State of Eritrea

Ministry of Health

Application For

GAVI Alliance Health System Strengthening (HSS) Grant

August 2008

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ACRONYMS

ANC	Ante-Natal Care
cMYP	Country Multi-Year Plan (UNICEF Programmes)
DG	Director General of MOH Eritrea
DHS	District Health System
DPT	Diphtheria, Pertussis and Tetanus vaccine immunization
EBDM	Evidence Based Decision Making
EDHS	Eritrea Demographic & Health Survey
EH	Environmental Health
EPI	Expanded Programme of Immunization
EPI INFO	Epidemiological Information processing statistical package
GNI	Gross National Income
GOE	Government of Eritrea
HCs	Health centres
HFs	Health facilities
HFMC	Health Facility Management Committee
HMIS	Health Management Information System
HMI	Health Management Information
HRD	Human Resource Development
HRH	Human Resource for Health
HSCG	Health Sector Core Group (equivalent of HSCC)
HSM	Health Systems Management
HWs	Health workers
ICT	Information Communication Technology
IGA	Income Generating Activity
IMAI	Integrated Management of Adulthood and Adolescent Illnesses
IMCI	Integrated Management of Childhood Illnesses
ISS	Integrated Supportive Supervision
IT	Information Technology
ITN	Insecticides Treated Nets
M&E	Monitoring & Evaluation
MCH	Maternal & Child Health
MOH	Ministry of Health
MOF	Ministry of Finance
MTEF	Medium Term Expenditure Framework
MTR	Mid-Term Review
NHP	National Health Policy
NHSDP	National Health Sector Development Plan
NPO	National Programme Officer
NSEO	National Statistics and Evaluation Office
NCEW	National Confederation of Eritrean Workers
NUEYS	National Union of Eritrean Youth and Students
NUEW	National Union of Eritrean Women
OQM	Optimum Quality Management
OR	Operational Research
PHC	Primary Health Care
PMTCT	Prevention of Mother to Child Transmission of HIV
PNFP	Private Not for Profit health service providers
PR	Principal Recipient
PRSP	Poverty Reduction Strategy Paper

RBM	Results Based Management
RED/REC	Reach Every District/Reach Every Child
R&HRD	Research & Human Resource Development
SPSS	Statistical Package for Social Scientists
TB	Tuberculosis
UNFPA	United Nations Fund for Population Assistance
USD	United States of America Dollars
VHT	Village Health Team
WES	Water and Environmental Sanitation
WFP	World Food Programme
WHO	World Health Organization
WHO/AFRO	WHO Africa Regional Office
ZMO	Zonal Medical Officer

OPERATIONAL DEFINITIONS

Zoba: A Zoba is an administrative area equivalent to a region. In Eritrea Zoba is therefore used synonymously with Region

Sub-Zoba: is an administrative precinct equivalent to district. Hence, in Eritrea a Sub-Zoba is the same as a district.

Kebabi: is the national term used in Eritrea for group of villages. The Kebabi is an important administrative precinct; it is the lowest Governance unit. Hence it serves as an important community interface and community mobilization unit.

Results-Based Management (RBM): is an output, outcome and impact oriented management of health services that enhances the functionality and performance of health systems. The components of RBM are: Strategic Planning & Strategic Management, Monitoring & Evaluation, and optimal quality HMIS for evidence-based decision making.

EXECUTIVE SUMMARY

Introduction and Background

Eritrea's determination for establishing a vibrant health system characterized by strategic directions was incepted by a vanguard for health sector management during the armed struggle for independence.
The post independence GOE espoused a protracted quest for sustainable, equitable, effective and efficient health system; Primary Health Care was maintained as the principal strategy to advance achievement of a robust health system in the context of resource constraints. Augmented by salient health system assessments and analytic reviews in the last five years, the Ministry of Health has been engaged in formulating National Health Policy and National Health sector development Plan enshrining broad principles and strategic directions for establishment of a robust health system that can deliver optimum health services equitably to all population strata. Hence, completion of these key Health Policy /Plan documents is one of the national health system imperatives to enable achievement of strategic health sector objectives.

Context of Eritrea's GAVI HSS Project

In this regard, therefore, the call for submission of application for GAVI Alliance Health System Strengthening was timely as the Health Sector Core Group (HSCG) had already identified the key challenges afflicting the health system. These priority health system barriers are categorized at three levels: health policy level barriers, health Service delivery level barriers and community level barriers.

Health Policy Level Barriers:

Completion of the formulation of the National Health Policy (NHP) and National Health Sector Development Plan (NHSDP); strengthening Human Resource Development for sustainable HRH work force production, retention and maintenance; lack of policy framework for RBM and utilization of HMIS for evidence-based decision making as well as for Health Promotion including lack of routine EPI specific communication policy framework and strategic plan.

Health Service Delivery Level Barriers:

Weak Results Based Management with evident skill deficits in Strategic planning, monitoring and evaluation and utilization of HMIS for evidence-based decision making; resource constraints in cold-chain management; Inadequate capacity of the MOH Regulatory Authority slowing down effective logistic management and coordination; destruction of health infrastructure by war, hence need for rehabilitation; lack of essential medicines and equipment depriving communities of access to quality health services; and challenges in implementation of communicable and non-communicable disease control programs at all levels.

Community Level Barriers:

The life style of the nomadic population at the coastal districts, high drop out rate between BCG – Measles, limited community empowerment, inequitable access to health services.

Although the MOH can adequately address most of the community level and some of the health service delivery level barriers, most of the health service delivery level and few policy level barriers are not being adequately addressed. Hence, this application to the GAVI HSS will mainly focus in addressing the health policy and health service delivery level barriers.

Consequently, the HSCG has formulated the evidence based goal and SMART objectives to effectively strengthen Eritrea's health system.

Objectives of the MOH GAVI Supported HSS Project

Goal:

To improve child and maternal health status in the population through strengthening the health system to provide effective and efficient health services, including EPI – in line with **MDGs**

Specific Objectives

Objective 1: To complete formulation of the National Health Policy and National Health Sector Development Plan by the end of 2009

Objective 2: To increase the production of new health workers by 7 % annually so as to strengthen the capacity of human resource for health to deliver health services effectively and efficiently

Objective 3: To establish functional participatory management structures at all levels of the health system by the end of 2009.

Objective 4: To strengthen Results Based Management[1] (RBM) of health services that reflects strong evidence based decision making (EBDM) at all levels of the health system

Objective 5: To rehabilitate health facility infrastructure for provision of quality health services

Objective 6: To improve delivery of essential health care packages[2], including provision of Integrated Maternal and child health (MCH) services[3], at all levels of health care provision

MOH GAVI supported HSS Project Proposal Development Methodology

The GAVI supported HSS project proposal commissioned by the Hon. Minister of Health was developed by the select HSCG, the top leadership of which comprised of Minister of Health, WHO Representative, UNICEF Representative and Minister of Finance.

Stakeholders at all levels of the health system contributed views substantially during the proposal development process; most of these views emanated from Zoba / Sub-Zoba based situational analyses, assessments or stakeholders workshops. Contributions from the implementation level stakeholders were presented to the TWG by the Zoba Health Officers.

The proposal process development was delegated and tasked to the TWG that was technically supported by a WHO / AFRO seconded Health Systems consultant.

A multi-sector national consensus building workshop in which representatives from Civil Service Organization participated, was held to review the final version of this proposal. Each objective was scrutinized for consistence in addressing health system priorities, feasibility of strategy, equity,

[1] Components of RBM: Strategic planning & management, monitoring-support supervision & evaluation, and optimal quality HMIS for evidence-based decision making

[2] Essential health care packages delivered to communities are level specific: the lowest primary level health facilities provide ***the minimum Activity Package (MAP)***, middle level primary level health facilities deliver ***the Intermediate Activity Package (IRAP)***, and the highest primary level health facilities deliver ***the Complementary Activity Package (CAP)***

[3] Expanded integrated MCH services entails provision of: ANC/PMTCT, EPI, Nutritional health education, Food security plus income generating activities (IGA), WES, RH/HIV/AIDS services.

community participation, and PHC context, synergy of partnership as well as effectiveness and efficiency.

MOH GAVI Supported HSS Project Implementation Framework and Strategies

Strengthening competence of health managers in results based management (RBM) of health the national health system was emphasized in the design of the project strategy. The GAVI HSS project monitoring and evaluation indicators have been developed to conform to the contemporary qualities embraced by professional M&E principles and practice.

Outcome and impact indicators for monitoring and evaluating the GAVI HSS project (look at p.29)

Indicator	Data Source	Baseline Value[4]	Source[5]	Date of Baseline	Target	Date for Target
1. National DTP3 coverage (%)[1]	HMIS	81.9/100	MOH	2006	85/100	2011
2. Number / % of Zobas achieving ≥80% DTP3 coverage	HMIS	2/6	MOH	2006	6/6	2011
3. Under five mortality rate (per 1000) [1]	EDHS	93/1,000	NSEO	2002	70/1,000	2011
4. Percentage of skilled birth attendance	HMIS	30%	MOH	2006	40%	2011
5. Percentage of hospitals that have NHSDP-based Strategic Plans to guide their current (prevailing) operational plans for health service delivery to the community	HMIS	NA[6]	MOH Planning Office	NA	75%	2011
6. Percentage of health facilities fulfilling at least 60% of the MOH recommended staffing norm in the current financial year	HMIS	40%	MOH, HRD Assessment Report	2006	60%	2011

[1] The last EDHS was carried out in 2002 and the next survey is planned to be conducted in 2009. So the latest credible data we have with regards to under five mortality is that of 2002.

Output indicators for monitoring and evaluating the GAVI HSS project

Indicator	Numerator	Denominator	Data Source	Baseline Value[Error! Bookmark not defined.]	Source	Date of Baseline	Target	Date for Target
1. The two key national health sector policy documents(NHP & NHSDP) formulated	NA	NA	MOH Annual Reports	0	DHS Assessment Report	2005	2	2009
2. Number of Regional Health	*Not applicable as the indicator*	*Not applicable*	- Reports from	3	HRH Assessment	2006	4	2011

[4] If baseline data is not available indicate whether baseline data collection is planned and when
[5] Important for easy accessing and cross referencing
[6] NA: means not available. The NHSDP I, which is based on the NHP, will be completed using the funds accruing from this round of GAVI HSS. This indicator will start getting collected from 2009 when both the NHP and the NHSDP will be in place at all levels of the health system; by then adequate RBM capacity will have been built in all hospitals and in most of the other health facilities.

	Training Institutions producing middle level health professionals	*is an absolute number*	*as the indicator is an absolute number*	Regional Health Training Institutions - MOH Annual Reports -Survey of health training institutions		Report			
3.	**% of sub-Zobas with functional HMCs**	# of functional sub-Zoba HMCs	Total Number of sub Zobas	HMIS & Zoba reports	25%	Zoba Medical Office	2006	100%	2011
4.	**Percentage of hospitals with at least 60% of the senior and middle level health managers trained in RBM 1& 2 courses**	Number of hospitals with at least 60% of the senior and middle level health managers trained in RBM 1& 2 courses	Total number of Hospitals	- Annual MOH Report - HMIS Report - Other Survey Reports	30%	- Annual MOH Report - HIS Assessment Report - HMIS Report - Other Survey Reports – Zoba Medical Office Annual Report - DHS Assessment Report	2005	50%	2011
5.	**Percentage of health centres upgraded to community hospitals**	Number of health centres upgraded to community hospitals	Total number of health centres	Medical Services division annual report	0%	Health Services Dept.	2006	15%	2011
6.	**Percentage of health facilities with functional referral systems**	Number of health facilities with functional referral systems	Total Number of health facilities	DHS Report	50%	DHS	2005	70%	2011

Methodologies mapped out for data collection, analysis and use took into regard operational feasibility, availability, validity, reliability and inherent health system need for utilization of ensuing information for health system / services management decision making. M&E and Technical support mechanisms have also been detailed in the proposal.

