END OF TERM EVALUATION OF

THE 3RD GSE/UNFPA COUNTRY PROGRAM

(2007-2011)

DECEMBER 2010
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<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>ANC</td>
<td>Antenatal Care</td>
</tr>
<tr>
<td>ARV</td>
<td>Anti-retroviral</td>
</tr>
<tr>
<td>ASRH</td>
<td>Adolescent Sexual and Reproductive Health</td>
</tr>
<tr>
<td>AWP</td>
<td>Annual Work Plan</td>
</tr>
<tr>
<td>BEmOC</td>
<td>Emergency Obstetric Care</td>
</tr>
<tr>
<td>CCA</td>
<td>Common Country Assessment</td>
</tr>
<tr>
<td>CEmOC</td>
<td>Comprehensive Emergency Obstetric Care</td>
</tr>
<tr>
<td>CP</td>
<td>Country program</td>
</tr>
<tr>
<td>CPAP</td>
<td>Common Country Action plan</td>
</tr>
<tr>
<td>CS</td>
<td>Cesarean Section</td>
</tr>
<tr>
<td>EDF</td>
<td>Eritrean Defence Force</td>
</tr>
<tr>
<td>EDHS</td>
<td>Eritrea Demographic Health Survey</td>
</tr>
<tr>
<td>FBOs</td>
<td>Faith Based Organizations</td>
</tr>
<tr>
<td>FGM</td>
<td>Female genital mutilation</td>
</tr>
<tr>
<td>FP</td>
<td>Family Planning</td>
</tr>
<tr>
<td>GBV</td>
<td>Gender Based Violence</td>
</tr>
<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
</tr>
<tr>
<td>GSE</td>
<td>Government of the State of Eritrea</td>
</tr>
<tr>
<td>HAMSET II</td>
<td>HIV/AIDS, Malaria, STI, and Tuberculosis including RH</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>HMIS</td>
<td>Health Management Information System</td>
</tr>
<tr>
<td>HRD</td>
<td>Human Resources Development</td>
</tr>
<tr>
<td>IDPs</td>
<td>Internal Displaced People</td>
</tr>
<tr>
<td>IEC</td>
<td>Information Education and Communication</td>
</tr>
<tr>
<td>ILO</td>
<td>International Labour Organization</td>
</tr>
<tr>
<td>IMCI</td>
<td>Integrated Management of Childhood Illness</td>
</tr>
<tr>
<td>IMIS</td>
<td>Integrated Management Information System</td>
</tr>
<tr>
<td>IPC</td>
<td>Inter Personal Communication</td>
</tr>
<tr>
<td>I-PRSP</td>
<td>Interim Poverty Reduction Strategy Paper</td>
</tr>
<tr>
<td>IUD</td>
<td>Intra Uterine Devices</td>
</tr>
<tr>
<td>KAP</td>
<td>Knowledge Attitude and Practice</td>
</tr>
<tr>
<td>LSS</td>
<td>Life Saving Skill</td>
</tr>
<tr>
<td>MCH</td>
<td>Maternal and Child Health</td>
</tr>
<tr>
<td>MDGs</td>
<td>Millennium Development Goals</td>
</tr>
<tr>
<td>MLW</td>
<td>Ministry of Labour and Social Welfare</td>
</tr>
<tr>
<td>MMR</td>
<td>Maternal Mortality Rate</td>
</tr>
<tr>
<td>MNH</td>
<td>Maternal and Neonatal Health</td>
</tr>
<tr>
<td>MoA</td>
<td>Ministry of Agriculture</td>
</tr>
<tr>
<td>MOD</td>
<td>Ministry of Defence</td>
</tr>
<tr>
<td>MOE</td>
<td>Ministry of Education</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>MOI</td>
<td>Ministry of Information</td>
</tr>
<tr>
<td>MoND</td>
<td>Ministry of National Development</td>
</tr>
<tr>
<td>MPMDA</td>
<td>Maternal and Postnatal Death Audit</td>
</tr>
<tr>
<td>Acronym</td>
<td>Full Form</td>
</tr>
<tr>
<td>---------</td>
<td>-----------</td>
</tr>
<tr>
<td>MWH</td>
<td>Maternity Waiting Homes</td>
</tr>
<tr>
<td>NATCoD</td>
<td>National AIDS and Tuberculosis Control Division</td>
</tr>
<tr>
<td>NCEW</td>
<td>National Confederation of Eritrean Workers</td>
</tr>
<tr>
<td>NGO</td>
<td>Non Governmental Organization</td>
</tr>
<tr>
<td>NHMIS</td>
<td>National Health Management Information System</td>
</tr>
<tr>
<td>NSO</td>
<td>National Statistics Office</td>
</tr>
<tr>
<td>NUEW</td>
<td>National Union of Eritrean Women</td>
</tr>
<tr>
<td>NUEYS</td>
<td>National Union of Eritrean Youth and Students</td>
</tr>
<tr>
<td>PAC</td>
<td>Post Abortion Care</td>
</tr>
<tr>
<td>PFDJ</td>
<td>Peoples Front for Democracy and Justice</td>
</tr>
<tr>
<td>PID</td>
<td>Pelvic Inflammatory Diseases</td>
</tr>
<tr>
<td>PMTCT</td>
<td>Prevention of Mother to Child Transmission</td>
</tr>
<tr>
<td>PPH</td>
<td>Post Partum Haemorrhage</td>
</tr>
<tr>
<td>RHCS</td>
<td>Reproductive Health Commodity Security</td>
</tr>
<tr>
<td>RH</td>
<td>Reproductive Health</td>
</tr>
<tr>
<td>RVF</td>
<td>Recto Vaginal Fistula</td>
</tr>
<tr>
<td>SPSS</td>
<td>Statistical Package for Social Science</td>
</tr>
<tr>
<td>SRH</td>
<td>Sexual and Reproductive Health</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infections</td>
</tr>
<tr>
<td>TBAs</td>
<td>Traditional Birth Attendants</td>
</tr>
<tr>
<td>UNDAF</td>
<td>United Nations Development Assistance Framework</td>
</tr>
<tr>
<td>UNDP</td>
<td>United Nations Development Programme</td>
</tr>
<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
</tr>
<tr>
<td>UoA</td>
<td>University of Asmara</td>
</tr>
<tr>
<td>VCT</td>
<td>Voluntary Counseling and Testing</td>
</tr>
<tr>
<td>VVF</td>
<td>Visio-Vaginal Fistula</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
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</table>
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UNFPA-Eritrea Country Office
EXECUTIVE SUMMARY

A. INTRODUCTION
To address the development challenges, the Eritrean government has taken important measures towards improving socio-economic development in the past nine years since the beginning of the first UNDAF (2002). The measures, among others, include:

✓ Interim Poverty Reduction Strategy Paper (I-PRSP),
✓ The Food Security Strategy, Education Sector Development Program,
✓ The National Water Supply Emergency Action Plan,
✓ The National Health Policy.

In line with the government’s strategy, the UN system has shown commitment to assist the country in reaching these goals.

The United Nations Development Assistance Framework (UNDAF) 2007-2011 for Eritrea aims at realizing the national priorities leading to the achievement of MDGs. To this end, the Government of the State of Eritrea has identified the strategic areas to work with the UN System and other bilateral partners. UNFPA, which is a partner under the UNDAF, has important contribution in the health sector, gender empowerment and population and development...

The 3rd Country Program (CP) under evaluation is designed to contribute to the achievement of rapid, balanced and sustainable economic growth that translates into improved standard of life through the promotion of reproductive health, gender equality and the integration of population issues in development process. The Country Program was implemented through three programme components namely:

✓ Reproductive Health,
✓ Gender
✓ Population & Development.

B. Major findings of the evaluation
a) Findings related to the program design

i. Efficiency in resources management
This is the extent to which resources are mobilized and used to optimal attainment of the expected results. A review of the contribution and use of UNFPA financial support to the program showed that there was generally a high resources mobilization rate. In general the budget mobilization rates were 91.38% for gender, 92.82% for FGM/C, 74.55% for RH and 94% for P&D. The consumption rates were relatively higher, 95.75% for Gender, 80.79% for FGM/C, 98.90% for P&D and 92.00% for RH.

A review of the contribution and use of UNFPA financial support to the program showed that there was generally a high resources mobilization rate and a high consumption rate of the finances so mobilized. As regards the mechanism for the utilization of the funds, it was observed that based on a joint action plan elaborated and approved by the implementing partners bodies of the GSE and the UN partners, funds are put at the disposal of the implementing partners and the other partners quarterly and on advance basis. Generally, further disbursements for subsequent quarters are done if and only if justifications for prior disbursements are received. Unfortunately, there were times of great delays in the onset of the disbursement of finances, sometimes starting as late as in June. This has led to a lot of
dissatisfaction on the part of the field workers who find themselves having to postpone activities due to lack of funds. The procurement procedure was found to be too slow, at times leading to very late supply of much needed material and equipment. The problem was found to be at the level of procurement request which were not always done early enough, and at the level of the purchase within UNFPA at international level which often had many orders to satisfy and had to work with the FIFO principle.

ii. Effectiveness
Looking at the programme components, their respective strategies and activities, there is an evident internal coherence and one can say with certainty that this was well thought of. Within the RH programme component for example there is a deliberate and evident investment to improve on supply of quality reproductive health services and to improve on the demand. The most evident indication of the internal coherence of the programme component is the degree of the accomplishment of the expected results. Contrary to the 2nd country program where clear baseline situation and targets were not set, the present program went a long way to set them, thus making it easy to evaluate program related progress.

iii. Relevance of the Programme components to National Priorities and to UNDAF
The programme components were all found to contribute to the bigger picture of general development orientations as defined by key national and international guiding documents most essential of which are the country’s policy and strategic plans in the respective domains and the UNDAF and CPAP documents, the Health Sector Strategic document “National Sexual And Reproductive Health Service; Policy And Guidelines” of April 2005, and the country’s Interim - Poverty Reduction Strategy Paper (I-PRSP, of 2004).

iv. Sustainability of the programme components
The sustainability of the UNFPA interventions and those of the other partners is ensured by the fact that they are mostly investing into the software and durable equipment, material and infrastructures. These include capacity development of the implementing partners’ staff, investment in institutional capacity building, advocacy to diversify the sources of finances, putting in place legal frameworks and policy documents which lay the groundwork for better working conditions etc.

b) Findings related to the level of accomplishment of planned activities
A number of essential activities were foreseen per programme components within the country program action plan to accomplish the related outcomes and outputs. The implementation of the related activities by the programme components was variably accomplished with the full participation of all its major stakeholders and partners amongst which is UNFPA.
From this evaluation there was a high level of accomplishment of the planned activities for the RH and gender programme components while this was less so with the P&D programme component for various reasons beyond the control of the implementers. The planned activities were duly decomposed into sub-activities that were subsequently implemented by the respective actors in the field.

c) Findings related to the situation of the output and outcome indicators
The findings of the evaluation in relation to the program indicators are summarized in the table below. There was a general increase for most of the indicators.

