No _____

Supportive supervision

		Yes	No
1	Do you receive supportive supervision?		
2	How often do you receive supportive supervision from the National level		
3	Do you get feedback after supportive supervision?		
4	How is feedback given to you?		
5	Do you have supportive supervision schedule?		
6	How often do you conduct the Supportive supervision to HCs and Health Stations		
7	Do you provide feedback after supportive supervision?		
8	How is feedback given?		

1. Are you able to provide monthly HMIS reports on time? Yes _____ No _____. If yes, show evidence of monthly reports. If no, Why not

2. What are the reasons for delays and incompleteness if any

IV.3. Sub-Zoba = Facility level (Primary = HS/HC + CHosp)

1. Do you have an Essential Dataset defined (or do you use that for the level above)?
 - a. If NOT, what data do you collect,
 - b. How do you collect it?
2. How many of the following data collection tools do you use
 - a. Registers
 - b. Patient cards
 - c. Tally sheets
 - d. Electronic medical records
 - e. Other data collection tools
 - f. Do you have adequate numbers of these data collection tools?
 - g. Have you had adequate training / supervision to use these tools ?
3. Who collects data at the facility?
 - a. Do you have enough staff to collect the data you are required to collect?
 - b. How many people have had training in HMIS or M&E in the past year?
4. Do you have an information systems for
 - a. Pharmacy and drug supply

- b. Laboratory
 - c. Human Resources
 - d. Equipment and medical supplies
5. What reports do you submit ?
 - a. Weekly? Monthly? Quarterly? Annually
 - b. Have you submitted all of the expected reports in the last year within the period set for the submission of reports (this period may vary)
 6. Do you receive feedback reports from the level above? (ask to see these)
 - a. What format do these take? (e.g. print out of the data entered into computer, supervision reports etc.)
 - b. What is the timeframe for these feedback reports?
 7. Do you trust the quality of the data you collect ?
 - a. Who is responsible for ensuring data quality?
 - b. Is there a system to validated data quality
 - c. Are reports checked, signed, before being sent to level above
 8. Look for graphs of indicators displayed? (on wall? On computers?)
 - a. are graphs up to date for the year and up to last reported month.
 - b. Can you explain what the graphs mean to you?
 9. Do you hold meetings to evaluate the data elements/ indicators
 - a. How often are these held, and are minutes kept?
 - b. What decisions are made at these meetings?
 10. What do you use routine facility data for
 - a. Supervision of staff?
 - b. Annual planning and budgeting process
 - c. Management of the facility (Human Resources, drugs, equipment,
 - d.
 11. Do you have any problems that have been identified through data use and addressed through an action plan?.
 - a. Has the effect of the action been monitored and can be shown.
 - b. Are the actions documented in a written report to the District, the clinic committee, or the annual report?
 12. What do you think can be done to improve the Health Information System?
 13. Are there any best practices that you would like to share with others?

IV.4. Community level (CBHS)

V. HEALTH CARE FINANCING AND FUNDING (Humphrey and Diana)

V.1. National level (Tertiary) (p. 65 - 68)

1. Health budget/expenditure as a % of government total budget/expenditure
2. % of external assistance in total health expenditure
3. Per capita health expenditure
4. Development partners funding on budget or on sector budget
5. % of people enrolled insurance schemes
6. Out-Of-Pocket expenditure as a % of total health expenditure
7. Any analysis of financial sustainability of the health sector conducted
8. Major achievements and challenges in moving towards increase of cost recovery through social health insurance system
9. Any study on NCDs burden on health care financing
10. Macroeconomic situation. Eg: Economic growth; Unemployment size; Size of the informal sector; Governance; etc...
11. Existence of a Health SWAp and its performance; Alignment of DPs to national priorities
12. Major achievements and challenges in :
 - o Resource collection: Main sources of funds for health care; Experience in equitable and efficient revenue generation; Types of collection approaches used
 - o Resource pooling: Management of health sector funds mechanisms aiming at increasing social health protection (eg: insurances)
 - o Purchasing: Allocation of financial resources for more equity and cost effectiveness; Efficient purchasing of health inputs and services

b) Any recent useful report in soft copy (eg: Integrated Household Living Conditions (EICV) report); DHS; NHA: etc.) or other reports from Ministry of Finance website?

VI. Health Care Financing (sources and management)

HSSDP Funding

HSSDP Budget and budget allocation

V.2. Zoba level (Secondary)

V.3. Sub-Zoba level (Primary = HS/HC + CHosp)

V.4. Community level (CBHS)