Project management, including management of the financial resources that will accrue, has been detailed following wide stakeholder consultations and consensus. The top leadership of the HSCG (MOH, WHO, UNICEF & MOF) has clearly stipulated roles and responsibilities in the project management to ensure effective project direction and coordination.

An objective-based total financial request / budget of five million US dollars (US $ 5M), detailed to each implementation year, has been projected over the initial project life of four years, 2008 – 2011. The budget and activity timelines have been prudently harmonized to ease accountability by project component line departments in MOH to HSCG that will in turn furnish accountability to GAVI Secretariat by the 15th May of each implementation year.

The proposal also presents plausible M&E framework, sustainability and reporting format designs reflecting the contexts of resource constraints in the environments of the health system. To ensure continuous tracking of resource inputs, implementation and results chain, reporting responsibilities by partner categories have been detailed in a ***reporting responsibility monitoring matrix-*** complete with MOH and GAVI set deadlines.

Reporting Schedule matrix

Type of Report	Frequency of Reporting						Deadline for reporting to:		
	Monthly		Quarterly		Annually		MOH / WHO Component Line Department	HSCG Secretariat	GAVI Secretariat
	Yes	No	Yes	No	Yes	No	05th of subsequent month	10th of first month of subsequent quarter	15th May 20…
Implementing Partner Reports	√		√		√		√	√	X
Financial Management Reports	√		√		√		√	√	X
Financial Audit Reports			√		√		√	√	X
Monitoring & Evaluation Reports	√		√		√		√	√	X
HSCG Reports		√	√		√		√	√	√

Finally, key recent health system assessment reports and salient HSCG minutes have been appended to provide proof of health system contexts scientifically and formally established.

Conclusion

The MOH and GOE uphold the GAVI Alliance partnership and are committed to ensuring the success of this proposed health sector investment to strengthen the current health system into a robust and responsive health system that will deliver sustainable, equitable, effective and efficient health services to all strata of the population so as to improve population health outcomes. This is envisaged to in turn improve national resource savings and population productivity which will yield national socio-economic development.

SECTION 1: APPLICATION DEVELOPMENT PROCESS

1.1: The HSCC (or country equivalent)

The Health Sector Core Group (HSCG) was commissioned by the Minister of Health **as a National Coordinating Body for the GAVI HSS proposal Development,** among other health system responsibilities. The undersigned members of the coordinating body met on 2nd October 2007 to finally review this proposal. The proposal was also endorsed in the meeting. Attached are the minutes of a number of meetings including the minutes of the last meeting to endorse this project proposal as an official document (See Annex…)

The health sector Core Group (HSCG), the equivalent of HCC has been operational with respect to the GAVI HSS since early 2005. The HSCG has been holding many meetings to identify priority health system problems as the main basis for developing this crucial project proposal submitted to GAVI Alliance Secretariat for the GAVI-HSS grant.

The HSCG top leadership is comprised of:

S.No.	Name/Title	Position at HSCG	Agency/Organization
1	H.E Mr. Saleh Meky, Minister of Health	Chairperson	Ministry of Health
2	H.E. Mr.Berhane Abrehe, Minister of Finance	Member	Ministry of Finance
3	Dr. Andrew M. Kosia, Country Representative (WR)	Member	WHO
4	Dr. Pirkko Heinonen, Country Representative	Member	UNICEF
5	Mr. Dirk Jenna, Country Representative	Member	UNFPA

Organisational structure: **The Technical Working Group (TWG) is the stand-alone technical committee charged with the day to day process of developing the GAVI HSS proposal**

The Technical Working Group membership (TWG) includes:

S.No.	Name/Title	Agency / Organization	Position at TWG
1	Mr. Berhane Gebretensae, D.G. of Health Services Department	MOH	Chairperson
2	Dr. Zemui Alemu, Director of Family and Community Health	MOH	Member
3	Dr. Berhane Debru, Director of Clinical services	MOH	Member
4	Dr. Ghirmay Tesfaselassie, Head of International Relations Office	MOH	Member
5	Dr. Tesfai Solomon, Director of Services Control & Quality Assurance	MOH	Member
6	Mr. Yemane Haile, Director of HRH Planning & Management	MOH	Member
7	Mr. Tewolde Yohannes, Head of Health Systems Management Unit	MOH	Member
8	Mr. Filli Said Filli, EPI Manager	MOH	Member
9	Mrs. Shashu Gebreselassie, Head of HMIS unit	MOH	Member
10	Mr. Teclemariam Amare, Health Systems Management Unit Staff	MOH	Member
11	Mr. Tedros Yehdego, EPI Unit Staff	MOH	Member
12	Dr.Usman, Abdulmumini, Epidemiologist	WHO	Member
13	Dr. Yohannes Ghebrat, Disease Prevention and Control Advisor	WHO	Member
14	Mr. Beiene Tseggai, Health Systems Delivery and Policies Advisor (MPN)	WHO	Member
15	Mr. Semere Gebregiorgis, Essential Drugs Management	WHO	Member
16	Mr. Debessai Haile, Health Project Officer	UNICEF	Member
17	Dr. Mismay Ghebrehiwot, Advisor of the Minister	MOH	Member

In case the GAVI Secretariat has queries of this submission, please contact:

1) Mr. Berhane Ghebretinsae, Director General of Health Services in the MOH
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Frequency of meetings: The HSCG has been holding meetings regularly, at least once a week, from the time it started developing this project proposal. These meetings were complimented by small scale meetings with concerned authorities of the MOH and other partners with the objective of collating and consolidating information for preparing the GAVI HSS project proposal.

Overall role and function:

The designated official role of the HSCG in the Health System

The overall role and function of the HSCG in the health system has been leading the Health Sector Strengthening Programme, thereby representing key stakeholders in crucial health system decision making in the following critical areas:

a) Strategic analysis for needs based priority setting and timely health system action.
b) Resource management , entailing resource needs analysis, resource mapping and resource mobilization strategies
c) Monitoring and evaluation through strategic information on health systems strengthening programme and subsequent results chain analysis to assess population level outcomes and impacts of health interventions.

Official role and function in the GAVI HSS project

The HSCG has been the platform for preparing the GAVI supported HSS project proposal for submission to the GAVI-Secretariat. It has been collating data and processing it into requisite information for the GAVI supported HSS project application. It will also coordinate and facilitate the implementation process of the project. The HSCG, in collaboration with other MOH authorities at all levels will also monitor and evaluate the overall implementation of HSS process.

1.2: Overview of application development process

Who coordinated and provided oversight to the application development process?

H.E the Minister of Health played a great role by providing strategic direction and guidance, especially addressing priority health system problems in the next five years through this proposed GAVI support for Health Systems Strengthening.

H.E. the Minister of Health subsequently conferred upon the Director General of Health Services the role of chairing and facilitating the application process. The WHO Representative and his senior staff have also been providing insight to the application development process. This is complimented by the strategic technical guidance provided to the HSCG from WHO/AFRO and GAVI Secretariat. These technical views and insights were duly incorporated by the HSCG, as evidenced by the minutes of the different consultative meetings conducted by the HSCG in the MOH. Details of HSCG partner roles and responsibilities in the proposal development are elaborated in the table under section 1.3 below.

Who led the drafting of the application and was any technical assistance provided?

Under the chairmanship of the Director General of the Health Services, drafting of the application has been led by the senior staff of the MOH, WHO Country Office, and UNICEF Office in Eritrea. The following departments of the MOH all played significant roles in producing the Zero Draft of the GAVI HSS application: the MOH Director General of Health Services, the Director General of Regulatory Services, the Director HRD, the Director of Family & Community Health, the Director of Medical Services, the EPI Program Manager, the Head of the Health System Management Unit, Head of the Planning Office and other senior staff of the MOH.

A group of MOH and WHO Country Office senior staff, who also attended the GAVI-HSS Technical Briefing and Training for Eastern Southern African Workshop of 19-21 March 2007 in

Harare Zimbabwe, had a significant role to play in the formulation and preparation of the project proposal. The group provided the HSCG with adequate guidance on the preparation of the project proposal and the precautions that should be considered**.**

To review and reset the overall project proposal, a technical consultant familiar with health system wide barriers to health service delivery in Sub-Saharan Africa and seconded by WHO/AFRO was involved in the final preparation of this project proposal.

Who was involved in reviewing the application, and what was the process that was adopted?
Both the Minister of Health and the Minister of Finance, including their senior staff were involved in reviewing the application. As mentioned above, from the Ministry of Health, the Director General of Health Services, the Director General of Regulatory Services, the Director HRD, the Director of Family & Community Health, the Director of Medical Services, the EPI Program Manager, the Head of the Health System Management Unit, Head of the Planning Office and other senior staff of the MOH were involved in reviewing the application. Moreover, the six Regional Medical Offices and representatives from the National Union of Erirean Youth and Students, National Women's association were also involved in reviewing the application. WHO and UNICEF Country Office Representatives and their senior program coordinators were also involved in reviewing the application at all stages. This was conducted in frequently held consultative meetings.

The Training Institutions were also consulted to verify their priority needs to be included in this proposal. The information obtained ratified the needs identified during survey of training institutions in the last three years.

Who approved and endorsed the application before submission to the GAVI Secretariat?
The application, after being reviewed and approved by the HSCG, was endorsed by the Hon. Minister of Health, Mr. Saleh Meky and the Hon. Minister of Finance, Mr. Berhane Abrehe.

1.3: Roles and responsibilities of key partners (HSCC members and others)

Title / Post	Organisation	HSCC member	Roles and responsibilities of key partners in the GAVI HSS application development
The Hon. Minister of Health	Ministry of Health	Yes	The minister provided the overall leadership of the HSCG The Ministry of Health senior staff both from the Head quarter and Zobas led the assessment process and preparation of the project proposal. In order to have an overview of the major activities, achievement, and challenges/constraint or barriers of the Health system development, the previous HMIS reports were reviewed and identified the major strengths and weaknesses in

			the health system.
The Director General of Health Services	Ministry of Health	Yes	Chairing and facilitating the GAVI supported HSS application process
Minister of Finance	Ministry of Finance	Yes	- Member of the top leadership of the HSCG - Fully participated in the development of the GAVI/HSS Application
WHO Representative Eritrea	WHO Country Office	Yes	- Member of the top leadership of the HSCG - Fully participated in the development of the GAVI/HSS Application - Provision of technical and financial assistance in the recent district health system functionality assessment - Coordinated sourcing of a health systems consultant by WHO/AFRO to give technical support for completion of the GAVI HSS proposal
UNICEF Representative	UNICEF Country Office	Yes	- Member of the top leadership of the HSCG - Fully participated in the development of the GAVI/HSS Application
UNFPA Representative	UNFPA Country Office	Yes	- Member of the top leadership of the HSCG - Fully participated in the development of the GAVI/HSS Application
Health sector Technical Working Group (TWG) of the HSCG. These are senior MOH, WHO, UNICEF and UNFPA Officials	MOH, WHO	Yes	- Members of the HSCG - Fully participated in the development of the GAVI/HSS Application - Collated health system data and conducted desk reviews and analysis at all levels, and field assessments especially in the Zobas
I-PRSP Technical Committee	MOH, WHO, UNFPA, MOF UNICEF, MOND	Yes	They were involved in desk reviews to identify and analyse the key health system bottlenecks, as well as setting priorities of health sector development strategy for PRSP.