<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>BASELINE</th>
<th>TARGET</th>
<th>ACHIEVEMENT</th>
<th>REMARK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Situation of Reproductive Health Outcome and Output Indicators</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Status of Indicators for RH OUTPUT : Strengthened technical and institutional capacity to provide quality integrated RH care</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Proportion of HS providing BEmOC</td>
<td>23%</td>
<td>45%</td>
<td>86%</td>
<td>Increase beyond target</td>
</tr>
<tr>
<td>Proportion of health facilities that are providing PNC</td>
<td>0%</td>
<td>75%</td>
<td>29.7% in 2009</td>
<td>Increase but though short of the target. Target likely to be met by end of 2011</td>
</tr>
<tr>
<td>The proportion of Health facilities providing ANC with VCT services</td>
<td>10 - 15%</td>
<td>100%</td>
<td>47%, in 2009</td>
<td>Increase but though short of the target</td>
</tr>
<tr>
<td>The proportion of health facilities providing at least three modern methods of family planning</td>
<td>51.3%</td>
<td>100%</td>
<td>100%,</td>
<td>Target met</td>
</tr>
<tr>
<td><strong>Status of Indicators for RH OUTPUT II: Increased availability of information and enhanced skills to influence RH related health-seeking behavior and practices of communities particularly women, men, young people and community leaders</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The proportion of men and women that can mention at least two danger signs associated with pregnancy and child birth</td>
<td>27%,</td>
<td>50%,</td>
<td>75%, for women</td>
<td>Men not measured</td>
</tr>
<tr>
<td>Proportion of men and women who know at least two benefit of modern contraceptive</td>
<td>50%,</td>
<td>70%,</td>
<td></td>
<td>By proxy indicator</td>
</tr>
<tr>
<td>Percentage of sexually active young people (15-24) who used a condom at last sex with a non-married, non-cohabitating partner in the last twelve months</td>
<td>36%</td>
<td>80%</td>
<td>90% males &amp; 87.7% females</td>
<td>Increase beyond target</td>
</tr>
<tr>
<td><strong>Status of Indicators for RH OUTPUT III: HIV prevention efforts scaled up with mitigation of stigma and discrimination of those infected and affected</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proportion of sites providing comprehensive PMTC</td>
<td>39%</td>
<td>50%</td>
<td>47%. (2009,)</td>
<td>On track for achievement</td>
</tr>
<tr>
<td>Proportion of young people</td>
<td>78%,</td>
<td>100%</td>
<td>92%</td>
<td>Increase short</td>
</tr>
<tr>
<td>INDICATOR</td>
<td>BASELINE</td>
<td>TARGET</td>
<td>ACHIEVEMENT</td>
<td>REMARK</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>----------</td>
<td>--------</td>
<td>-------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>aged 15-24 who know at least two ways of preventing HIV transmission</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percent of respondents expressing accepting attitude towards people living with HIV AIDS (PLWHA)</td>
<td>16%</td>
<td>100%</td>
<td>73%</td>
<td>Increase short of target</td>
</tr>
</tbody>
</table>

**Status of Indicators for RH OUTCOME INDICATORS:** Improved availability, access to and utilization of quality, gender sensitive, integrated RH information and services with special focus on RHCS, EmOC, HIV/AIDS, disaster and emergency response, young people and other vulnerable groups

<table>
<thead>
<tr>
<th>Percentage of births attended by skilled birth attendants</th>
<th>28.3%</th>
<th>40%</th>
<th>28% (HMIS 2010)</th>
<th>Stagnant</th>
</tr>
</thead>
<tbody>
<tr>
<td>CS as a proportion of all births</td>
<td>3%</td>
<td>5%</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>Contraceptive prevalence rate</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>The HIV prevalence among young people aged 15-24 years, by sex</td>
<td>2.4%, F &amp; 0.75% M</td>
<td>1% F &amp; 0.25% M</td>
<td>0.75% F &amp; data for M is not available (NATCoD 2010)</td>
<td>Only females were tested.</td>
</tr>
<tr>
<td>Proportion of service delivery points without stock outs of reproductive health commodities</td>
<td>nil</td>
<td>100%</td>
<td>95% - 100%</td>
<td>on track</td>
</tr>
</tbody>
</table>

**SITUATION OF POPULATION & DEVELOPMENT OUTCOME AND OUTPUT INDICATORS**

**Status of The indicators for P&D Outcome:** Quality disaggregated data is available, accessible and utilized for the formulation of policies, national development plans and programmes

<table>
<thead>
<tr>
<th>Sector development plans reflecting the use of disaggregated data by age, gender, and vulnerability</th>
<th>Education sector development plan</th>
<th>12 Sector Ministries</th>
<th>12 Sector Ministries</th>
<th>Target met</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>Advanced preparations done</td>
</tr>
</tbody>
</table>

**Status of The indicators for P&D Output 1:** Strengthened capacity of NSO and sectoral ministries to generate, analyze and disseminate appropriate population and socio economic data

<table>
<thead>
<tr>
<th>A functional Integrated Management Information System available</th>
<th>0</th>
<th>1</th>
<th>0</th>
<th>Advanced preparations done</th>
</tr>
</thead>
<tbody>
<tr>
<td>Survey reports disseminated</td>
<td>2002 EDHS</td>
<td>2010 EPHS</td>
<td>0</td>
<td>2010 EPHS</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>BASELINE</th>
<th>TARGET</th>
<th>ACHIEVEMENT</th>
<th>REMARK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population and Housing Census</td>
<td>Nil</td>
<td>2007/8 Census</td>
<td>Nil</td>
<td>Census not conducted</td>
</tr>
<tr>
<td>Number of sectors developing relevant data sets</td>
<td>Nil</td>
<td>12</td>
<td>12</td>
<td>But there are no standard format</td>
</tr>
</tbody>
</table>

**SITUATION OF GENDER OUTCOME AND OUTPUT INDICATORS**

**Status of GENDER output 1 indicators: supportive policies, legislation and other legal frameworks are in place and enforced**

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Baseline</th>
<th>Target</th>
<th>Achievement</th>
<th>Remark</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportions of gender related articles in the penal and civil codes that are reviewed in line with international instruments (CEDAW and African protocols) and implemented</td>
<td>50%</td>
<td>100%</td>
<td>Nil</td>
<td>However the constitution make provisions</td>
</tr>
<tr>
<td>Number of institutions mainstreaming the National Gender Action Plan in their sectoral plans</td>
<td>0</td>
<td>12</td>
<td>3</td>
<td>9 have adopted strategy.</td>
</tr>
<tr>
<td>The FGM/C Law enacted and implemented</td>
<td>Draft</td>
<td>1</td>
<td>1</td>
<td>Since March 20th 2007</td>
</tr>
</tbody>
</table>

**Level of achievement of GENDER output 2 indicators: Strengthened institutional capacities for gender analysis and mainstreaming in the development sectors**

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Baseline</th>
<th>Target</th>
<th>Achievement</th>
<th>Remark</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of institutions with capacity to undertake gender analysis and mainstreaming</td>
<td>0</td>
<td>12</td>
<td>11</td>
<td>Target virtually met</td>
</tr>
<tr>
<td>Number of institutions mainstreaming gender in their plans and programmes</td>
<td>0</td>
<td>12</td>
<td>11</td>
<td>Target virtually met</td>
</tr>
</tbody>
</table>

**Level of achievement of GENDER output 3 indicators: Socio-cultural values, norms and practices are positively influenced in support of women and girls reproductive rights and their empowerment.**

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Baseline</th>
<th>Target</th>
<th>Achievement</th>
<th>Remark</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Community courts supporting legislation promoting the rights of women and girls</td>
<td>Nil</td>
<td>all functioning community courts</td>
<td>Cannot be determined</td>
<td>data not available</td>
</tr>
<tr>
<td>Number of GBV cases reported</td>
<td>Nil</td>
<td>all new cases reported</td>
<td>Cannot be determined</td>
<td>data not available</td>
</tr>
</tbody>
</table>
d) Findings related to the major achievements of the country programme

i. Major achievements of the RH programme component

- Most health facilities visited had adequate number of RH materials, equipments and drugs for FP, antenatal, delivery and postnatal care.
- There was a generally good coverage of the population in terms of RH service provision, medical laboratories etc.
- The timely response of partners like UNFPA to address critical personnel shortage by supporting recruitment of international health personnel to fill the gap while the government is building its institutional capacity.
- The Eritrean Defense Force (EDF’s) use of Change Agents or organizations like NUEYS & NUEW by virtue of their extensive territorial coverage and strong organization was an effective means of affecting behavior change not only within their personnel but also within the communities at large where they are stationed.
- There was a laudable effort to provide health services to the population by use of approaches such as the post partum home visits, the lab in suitcase, and the maternity waiting homes, which greatly helped to extend coverage of the much needed services.
- The introduction of the maternity waiting home particularly helped to timely bring pregnant mothers into the health facilities for skilled attended deliveries.

ii. Major achievements of the P&D programme component

- The National Statistics Office, in collaboration with UNFPA and other key partners, has accomplished tasks pertaining to data collection, capacity building for the EPHS; conduct an inventory of the existing national databases, training in the use of Devinfo presentation and dissemination software. However, much of the planned activities of the P&D programme component during the Third Country Program have not been carried out.
- Some NSO staff members have received trainings in-house and abroad. To some extent, this has increased their capacity to take on the onerous task of data generation, analysis and dissemination. Their participation in the 3rd EPHS and LSMS...
surveys as well as their technical assistances to the MoE surveys are testimonies of their skills.

- The financial and logistic support from the partners like UNFPA went a long way to equip NSO. This included: computers and accessories, photocopiers, software among others. This has strengthened the working capacity of the Office in many ways, notably in the area of production, analysis and dissemination of demographic data.

iii. Major achievements of the Gender programme component

- The technical skills on gender mainstreaming inbuilt within the programme as well as monitoring capabilities were enhanced thus increasing the capacity of NUEW to take on the task of designing and facilitating gender mainstreaming training at policy and community levels.

- The extension of NUEW membership at all levels including those in the diaspora has strengthened the sustainability of the programme component as the sources of resources have been increased and diversified.

- The approach of identifying gender component as a programmatic aspect of the UNDAF has contributed to greater visibility and ability to focus and better influence behaviour and practices.

- The use of gender thematic groups is useful to ensure sharing and consistent knowledge on the gender equality work.

d) Findings related to the areas to improve on in the next country programme

i. RH programme component

- Difficulties were encountered in measuring progress of some indicators due to non-inclusion of the related data in the HMIS tools and or the absence of a baseline situation, for example Post Partum Care (PPC) - home visits.

- Most of the newly graduated midwives had inadequate experience, exposure and skill in obstetrics and gynecology, and were not very operational on the field as they themselves acknowledged.

- The neonate care unit in all hospitals and health centers visited was not established and equipped to provide basic or comprehensive neonatal care.

- Due to the Ministry of Finance policy, most of the training components and supportive supervision were not conducted in the year 2010 but done in the previous years of the 3rd CP i.e. 2007-2009.

- The level of Insanitation of some health facilities was exacerbated by the lack of piped water especially in the health stations, thus the improper use of the latrines, showers and lavatories noticed.

- There is a reduced use of ANC services according to the registers.

- Feedback within the referral system was almost completely absent. This could have served not only in strengthening the referral system but also in improving capacity of staff involved.

- The change agents often had accommodation and transport problems in remote villages that need to be addressed, especially when they have to spend nights out.

- Financial approval process is so slow that it often created unnecessary delays in the implementation of the activities.
ii. P&D programme component.

- Some essential activities were not carried out as planned due to the procedural reasons, which took a much longer time than previously thought. The national population and housing census and promulgation of statistical act were among the activities/areas that showed little or no progress during the period.
- With regards to EPHS, there were critical shortages of field vehicles (for rural clusters and supervision activities) resulting in the delay of the fieldwork for the rural clusters. Furthermore, due to problems related to the delivery of items for weight and height measurements and DBS collection the survey was delayed.
- Because of the absence of the Statistical Act and consequently of the common national data base, sector ministries tend to collate, produce and disseminate and utilize their own data, without reference to the NSO. In such situation, there is no guarantee of the quality of data produced here and there.

iii. Gender programme component.

- Inadequate sex disaggregated data P&D has hindered the collection of baseline information as well as capture developmental trends that are likely to have different impacts on women and men.
- Slow pace in terms of reforming the decision making profile of women in high positions of power. Whilst it is notable that women are largely visible in the public offices, their positioning is dominant at the middle and lower levels.
- Absence of reporting system hinders successful monitoring trends of the community court and other courts on jurisprudence on gender equality. It is recommended that dialogue with the Attorney General and the judiciary be commenced to identify appropriate means to document court judgments and conduct trends analysis as a tangible means of witnessing the impact of the law enforcement training.
- Insufficient institutionalization of knowledge and processes on NUEW operations. Whilst NUEW has nearly a country wide membership, its programmatic implementation processes are largely housed with the Programme Coordinator and Board. As a result, other officers within the organization are hesitant to share or provide information with other actors.

e) Findings related to the challenges

i. Common Challenges of the program

- Since the issue of border demarcation between Eritrea and Ethiopia has not been resolved, one noticeable result of this is that census cannot take place in these conditions.
- The lack of current denominator information on the population constitutes a problem for calculating target population and coverage.

ii. Challenges specific to the RH programme component

- Shortage of human resource such as doctors, anesthetists, midwives etc.; especially in seven hospitals to make them fully functional for comprehensive EmOC was a serious problem.
- Inadequate transport and communication services including shortage of fuel; which negatively affects the referral and outreach activities.
The multiplicity of local languages constitutes a barrier to effective Behavior change communication (BCC) which makes it difficult for the change agents in addressing various populations and also for the producers of IEC material to produce material that is widely appropriate.

iii. Challenges specific to the P&D programme component

- Absence of Statistical Act. This is identified as a major constraint to achieving the outcome of the programme component. A draft of this essential tool is yet to be validated and approved by the government.
- Shortage of high level experts. Data management requires in many aspects high specialists that NSO cannot afford thus leading to the call for external Technical Assistance to fill the gap.