1.4: Additional comments on the GAVI HSS application development process

Application for the GAVI HSS fitted precisely into the established continuous health system assessment process. It provided an evaluative review that substantiated the health system problems, bottlenecks and development barriers identified by senior MOH officials during their frequent assessment visits to regional health offices and health facilities. Similarly, annual and biennial meetings held in the MOH also offer opportunities to scrutinize the entire health system functionality. During these meetings, the Regional Medical officers bring all health problems in their regions to the attention of key policy and decision makers. In such meetings, strengths and weaknesses of the system are identified and prioritized.

MOH and the government of Eritrea have built strong partnership with key partners in development. WHO, UNICEF, WFP, among others, have been a part of our development efforts. The PNFPs (Private Not for Profit Organizations) constituted mainly by the Catholic and Protestant churches play significant roles in health service delivery to communities, including hard-to-reach communities; this partnership augments the MOH efforts to ensure equity of access to health services in the country as a whole.

Our partners are involved in all crucial health forums as well as in the implementation process of most of our programs. Therefore, they do know the weaknesses and strength of our health system at any point in time. Thus, we all have a common understanding of the problems and priorities of our pressing needs in the health system, and we principally profess one health system goal. The Health Sector Core Group (HSCG) is, therefore, just consolidating the views of all its partners in this project proposal.

SECTION 2: COUNTRY BACKGROUND INFORMATION

2.1: Current socio-demographic and economic country information

Information	Value	Information	Value
Population	*3,320,675*	*GNI per capita*	*$200 US****
Annual Birth Cohort	*4%*	*Under five mortality rate*	*93/ 1000 **
Surviving Infants	*126,451*	*Infant mortality rate*	*48/ 1000**
Percentage of GNI allocated to Health	*4.8%*	*Percentage of Government Expenditure on Health*	*5.6%***

*Sources: *EDHS 2002; ** WHO Report 2005; ***WHO Report 2006, *** CMYP*

2.2: Overview of the National Health Sector Strategic Plan

Eritrea is one of the newest nations in the African region. It gained its independence in 1991. The evolution of the health sector and health sector strategic plan goes back to the time of armed struggle for independence. The health sector vanguard used to conduct SWOT analysis of the budding health system during the liberation struggle. The SWOT analysis provided basis for drawing health sector development plans ensure acceptable health standards for the vulnerable displaced populations,. The over all strategy of the health sector vanguard was provision of quality health care to the vulnerable populations through accessible primary health care (PHC) in the context of war and extreme resource constraints.

After independence, in line with National Macro-policy, the health sector developed a national health sector policy and health sector strategic plan. This was formulated and made operational from 1997 -1999. PHC has been the central strategy of the health sector since those years. In early 2000 the Ministry of health conducted a review study of the over all health system including the achievements, challenges /constraints of the health development system. From the study results it was resolved that the Health Development Policy and Health sector Development strategic plan be reviewed and reformulated. Now, the policy is largely revised and almost reaching its final draft. The National Health Sector Development Plan design, too, is under way. To ensure focus to accomplish these crucial health sector policy documents, a Planning Office has been established to carry out the over all health sector development plan in collaboration with the different departments and divisions of the ministry both at the head quarter and the regions. During this transitional period of development of the NHP and HSDP, the ministry of health will continue to use the previous strategic plan with some adjustment to provide direction for health sector development until the latest HSDP is put in place.

The NHP is aimed at providing direction towards improvement and sustainability of the health status of the Eritrean people by reducing morbidity, disability, and mortality, improving nutritional status and raising life expectancy by recognizing the cardinal role of good health in poverty reduction and economic development. It also revolves around mobilizing and managing limited resources in order to maximize quality of care and provide cost-effective, health services as close to the household as possible

The completion of the NHP and NHSDP is included as one of the objectives of this round of GAVI-HSS grant. Taking in to consideration the over all socio-economic situations of Eritrea and the current state of development of the health sector in one side and taking note of the prevailing resource limitation and high demand of health services from the general population on the other, the

GAVI-HSS grant funding will focus on the health system issues of priority concern at the following major two levels: health service delivery level barriers and health policy level barriers. Details of these are presented in section 3.2 of this application.

SECTION 3: SITUATION ANALYSIS / NEEDS ASSESSMENT

3.1: Recent health system assessments

Title of the assessment	Participating agencies	Areas / themes covered	Dates
Situational Analysis of the District Health System Functionality	MOH , WHO, ZMOs and the regional governors and PNFPs	The entire health system functionality was assessed and analysed: Management structures and their functionality; Community structures and their functionality; Community Participation; Logistics and infrastructure development; Collaborations and partnerships, level specific implementation of health service packages;	2006
Health Sector Note	MOH, World Bank, WHO, UNFPA, UNAIDS, Youth and Women's Associations	This included the overall assessment of the health sector from policy, strategy, program activities and coverage perspectives. SWOT analysis of the Ministry was conducted both at the health quarter and zonal levels.	2002
Health Information System Assessment	MOH, Health Matrix Network, WHO, National Statistics Office, UNICEF, UNFPA	The Health Information system in the country was assessed for availability of resources and availability of information, quality of information and its use and existing gaps using the Health Matrix Network assessment tool	2006
Nation-wide Human Resources assessment in Health facilities	MOH/R&HRD	Health facilities were assessed for HRH from the perspective of: geographical distribution, staffing pattern, skill mix and work load, duration of stay (Attrition rate or rate of turn over) and other parameters affecting the utilization of HRH in the facilities	2005
Nation wide infrastructural assessment	Minster's Office and The Regional medical Offices	Assessment focused on buildings, electric supply, solar power, water supply.(field /desk)	2003 and 2006
cMYP	MOH/UNICEF	EPI / MCH Service Delivery	2006

3.2: Major barriers to improving immunization coverage identified in recent assessments

Community level barriers:

- Life style of the nomadic population at the costal districts
- High drop-out rate between BCG - Measles in four out of the six districts (Zobas)
- Need for community empowerment
- Limited community access to essential information on health services delivered by health facilities
- No forum for community-health provider interface/dialogues

- Lack of awareness on health rights and responsibilities
- Equity of access to health services still sub-optimal

Health Service Delivery/Facility Level Barriers:

- Weak health provider-community interface / dialogues hampering community participation and community demand for EPI and other health services: Health workers lack skills for effective interpersonal communication with patients, care givers and clients

Constraints in cold-chain management:

- Shortage of trained cold chain technicians
- Replacement of aging cold chain equipment and procurement of spare parts
- Difficulty in meeting costs of assessment and annual inventory of cold chain equipment
- Need to computerise EPI equipment and commodity database
- Weak Results Based Management:
- Need to enhance Optimal Quality Management (OQM) of the health system through: Strategic planning & management, monitoring, evaluation and support supervision, and evidence-based decision making
- Inadequate technical and financial capacity to improve the quality and management of the HMIS, including enhancing utilization of HMIS for evidence-based decision making
- Strengthening HMIS at National and Zoba level to ensure availability of information for planning , implementation, monitoring and evaluation
- Establishing sustainable evidence-based decision making with strong community based HMIS using the VHTs
- Developing HMIS Databases at all levels
- Extensive Destruction of health infrastructure; need for rehabilitation:
- Constructing and rehabilitating health facilities damaged by war;
- Essential Medicines and Equipment: Ensuring the availability of essential medicines and medical supplies;
- Challenges in implementation of communicable and non-communicable disease control programs at all levels:
- Minimal community based disease surveillance and reporting
- Referral system weakened by several bottlenecks
- Attaining equitable coverage to provide basic clinical and emergency services so as to enhance equity of access to health services in all communities;
- Lack of means of transport and communication for integrated outreach services at all levels

Health Policy Level Barriers:

- - Completing the formulation of the National Health Policy (NHP)
- - Completing formulation of the Health Sector Strategic Plan (HSSP)
- - Strengthening Human Resource Development for sustainable HRH work force production and - maintenance: there is currently shortage of skilled HRH
- - Challenges in IEC for Health Education and Health Promotion: No routine EPI specific communication policy and strategic plan
- - No policy framework for RBM and utilization of HMIS for evidence-based decision making
- - Occasional resource constraints for operationalizing HSCG functions
- - Constraints in sustaining health sector achievements at all levels: Mapping out sustainability strategies for all levels of health sector achievements

3.3: Barriers that are being adequately addressed with existing resources

- National DPTHepB1- DPTHep3 dropout rate being sustained to < 10% for the last 3 years
- Training on Development of Annual District Micro plans to ensure that every child is reached (RED/REC Approach)
- Innovative approaches for reaching out to the nomadic populations and improving their access to health services
- Constraints in sustaining health sector achievements at all levels: Mapping out sustainability strategies for all levels of health sector achievements
- Establishing community based HMIS and disease surveillance systems
- Constraints in cold-chain management: Shortage of trained cold chain technicians
- Weak health provider-community interface / dialogues hampering community participation and community demand for EPI and other health services: Health workers lack skills for effective interpersonal communication with patients, care givers and clients
- Occasional resource constraints for operationalization HSCG functions

3.4: Barriers not being adequately addressed that require additional support from GAVI HSS

Health Policy Level Barriers

- Completing the formulation of the National Health Policy (NHP)
- Completing formulation of the National Health Sector Development Plan (NHSDP)
- Strengthening Human Resource Development for sustainable HRH work force production and maintenance: there is currently shortage of skilled HRH
- Challenges in IEC for Health Education and Health Promotion: No routine EPI specific communication policy and strategic plan
- No policy framework for RBM and utilization of HMIS for evidence-based decision making

Health Service Delivery Level Barriers

- Financial resource constraints in cold-chain management:
  - Replacement of aging cold chain equipment and procurement of spare parts
  - Difficulty in meeting costs of assessment and updating inventory of cold chain equipment annually
  - Need to computerise EPI equipment and commodity databases at national and regional levels
- Strengthening the capacity of the MOH Regulatory Authority:
  - Technical and financial support in vaccine regulation – quality, potency and standards
  - Lack of computerisation of the logistic system hampering effective logistic management and coordination; need for computerization of the logistic system
- Weak Results Based Management:
  - Need to enhance Optimal Quality Management (OQM) of the health system through: Strategic planning & management, monitoring, evaluation and support supervision, and evidence-based decision making
- Inadequate technical and financial capacity to improve the quality and management of the HMIS, including enhancing utilization of HMIS for evidence-based decision making):
  - Strengthening HMIS at National and Zoba level to ensure availability of information for planning , implementation, monitoring and evaluation
  - Establishing sustainable evidence-based decision making with strong community based HMIS using the VHTs
  - Developing HMIS Databases at all levels
- Extensive Destruction of health infrastructure; need for rehabilitation:
  - Constructing and rehabilitating health facilities damaged by war;
- Essential Medicines and Equipment: Ensuring the availability of essential medicines and medical supplies;
- Challenges in implementation of communicable and non-communicable disease control programs at all levels:
  - Minimal community based disease surveillance and reporting
  - Referral system weakened by several bottlenecks
  - Attaining equitable coverage to provide basic clinical and emergency services so as to enhance equity of access to health services in all communities;
  - Lack of means of transport and communication for integrated outreach services and for adequate supply of vaccines on quarterly basis at all levels

SECTION 4: GOALS AND OBJECTIVES OF THE GAVI HSS PROJECT

4.1: Goals of GAVI HSS support

To improve child and maternal health status in the population through strengthening the health system to provide effective and efficient health services, including EPI – in line with MDGs

4..2: Objectives of GAVI HSS Support

Objective 1: To complete formulation of the National Health Policy and National Health Sector Development Plan by the end of 2009

Objective 2: To increase the production of new health workers by 7 % annually so as to strengthen the capacity of human resource for health to deliver health services effectively and efficiently

Objective 3: To establish functional participatory management structures at all levels of the health system by the end of 2009.