C. Recommendations

i. RH programme component related recommendations

Besides stressing the need for addressing the challenges and perpetrating the major achievements indicated above, the following recommendations are made for the next programme:

a) To follow up on, document and publish the results of innovative experiences in the current program like, maternity waiting homes, lab-in-suitcase services and post partum home visits and scale them up as a means to extend coverage of the population with essential health services.

b) To introduce a feedback system within EmOC referral not only as a means of strengthening the referral system but also of improving capacity of staff in obstetric health care service provision.

c) To consider introducing an EmOC network system which aims more at population coverage than of territorial/administrative coverage as a means of maximizing the use of limited resources to cover the maximum population possible. Some health facilities located in strategic and distant places may have to be upgraded, equipped and staffed to manage all emergency obstetrical and other critical patient care from their surroundings, as against trying to get people to use distant ones.

d) To improve on the supply of energy as a means of optimizing the use of electrical appliances. Solar power is good as a source of lighting and running the fridges or other light appliances, but not for heavy duty appliances.

e) To improve pipe water supply especially in health stations as a means to improve on general sanitation, proper utilization of the latrines, showers and lavatories or general cleanliness.

f) To improve on the availability and maintenance of ambulances in all health facilities as a means of enhancing emergency obstetrical care. This implies acquiring more ambulances but within the framework of a network system where a centrally positioned ambulance is made to cover a number of communities and health facilities all equipped with communication systems that can permit them to call the ambulance as needs arise. The practical modalities of how this will operate have to be well thought about taking into
consideration the contributions of users (community, Individuals, Health facilities, etc.) in view of the sustainability.

g) To strengthen the team of obstetrician and anesthetists and assign them to strategically located health facilities (Example Assab, Tio, and Afabet hospitals) to provide cEmOC.

h) To make an extra effort in order to clear the back log of fistula cases that urgently need treatment and rehabilitation.

i) To strengthen and possibly scale up innovative and promising best practices like the post partum care home visits, and maternity waiting homes as a means of bringing services closer to the people. The population is very much pro-actively in support and the program needs to capitalize on the dynamic in place currently.

j) To be more aggressive in stimulating the demand and use for ANC services. The community health workers (TBAs, CHAs etc.) should be organized to sensitize and mobilize mothers for ANC, facility delivery and to have birth preparedness plans.

k) To support the implementation of the MP&DA forms, particularly at the community level, in order to identify the causes of maternal and newborn deaths in the community so as to take appropriate corrective measures.

l) To strengthen RH Commodities Security to ensure the minimum 3 optional FP methods in the health facilities. Special care is to be given to condom given its dual protection of HIV and pregnancy especially given the increasing demand noticed in the field.

m) To strengthen the human resource for the provision of quality RH services, with focus on training of midwives, Ob/Gyn specialists, anesthetists and LSS training. There is an urgent need to introduce apprenticeship training for general practitioners on major gynecological and obstetrical surgical procedures so as to improve on the cEMOC coverage.

n) To introduce the more personal and intimate behaviour change communication strategies as a means of sustaining and fostering the impetus given to risky behavioural change that has been accomplished so far by mass communication, e.g. VCT in school settings or in youth centres.

o) To better target and give attention to young girls and women getting into sex work for various reasons, but who unfortunately do not identify themselves as CSWs, and as such do not benefit from related BCC strategies and activities.

p) To support the community to construct habitable and more durable maternity waiting homes.

q. To ensure adequate and timely release of fund annual work plans should be prepared as early as December to make sure all necessary approvals are gotten in view of an early start of disbursements in January of the next budgetary year.

r. The capacity of the focal person at the MOH need to be strengthened to follow up the financial documents related funds from partner agencies for the RH program on a more regular basis.

ii. P&D programme component related recommendations

The P&D sub-program, as a pivotal component of the 3rd CP, should be strengthened further in order to mobilise demographic and socio-economic data for comprehensive development policies in Eritrea. The following recommendations will contribute to achieving this:

(a) Approval and promulgation of the ‘National Statistics Act’ should be of strategic importance as this provides the legal framework for data collection and utilization at all levels.
(b) The issue of a National Population Policy should also be given priority attention.
(c) In-house training and study tours abroad should be enhanced to further contribute to the capacity building of NSO and other sectoral Ministries at a higher expert level. More advanced trainings should be planned and provided for all NSO and ministries staff who deal with data issues.
(d) Census should be rescheduled as soon as internal and external conditions are favourable.
(e) The need to implement CP review recommendations is paramount, so that the problems associated with specific issues do not continue to crop up or multiply the consequences of non-implementation.

iii. GENDER programme component related recommendations
The gender programme component is an integral part of assuring meaningful and efficient development interventions. It enables the comprehensive delivery of the 3rd country programme by capturing the breadth of intervening socio-cultural factors that undermine development, particularly maternal mortality and advances in the reproductive health arena. Thus, it should be strengthened as a vehicle to deliver on GSE goals set out in NGAP and commitments to its internationally stated obligations particularly MDG’s. These are some of the recommendations:

a) NUEW should be strengthened to monitor and report on progress made on improvements on women’s decision making status. The threshold of 30% should be implemented at all levels of decision making and that this affirmative action provision should not be viewed as the maximum but rather as the bare minimum to fulfill gender equality.

b) As reporting on legal cases is yet to be instituted, it is recommended that monitoring visits to the community courts are made to determine changes in behaviour and management of accused persons by the community judges.

c) Efforts to have baseline surveys around the themes of the programme will significantly strengthen the programme particularly in targeting necessary interventions.

d) Activities that contribute to outputs 1 and 3 should be harmonized.

e) There is a need to intensify activities targeting young people at school.

f) The approach to work in the rural areas and adopt a bottom up approach is successful as shown in the case of FGM campaigns, thus there is need to have the programme expanded to all the rural settings and allocate enough transport facilities and running costs.

D. CONCLUSION

The overall performance of the 3rd country program is very satisfactory in relation to its design, relevance, effectiveness, efficiency, sustainability, and implementation. In its design the program was found to be in line with the national priorities as defined in the strategic documents reviewed in the evaluation. It was found to be in line with the orientations in the UNDAF and CPAP documents. There was a high level of accomplishment of planned activities. The review revealed that most of the envisaged tasks had been accomplished successfully while others are partially done. In RH, significant efforts were made in strengthening service provision and soliciting its demand. In some of the components there has been some innovative and promising initiatives, which need close follow up, documentation and subsequent scaling up
to ensure total coverage of the population. The gender mainstreaming is taking root in line ministries and national institutions. The NSO is well-equipped and now skilled to undertake activities related to data collection, analysis and dissemination. The preliminary report of the 3rd EPHS has been prepared and is being assessed by the government. The program results (output and outcome levels) were largely met. Of course there are still areas for improvement and some major challenges to address in order to optimize the results of the country program.
I. MAIN EVALUATION REPORT

a. Introduction

i. Generalities

The Government of the State of Eritrea (GSE) inherited poor socio-economic conditions at the time of independence in 1991. In 1994, the Government issued a comprehensive Macro Policy outlining the strategies for development with high priority on food security; human resources development, physical and social infrastructural development and environmental restoration and protection. The Government also followed liberal trade and investment policies as a result of which, the economy gained momentum and showed significant improvements during the years 1992 to 1997. Furthermore, the government welcomed partnership in overcoming the development challenges of the country. Hence, since the time Eritrea emerged as a sovereign state, the UN system has been a close and supportive partner.

The Ethiopian - Eritrea war in May 1998, which began as a border conflict, escalated into a devastating war, and inflicted heavy damages on the Eritrean economy. Zoba Gash Barka and Zoba Debub, the agriculturally most productive regions of the country, sustained heavy damage, in particular. The investment made in agriculture, education and health sectors were either purposefully destroyed or looted by the invading Ethiopian army. Moreover, the war has created uncertainty that has adversely affected the inflow of direct foreign investment, causing macroeconomic instability. The country’s economic growth has thus remained below those of before 1998. This declining situation has adversely affected the achievement of Millennium Development Goals (MDGs), although noticeable strides have been made towards them in several areas.

ii. Enabling policies for sustainable economic development

Eritrea is advancing towards achieving the Millennium Development Goals (MDGs) with regard to gender equality at the primary school level, improved child and maternal health. But the country still faces challenges with respect to the primary goal of eradicating extreme poverty. Recurrent droughts, subsistence means of livelihood and the continued stalemate over the border conflict have greatly undermined the production capacity of the rural communities. To address the development challenges, the Eritrean government has taken important measures towards improving socio-economic development in the past nine years since the beginning of the first UNDAF (2002). The measures, among others, include:

- Interim Poverty Reduction Strategy Paper (I-PRSP),
- The Food Security Strategy,
- Education Sector Development Program,
- The National Water Supply Emergency Action Plan,
- The National Reproductive Health Policy.
In line with the government’s strategy, the UN system has shown commitment to assist the country in reaching these goals.

iii. Strategic areas of development cooperation

The United Nations Development Assistance Framework (UNDAF) for Eritrea aims at contributing to realizing the national priorities leading to the achievement of MDGs. To this end, the Government of the State of Eritrea has identified the strategic areas which it needs to work with the UN Systems and other bilateral partners. UNFPA, which is a partner under the UNDAF, has important contribution in the health sector, gender empowerment and population and development. The intervention of the program is consistent with UNFPA mandate in the three thematic areas. The 3rd Country Program (CP) under evaluation is designed to contribute to the achievement of rapid, balanced and sustainable economic growth that translates into improved standard of life through the promotion of reproductive health, gender equality and the integration of population issues in development process. The Country Program thus has three components in the domains of Reproductive Health, Gender and Population & Development.

b. Third Country Programme (CP) Components

i. Reproductive Health programme component

The main goal of the GSE is to improve the quality of health services through enhancing its availability and accessibility. Since the country’s liberation in 1991, provision of basic social services such as health and education, have improved through a government programme of rehabilitation and rapid expansion of health facilities and schools. Health facilities are now more equitably distributed throughout the country. As a result, access to health services has increased from 46% in 1991 to about 75% at present. These interventions among others have led to some improvement in the major health indicators as revealed in the 2002 Eritrean Demographic and Health Surveys (EDHS). There have been some improvement on indicators like, infant mortality rate, mortality of children under five, and % skilled attended births, and the prevalence of HIV and malaria. In spite of the general improvement of most of the health indicators, some still remain high. In the domain of reproductive health some of the major challenges include:

- limited access to emergency obstetric care (EmOC) services
- shortage of skilled service providers, particularly midwives, doctors and anaesthetists;
- inadequate transport and communication facilities;
- harmful socio-cultural beliefs and practices;
- Economic and political factors, especially at a time of “no-war-no-peace” with Ethiopia.

It is in this light that within the 3rd GSE-UNFPA Country development assistance program, the government in close collaboration with UNFPA and other development
partners sort to address the burning issues of reproductive health. The expected outcome of the program was to increase availability of, access to and utilization of high-quality, gender-sensitive and integrated reproductive health information and services. To achieve the outcome, 3 major outputs were expected, namely:

- Output I - Strengthened technical and institutional capacity to provide quality integrated RH care
- Output II - Increased availability of information and enhanced skills to influence RH related health-seeking behavior and practices of communities
- Output III - HIV prevention efforts scaled up with mitigation of stigma and discrimination of those infected and affected.

ii. Population and Development programme component

The Population and Development (P&D) programme component is intended to contribute to the national priority of Eritrean Government in “Strengthening the capacity to plan, monitor and evaluate at national, regional, and local levels”. The P&D outcome is: “Quality disaggregated data is available, accessible and utilized in the formulation of policies, national development plans and programmes” and is expected to be achieved through the following output of institutional/human resources capacity development. Similarly, the CPAP P&D Output is: Strengthened capacity of the National Statistical Office and sectoral ministries to generate, analyze and disseminate appropriate population and socioeconomic data.

iii. Gender program component

The Gender programme component has two joint programmes: Joint Programme on Gender Equity and Joint programme on FGM/C. These two joint programmes have been designed to deliver on the Government of Eritrea’s priorities articulated in the National Gender Action Plan (NGAP) and National Policy on Gender (NPG) as well as priorities outlined in the UNDAF 2007 – 2011 under Outcome 5.

Because of inadequate incorporation of gender as a cross-cutting concern in the 2nd CP a gender mainstreaming approach was adopted. Hence this required a consistent institutional collaboration to build capacities for effective gender mainstreaming. Consequently, the Country programme (CP) gender outcome is, “Capacity for gender responsive advocacy, planning, monitoring and evaluation for gender equality strengthened in 12 key national institutions including National Union of Eritrean Women (NUEW) and other civil society organizations”. The outcome is to be realized through the achievement of the three outputs as follows:

- Output 1 - Supportive policies, legislation and other legal frameworks in place and enforced
- Output 2. Strengthened institutional capacities for gender analysis and mainstreaming in the development sectors
• Output 3. Positive socio-cultural values, norms and practices in support of women’s and girls’ reproductive rights and their empowerment

c. The 3rd CP Evaluation Process

i. Purpose of the Evaluation

The overall purpose of the evaluation was to conduct an independent assessment of the entire programme over the operational period of 2007-2010 so as to measure programme performance with emphasis on achievements of outputs and outcomes, relevance, effectiveness, sustainability, efficiency, impact and lessons learned by UNFPA and partners during implementation of the country programme.

In particular, the evaluation was intended to specifically:

• Determine the extent to which the 3rd Country Programme of UNFPA has contributed to the realization of the government’s objective to improve the quality of life of the people.
• Document lessons learned and possible best practices and make recommendations for future programmes and the way forward for UNFPA and its partners.

ii. Scope of the Evaluation

The evaluation covered mainly the project regions in the country. Special attention was given to documenting lessons learned, findings, conclusions and recommendations through:

• Assessment and analysis of the Country Programme by Programme Component in accordance with respective performance indicators and outcomes i.e. whether they have been achieved in part or in full as was intended, the reason for any shortfall in its achievements and whether any unexpected results or outcomes have occurred. The evaluation appraised the relevance of performance to the intended outcomes;
• Analyzed factors within and beyond UNFPA’s control (risks and assumptions) that influenced performance and success of the project in contributing to the realization of the outcomes/outputs;
• Analysis of whether UNFPA’s interventions can be credibly linked to achievement of the UNDAF outcomes, including the key outputs and assistance provided both soft and hard, as well as how the support has influenced the institutional strengthening of IPs.
• Explore whether UNFPA’s current approach in programme implementation contributes to strengthen existing strategy and/or sustainability of programs.
• Assessment of strengths, weaknesses, opportunities and threats as well as possible partnerships for effective implementation and resource mobilization;
iii. Methodology

The evaluation was both quantitative and qualitative, comprising of two approaches:

- A retrospective study for past and present performances in terms of activities carried out, service provision, population coverage, and program management issues, and
- A cross-sectional study to get the state of material and equipment coupled with client satisfaction.

The data collection involved various methods such as, rapid assessment, interviews with beneficiaries, key stakeholders, direct observation, focus group discussions and in-depth reviews of documents, and filling checklists to assess physical conditions of assets.

iv. Key documents reviewed

The UNFPA Country Office provided the following relevant documentations to the team:

- Country Programme Action Plan (CPAP) 2007-2011
- UNFPA 3rd CP Mid-term Review Report
- UNDAF Mid-term Review Report
- Standard Progress Reports from UNFPA CO

These were accompanied by some sub-program specific documents that included documents from the executing agents (NSO for P&D, MOH, NUEYS, and EDF for RH and NUEW for Gender):

- Annual work plans and progress reports,
- Reports on studies
- Annual statistics report etc, (See sub-program reports for details)

Presented below are the findings, recommendations and conclusion per component-program
II. THE FINDINGS OF THE EVALUATION

Programme components Design (Relevance, Effectiveness and Efficiency)

i. Efficiency in resources management

This is the extent to which resources are mobilized and used to optimal attainment of the expected results.

The MOH is the programme manager for the RH programme component and the implementing partners are the MOH, EDF, NUEYS and MOE. Funds for all partners are transferred on the basis of the letter of understanding and annual work plans signed by each partner. The financial contributions of UNFPA to the RH programme component were as follows.

Table I: Financial Resources For The RH Programme Component

<table>
<thead>
<tr>
<th>Description</th>
<th>Budget year</th>
<th>Budget Allocation</th>
<th>Total Expenditure</th>
<th>Balance</th>
<th>Rate of Implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reproductive Health, Fistula, HIV/ AIDS</td>
<td>2007</td>
<td>1,452,519</td>
<td>1,218,328</td>
<td>234,191</td>
<td>83.88%</td>
</tr>
<tr>
<td></td>
<td>2008</td>
<td>1,967,589</td>
<td>2,027,811</td>
<td>(60,222)</td>
<td>103.06%</td>
</tr>
<tr>
<td></td>
<td>2009</td>
<td>2,757,141</td>
<td>2,566,495</td>
<td>190,646</td>
<td>93.09%</td>
</tr>
<tr>
<td></td>
<td>2010</td>
<td>2,776,101.05</td>
<td>2,424,679.98</td>
<td>351,421</td>
<td>87.34%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>8,953,350</td>
<td>8,237,314</td>
<td>716,036</td>
<td>92.00%</td>
</tr>
</tbody>
</table>

Except for the year 2007 when the rate of budgetary implementation was relatively low (67%) all the other years saw an execution rate of above 87%. In total there has been a total of 91% implementation rate of the UNFPA budget for the RH program.

Table 2: RH programme component, status of resource mobilization (Core-Non-Core) In USD

<table>
<thead>
<tr>
<th>Resources planned to be Mobilized for 3rd CP</th>
<th>Resources Mobilized</th>
<th>Resources yet to be Mobilized</th>
<th>Mobilization Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>$8,400,000.00</td>
<td>$6,261,846.65</td>
<td>$2,138,153.35</td>
<td>74.55%</td>
</tr>
</tbody>
</table>

In line with its mission of supplementing core funds by mobilizing funds from other sources, UNFPA succeeded so far in mobilizing 74.55% ($6,261,846.65) of the total $8,400,000.00 that had to be mobilized.
Financial resources for the P&D programme components

The initial estimated budget was USD 6.2 million for the 5 year period (2007-2011), of which USD 2.2 million was expected from the regular resources and USD 4 million from other sources, i.e. through co-financing modalities. UNFPA has provided financial support in due time to the implementation of the P&D programme component. The NSO, on its part, has utilized the budget allocated for the various activities outlined under the Third Country Program. Out of the total budget earmarked for the period (2007-2011), the larger share has been allotted towards technical activities. The total amount of resources for the five-year country program (2007-2011) allocated for the P&D Program Component is as follows:

Table 3. Actual budget allocation Vs Implementation in USD as at 30/10/2010

<table>
<thead>
<tr>
<th>Description</th>
<th>Budget year</th>
<th>Budget Allocation</th>
<th>Total Expenditure</th>
<th>Balance</th>
<th>Rate of Implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>P&amp;D, Data for Development joint program</td>
<td>2007</td>
<td>136,963.00</td>
<td>141,943.00</td>
<td>(4,980.00)</td>
<td>103.64%</td>
</tr>
<tr>
<td></td>
<td>2008</td>
<td>130,529.00</td>
<td>92,041.00</td>
<td>38,488.00</td>
<td>70.51%</td>
</tr>
<tr>
<td></td>
<td>2009</td>
<td>1,211,229.00</td>
<td>1,213,698.00</td>
<td>(2,469.00)</td>
<td>100.20%</td>
</tr>
<tr>
<td></td>
<td>2010</td>
<td>1,273,600.00</td>
<td>1,273,600.00</td>
<td>0.00</td>
<td>100.00%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>2,752,321.00</td>
<td>2,721,282.00</td>
<td>31,039.00</td>
<td>98.87%</td>
</tr>
</tbody>
</table>

Except for the year 2008 when the rate of budgetary implementation was relatively lower (70.51%), all the other years saw very high execution rate. In total there has been a total of 98.9% implementation rate of the UNFPA budget for the P&D program component.

To date, there has been a total expenditure of US$ 2,721,282.00, which is 98.9% implementation rate of the UNFPA budget for the P&D programme component.

Table 4: Status of resource mobilization in USD

<table>
<thead>
<tr>
<th>Resources planned to be Mobilized for 3rd CP</th>
<th>Resources Mobilized</th>
<th>Resources yet to be Mobilized</th>
<th>Mobilization Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>$3,516,492.00</td>
<td>$3,296,152.00</td>
<td>220,340.00</td>
<td>93.73%</td>
</tr>
</tbody>
</table>
As can be seen from the table above, the mobilization rate for the P&D programme component is about 94% and this is a relatively high rate of funds mobilization. However, it should be pointed out that the resource mobilization plan indicated above does not include that of the support for the conduct of the Population and Housing Census, which was initially planned to take place during the third CP but was not implemented due to reasons beyond the control of the CO.

**Financial resources for the Gender programme component**

The actual budget allocation Vs implementation and status of resource mobilization is demonstrated in the following Tables 5 & 6 below. In the four budget years the implementation rate for Gender equity program component ranges from 127.14% in 2007 to 83.26% in 2010 while the average rate of the total budget years is 95.75%. For the FGM/C program component the rate varies from 48.45% in 2008 to 95.76% in 2010 while out of the total allocated budget from 2007 to 30th October, 2010 the expenditure/implementation rate constitutes 80.79%.

Table 5: Actual budget allocation Vs Implementation as at 30/10/2010 –

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>BUDGET YEAR</th>
<th>BUDGET ALLOCATION</th>
<th>TOTAL EXPENDITURE</th>
<th>BALANCE</th>
<th>IMPLEMENTATION RATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender Equity</td>
<td>2007</td>
<td>224,026.70</td>
<td>284,823.02</td>
<td>(60,796.32)</td>
<td>127.14%</td>
</tr>
<tr>
<td></td>
<td>2008</td>
<td>376,040.86</td>
<td>328,430.80</td>
<td>47,610.06</td>
<td>87.34%</td>
</tr>
<tr>
<td></td>
<td>2009</td>
<td>555,520.77</td>
<td>530,592.65</td>
<td>24,928.12</td>
<td>95.51%</td>
</tr>
<tr>
<td></td>
<td>2010</td>
<td>299,559.74</td>
<td>249,409.10</td>
<td>50,150.64</td>
<td>83.26%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>1,455,148.07</td>
<td>1,393,255.57</td>
<td>61,892.50</td>
<td>95.75%</td>
</tr>
</tbody>
</table>

Table 6: Description of Abandonment of FGM/C –

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>BUDGET YEAR</th>
<th>BUDGET ALLOCATION</th>
<th>TOTAL EXPENDITURE</th>
<th>Balance</th>
<th>Rate Implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abandonment of FGM/C</td>
<td>2007</td>
<td>92,509.66</td>
<td>94,841.63</td>
<td>(2,331.73)</td>
<td>102.52%</td>
</tr>
<tr>
<td></td>
<td>2008</td>
<td>252,653.22</td>
<td>122,404.43</td>
<td>130,248.79</td>
<td>48.45%</td>
</tr>
<tr>
<td></td>
<td>2009</td>
<td>543,704.28</td>
<td>468,320.86</td>
<td>75,383.42</td>
<td>86.13%</td>
</tr>
<tr>
<td></td>
<td>2010</td>
<td>217,410.00</td>
<td>208,203.44</td>
<td>9,206.56</td>
<td>95.76%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>1,106,277.40</td>
<td>893,770.30</td>
<td>212,507.04</td>
<td>80.79%</td>
</tr>
</tbody>
</table>
A review of the contribution and use of UNFPA financial support to the program showed that there was generally a high resources mobilization rate and a high consumption rate of the finances so mobilized. As regards the mechanism for the utilization of the funds, it was observed that based on a joint action plan elaborated and approved by the implementing parties and the UN partners, funds are put at the disposal of the implementing parties quarterly and on advance basis. Generally, further disbursements for subsequent quarters are done if and only if justifications for prior disbursements are received. Unfortunately, there were at times great delays in the onset of the disbursement of finances, sometimes starting as late as in June. This has led to a lot of dissatisfaction on the part of the field workers who find themselves having to postpone activities due to lack of funds. The procurement procedure was found to be too slow, at times leading to very late supply of much needed material and equipment. The problem was found to be at the level of procurement request which were not always done early enough, and at the level of the purchase within UNFPA at international level which often had many orders to satisfy and had to work with the FIFO principle.

ii. Effectiveness

Effectiveness is understood to be the level of meeting the expected results by the program. In this respect, measuring the progress towards the expected results is given by the level of the related objectively verifiable indicators (OVI) (The level of accomplishment of set target per indicator). This calls for a strong vertical and horizontal logic within the logical framework of the program. An evaluation of the logical framework of the CPAP indicates that the activities of the respective programme components are complementary and aim to reach the various expected results at all levels (Goal, outcome and Outputs).