Objective 4: To strengthen Results Based Management[7] (RBM) of health services that reflects strong evidence based decision making (EBDM) at all levels of the health system

Objective 5: To rehabilitate health facility infrastructure for provision of quality health services.

Objective 6: To improve delivery of essential health care packages[8], including provision of integrated maternal and child health (MCH) services[9], at all levels of health care provision

[7] Components of RBM: Strategic planning & management, monitoring-support supervision & evaluation, and optimal quality HMIS for evidence-based decision making

[8] Essential health care packages delivered to communities are level specific: the lowest primary level health facilities provide ***the minimum Activity Package (MAP)***, middle level primary level health facilities deliver ***the Intermediate Activity Package (IRAP)***, and the highest primary level health facilities deliver ***the Complementary Activity Package (CAP)***

[9] Expanded integrated MCH services entails provision of: ANC/PMTCT, EPI, Nutritional health education, Food security plus income generating activities (IGA), WES, RH/HIV/AIDS services.

SECTION 5: GAVI HSS ACTIVITIES AND IMPLEMENTATION SCHEDULE

5.1: Sustainability of GAVI HSS support

The MOH and the Government of Eritrea (GOE) are committed to the well being and survival of mothers and children, with MCH and EPI programmes being among the top priorities of the MOH. The MOH very well recognizes that safe motherhood and vaccination rates could be achieved and sustained, if only a strong and vibrant health system exists. We therefore assert our commitment to ensuring remarkable population health outcomes and impacts are achieved through the GAVI support to HSS in Eritrea. However, in the event of unavailability of GAVI HSS resources, tenable sustainability strategies have been designed by MOH in liaison with the GOE, and projected at three levels.

Community level sustainability strategies:

Communities will be empowered through increasing their access to health information, practically participating in planning health interventions in their own environment (especially through micro-plans), participation in health forums and dialogues, good representation on health facility management committees, income generating activities and improving household food security.

Health Service Delivery Level sustainability strategies:

Once completed, the National Health Sector Development will give clear objectives that enshrine promotion of maternal and child health as priority health investments. Regular (annual and five yearly) reviews of the NHSDP will ensure commitment to and focus on sustained improvement of maternal and child health outcomes, and that of the rest of the population.

Continued strong partnership with multilateral and bilateral development partners and the private sector will further strengthen sustainability of health outcomes.

Mentoring of health professionals by technical support teams of experts will establish continuity of good professional performance by Eritrean health professionals. This in turn will yield sustainability of achieving desired health outcomes and impacts.

The strong spirit of commitment of the HRH in the country will further be strengthened through provision of innovative motivations and incentives to the HRH.

MOH and GOE have been known for their commitment in maintaining the health infrastructure even under difficult circumstances. Since there are planned regular Infrastructure / logistics and District Health System assessments / situational analyses, health infrastructures that need rehabilitation will be easily identified and brought to attention duly.

Policy and Governance level sustainability strategies:

Completing the formulation of the National Health Policy will give clear broad guidance and focus on achieving population health outcomes and impacts.

Among the salient areas of the health policy will be attainment of fair and sustainable health financing. MOH and GOE have already taken pragmatic steps in discussing strategies for establishing fair and sustainable health financing. These strategies will be detailed and elaborated in both the NHP and NHSDP that will be produced by the end of 2008, as projected in this GAVI HSS proposal. This is envisaged to provide health risk protection to the population as well as protecting

them against catastrophic household expenditures on health. These measures when implemented will invariably achieve sustainable health outcomes and impacts in the population.

Objective # 2 of the GAVI HSS proposal is on establishing sustainable production, retention and maintenance of HRH in the Eritrean health system. Should this proposal be funded, the current MOH & GOE efforts towards sustainable HRD by MOH will have been greatly enhanced. Effectiveness of HRH in the health sector is further enhanced by the fact that the nursing cadre produced is comprehensive in nature, capable of manning both midwifery and nursing duties at all levels of health facilities.

5.2: Major Activities and Implementation Schedule

Major Activities	Year 1 (2008)				Year 2 (2009)				Year 3 (2010)				Year 4 (2011)			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Objective 1: To complete formulation of the National Health Policy and National Health Sector Development Plan by the end of 2009																
Activity 1.1: Finalize formulation of the National Health Policy Document																
Activity 1.2: Disseminate the National Health Policy Document at all levels, including the diplomatic corps																
Activity 1.3: Finalize formulation of the National Health Sector Development Plan																
Activity 1.4: Disseminate the National Health Sector Development Plan at all levels including the diplomatic corps																
Objective 2: To increase the production of new health workers by 7% annually so as to strengthen the capacity of human resource for health to deliver health services effectively and efficiently																
Activity 2.1: Strengthen existing central and zonal training institutions to produce middle level health professionals																
Activity 2.2: Upgrade the technical capacity of training school tutors / instructors, by training them in areas of identified skill deficits through: distance education, post graduate and other relevant courses																
Activity 2.3: Support central and zonal training institutions with requisite teaching materials that includes audio visual materials, books, computers etc																
Activity 2.4: Review the current staffing pattern in order to establish the MOH Recommended Minimum Staffing Norm for health facilities at all																

levels																
Activity 2.5: Update the existing job descriptions of health workers at all levels of the health system.																
Activity 2.6: Disseminate the existing job descriptions of health workers to all levels of the health system.																
Activity 2.7: Develop health workers transfer policy																
Activity 2.8: Develop health workers transfer policy implementation guidelines																
Activity 2.9: Provide recreational amenities for health workers working in 10 selected remote health facilities																
Activity 2.10: Introduce reward package system to best performing individual health workers and teams at national and Zonal levels																
Objective 3: To establish functional participatory management structures at all levels of the health systems by the end of 2009																
Activity 3.1: Scaling health management committees in 3 zobas (regions) and 29 sub-zobas (districts)																
Activity 3.2: Train health management committees in 3 zobas (regions) and 29 sub-zobas (districts) on their roles and responsibilities																
Activity 3.3: Establish village health committees at 350 kebabis																
Activity 3.4: Train village health committees in 350 kebabis on their roles and Responsibilities																
Activity 3.5: Provide one week training to 120 health management team members in 3 zobas on research, district health systems management, data management and community entry and participation																

Objective 4: To strengthen Results Based Management (RBM) of health services to reflect strong evidence based decision making (EBDM) at all levels of the health system																
Activity 4.1: Provide one week training to senior and middle level health managers in **RBM skills- 1**: - Strategic Planning and Management - Monitoring & Evaluation skills - Report writing skills																
Activity 4.2: Provide one week training to senior and middle level health managers in **RBM skills-2**: - HMIS Data management - HMIS Data Transformation into information - Operational Health System Research - Making Evidence Based Decisions for health action																
Activity 4.3: Support the identification of core minimum national indicators by sponsoring a participatory consensus building workshop																
Activity 4.4: Support the production of quarterly HMIS bulletin																
Activity 4.5: Support the dissemination of quarterly HMIS bulletin																
Activity 4.6: Procure ICT equipment for computerisation of HMIS system in 29 selected sub-zobas [Computer systems, Printers, Broad Band Internet services]																
Activity 4.7: Train Health Workers in ICT and Computerised data management skills relevant for operating computerised HMIS																
Activity 4.8: Scale up district health systems assessment from the already piloted two zobas to cover the remaining four zobas																

Objective 5: To rehabilitate health facility infrastructure for provision of quality health services																
Activity 5.1: Provide water supply in selected health facilities																
Activity 5.2: Supply photo voltaic solar power and cold chain system to selected health facilities																
Activity 5.3: Conduct training for cold chain technicians in six zobas																
Activity 5.4: Construct incinerators in 10 health facilities																
Activity 5.5: Construct placenta pits in 10 health facilities																
Activity 5.6: Upgrade 3 health centres to the level of community hospitals (district hospitals)																
Activity 5.7: Construct accommodation for health workers in selected 3 remote health Facilities																
Objective 6: To improve delivery of essential health care packages' including provision of integrated maternal and child health (MCH) services, at all levels of health care provision																
Activity 6.1: Carry out community health education and promotion on Environmental Health / WES in all zobas																
Activity 6.2: Carry out household based water quality control in all the six Zobas during both rainy and dry seasons																
Activity 6.3: Supply chemicals and reagents (e.g. PUR, Water guard, etc) for water quality control in all the six zobas																
Activity 6.4: Conduct integrated outreach services																
Activity 6.5: Develop the Referral and Emergency Policy and Implementation Framework																

Activity 6.6: Improve referral system through training in triage and emergency management, including referral of patients /clients (using the Emergency & Referral manual)																
Activity 6.7: Procure standard equipment and supplies for referral & emergency service provision at selected health facilities																
Activity 6.8: Carry out regular integrated supportive supervisions																
Activity 6.9: Train health workers in early detection and response to outbreak of vaccine preventable diseases																
Activity 6.10: Train communities (VHTs, HFMCs & Teachers) in early detection and response to outbreak of vaccine preventable diseases																

SECTION 6: MONITORING, EVALUATION AND OPERATIONAL RESEARCH

Outcome and impact indicators for monitoring and evaluating the GAVI HSS project

Indicator	Data Source	Baseline Value[10]	Source[11]	Date of Baseline	Target	Date for Target
1. National DTP3 coverage (%)[1]	HMIS	81.9/100	MOH	2006	85/100	2011
2. Number / % of Zobas achieving ≥80% DTP3 coverage	HMIS	2/6	MOH	2006	6/6	2011
3. Under five mortality rate (per 1000) [1]	EDHS	93/1,000	NSEO	2002	70/1,000	2011
4. Percentage of skilled birth attendance	HMIS	30%	MOH	2006	40%	2011
5. Percentage of hospitals that have NHSDP-based Strategic Plans to guide their current (prevailing) operational plans for health service delivery to the community	HMIS	NA[12]	MOH Planning Office	NA	75%	2011

[10] If baseline data is not available indicate whether baseline data collection is planned and when
[11] Important for easy accessing and cross referencing
[12] NA: means not available. The NHSDP I, which is based on the NHP, will be completed using the funds accruing from this round of GAVI HSS. This indicator will start getting collected from 2009 when both the NHP and the NHSDP will be in place at all levels of the health system; by then adequate RBM capacity will have been built in all hospitals and in most of the other health facilities.