Looking at the programme components, their respective strategies and activities, there is an evident internal coherence and one can say with certainty that this was well thought of. Within the RH programme components for example there is a deliberate and evident investment to improve on supply of quality reproductive health services and to improve on the demand. The most evident indication of the internal coherence of the programme components is the degree of the accomplishment of the expected results as presented below. Contrary to the 2nd country program where clear baseline
situation and targets were not set, the present program went a long way to set them, thus making it easy to evaluate program related progress.

iii. Enablers to Programme Effectiveness

Though much still remains to be done, a lot has been accomplished to improve the coverage of the country with infrastructure and qualified personnel. New health facilities have been constructed (health centres and maternity homes). Investments have been done towards better equipping and staffing the health facilities in general. UNFPA provided funding for the recruitment of international health personnel by the MOH.

The implementation of the CP by institutions that have a good grass-root implantation and good audiences at central level greatly enabled effective implementation. Within the RH programme component the civil society represented by NUEYS and NEUW are working on the demand side within the population and the MOH is concentrating on both the service provision and the demand side. Meanwhile in the P&D and Gender programme components NSO and NUEW are respectively at the centre of the activities.

iv. Relevance of the program components to the National Priorities and UNDAF

Relevance is understood to be the degree to which the programme components contribute to the bigger picture of general development orientations as defined by key national and international guiding documents most essential of which are the country's policy and strategic plans in the respective domains and the CPAP and UNDAF documents.

(1) Relevance of the programme components to CPAP and consequently to UNDAF

As seen below, the outcomes, outputs and the related activities of the programme components of the CP effectively contribute to the general CPAP outcomes and consequently to the UNDAF outcomes.

By aiming at strengthening institutional and technical capacity for RH services and commodities provision, increasing demand coupled with the scaling up of efforts towards HIV prevention and mitigation of stigma and discrimination of PLWHA, the 3 outputs of the RH programme component and their related activities effectively contribute to the CPAP outcome 1 ( “Improved availability, access to and utilization of quality, gender sensitive, integrated reproductive health (RH) information and service with special focus on RHCS, EmOC, HIV/AIDS, disaster and emergency response, young people and other vulnerable groups”). Consequently the RH programme components contribute to the UNDAF Outcome 1 and 4 which respectively are:

- “By 2011 equitable access and utilization of quality basic social service is increased by 30% per service with special emphasis on vulnerable groups” and
“By 2009, assist the government through an integrated multi-sector approach, to ensure that IDPs, expellees, returnees and other war and drought-affected are re-integrated and have secure livelihoods and access to basic services”, (UNFPA).

The CPAP P&D Output: “Strengthened capacity of the National Statistical Office and sectoral ministries to generate, analyze and disseminate appropriate population and socioeconomic data” P&D contributes to the P&D programme components in its outcome: “Quality disaggregated data is available, accessible and utilized in the formulation of policies, national development plans and P&D programmes” and consequently to the UNDAF outcome 2.1 and 2.2 respectively state that

“By 2011, capacity is improved and a system established within the National Statistics Office and sectoral ministries to conduct surveys collect and disseminate data and update the national database”. And

“By 2011, development planning, budgeting processes, monitoring and evaluation in the Ministry of National Development and key national stakeholders are strengthened by using gender and age disaggregated data”.

The gender programme components outcome i.e. “Enhanced institutional mechanisms and socio-cultural practices that promote gender equality, equity and women’s empowerment and protect the rights of the women and girls” contributes to the UNDAF outcome 5 “Achieved equal opportunities, rights, benefits and obligations in all life areas” and consequently to the attainment of the MDG’s.

(2) Relevance of the country programme components to country priorities

The relevance of the country program as a whole and the RH programme components in particular is further ensured by the approach to the planning process whereby, the key actors worked to identify programme component related strategies and activities having for reference the CPAP document and the “Health Sectoral Strategic document “National Sexual And Reproductive Health Service; Policy And Guidelines” of April 2005 (though still in draft form). They thus clearly address the priorities of the Eritrean people in the domain of reproductive health. It clearly states that the goal of the Reproductive Program is “To contribute to the improvement in the quality of life and reduction of poverty through improvement in reproductive health, gender equality and equity, reduction in HIV/AIDS prevalence and harmonization of population dynamics with sustainable development” by:

- Promoting reproductive health and rights
- Improving access to reproductive health information and services,
- Reducing the incidence of HIV/AIDS,
- Reducing maternal mortality and
- Reducing gender disparities and inequality between men and women

The Population and Development (P&D) programme component of the 3rd CP in its output mentioned above, contributes to the national priority of Eritrean Government which is “Strengthening the capacity to plan, monitor and evaluate at national, regional, and local levels”.

11
By supporting the GSE’s commitment to gender equity, and mainstreaming gender the UN system within the gender programme component contributes to the achievement of the country’s priorities as defined in the GSE in its 2004 Interim - Poverty Reduction Strategy Paper (I-PRSP)), which identifies gender equity as one of the focal themes in the nation’s economic growth and poverty reduction strategy and is therefore, fully committed to raising their status. This is further materialized in the National Policy on Gender and Action Plan which affirms that gender issues are part of the national development programmes. It is an “overall policy guidance to uphold the principles of gender equity and equality in Eritrea by insuring that the gender issues are integrated into the national development process.”

v. Sustainability of the programme components

The sustainability of the UNFPA interventions and those of the other partners is ensured by the fact that they are mostly investing into the software and durable equipment, material and infrastructures. These include:

- Capacity development of the local staff who will continue within the health system is capital in ensuring that the investments made within this assistance program continues
- Investment in institutional capacity building which calls for the investment in the development of the capacity of the major local institutions like NUEW and NUEYS, (involved in RH), and NSO (in P&D) or NUEW (in gender issues) coupled with the provision of related equipment to the institutions.
- Advocacy to diversify the sources of finances. It is hoped that some of them will continue even after this assistance program may have stopped.
- Putting in place legal frameworks and policy documents which lay the groundwork for better working conditions etc

It is however worth noting that the sustainability of the P&D programme component contributions will further depend on a number of factors, which include the enactment of the National Statistical Act

III. LEVEL OF ACCOMPLISHEMNT OF PLANNED ACTIVTITES

A number of essential activities were planned per programme component within the country program action plan to accomplish the related outputs and outcomes. The implementation of the activities by the programme components was variably accomplished with the full participation of all the major stakeholders and partners amongst which is UNFPA.

From this evaluation there was a high level of accomplishment of the planned activities for the RH and gender programme components while this was less so with the P&D programme component for various reasons beyond the control of the implementers. All of the planned key activities were duly decomposed into sub-activities that were subsequently implemented by the respective actors in the field as can be seen below.
a. Level of accomplishment of planned activities of the RH programme component

i. Activities for expected Output one.

The activities of the RH programme component were largely implemented with the full participation of all its major aforementioned stakeholders and partners. The following are the activities for Expected Output One, which is, “TO Strengthen technical and institutional capacity to provide quality integrated RH care, with the emphasis on RHCS, FP, EmOC, The referral system, PNC, obstetric fistula, STI, Management, HIV prevention”

ACTIVITY 1. a) Develop tools to support Sexual and Reproductive Health (SRH) information and services;

Within the current program a good number of tools have been developed to strengthen the RH service provision capacity of the Ministry of Health. The major ones are as stated below:

- SRH policy was drafted, following consultations with partners and technical input from international consultants. However, the publication of the document is on hold, as the MOH has developed a National Health Policy and produced a comprehensive Health Sector Strategic Development Plan (2010-2014) thus imposing the need to assure harmony between them. Key points in the draft SRH Policy will be incorporated in the National Health Policy.
- Maternal and Peri-natal Death Audit (MPDA) protocol and forms were developed and distributed nationally.
- A curriculum to upgrade midwives to perform EmOC was developed and is ready for implementation.
- A curriculum for the Ob/Gyn residency program, including the logbook and guide to structured training was developed with the assistance of international consultants.
- Training manuals for postpartum care home visit, post abortion care, and family planning were updated.
- Protocol on Magnesium Sulphate for the treatment of pregnancy induced hypertension was elaborated and introduced at national level.
- Draft BCC and community discussion guide documents were produced.
- In 2009, after four consensuses building workshops organized for Zobas & national referral personnel, a draft protocols and guidelines for the use of misoprostol in the treatment of PPH and induction of labor was produced.
- A consensus document on strategies for the reduction of maternal and newborn mortality and morbidity in Eritrea was developed during a workshop.
- The document “Roadmap for Maternal and Newborn Health (2009-2014)” was produced, disseminated and costed. However, a round-table fund raising meeting still needs to be arranged, in collaboration with partners.
- The draft SRH Strategic Plan for 2011-2014 was produced. This document is still to be finalized but will be ready for use starting in 2011.
• The RH Unit, in collaboration with the HMIS Unit, identified gaps in data collection for RH indicators and intends to conduct consultations with relevant zoba authorities to reach a consensus and proceed to their inclusion in the HMIS in 2011.
• 200,000 client admission cards, 1000 copies of death audit forms plus guide and 200,000 family cards were printed.

**ACTIVITY 1. b) Enhance knowledge and skills of service providers and managers;**

- **Pre And In-Service Trainings**

In the domain of capacity development for the personnel the joint efforts of all partners came into play. The inputs here aimed at the pre-service and in-service trainings as a sustainable approach. It is in this light that the following were thus accomplished:

- The first batch of 31 medical students graduated in December 2009. Five out of the 31 graduates have made OBS/GYN as their first choice of speciality and 3 have made it their second choice. Within the residency program in the training school, UNFPA supported the salary of the Director in charge of the program.

- On the job trainings were given by the MOH-RH Unit to the health workers’ of 2 zobas (NRS and SRS) to strengthen their skills based on their pre-identified weak points. This covered areas like ANC, active management of 3\textsuperscript{rd} stage of labour, management of PID, PPH, anemia in pregnancy, infection prevention, use of partograph; and PPC.

- In 2009, ultrasound training was given to 5 doctors, 5 nurses, 5 x-ray technicians on obstetric conditions and general orientation to 23 nurses from all zobas.

- A total of 411 health workers (262 females and 149 males) from five national referral hospitals received training on interpersonal communication skills.

- A total of 197 counselors from six zobas (116 females and 81 males) from 130 health facilities received refresher training on PMTCT and counseling, 40 health workers were trained as new professional counselors.

- Training on counseling services was given to 25 young people (16 female, 9 male) for 8 weeks in Gash Barka to expand preventative service to the community. The participants were professional counselors and are now providing services to young people in their communities.

- 50 physicians and 92 nurses and other health staff were trained on the clinical management of HIV/AIDS and ART.

- Training of Trainers of community RH promoters was given to 76 MOH staff members and NUEW members in 2009.
Training on safe motherhood and emergency referral was given to 84 community members of Dahlak Islands; participants were from the ministry of local government, community leaders, NUEW and PFDJ in 2008.

Table 7: Summary of different type of training conducted in 2007-2010.