6. Percentage of health facilities fulfilling at least 60% of the MOH recommended staffing norm in the current financial year	HMIS	40%	MOH, HRD Assessment Report	2006	60%	2011

[1] The last EDHS was carried out in 2002 and the next survey is planned to be conducted during the third quarter of 2008. So the latest credible data we have with regards to under five mortality is that of 2002**.**

6.2: Output Indicators

Indicator	**Numerator**	**Denominator**	**Data Source**	**Baseline Value**[Error! Bookmark not defined.]	**Source**	**Date of Baseline**	**Target**	**Date for Target**
The two key national health sector policy/plan documents(NHP & NHSDP) formulated	NA	NA	MOH Annual Reports	0	DHS Assessment Report	2005	2	2009
Number of Central and zonal Health Training Institutions producing middle level health professionals	*Not applicable as the indicator is an absolute number*	*Not applicable as the indicator is an absolute number*	- Reports from Regional Health Training Institutions - MOH Annual Reports -Survey of health training institutions	3	HRH Assessment Report	2006	4	2011
Percentage of sub-Zobas with functional health management committees	Number of functional sub-Zoba health committees	Total Number of sub Zobas	HMIS Zoba medical Office Annual Reports	25%	Zoba Medical Office	2006	90%	2011

Percentage of hospitals with at least 60% of the senior and middle level health managers trained in RBM 1& 2 courses	Number of hospitals with at least 60% of the senior and middle level health managers trained in RBM 1& 2 courses	Total number of hospitals	- Annual MOH Report - HMIS Report - Other Survey Reports	30%	- Annual MOH Report - HIS Assessment Report - HMIS Report - Other Survey Reports – Zoba Medical Office Annual Report - DHS Assessment Report	2005	50%	2011
Percentage of health centres upgraded to community hospitals	Number of health centres upgraded to community hospitals	Total number of health centres	Medical Services division annual report	0%	Health Services Dept.	2006	10%	2011
Percentage of health facilities with functional referral systems	Number of health facilities with functional referral systems	Total Number of health facilities	DHS Report	50%	DHS	2005	70%	2011

Eritrea GAVI - HSS Progress Report Indicators [1]

	Indicator	2008 target	2009 target	2010 target	2011 target
Objective 1: National Health Development Plan	# of key NHP & plan documents formulated and disseminated		NHPD drafted and disseminated	NA	NA
Objective 2: Increase new health workers	# of HWs deployed according to HRH plan		# of HWs. distributed according to plan	# of HWs. distributed according to plan	# of HWs. distributed according to plan

Objective 3: Participatory management	• # of participatory management structures established		• 32 HMCs established • 900 HMC members trained	NA	NA
Objective 4: Results-Based Management	• # of training sessions conducted in RBM skills1 & 2 • # of subzobas for which ICT equipment procured and provided		• 4 sessions conducted (one each respectively) • 20 subzobas	20 subzobas	• 18 subzobas
Objective 5: Rehab infrastructure	• # of Health Facilities rehabilitated		• One HF.provided with water supply & solar system • One HF provided with staff accommodation • One HC upgraded • 3 HFs with incinerators and placental pits	• One HFprovided with water supply & solar system • One HF provided with staff accommodation • One HC upgraded • 3 HFs with incinerators and placental pits	• One HFsprovided with water supply & solar system • One HF provided with staff accommodation • One HC upgraded • 4 HFs with incinerators and placental pits
Objective 6: Essential Health Care Package	• # of HFs delivering essential health care package relevant to its level	• # integrated out reach services conducted	• Two community health education sessions on environmental health • # integrated out reach services conducted • Referral and emergency services	• Two community health education sessions on environmental health • # integrated out reach services	• Two community health education sessions on environmental health • # of HWs trained in

			policy document developed • # of HWs trained in triage and emergency management One HF for which standard equipment and supplies for referral and emergency services procured and provided • 6 ISS conducted - National to Zoba level(one in each zoba)	conducted • # of HWs trained in triage and emergency management • One HF for which standard equipment and supplies for referral and emergency services procured and provided • 6 ISS conducted - National to Zoba level(one in each zoba)	triage and emergency management • # integrated out reach services conducted • One HF for which standard equipment and supplies for referral and emergency services procured and provided • 6 ISS conducted - National to Zoba level(one in each zoba)

[1] This GAVI-HSS Annual Progress Indicators table was inserted based on the recommendations of GAVI Secretariat

6.3: Data collection, analysis and use

Data collection, analysis and use: Output indicators

Indicator	Data collection	Data analysis	Use of data
Output			
1. The two key national health sector policy/plan documents(NHP & NHSDP) formulated	MOH Annual Reports will indicate the availability of the key documents. However, it is important to know what & how data will be collected for formulating these documents: The principle of triangulation of data will be used to provide reliability and validity of data that will be processed to provide valuable information for formulation of these key policy documents. Quantitative data: Primary data in this category will be collected from house hold surveys, HMIS reviews, Programmatic data reviews, Operational Research data, and other surveys. EDHS will provide crucial data input. Secondary data will be collated principally from HMIS annual reports, programmatic reports e.g. EPI reports, HIV/AIDS reports, Health facility reports and reports from other health institutions. Data inputs from line ministries and institutions will also be sourced, especially NSEO for Census and other needed data, Ministry of Education, Ministry of natural and Water Resources, Ministry of Transport and communication etc. Qualitative data: Various consultative workshops will be held for various stakeholders on topical health issues and views will be collected. Consensus workshops will also be conducted. Secondary review of reports of health conferences /	Availability of the NHP & NHSDP will be indicated by absolute numbers (2, or 1 or 0), and no analysis will be needed. However, it is important to know how the data collected for formulating these documents will be analysed: Quantitative data: Data in this category will be analysed using the locally available statistical packages: EPI Info, SPSS, STATA and Excel. Analytical reviews of existing data sets will also be carried out using the same statistical methodologies of proven reliability. Qualitative data will be analysed using either of the following methods: Manual Master sheet thematic analysis one of the following statistical packages: NUDIST or	The analysed data processed into reports will provide evidence on contextual health issues to consider for formulation of the NHP and NSDP. During consultative reviews and consensus building, excerpts from reports furnished will facilitate decisions on key health issues / strategies to include in the NHP and NHSDP. Information obtained will also provide comparative trend analyses of the health of the Eritrean population. All these information will consolidate formulation of strategic directions (NHP/NHSDP) for sustainable enhancement of the health of the Eritrean population. All reports furnished will be archived for future reviews and references

	workshops, minutes /deliberations of important meetings will be reviewed and gathered. Reports of key surveys will be reviewed for qualitative data inputs. Global reports data will also be collated to scrutinize comparative variables on Eritrea. The following reports will be reviewed to provide comparative trend on population health indicators: World Health Reports (WHO), Human Development reports (UNDP), World Development reports (World Bank), etc.	AskSam.	
2. Number of Regional Health Training Institutions producing middle level health professionals	Quantitative data: Will be obtained primarily from National surveys on HRD/HRH, Training institution specific surveys and Reports and Health facility surveys Secondary data will be obtained from extensive reviews of previous HRD/HRH Assessment reports, DHS reports, as well as reviews of data sets from HMIS, EDHS reports, NSEO data and Public Service and PNFP data sets. Once the NHSDP is completed, annual HSDP performance reviews will also provide data on the indicator. Qualitative data: Will be collated from qualitative excerpts from survey and assessment reports. Health facility community (patient / client) satisfaction surveys will provide invaluable data. HRH aspects of reports will also be reviewed for important qualitative data inputs.	Quantitative data will be analysed using the available routinely used statistical packages (EpiInfo, SPSS, STATA & Excel). Manual analysis for small data sets will also be encouraged provided they are adequately validated by other forms /sources of data. Qualitative data will be analysed manually using the Master Sheet Thematic approach.	The information so obtained will be used for HRD planning so as to produce, retain and maintain HRH in a sustainable way in the context of resource constraints. The information obtained will also be used to match HRH availability with population health needs / health status, hence a proxy for equity of health services. The information obtained will also be used for projection of HRD by MOH & GOE. This indicator will help assessment of HRH : Population ratio in the context of nursing services- an important HRD index.
3. Percentage of sub-Zobas with functional health management	Quantitative data:	As for indicator # 1 above	Information on this indicator is useful for gauging pragmatic

committees	Primary quantitative data will be collected through health facility surveys. Regular DHS (District Health System) situational analysis, too, will provide primary data on the indicator. Annual Zoba Health Reports will also feed data on this indicator. Routine HMIS will be updated to capture data on health facility boards / committees Annual HSDP performance reviews will also provide data input on the indicator. Qualitative Data: Qualitative aspects of surveys mentioned above will also provide data on the indicator. Health forums at sub-zoba, Zoba and National levels will also generate data on this indicator. Reviews of qualitative aspects of reports of key surveys will provide good data on this indicator. Review of HFMC meeting Minutes are sources of such data. Annual HSDP performance reviews will also provide additional data on the indicator.		community participation on health issues of their environment. This information can also be used to assess whether communities are adequately represented to leverage health service decisions and generate demand for needed health services. This information can assist the MOH to lay strategies for effective and efficient community resource mobilization for health actions / interventions.
4. Percentage of health facilities with at least 60% of the senior and middle level health managers trained in RBM 1& 2 courses	Quantitative data: Primary data on this will be collected through DHS Situational analysis, National HRD surveys, Health facility surveys, HRD annual reports. Likewise, Annual HSDP performance reviews will provide data input on the indicator on regular basis. Secondary data will be obtained from HRD/HRH reports, health facility reports, training reports and HRH performance appraisal reports.	As for indicator # 1	RBM competence is an indicator of likelihood of effective and efficient performance of the health system. Information obtained also enlightens stakeholders on the following key questions: Can health managers match health interventions competently with population health needs in the context of available resources? Can health managers prioritize interventions for effective, efficient and sustainable population health gains? Can health sector be strengthened to contribute significantly to national productivity and socio-economic development through competently designing

			strategic sector directions? The information enables the MOH and GOE know the level of professional proficiency with which the health sector is managed to realize past, prevailing and future population level outcomes and impacts. These tenets of information improve the precision of health sector planning.
5. Percentage of health centres upgraded to community hospitals	Quantitative data: Primary data on this indicator will be obtained from: Annual HSDP performance reviews, annual HMIS reports since reporting is clearly health facility level specific. National infrastructure and logistic surveys, health facility surveys and other surveys reports as well provide data on this indicator. Sections of house hold surveys also feed data on this indicator. Annual HSDP performance reviews will also provide specific data on the indicator. Secondary data will be collated from health facility reports, Logistic and infrastructure reports, Zoba health office reports, as well as review of NSEO data sets. EDHS also provide specific data on this. Qualitative data: These will basically be obtained from the qualitative sections of the surveys and reviews mentioned above.	As for indicator # 2 above	The information obtained will be used by MOH and other stakeholders to assess geographical coverage and accessibility of health services by the community. The information is a proxy gauge for equity of access by the community. This information can be used to plan equitable provision of health services; it helps to make feasible strategies for providing hard-to-reach communities with health services.