<table>
<thead>
<tr>
<th>Year</th>
<th>EmoCL</th>
<th>SST</th>
<th>PPC</th>
<th>Counseling</th>
<th>RH/FP</th>
<th>MND</th>
<th>NBC</th>
<th>PAC</th>
<th>Breast feeding</th>
<th>Fistula Repair</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>151</td>
<td>75</td>
<td>120</td>
<td>105</td>
<td>285</td>
<td>228</td>
<td>4</td>
<td>218</td>
<td>716</td>
<td>128</td>
</tr>
<tr>
<td>2008</td>
<td>172</td>
<td>273</td>
<td>8</td>
<td>68</td>
<td>332</td>
<td>36</td>
<td>6</td>
<td>22</td>
<td>236</td>
<td>128</td>
</tr>
<tr>
<td>2009</td>
<td>263</td>
<td>142</td>
<td>56</td>
<td>60</td>
<td>617</td>
<td>229</td>
<td>60</td>
<td>286</td>
<td>120</td>
<td>25</td>
</tr>
<tr>
<td>2010</td>
<td>58</td>
<td>236</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>634</td>
<td>716</td>
<td>128</td>
<td>229</td>
<td>617</td>
<td>60</td>
<td>286</td>
<td>120</td>
<td>25</td>
<td></td>
</tr>
</tbody>
</table>

Source: MoH RH unit 2010.

ACTIVITY 1. c) Improve institutional ability to support RH service delivery;

This part of the intervention covered inputs mainly in terms of strengthening human resources and institutional capacities.

- **Strengthening of human resources**

All the trainings mentioned above went a long way to strengthen the program institutionally. This was further strengthened by recruitments, redeployment to meet critical needs of the moment.

At the central level of the MOH, in spite of the fact that the RH unit is run by a dedicated team of staff, lead by an experienced Public Health expert and 1 experienced midwife, the workload was just too much for them. UNFPA thus supported the team by sponsoring the recruitment of a Senior Technical Advisor. This intervention lessened the burden but the staffing level is still inadequate and needs further strengthening. Requests have thus been made for replacements and additional staff. In each zoba there is one focal person of the MOH appointed to assist in coordinating the reproductive health activities of the zoba.

The main constraint at the moment for effective cEmOC is the shortage of anesthetists, but the problem is expected to ease through the deployment of the 8 nurse anesthetists, who graduated from the College of Health Sciences, with Masters Degree. UNFPA has already funded the recruitment of 3 obstetrician/gynecologists and 4 anesthetists to remedy the situation in 2008, and presently 9 anesthetists, have been recruited through same funding modality.
During the present evaluation five out of 6 zonal referral hospitals visited were found to have obstetricians, general medical practitioners, anesthetists, midwives, nurses, associate nurses, laboratory technicians, pharmacy technicians, and ambulance drivers, who were actively involved in the reproductive health programs. Asseb maternity unit as a zonal referral hospital, and Afabet, Dekemhare hospitals do not have obstetricians and anesthetists to conduct comprehensive emergency obstetric care or any other surgical intervention as required. It is worth noting that the graduation of 221 nurse midwives, in early 2010, greatly improved the availability of nurses in health facilities. The in-service training being provided in the form of Life Saving Skills (LSS), PAC, Family Planning etc. is designed to increase the knowledge, experience and confidence of service providers. From the survey it was found that the working conditions of the staff were quite varied. While staff members were over loaded in some health facilities in others they were less so. In spite of this situation for most of the health facilities visited, the staff organized themselves to provide 24 hour coverage of the population. In this evaluation 80% of the respondents (exit clients) confirmed that the health facilities were open 24 hours daily and that the health staff were readily available too. Looking at the qualifications and obstetric experience of the midwifery staff during the present evaluation it was found out that:

- The recently graduated midwives had not been exposed to the required number of deliveries necessary before graduation and lacked some of the required skills in the field of obstetrics and gynecology. In fact 50% (21/43), of the fresh graduate midwives and associate nurses from the facilities visited acknowledged that they do not have adequate skill in obstetrics and gynecology and requested for Life Saving Skill Training (LSST) to catch up.
- Most of the senior midwives in the zonal referral hospitals and in the health centers had received life saving skill training but felt that they needed regular refresher training to perform quality work. There was however at least one LSS trained staff in each health station visited.
- Gherenfit, Alebu, Alla, Egroly, Afhimbol (Kitrenai) etc., health stations do not have adequate number of skilled staff, to provide quality maternal and child health activities.
- Medical laboratories and consequently the laboratory technicians were not available in all health stations although it is statutory. Since, the activities of the facilities warrant at least minimal lab services like testing for Hb, albuminuria, glycemia etc in ANC, they presently have to refer the cases to far off laboratories. To remedy the staff shortage it was not uncommon for laboratory technicians, pharmacy technicians, administrative staff and ambulance drivers to be called on to be polyvalent and were assigned to give different services to the facilities as whole.

➢ Technical capacity strengthening of existing health facilities.

Fistula repair services

Since 2004, UNFPA has an agreement with Stanford University whereby the latter would send a team to provide:
- Technical assistance via on-the-job training of local surgeons and midwives;
- Specialist care for complicated fistula cases;
- Trainee follow-up, and
- Technical assistance for community mobilization; design, monitoring and evaluation.

Accordingly, except for 2004 which had only one mission, the rest of the years, starting from 2005, saw two missions per year.

UNFPA provides support in strengthening the fistula hospital and other RH services through the purchases of related drugs, equipment and supplies including FP commodities.

As an extension of the National Fistula repair project in Mendefera hospital, a satellite fistula repair site was opened in Keren hospital, Zoba Anseba with 10 patient beds and an operation theatre in 2009 to manage the un-complicated cases of the Western and Northern part of the country. The new fistula ward was established to treat patients with simple case by an obstetrician/gynecologists. During the present evaluation, it was observed that the Keren hospital is well equipped, staffed and well organized and providing quality service to the community but unfortunately few patients use it as most of them prefer to go to Mandefera Hospital, which involves not only fistula repairs but also prevention and rehabilitation of treated cases.

Table 8: Obstetric Fistula

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Yearly performances</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2007</td>
</tr>
<tr>
<td>Total No. of births delivered by health workers</td>
<td>28,065</td>
</tr>
<tr>
<td>Fistula (obstetric)</td>
<td>95</td>
</tr>
<tr>
<td>% of obstetric fistula per yearly delivery by health worker</td>
<td>0.3%</td>
</tr>
</tbody>
</table>

(Source: MOH-RHU)

The program has procured modern training aid modules, and has equipped the Orotta maternity hospital, Anseba, Massawa and Debub hospitals which are serving as training centers for obstetrics and gynecology and for all other health professionals.

➢ Infrastructural development and coverage

For the health facilities visited 29% (139/473) of the target villages for RH are located in remote areas (beyond 12km radius of the HF) and are thus hard to reach by any outreach program just as much as the communities may find it difficult to access any health facility based reproductive health programs. This is the situation of health facilities like Tio, Edi, Kitrenai, Ghernfit, Egroly etc. which are very far from the zonal
referral hospitals, and thus have difficulties in evacuating emergencies for more appropriate care. Other observations in relation to infrastructure include the following:

- For the health facilities visited the electricity supply is either lacking or is hindered by frequent and long interruptions which could last for more than 12 hours (Foro, Edi, Afabet, Mai-ini, Gherenfit, Egroly and Afhimbol (Kitrenai). This is a serious handicap for facilities that rely on the supply to run their apparatus. The power supply from solar energy was limited and was only used for refrigerators and light during delivery.

- 16% (7/43), of the health facilities visited (Foro, Edi, Afabet, Mai-ini, Gherenfit, Egroly and Afhimbol (Kitrenai) do not have piped water supply. The latrines, showers and lavatories were not functional due to shortage of water.

- 6.98% (3/43), of the health facilities visited (Senafe, Gherenfit and Afhimbol) are working in relatively small and inappropriate space and consequently the maternity rooms were inadequate to run all maternity activities as required.

- The wind blew off the roofs of Afhimbol (Kitrenay) health station, and has not yet been completely repaired. Consequently the facility presently has limited space to function and thus affecting maternity activities.

- In Mai-aini and Fiachekemete, are newly constructed health centers and yet to be officially opened. Presently, electricity and water supplies were not installed. They have power supply from solar energy which could only be limited for refrigerators and light.

- To remedy the shortage of laboratories mentioned above and to improve on the access to the related service, the “Lab-in-a-Suitcase” (a new portable technology) was introduced in ten pilot health facilities in zoba Debub and Anseba, in collaboration with the National Health Laboratory and Clinical Services. Staff were trained and acquainted with the lab package.

**ACTIVITY 1. d) Scale up postpartum care at home**

Besides working to strengthen the health service provision of the PPC the program tried to scale up the innovative best practices that had been put in place in order to extend coverage of the population.

Postpartum home visit was introduced nationally at the end of 2006, where health workers would go and visit postpartum mothers and newborns in their homes. The second, third and forth visits are done at 6 days, 6 weeks and 6 months interval. If the mother is delivered in health facility, the first visit (6 hours) is done in the facility. If the mother delivers at home, health workers are informed by the family members or TBA and they go and visit the mother and her newborn at home in 6 hours time.

Most of the health facilities visited had introduced home visit, and the program was known as Post Partum home Visit (PPHV) and was running smoothly. In an interview with mothers attending the health facilities for reproductive health service 70% of the respondents confirmed the existence of the service, and emphasized the importance of intervention. According to the MOH, RH Unit, 2010 midterm report the proportion of Health facilities providing post natal care stood at 77% as against a baseline situation of Nil. This was more than the program target of 75%. According to the present program evaluation the performance stands at 93%. All hospitals visited were not giving post
partum care home visits, as the service was provided by the surrounding health stations. Most of the focus group discussants in all health facilities underlined the importance of post partum care home visit, and its life saving nature both for mother and baby.

**ACTIVITY 1. e) Improve the efficiency of existing maternity waiting homes;**

Maternity waiting homes were introduced by the Ministry of Health initially with UNFPA support and progressively in collaboration with other partners as a means to provide a setting where women from remote areas can be accommodated during the final weeks of their pregnancy near a hospital or health centre with emergency obstetric care facilities, in the hope of contributing to the reduction of maternal mortality. Some of them have widened their mission to include neonatal health. In these homes additional emphasis was put on education and counseling regarding pregnancy, delivery and care of the newborn infant and family.

So far there are 34 maternity waiting homes, as seen in Table 8 below. They markedly increased skilled care attendance during prenatal, labor and postnatal periods. The basic obstetric care services and referral systems also improved.

Table 8: Number Of Maternity Waiting Homes Established From 2006-2010 By Zoba And Site.

<table>
<thead>
<tr>
<th>S. No.</th>
<th>Zoba</th>
<th>Site</th>
<th>Total no of MWH.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Anseba</td>
<td>Habero, Kerkebet, Sela, Keren etc.</td>
<td>13</td>
</tr>
<tr>
<td>2</td>
<td>Debub</td>
<td>Dekemhare, Adiquala, Kudobeuor</td>
<td>3</td>
</tr>
<tr>
<td>3</td>
<td>DKB</td>
<td>Ayumen, Egroli, Aytus, Afambo, Edi, Wade, Beylul, Rahayta</td>
<td>8</td>
</tr>
<tr>
<td>4</td>
<td>Gash Barka</td>
<td>Dighe, Mulki, Mogolo, Hycota, Gogne</td>
<td>5</td>
</tr>
<tr>
<td>5</td>
<td>SKB</td>
<td>Bada, Foro, Gelalo</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>All Sites</td>
<td>34</td>
</tr>
</tbody>
</table>

Of all the staff assigned to health facilities with maternity waiting homes in Southern and Northern Red Sea, 90% were trained in Life Saving Skills (LSS). The waiting homes of 3 health facilities visited were not fully equipped and furnished. However the related health facilities had adequate drugs and medical supplies for basic emergency obstetric care. In some areas (in the nomadic populations) maternity waiting home services were provided under tents, which were culturally more acceptable.
In the health facilities visited in Gash Barka (HC/HS), where there were no established maternity waiting homes, the communities have taken the initiative to build traditional thatched houses to serve as multipurpose waiting homes. These initiatives to build the houses like in Gogne and Haikota indicate the need and demand for the service.

Diagram 2. Community involvement in expanding Maternity waiting homes in SRS.