6. Percentage of health facilities with functional referral systems	Quantitative data: Primary data will be obtained from Health Facility surveys, Household surveys, Routine HMIS data, referral databases, DHS situational analysis and Infrastructure and logistic surveys. Annual HSDP performance reviews will also augment data input on the indicator. Secondary data will be obtained from MOH assessment reports, Zoba health office and health facility reports, as well as HMIS datasets. Qualitative data: Qualitative sections of sections of surveys and assessments mentioned above will contribute data on the indicator. Reviews of health facility reports and minutes / deliberations of important meetings & health forums will as well provide data on this indicator.	As in indicator # 1 above	This information will be used for improving maternal and child health services since children and mothers are the main users of referral services. The information also enlightens health managers and target communities on availability of needed health services. This indicator provides information on directly or indirectly on met and unmet community health needs- which in fact influence health outcomes. The information is also a tool for communities to demand for health lacking health services or improved means of accessing them. Hence this is another proxy indicator for equity of health service provision. To MOH and development partners this is invaluable information for health planning.

Data collection, analysis and use: Outcome and impact indicators

Indicator	Data collection	Data analysis	Use of data
Impact and outcome			
1. National DTP3 coverage (%)	Quantitative data: Primary data will be obtained from routine HMIS reports, Annual MOH EPI reports, Health facility reports, EPI data audit reports, Health facility, as well as EPI targeted and household surveys. EDHS also provides updated data on this as well as Annual HSDP performance reviews. Secondary data: Review of NIDS data sets, Census data sets, Survey reports and past EDHS, Qualitative data: Obtained from relevant qualitative sections of surveys mentioned above.	Quantitative data: Data in these categories will be analysed using the locally available statistical packages: EPI Info, SPSS, STATA and Excel. Analytical reviews of existing data sets will also be carried out using the same statistical methodologies of proven reliability. Qualitative data will be analysed using either of the following methods: Manual Master sheet thematic analysis one of the following statistical packages: NUDIST or AskSam.	This information obtained on the indicator is one of the core indicators of national child health indicators. The information also denotes the level of heard immunity the country has far attained against vaccine preventable childhood diseases. This indicator is a good proxy indicator for poverty. It informs the MOH and the GOE on the progress of poverty reduction strategies attained so far. Hence this information is one core source to gauge population health & socio-economic status. It is closely linked to child mortality indicators. Disaggregated data shows population strata vulnerabilities and hence gaps in coverage- the reasons for which have to be investigated through operational researches. This information is therefore crucial for strategic health sector planning.

2. Number / % of districts achieving ≥80% DTP3 coverage	Quantitative data: Primary data will be obtained from routine HMIS reports, Annual MOH EPI reports, Health facility reports, EPI data audit reports, Health facility, as well as EPI targeted and household surveys. EDHS also provide updated data on this as well as Annual HSDP performance reviews. Secondary data: Review of NIDS data sets, Census data sets, Survey reports and past EDHS, Qualitative data: Obtained from relevant qualitative sections of surveys mentioned above.	As for indicator # above	Information obtained from here will be used for crucial health planning decisions. It can be used for making strategies for closing gaps in health service coverage as shown by the indicator. It is also an important horizontal equity indicator. This indicator can also be used for resource mobilization by various stakeholders to address gaps in coverage and inequity. Communities can also use the information for bolstering demand for health services. The information obtained also shows progress being made in implementing NHP and NHSDP. This is also an important information for planning
3. Under five mortality rate **(per 1000)**	Quantitative data: Primary data will be obtained from, Annual MOH reports household reports, Morbidity and mortality surveys, Health facility reports as well as UNICEF state of the health of children reports and EDHS. Updated data on this as well as Annual HSDP performance reviews. Secondary data: Review of HMIS data sets, Census data sets, Survey reports and past	As for indicator # 1 above.	Data use will be as in indicator # 1 above

	EDHS, Qualitative data: Obtained from relevant qualitative sections of surveys mentioned above. However, focussed qualitative surveys will be carried out in this regard.		
4. Percentage of skilled birth attendance	Quantitative data: Primary data: Health facility surveys, EDHS, Household surveys will be used to collect information on this. Maternal Health Situational Analysis and Annual NHSDP performance reviews also provide updated information on this. Secondary data: Extensive reviews will be done on HMIS and census data sets, reports of health facilities, and demographic surveillance reports.	As for indicator 1 above.	The data obtained will inform MOH, communities, and other stakeholders on the prevailing status of maternal and peri-natal, health. This is also an important proxy indicator of child health which is akin to maternal health. The information can also be used for assessing NHSDP performance. The data clearly shows unmet maternal (obstetric) needs, hence imperative for MOH/health system intervention. This is also a good proxy for assessment of poverty alleviation strategies in the country. Regional disaggregation will show equity differentials in population health coverage, access, health seeking behaviour of choices. This will call for strategic and innovative MOH intervention designs for enhancing maternal and child health status.
5. Percentage of hospitals that have NHSDP-based Strategic Plans to guide their current (prevailing) operational plans for health service delivery to the community	Quantitative data: Annual HSDP performance reviews will provide regular crucial data on the indicator. Secondary data will be obtained from Annual R& HRD reports,		Strategic planning skills obtained from sequential RBM training competence is an indicator of likelihood of effective and efficient performance of the health facility. Information obtained also enlightens

	Health Facility reports and Training reports.	As for indicator # 1	stakeholders on: ability of Zoba health management and health facility management to match health interventions competently with population health needs in the context of available resources, ability of health management for priority setting in health interventions for effective, efficient and sustainable health outcomes and subsequent health impacts in the population. The information enables the MOH and GOE know the level of professional proficiency needed for managing health facilities so as to achieve population level outcomes and impacts. This information is critical for planning health interventions and health service delivery at policy implementation level.
6. Percentage of health facilities fulfilling at least 60% of the MOH recommended staffing norm in the current financial year	Quantitative data: Will be obtained primarily from National surveys on HRD/HRH and Health facility surveys Secondary data will be obtained from extensive reviews of previous HRD/HRH Assessment reports, DHS reports, as well as reviews of data sets from HMIS, EDHS reports, and Public Service and PNFP data sets. Once the NHSDP is completed, annual HSDP performance reviews will also provide some of the up to date data on the indicator.	Quantitative data will be analysed using the available routinely used statistical packages (Epi Info, SPSS, STATA & Excel). Manual analysis for small data sets will also be encouraged provided they are adequately validated by other forms /sources of data. Qualitative data will be analysed manually using the Master Sheet Thematic approach.	The information got from these data will be used for HRD / HRH planning so as to inform policy on production, retention and maintenance strategies needed in view of contextual resource environments. Like wise, the information obtained will also be used to match HRH availability with population health needs / health status, hence a proxy for equity of health services. The information obtained will also be used for projection of HRD by MOH & GOE to ensure synchrony of HRD / HRH costs with optimal HRH deployment for achieving

	Qualitative data: Will be collated from qualitative excerpts from survey and assessment reports. HRH satisfaction surveys will also provide invaluable data. HRH aspects of various data sets and reports will also be reviewed for important qualitative data inputs.		internationally acceptable population health status.. This information, aggregated and disaggregated, will help assessment of HRH : Population ratio in the context of Health services- an important HRD index.

6.4: Strengthening M&E system

The overall strategy for strengthening M&E in the health system through this project is enshrined in 'strengthening Results Based Management, RBM'. Results based management is a proven way of establishing strategic directions for achievement of population level health outcomes from health interventions. M&E is an inherent component of RBM. Subject to GAVI HSS funding, at least 80% of the senior and middle level health managers in the entire health system will be trained in M&E skills to level of professional proficiency. Technical and financial support need to be provided to the HMIS in order to analyze data and disseminate information. Some logistics support such as computers, and means of communication need to be provided to the sub-zobas to produce timely reports.

Continuous RBM / M&E technical support will be provided to the MOH GAVI HSS by acknowledged centers in the following ways:

- training senior and middle level health managers in all the regions of the country;
- carrying out quarterly and annual evaluations of the GAVI supported HSS jointly with MOH and WHO Eritrea;
- Creating a relational database for tracking HSS and other health sector indicators so as to detect at the earliest opportunity need for timely intervention in any component of the HSS project. Also responsiveness in providing information for decision making at any stage of the project will be feasible through this database;
- mentoring MOH professionals in results based management (RBM) practice and training of other health professionals to maintain and sustain a critical mass of health professionals proficient in RBM;
- providing training opportunities in selected high value public health courses (e.g. Public Health in Complex emergencies & high level distance education training in public health principles and practice in developing economies)

6.5: Operational Research

Research capacity is one of the weak areas of the health system. The GAVI HSS funding will be used to strengthen research capacity by training health workers in operational research methodology so as to enable them to conduct operational research in priority health system /services areas to informed health management decisions as well as health policy formulations. Operational research skill enhancement has been placed under RBM 2, and presented as training in data management, transformation of data into information and making evidence based decisions for health management action. (Please refer to Objective # 4 for details on this).

Various indicators will also be monitored partly through valid and reliable data provided by operational researches scattered throughout the five years of this project. Ministry of Health / Zoba departments will be responsible for management of Operational Research in a particular/specific project component.

Since the last EDHS was conducted in 2002, the MOH needs to facilitate for another EDHS, possibly between 2008 and 2009. This proposal also entails establishing community based health information system that will generate information on infant deaths, child and maternal deaths, registration of births & deaths, disease surveillance data, and other relevant community health information. The activities for establishing community based HMIS are clearly presented in Objectives 3, 4 and 6.

SECTION 7: IMPLEMENTATION ARRANGEMENTS

7.1: Management of GAVI HSS support

Management mechanism	Description
Name of lead individual / unit responsible for managing GAVI HSS implementation / M&E etc.	Health Services Department / Medical Services Division / Health Systems Unit
Role of HSCG in implementation of GAVI HSS and M&E	• Review and approve work plan and budgets • Disburse funds according to approved Work plan • Promote and coordinate resource mobilization • Review progress of implementation of programme activities • Support the executive secretariat • Manage and oversee implementation of activities • Collect and disseminate information about GAVI activities

Mechanism for coordinating GAVI HSS with other system activities and programs	• DG Health Services – Chair, • Continuous coordination and inter-component networking support; linking up all project components to ensure harmony of implementation. • Joint planning meetings among the TWG and the relevant units within the MOH as well as partners, • The TWG will also identify technical support needs. It will provide continuous monthly debriefing to the Minister of Health • Quarterly monitoring and evaluation reports • Quarterly Financial management and audit reports • Quarterly monitoring and planning meetings on both technical and financial issues to assess progress towards the targets, • Annual M&E and financial reports • Annual review and planning meetings based on the annual M&E and financial reports • To ensure effective integration, annually, all GAVI HSS project activities will be reflected in the Operational Plan of each implementing partner. All the activities under the GAVI HSS will be integrated into the existing health system strengthening activities at both the national and Zoba (Regional) levels. MOH or Zoba departments may either get additional financial resources for existing / similar HSS activities or may get additional funding for new activities from the GAVI HSS deemed to fall under this particular department. This will annul duplication of responsibilities and escalation of implementation costs while maximizing efficiency gains at all levels during project implementation.

7.2: Roles and Responsibilities of Key Partners (HSCG members and others)

Title / Post	Organisation	HSCG member yes/no	Roles and responsibilities of this partner in the GAVI HSS implementation
Minister of Health	**MOH**	**Chair**	▪ Reviews work plans and budgets; ▪ Review progress of implementation of the HSS programme; ▪ Presents the annual plans, budgets and quarterly progress reports to the HSCG and MOF.
Minister of Finance	**MOF**	**Yes**	▪ Approves budget based on annual plans and progress reports.
DG – Health Services	**MOH**	**Secretary**	▪ Presents the annual plans, budgets and quarterly progress reports to HSCG and to H.E. the Minister of Health for further action
WHO Representative	**WHO**	**Yes**	▪ Provides technical advise on HSCG Management ▪ They identify key WHO staff to augment MOH and Zoba staff in

			implementation of the GAVI HSS activities ▪ Coordinates MOH technical support needs for implementation of GAVI HSS WHO / AFRO so as to source the best technical support for MOH
UNICEF Representative	**UNICEF**	**Yes**	▪ Provides technical advise on HSCG Management ▪ They identify key UNICEF staff to augment MOH and Zoba staff in implementation of the GAVI HSS activities ▪ Coordinates MOH technical support needs for implementation of GAVI HSS interventions.
UNFPA Representative	**UNFPA**	**Yes**	▪ Provides technical advise on HSCG Management ▪ They identify key UNFPA staff to augment MOH and Zoba staff in implementation of the GAVI HSS activities ▪ Coordinates MOH technical support needs for implementation of GAVI HSS interventions.

Technical Working Group (TWG), GAVI HSS			
Title / Post	**Organisation**	**TWG member yes/no**	**Roles and responsibilities of this partner in the GAVI HSS implementation**
DG – Health Services	**MOH**	**Yes (Chair)**	▪ Coordinates the TWG meetings and gives over all directions to the TWG. ▪ Coordinates the preparation of annual plans, budgets and quarterly progress reports to be submitted to H.E. the Minister of Health for further action
Director – Family and Community Health	**MOH**	**Yes**	▪ Participates at the TWG meetings ▪ Prepares annual plans, budgets and quarterly progress reports and submits to the TWG in regard to his work area.
Director – Medical Services	**MOH**	**Yes**	▪ Participates at the TWG meetings ▪ Prepares annual plans, budgets and quarterly progress reports and submits to the TWG in regard to his work area.
Director – HR Mgt. and Planning	**MOH**	**Yes**	▪ Participates at the TWG meetings ▪ Prepares annual plans, budgets and quarterly progress reports and submits to the TWG in regard to his work area.
Head of Planning and International Cooperation Office	**MOH**	**Yes**	▪ Participates at the TWG meetings ▪ Prepares annual plans, budgets and quarterly progress reports and submits to the TWG in regard to his work area.
Director of Services Control and Q.A.	**MOH**	**Yes**	▪ Participates at the TWG meetings ▪ Prepares annual plans, budgets and quarterly progress reports and submits to the TWG in regard to his work area.
Director of M&E	**MOH**	**Yes**	▪ Participates at the TWG meetings ▪ Prepares annual plans, budgets and quarterly progress reports and submits to the TWG in regard to his work area.

Head – Health Systems	**MOH**	**Yes (Secretary)**	▪ Participates at the TWG meetings ▪ Prepares annual plans, budgets and quarterly progress reports and submits to the TWG in regard to his work area.
Head – EPI	**MOH**	**Yes**	▪ Participates at the TWG meetings ▪ Prepares annual plans, budgets and quarterly progress reports and submits to the TWG in regard to his work area.
Head – HMIS	**MOH**	**Yes**	▪ Participates at the TWG meetings ▪ Prepares annual plans, budgets and quarterly progress reports and submits to the TWG in regard to his work area.
Head of Budget and Planning	**MOF**	**Yes**	▪ Participates at the TWG meetings ▪ Oversees financial regulations are in place
DPC - Advisor	**WHO**	**Yes**	▪ Participates and contributes technical support at the TWG meetings
Epidemiologist	**WHO**	**Yes**	▪ Participates and contributes technical support at the TWG meetings
MPN Advisor	**WHO**	**Yes**	▪ Participates and contributes technical support at the TWG meetings ▪ Serves as the focal point representing WCO
EDM Advisor	**WHO**	**Yes**	▪ Participates and contributes technical support at the TWG meetings
National Health Project Officer	**UNICEF**	**Yes**	▪ Participates and contributes technical support at the TWG meetings
Private Not For Profit health providers (PNFPs)			
NUEWS Representative	**NUEWS**	**No**	▪ Project implementation / service delivery
NUEYS Representative	**NUEYS**	**No**	▪ Project implementation / service delivery
NCEWs Representative	**NCEWs**	**No**	▪ Project implementation / service delivery
Catholic Church Representative	**Catholic Services Secretariat**	**No**	▪ Project implementation / service delivery
Protestant Church Representative	**Protestant Church**	**No**	▪ Project implementation / service delivery

M&E Technical Support Resources			
Centre of Excellence for Health Systems Strengthening.	Makerere University School of Public Health (MUSPH)	No	▪ MUSPH will provide technical support when and where needed in several ways in all areas of Results Based Management (RBM)

7.3: Financial management of GAVI HSS support

Mechanism / procedure	Description
Mechanism for channelling GAVI HSS funds into the country	*Based on GAVI's approval to the financial request by the HSCC, funds will directly be transferred to the country, National Bank (MOF), to be transferred to the account of the MOH, equal to the amount requested for that period of time.*
Mechanism for channelling GAVI HSS funds from central level to the periphery	*In line to the agreed upon proposal, the MOH will channel funds to the respective zones equal to the amount requested through the existing government channels. These channels require that the Zoba Governors get involved in the financial disbursement and proper implementation control. Accordingly funds shall be released twice a year based on the submission of financial and technical reports of previously released funds, in order to reduce interruption on implementation of activities.*
Mechanism (and responsibility) for budget use and approval	*Once funds are transferred to the country, funds will be released upon request using an agreed upon format and the signature of the chair of the HSCC. The HSCC through its secretariat will make sure that funds disbursed are appropriately utilized within the allocated interval via regular meetings and reports. Financial and technical reports will be submitted within agreed upon time frame. At central level a GAVI/HSS finance office will be established and would exclusively follow financial transactions of the project. At Zoba level these functions will be integrated into the existing system.*
Mechanism for disbursement of GAVI HSS funds	*The HSCC shall make sure that funds released are solely used for the program purposes and consistent with the terms of the agreement. Funds will be released to country upon an official request signed by the person or persons authorized by the Principal Recipient (PR). The PR will demonstrate that it has achieved programmatic results consistent with the indicators set forth in the program implementation.*
Auditing procedures	*There will be an internal and external auditing of both the PR and Sub-recipients.* *The PR and sub-recipient shall maintain Program Book and Records in accordance with the generally accepted accounting standards in the Country. Program Books and Records must be kept in the possession of the PR for at least 3 years after the date of last disbursement under that Agreement. The PR shall notify the GAVI the independent auditor that it has selected to perform the annual audits in line to agreed upon time of audit. Similarly, the PR shall permit or ensure authorized representatives of GAVI access at all times the Program Books and Records as well as authorize GAVI to perform the audits required to conduct financial review, forensic audit or evaluation, or to take any other actions to ensure the accountability of the PR and Sub-recipients at specified period of time..*

7.4: Procurement mechanisms

GAVI does not have its own procurement system in Eritrea; however, all procurements shall be conducted in line with the existing Government of Eritrea policies and MOF rules and regulations.

The PR shall ensure that the following policies and practises are followed at all times:

a) Contract shall be awarded on a transparent and competitive basis,
b) All solicitations for contract bids must be clearly notified to all prospective bidders, with sufficient time given to respond to such solicitation,
c) Solicitation for goods and services shall provide all information necessary for a prospective bidder to prepare a bid,
d) Conditions to the participation in a contract bid shall be limited to those that are essential to ensure the participant's capability to fulfil the contract in question and compliance with domestic procurement laws,
e) Contracts shall be awarded to responsible contractors that possess the ability to successfully perform the contracts,
f) A reasonable price, as determined by a comparison of price quotations and market prices shall be paid to obtain goods and services,
g) The PR shall maintain records documenting in detail the receipt and use of goods and services acquired under this Agreement,
h) The PR shall ensure that the Sub-recipient comply with the agreed upon requirements when Sub-recipients undertake procurement of goods and services for the program,
i) The PR shall ensure that all goods and services and activities financed with Grant Funds, including those procured and implemented by Sub-recipients, are used solely for Program purposes.
j) The PR shall be responsible for all procurement and in circumstances where the sub-recipient possesses the requisite procurement capacity, may even permit its sub-recipient to contract local procurements.

7.5: Reporting arrangements

Tracking of the GAVI supported HSS project M&E indicators will be carried out using timely and regular reporting by all key partners. Financial and technical reports will be handled by the GAVI/HSS project office at head quarter in collaboration with the technical implementing units. Careful monitoring of implementation of project components has been planned to be maintained through clearly identified reporting responsibility categories. The HSCG Top Leadership will, through the HSCG secretariat, coordinate reporting of project implementation progress as detailed in the table below:. Reporting responsibility categories are: Implementing Partners, Financial Management department / accounts of MOH / WHO, Financial Audit section of WHO/MOH, M&E of MOH / WHO / M&E Support Institution and the HSCG, as listed in the table below.

Details of reporting responsibility categories, including timing

Type of Report	Frequency of Reporting						Deadline for reporting to:		
	Monthly		Quarterly		Annually		MOH / WHO Component Line Department	HSCG Secretariat	GAVI Secretariat
	Yes	No	Yes	No	Yes	No	05th of subsequent month	10th of first month of subsequent quarter	15th May 20…
Implementing Partner Reports	√		√		√		√	√	X
Financial Management Reports	√		√		√		√	√	X
Financial Audit Reports		√	√		√		√	√	X
Monitoring & Evaluation Reports	√		√		√		√	√	X
HSCG Reports		√	√		√		√	√	√

Implementing Partners at Zoba and PNFP levels will report to the MOH/WHO component line departments on monthly, quarterly and annual basis- copied to the HSCG Secretariat. While to the HSCG a comprehensive progress report will have to be submitted by the 10th of the first month of the subsequent quarter. Financial Management and Financial Audit reports follow similarly. However, the Financial Management and Financial Audit reports will be addressed to the HSCG but copied to the MOH/WHO component line departments. Finally, the HSCG secretariat will prepare a comprehensive report, endorsed by the HSCG Top leadership, for submission to GAVI Secretariat NOT LATER THAN 15th May of each implementation year of the GAVI HSS project.