In some cases different villages and hamlets have collectively built 4 to 6 waiting rooms in the HC. However, they were not fully equipped and furnished. Despite the financial constraint to support food distribution, the maternity waiting homes remain a useful service for saving mothers’ and unborn children. It is worth noting that the intervention has been assisting the community-built maternity waiting homes through the purchase of cooking utensils and provision of food for duration of the observation period, hence, they need to be strengthened materially and financially.

ACTIVITY 1. f) Improve the referral system for EmOC

One of the main challenges in reducing maternal deaths is improved access to transport and means of communication (telephones) for easy, timely and effective evacuation of cases needing expert care. Improving access to the means of transportation and its affordability will be the most important factor for the implementation of emergency obstetric care. It is in this light that

- Five pre-existing Land Cruiser vehicles were converted to ambulance and delivered to the zobas for patient referrals. Six.
- 70 mobile telephones were procured using UNFPA and WHO funds and have been distributed to the Zobas Six.
- Bicycles have also been procured to enhance service providers’ mobility, especially in the provision of outreach services, such as postpartum care especially in cases of home based deliveries.

During the present evaluation it was found in relation to EmOC services provision that:

- All health centers visited provide basic EmOC services.
- 54% (23/43), of the health stations and health centers visited do not own or have access to a functional ambulance either because they were old or out of use or they do not exist at all.
• Currently, 11 (61%) of the 18 hospitals visited are providing comprehensive emergency obstetric care (annex 5.7). The 7 Hospitals that were not providing comprehensive EmOC, (annex 5.8) could not do so because of the lack of obstetrician and anesthetists, to conduct the necessary surgical intervention.
• All of the health facilities visited do not have appropriate neonatal care units.
• The basic emergency obstetric care program at the health stations and health centers incorporates: administration of parenteral antibiotics, oxytocic drugs and anticonvulsants, manual removal of placenta, removal of retained products, and provision of ambulance services, assisted vaginal delivery and new born resuscitation.
• The comprehensive emergency obstetric interventions of the hospitals include all the basic EmOC intervention as well as caesarean section, dilating and curettage, induction of labour, (management of complicated delivery) and blood transfusion.
• The most common complication during pregnancy in most hospitals and health centers visited were hemorrhage, eclampsia, obstructed labor, complications of abortion and puerperal infection.

Table 9: Proportion of delivery conducted in Health Facilities

<table>
<thead>
<tr>
<th>No.</th>
<th>Facility</th>
<th>Number of facilities providing delivery service</th>
<th>% of delivery in health facilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Hospitals</td>
<td>17</td>
<td>67.0%</td>
</tr>
<tr>
<td>2</td>
<td>Health Centers</td>
<td>48</td>
<td>15.0%</td>
</tr>
<tr>
<td>3</td>
<td>Health station</td>
<td>160</td>
<td>13.2%</td>
</tr>
<tr>
<td>4</td>
<td>MCH clinics and others</td>
<td>6</td>
<td>3.8%</td>
</tr>
<tr>
<td>5</td>
<td>Total</td>
<td>231</td>
<td>100%</td>
</tr>
</tbody>
</table>

(Source MOH-RHU 2010)

ACTIVITY 1. g) Improve access to RH commodities;

➢ Availability of RH drugs and consumables in health facilities
  • All the facilities visited had basic medicaments for obstetrical care (Ergometrin, oxytocin, magnesium sulfate, infusion fluids, sedatives and antibiotics for injection). Barentu and Keren maternity units; and Senafe health center sometimes had shortage of disposable gloves, gauze, cotton wool and modes. These items were highly demanded (see annex 5.13-14).
  • Iron and folate therapy was given free of charge to many mothers attending antenatal clinic.

The RH commodities are a package of equipment, pharmaceuticals and supplies for obstetric and maternal health care, the prevention, diagnosis and management of reproductive tract infections, and contraceptive supplies including male and female
condom. Eritrea is one of the countries eligible for financial support by the Global Program with the objective to enhance Reproductive health commodity security and UNFPA is the main supplier of the reproductive health commodity in Eritrea.

- **UNFPA Financial input into RH commodities and equipment**
  - RH commodities worth US$ 305,243 and pharmaceuticals at the cost of US$ 247,300 were procured and delivered to MoH\(^6\).
  - Medical supplies and laboratory reagents worth US$ 41,191.93 and 29,625 respectively were procured and delivered to MoH\(^6\).
  - Medical equipment, commodities and supplies at the cost of US$ 470,690.52 were procured and delivered in 2008\(^6\).
  - Furniture and fixtures were bought for Keren maternity unit in 2007\(^6\), especially in relation to the operation theatre.
  - Medical equipment, commodities and other equipment (6 solar panels, 40 data processing equipment, 23 computers, 17 printers) were bought at the cost of US$ 438,778 in 2009 and delivered to the MoH\(^6\).

- **Availability of RH Laboratory reagents in health facilities**
  - Blood transfusion sets are available in all zonal referral hospitals.
  - All hospitals and health centers visited during this evaluation had reagents to perform blood grouping, x-matching, Hemoglobin, Rh factor, urine tested for albumin glucose, syphilis and HIV tests.
  - Two laboratories (Senafe and Dubarwa) reported a shortage of some chemicals and reagents and spare parts for the laboratory equipment associated to obstetric care.
  - All health stations do not have laboratories and refer mother to the nearby health center or hospital.

- **Availability of FP Commodities in health facilities**
  As earlier stated the RH commodities purchased within the program included male and female condom both for FP and for HIV/AIDS prevention. This ensured some availability during the life of the current program, though according to HMIS reports, the monthly notification stock out were often relatively high within the health facilities (see table 10).
Table 10: Monthly commodity stock-out notification by HC and HS in %

<table>
<thead>
<tr>
<th>Year</th>
<th>% OF HF MONTHLY NOTIFICATION OF STOCK OUT PER METHOD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pills</td>
</tr>
<tr>
<td>2000</td>
<td>33</td>
</tr>
<tr>
<td>2001</td>
<td>40</td>
</tr>
<tr>
<td>2002</td>
<td>57</td>
</tr>
<tr>
<td>2003</td>
<td>45</td>
</tr>
<tr>
<td>2004</td>
<td>33</td>
</tr>
<tr>
<td>2005</td>
<td>24</td>
</tr>
<tr>
<td>2006</td>
<td>29</td>
</tr>
<tr>
<td>2007</td>
<td>27.8</td>
</tr>
<tr>
<td>2008</td>
<td>30.1</td>
</tr>
<tr>
<td>2009</td>
<td>33.1</td>
</tr>
</tbody>
</table>

Source: HMIS, 2008\(^{15}\)

According to HMIS, 2009\(^{15}\) the monthly stock out notification level for pills has generally rose from 33% in 2000 to 57% in 2002 then steadily dropped to 24% in 2004, but has since then had a steady rise to 33.1% in 2009. At the same time the proportion of women contraceptive users that uses pills has decreased from 2007 level by 13 % (HMIS, 2009\(^{15}\)).

In spite of this bleak picture from HMIS data, the current evaluation found that 98% of the health facilities visited had at least 3 FP methods available. It is suspected that there might be some under reporting within the HMIS thus the apparent poor performance projected.

**Cesarean Section Services**

Out of the 18 hospitals that provide delivery services, 11 (61%) perform C/S the same as in 2008. The main reason for performing C/S was obstructed labor due to cephalo-pelvic disproportion (HMIS\(^{15}\), MoH, RH, annual report\(^2\)).

The hospitals that do not perform C/S are: Nakfa, Tio, Adequala, Senafe, Dekemhare, Afabet and Bietmekae hospitals. This is mainly due to the absence of a gynecologist and obstetrician (or a competent replacement) and an anaesthetist.
ANC service provision

A good EmOC depends on a good ANC for efficient and timely evacuation of cases warranting evacuation. A lot was thus done to ensure that the ANC services were improved both quantitatively and qualitatively.

According to the MOH-RH Unit report of 2010, out of the 371 health facilities nationwide (including private clinics), 248 (67.1%) provided ANC services to pregnant women. Excluding the 85 private and industry clinics which are generally not interested in providing this service, 87.1% of health facilities (hospitals, HC, HS and MCH clinics) were providing ANC services in 2010 as against 70.6% in 2006. Considering the type of health facilities, 72.2% of hospitals (13 out of 18), 100% of health centres (48), 86.2% of health stations (177 out of 206), 8 MCH clinics, 3 health posts in government and one NGO clinic providing ANC services in 2010. It is worth noting that the 5 hospitals above that did not provide ANC were either specialized hospital (Ophthalmology, psychiatry) or had health centres in their immediate vicinity that did so.

Concerning health facilities where pregnant women get access to the ANC service, about 45.3% were seen in health stations, 33.3% in Health Center, 14.45% are served in hospitals and 7.86% in MCH and other clinics (MoH, RH Unit 2010). This trend indicates that the contribution of health stations and health centers is increasing while that of hospital is decreasing. Health stations are serving the largest number of ANC (45.3%), followed by Health Centers (32.3%).

ii. Activities for Output 2:

The following are the activities for Expected Output two, which reads, “Increase availability of information and enhanced skills to influence RH-related health-seeking behavior and practices of communities”

ACTIVITY 2. a) Develop relevant messages and IEC materials on RH.

- by MOH
  • IEC materials development workshop was conducted to facilitate the production of relevant materials for the RH program in collaboration with the health promotion center of MoH. Two types of IEC, materials (brochure and posters) were reviewed, revised and translated into Tigre and Arabic languages and printed.
  • The MoH has signed an important contract with the cultural affairs service of the Peoples’ Front for Democracy and Justice (PFDJ) to produce a serial film on behavior change communication on RH issues. Film production is at an advanced stage and the broadcast of the series, in ERI-TV, is planned to last for one year, starting 2011.

- by NUEYS
  • 4,000 copies of posters on PMTCT was printed and distributed. The posters were developed jointly with MOH.
  • Pastoralist health awareness illustrating materials were developed and distributed to the nomadic population.
• PMTCT poster and condom fact sheet were distributed to all zobas.
• Male and female condom fact sheetS were developed and translated into Arabic and Tigre languages and distributed to all Zobas.

➢ by EDF

• 7000, HIV/AIDS handbill were distributed to military personnel in 2008 and 2009.
• A calendar of 2009/2010 containing information on HIV/ADS was published and distributed to all EDF regional operational members.
• The first volume of a quarterly journal, (Ray of Health) was published and distributed to the EDF battalions. The second edition is in the process of being printed. The volumes are made available to all members of the armed forces.
• Training manual for training of trainers (TOT) was developed. The manual was revised many times; and incorporates topics on balanced diet, opportunistic infection, care of the sick and positively living with HIV/AIDS.

ACTIVITY 2, b) Build community-level capacity for development support communication;

➢ Establishment of post-test Clubs (NUEYS)

These are clubs of people who have gone through the HIV test and know their results. They meet once weekly to discuss on the issues of stigmatization, staying negative if HIV negative and leaving positively with HIV if positive. They ensured follow up on the sensitization initiated during the VCT services. Consequently the following were achieved:
• Six post VCT test club, one in each Zoba were established and sensitization campaign was conducted for 325 youths in 2008.
• 18 post test clubs established in six zobas with the aim of reducing stigma and discrimination through workshops, seminars, music and drama in 2009.
• 18 post test mobile VCT and post test clubs were formed in six zobas in 2010.
In the last 3 years (2008-2010) 42 post test clubs with 1220 members were established with the aim of enhancing and increasing the use of VCT services. This activity was conducted in collaboration with the National Bidho Association of Eritrea.

➢ Capacity development of community members

NEUYS and EDF did a lot in terms of community capacity development during the present program. The major ones can be seen from the following table.