7.6: Technical assistance requirements

Activities requiring technical assistance	Anticipated duration	Anticipated timing (year, quarter)	Anticipated source (local, partner etc.)
1. Finalize formulation of National Health Policy	Five (5) Weeks	1st quarter of 2009	GAVI-WHO
2. Finalize formulation of National Health Sector Development Plan	Seven (7) weeks	1st quarter of 2009	GAVI-WHO
3.Staffing pattern and job description development	Two weeks	1st quarter of 2009	Local
4.Production of HMIS quarterly bulletin	Two weeks	1st and 2nd quarter of 2009	GAVI-WHO
5. Development of Referral Policy and referral Policy Guidelines	Two weeks	1st and 2nd quarter of 2009	GAVI-WHO
6. M&E Technical Support: a) mentoring support to the MOH M&E team in quarterly M&E support supervision in the first and third quarter of the first implementation year b) Training Senior and middle level health managers in RBM (Strategic Planning / Management, M&E and HMIS Data utilization of evidence-based decision making	a) Four weeks; one week in the first quarter and one week in the third quarter b) Four weeks [two trainings (**RBM-1 & RBM-2**), each one week in the first and third year of project implementation.	1st and 3rd quarter of 2009 2nd and 4th quarter of 2009, and 2nd and 4th quarter of 2010	

SECTION 8: COSTS AND FUNDING FOR GAVI HSS

8.1: Cost of implementing GAVI HSS activities

Area for support						
	Year of GAVI application	Year 1 of implementation	Year 2 of implementation	Year 3 of implementation	Year 4 of implementation	**TOTAL COSTS**
	2007	2008	2009	2010	2011	
Activity costs		**45,000**	**575,055**	**595,580**	**656,715**	**1,872,350**
Objective 1:		**8,000**	***34,000***	**==**	**==**	***42,000***
Activity 1.1:		8,000	8,000	==	==	**16,000**
Activity 1.2:			5,000	==	==	**5,000**
Activity 1.3:			16,000	==	==	**16,000**
Activity 1.4:			5,000	==	==	**5,000**
Objective 2:			**118,555**	**163,000**	**191,000**	**472,555**
Activity 2.1			27,000	46,000	89,000	**162,000**
`Activity 2.2		==	22,000	52,000	42,000	**116,000**
Activity 2.3			19,555	32,000	36,000	**87,555**
Activity 2.4			13,000	==	==	**13,000**
Activity 2.5			10,000	==	==	**10,000**
Activity 2.6		==	7,000	==	==	**7,000**
Activity 2.7			6,000	==	==	**6,000**
Activity 2.8		==	==	9,000	==	**9,000**
Activity 2.9		==	8,400	17,000	17,000	**42,400**
Activity 2.10			5,600	7,000	7,000	**19,600**
Objective 3			***61,500***	***7,000***	***000***	***68,500***
Activity 3.1			6,000	==	==	**6,000**
Activity 3.2			8,500	==	==	**8,500**
Activity 3.3		==	12,000	==	==	**12,000**
Activity 3.4		==	14,000	7,000	==	**21,000**
Activity 3.5			21,000	==	==	**21,000**
Objective 4		**27,000**	**85,000**	**67,000**	**55,000**	**234,000**
Activity 4.1			11,000	15,000	==	**26,000**

Activity 4.2			11,000	10,000	==	**21,000**
Activity 4.3		7,000				**7,000**
Activity 4.4			8,000	5,000	8,000	**21,000**
Activity 4.5			2,000	2,000	2,000	**6,000**
Activity 4.6		20,000	24,000	30,000	40,000	**114,000**
Activity 4.7			5,000	5,000	5,000	**15,000**
Activity 4.8			24,000	==	==	**24,000**
Objective 5			**155,000**	**199,580**	**220,715**	**575,295**
Activity 5.1			23,000	30,000	45,000	**98,000**
Activity 5.2			23,000	30,000	45,000	**98,000**
Activity 5.3			20,000	==	==	**20,000**
Activity 5.4		==	21,000	30,000	41, 500	**92,500**
Activity 5.5		==	7,000	10,000	10,500	**27,500**
Activity 5.6			31,000	50,000	*16,715*	**97,715**
Activity 5.7			30,000	49,580	62,000	**141,580**
Objective 6		**10,000**	**121,000**	**159,000**	**190,000**	**480,000**
Activity 6.1			9,000	14,000	14,000	**37,000**
Activity 6.2			8,000	8,000	8,000	**24,000**
Activity 6.3			9,000	14,000	14,000	**37,000**
Activity 6.4		10,000	11,000	11,000	11,000	**43,000**
Activity 6.5			15,000	==	==	**15,000**
Activity 6.6			14,000	18,000	15,000	**47,000**
Activity 6.7			30,000	55,000	86,000	**171, 000**
Activity 6.8			7,000	7,000	7,000	**21,000**
Activity 6.9			11,000	25,000	35,000	**71,000**
Activity 6.10			7,000	7,000	==	**14,000**

Support costs*						
Management costs		69,000	50,000	50,000	50,000	**219,000**
M&E support costs			19,000	19,000	19,000	**57,000**
Technical support			40,000	40,000	= =	**80,000**
TOTAL COSTS		**69,000**	**109,000**	**109,000**	**69,000**	**356,000**

8.2: Calculation of GAVI HSS country allocation

GAVI HSS Allocation	Year of GAVI application	Year 1 of implementation	Year 2 of implementation	Year 3 of implementation	Year 4 of implementation	**TOTAL FUNDS**
	2007	2008	2009	2010	2011	
Birth cohort		132,827	138,811	140,916	145,143	**555,697**
Allocation per newborn		$5	$5	$5	$5	**$5**
Annual allocation		**664,135**	**684,055**	**704,580**	**725,715**	**2,778,485**

Overall Request for GAVI HSS Support

Overall GAVI HSS Request	Year of GAVI application	Year 1 of implementation	Year 2 of implementation	Year 3 of implementation	Year 4 of implementation	**TOTAL FUNDS**
Annual activity allocation		**45,000**	**575,055**	**595,580**	**656,715**	**1,872,350**
Total Support costs		**69,000**	**109,000**	**109,000**	**69,000**	**356,000**
GRAND TOTAL GAVI COSTS		**114,000**	**684,055**	**704,580**	**725,715**	**2,228,350**

Source and date of GNI and birth cohort information:
GNI: Ministry of National Development of Eritrea

Birth cohort: EDHS 2002

8.3: Sources of all expected funding for health systems strengthening activities

Funding Sources						
	Year of GAVI application	Year 1 of implementation	Year 2 of implementation	Year 3 of implementation	Year 4 of implementation	**TOTAL FUNDS**
	2007	2008	2009	2010	2011	
GAVI		**114,000**	**684,055**	**704,580**	**725,715**	**2,228,350**
Government	**16,600,000**	**17,300,000**	**17,800,000**	**18,,000,000**	**18,500,000**	**88,200,000**
Donor one WHO	**3,032,000**	**3,590,000**	**3,590,000**	=	=	**10,212,000**
Donor two UNICEF	**1,881,500**	**1,881,500**	**1,881,500**	**1,881,500**	**1,881,500**	**9,407,500**
Donor three UNFPA	**1,665,540**	**1,680,000**	**1,645,000**	**1,680,000**	**1,710,000**	**8,380,540**
Donor four. Global Fund	**12,329,060**	**17,103,641**	**14,206,557**	**11,845,300**	**12,254,756**	**67,739,314**
Donor five World Bank	**8,000,000**	**8,000,000**	**8,000,000**	=	=	**24,000,000**
Total	**43,508,100**	**49,669,141**	**47,807,112**	**34,111,380**	**35,071,971**	**210,167,704**

Source of information on funding sources:

GAVI: **GAVI Secretariat Guideline**

Government: **Ministry of Health Finance office**

Donor 1: **WHO-Eritrea Finance Office**

Donor 2: **UNICEF-Eritrea Finance Office**

Donor 3: **UNFPA –Eritrea Finance Office**

Total other: **WB, MOH-PMU Office**

GAVI HSS Application Form 2007

ANNEX 2 Banking Form

GLOBAL ALLIANCE FOR VACCINES AND IMMUNISATION	Banking Form

SECTION 1 *(To be completed by payee)*

In accordance with the decision on financial support made by the Global Alliance for Vaccines and Immunisation dated 2nd October 2007 , the Government of the State of Eritrea , hereby requests that a payment be made, via electronic bank transfer, as detailed below:

Name of Institution: ***(Account Holder)***	Ministry of Health of Eritrea		
Address:			
City – Country:	Asmara - Eritrea		
Telephone No.:	+291-1-120818	**Fax No.:**	+291-1-122899; +291-1-125835
Amount in USD:	(To be filled in by GAVI Secretariat)	**Currency of the bank account:**	USD
For credit to: ***Bank account's title***	*Ministry of Health of Eritrea at Bank of Eritrea – Asmara.*		
Bank account No.:	1203010107		
At: ***Bank's name***	National Bank of Eritrea		

Is the bank account exclusively to be used by this program? **YES ( ) NO (X)**

By whom is the account audited? By internal and National auditors

Signature of Government's authorizing official:

Name:	H.E. Saleh Meky	**Seal:**
Title:	Minister of Health	
Signature:		
Date:	3rd October 2007	

GAVI HSS Application Form 2007

SECTION 9: ENDORSEMENT OF THE APPLICATION

9.1: Government endorsement

The Government of State of Eritrea commits itself to providing immunization and other child and maternal health services on a sustainable basis. Performance on strengthening health systems will be reviewed annually through a transparent monitoring system. The Government requests that the GAVI Alliance funding partners contribute financial assistance to support the strengthening of health systems as outlined in this application.

Ministry of Health:	*Ministry of Finance:*
Name: H.E Mr. Saleh Meky, Minister of Health	Name: H.E. Mr. Berhane Abrehe, Minister of Finance
Title / Post: Minister of Health	Title / Post: Minister of Finance
Signature:	Signature:
Date: 3rd October 2007	Date: 3rd October 2007

9.2: Endorsement by Health Sector Coordination Committee (HSCC) or country equivalent

Members of the Health Sector Coordination Committee or equivalent endorsed this application at a meeting on 29th September 2007. The signed minutes are attached as Annex 1.

Chair of TWG for GAVI/HSS:	
Name: Berhane Ghebretensae	Post / Organisation: Director General of Health Services Department, MOH
Signature:	Date: 3rd October 2007

BERHANE GHEBRETENSAE
DIRECTOR GENERAL
HEALTH SERVICES DEPT.

9.3: Person to contact in case of enquiries:

Name: Dr. Berhane Debru
Title: Director of Medical Services Division, MOH
Tel No:+291-1-120432
Address: Ministry of Health of Eritrea
P.O.Box 212, Asmara-Eritrea
Fax No. +291-1-122899
Email: berhanedb57@yahoo.com;berhaned@moh.gov.er

ANNEX 1 Documents Submitted in Support of the GAVI HSS Application

Document (with equivalent name used in-country)	Available (Yes/No)	Duration	Attachment Number
National Health Sector Strategic Plan (or equivalent) [The Health Sector Note]	Yes	2001 - 2007	**1**
Comprehensive Multi- Year Plan (cMYP) 2007-2011	Yes	2007-2011	**2**
District Health System Situational Analysis (Functionality Assessment)	Yes	Two Months 2005	**3**
Health Information System Assessment	Yes	2006	**4**
Nationwide Human Resource Assessment	Yes	2006	**5**
TWG minutes, signed by Chair of TWG	Yes	2007	**6**
Draft National Health Policy	Yes	2006	**7**