<table>
<thead>
<tr>
<th>Year</th>
<th>Implementing partner</th>
<th>Activity performed</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>EDF</td>
<td>333 coordinators were trained</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Refresher course on HIV/AIDS was conducted for 100 Change Agents</td>
</tr>
<tr>
<td>2008</td>
<td>NUEYS</td>
<td>Trained 12 counselors and 16 peer educators</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Conducted TOT to 60 youth on post test club</td>
</tr>
<tr>
<td>2009</td>
<td>EDF</td>
<td>Refresher course on HIV/AIDS was conducted for 379 change agents in all zobas</td>
</tr>
<tr>
<td>------</td>
<td>-----</td>
<td>--------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>EDF</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>NUEYS</td>
<td>35 counselors, 70 peer educators were trained</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sensitization was conducted for 21,780 people</td>
</tr>
<tr>
<td></td>
<td></td>
<td>BCC peer group discussion was conducted for 3000 peers</td>
</tr>
<tr>
<td>2010</td>
<td>EDF</td>
<td>Refresher course on HIV/AIDS was conducted for 192 change agents who have moved with their units to other zoeba and assigned in other jobs</td>
</tr>
<tr>
<td></td>
<td>NUEYS</td>
<td>200 promoters were trained</td>
</tr>
</tbody>
</table>

**ACTIVITY 2, c) Undertake community sensitization and mobilization;**

- **Community sensitization and mobilization by MOH**
  - In 2007, a refresher course on community-based RH services was provided to 120 peer educators in zoba Maekel.
  - Sensitization workshop on safe motherhood was conducted for 118 peer counselors and 300 safe motherhood promoters in Assab in 2008.
  - 217 village administrators and 83,144 community members were sensitized on safe motherhood, danger sign of pregnancy and child spacing in 2008.
  - A total of 9,825 young students were reached and informed in sexual and reproductive health in 2008. This was done through 56 senior members of the Ministry of Health who are members of the NUEYS.
  - February 6, 2008 was celebrated with the spirit of anti FGM campaign. Various competitions involving school children and mothers were conducted on FGM related issues and substantive prizes were given to the winners in a ceremony held at Intercontinental Hotel.
  - In 2009, orientation on adolescent health, HIV/AIDS and STIs was conducted for 6,199 high school students in Asmara.
  - In 2009, 100 participants, religious leaders and administrators, from zoba Southern Red Sea and 200 from zoba Gash Barka were trained on problem identification skills.
  - Orientation on RH in general and gender based violence in particular was conducted for 93 female police officers from Asmara in 2010.
The Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA) was launched in Eritrea in September 2010. The Campaign is aimed at providing additional value to ongoing global and regional efforts, such as the Program of Action of the International Conference on Population and Development (ICPD), the Millennium Development Goals (MDGs), the Africa Health Strategy etc., which advocate for resource mobilization and increased support in order to strengthen health systems and improve access to sexual and reproductive health (SRH) information and services.

IEC material development workshop was conducted in Massawa to facilitate production of relevant materials for RH Program, to the MOH staff working in all zoba, MOI, NUEYS and NUEW in collaboration with the Health Promotion Center, MOH.

February 06 was celebrated as Anti-FGM day with Sawa high school students. Around 5,000 students’ participated, Video show and lecture on abandonment of FGM was conducted for students in 2009.

Community sensitization and mobilization by NUEYS

In 2008 the following major accomplished are recorded:

- VCT awareness raising and mobile VCT services training were conducted to 7250 students in 4 colleges: Hamelmalo Agricultural College, Hagaz Technical School, Massawa Marine College and Sawa Institutions.
- Sanitization seminar was conducted on HIV/AIDS, VCT and PMTCT to increase the awareness of youth in six zobas for 60 youths.
- 20 dramas were shown to 15,000 youths in all Zobas.
• In 2009:
  o Community based campaign was conducted for post test clubs formation to 1650 youth at least 70 persons participated from each zoba.
  o Five youth discussions was conducted from all zobas in collaboration with Ministry of Information; and aired in Eritrean TV on sexual behaviour, HIV/AIDS, RH and STDs, stigma and discrimination, 700 youth participated on the discussion; and is expected to be viewed by more than 243,000 people.
  o Sensitization campaigns through music and drama were conducted for 29 days in Gash Barka and Anseba, to about 15,000 youth, to raise their awareness on HIV/AIDS, VCT, PMTCT and mitigating stigma and discrimination of people living with HIV/AIDS.
  o Work shop was conducted on RH awareness raising through music and drama for youth out of school and in higher institutes in 6 NUEYS administrative Zobas.
  o 325 youths were sensitized to raise their VCT awareness in Sawa and higher institutes.

• In 2010 following are main activities undertaken:
  o A total of 7 seminars were conducted to 550 youth in Zoba Anseba and Gash Barka for 10 days. The seminar was on HIV/AIDS and STI in general, and emphases were given on the importance of VCT, PMTCT and reproductive health.
  o 34 mobile video shows were conducted to raise awareness of youths in remote areas.
  o 34 outreach campaigns were launched, (18 in Gash Barka and 16 in Zoba Anseba) targeted at people from remote places with limited awareness on SRH.
  o A total of 2850 young boys and girls participated on weekly peer group education conducted to promote healthy behavior as continuations of the last 2 quarters of 2010 in all zobas.

➢ Community sensitization and mobilization by EDF.

The Change Agents have conducted discussion sessions in the four zobas (Zoba Debub, Gash Barka, Anseba and SRS) and have reached:

<table>
<thead>
<tr>
<th>Period</th>
<th>New people reached</th>
<th>Old coverage</th>
<th>Total coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>January-December 2008</td>
<td>215,626</td>
<td>154,174</td>
<td>369,800</td>
</tr>
<tr>
<td>January-December 2009</td>
<td>174,499</td>
<td>509,984</td>
<td>683,984</td>
</tr>
<tr>
<td>January-June 2010.</td>
<td>81,072</td>
<td>256,122</td>
<td>337,194</td>
</tr>
</tbody>
</table>
• After an extensive HIV education campaign in Gash Barka, 700 individuals requested for HIV test but due to shortage of reagents, only 225 individuals were tested for HIV status.
• Change Agents were conducting their sensitization to village Baito, under shadow of trees, place of residence, church compound, sport fields, mosques, health facilities, public gathering, school, meetings etc..
• Most commonly covered topics during the outreach program were: proper use of condom, mode of disease transmission and prevention, and the effect of HIV/AIDS in society, sign and symptom of HIV/AIDS, STDs, benefits of VCT, unprotected sex, seeking early treatment of STD etc.

ACTIVITY 2 d) Provide support for quality SRH information and services for young people

• In 2009, a group of health workers visited and trained students in 6 schools and around 6,199 students were reached and given orientation on sexual and reproductive health.
• Advocacy and sensitization seminar was celebrated as Anti-FGM day with Sawa high school students. Around 5,000 students’ participated, video show and lecture on abandonment of FGM was given to the students.
• One youth friendly VCT center was established in Haikota (a sub zone in Zoba Gash Barka). The center was equipped as MOH, VCT standard.

ACTIVITY 2 e) Involve men in SRH and gender based violence (GBV) issues;

Male involvement in SRH and GBV issues was at the centre of a number of activities during the life of the current program.

• In collaboration with the Ministry of Information, discussions and consultations were conducted in 2009, with a wide range of participants; on ‘Male involvement and participation in RH’. The discussion was broadcasted
through ERI/TV for national coverage. Such discussions were conducted not only in Asmara, but also in Southern Red Sea and Gash Barka regions. The participants included administrators, religious leaders, health workers, women and youth.

- In Adiquala sub-zoba, orientation was given for communities targeting men in SRH. Film on labour and delivery and drama shows were used as educational tools. Around 200 community members participated including religious and community leaders. As part of the sensitization process, testimony was also given by a former fistula victim in 2008.
- Addressed military officers to sensitize them on SRH in which 100 officers participated in 2009. The participants recommended the expansion and sensitization to all members of the army.
- Open discussion (Medeb Begahdi) through media was organized to talk about male involvement in RH and parenting issues. There were around 200 participants, including couples, teachers, high school students, NUEYS, NUEW, community members, health professionals and journalists. The discussion was transmitted through Eritrean TV for several weeks.

**ACTIVITY 2 f) Undertake studies and document lessons learned;**

Some studies were carried out within the present program by the various actors as presented below.

- **Survey and Research by NEUYS**
  - To assess the prevalence of early marriage and teen pregnancy in Eritrea, survey was conducted in 30 sub-zones across the country.
  - Condom availability survey was conducted to assess the situation in the country.

- **Survey and Research by MOH**

In the EPHS presently ongoing, the MOH and partners have ensured the inclusion in the survey questionnaires issues on maternal mortality; obstetric fistula; female genital mutilation (FGM), and HIV/AIDS and the final survey report is expected to be produced in early 2011. Other studies carried out were the following.

• MOH and Orota Medical students conducted a research on “Knowledge, attitude and practice of contraceptive in high school, technical school and college students in Eritrea”.

➢ **MONITORING AND SUPERVISION**

**By NUEYS**

Monitoring visits to supervise and observe progress of implementation was conducted as follows

From the central level:

- In 2008, project coordinators from the head quarter conducted 16 days monitoring/supervision visits to cover all the Zobas.
- In 2009 project coordinators from the head quarter conducted 24 days monitoring/supervision visits to cover all 6 zobas.
- In 2010 project coordinators from the head quarter conducted 17 days Monitoring visit in quarter 2 to supervise and observe the progress of implementation in 6 zobas

Meanwhile, from the Zoba levels, sub-zobas were also supervised more often, though details of their activities were not available. See annex 3 for the activities and places.

➢ **By the Ministry of Health**

Supervision visits were conducted to the following places by the Unit during the life of the current program.

1. In 2010 the Unit visited RH personnel in Keren, zoba Anseba and also Agordet, Barentu and Teseney hospitals in zoba Gash Barka and assessed
   - 2009 death audit report;
   - Severe anemia in pregnancy
   - The detection of women living with obstetric fistula at zonal level.

2. In 2009 the Unit visited the Post abortion care trainers in Mendefera, Adiquala, Ghinda, Keren, Adikeyeh, Senafe Tesenei, Barentu, Akurdet, Amatere, and Orotta hospitals and assessed,
   - Post abortion care
   - Collection of baseline data on comprehensive post abortion care program.

3. In 2009 the Unit visited Faith based organizations, FGM committee, members of Bideho, NUEYS, NUEW at zoba SRS and assessed the role of men in women’s reproductive health issues

4. In 2007 the Unit visited Managers of Keren hospital and discussed the making of the second operation theater fully functional for the provision of obstetrics and gynecology surgery

5. In 2007, the Unit visited Adikeyeh, Dekemhare, and Mendefera hospitals and discussed with the RH personnel on the provision of CEmOC service

6. In 2007 the Unit visited RH personnel at Senafe, Segeneiti, Adiquala, and Kudobuur and assessed the provision of basic EmOC services
In 2007 the Unit visited Biet-meka community hospital and discussed with RH personnel on the evaluation of needs for providing quality maternal and neonatal care services.

iii. Activities for Output 3:
The following are the activities for Output three, which reads, “HIV prevention efforts scaled up with mitigation of stigma and discrimination of those infected and affected”.

ACTIVITY 3 a) Develop skills of health care providers and peer educators to address vulnerable groups.

A workshop was conducted for 10 days in 6 administrative zobas of NUEYS, on HIV/AIDS, targeting 385 high risk groups: young boys and girls, who are involved in commercial sex works, assistant drivers, mechanic, and girls working in bars, restaurants and cafeteria.

ACTIVITY 3 b) Male and female condom programming;
Within the reproductive health program there has always been an effort to ensure the supply of RH commodities in general and condoms in particular, all along the past years as can be seen from table 11 below. It is thus not surprising that according to the 2009 HMIS report, the proportion of health facilities providing at least three modern methods of family planning stands at 71% as against a baseline of 51.3%. This is below the program target of 100%. However the present evaluation showed a 96% score for all the health facilities visited.
Table 11: Yearly male condom sales and distribution in 1998-2009

<table>
<thead>
<tr>
<th>Year</th>
<th>ANNUAL QUANTITIES SUPPLIED PER SOURCES</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>By MoH</td>
<td>By ESMG</td>
</tr>
<tr>
<td>1998</td>
<td>2,997,760</td>
<td>1,488,825</td>
</tr>
<tr>
<td>1999</td>
<td>2,725,792</td>
<td>2,932,272</td>
</tr>
<tr>
<td>2000</td>
<td>4,056,464</td>
<td>4,550,432</td>
</tr>
<tr>
<td>2001</td>
<td>3,520,338</td>
<td>5,267,849</td>
</tr>
<tr>
<td>2002</td>
<td>5,330,400</td>
<td>6,312,797</td>
</tr>
<tr>
<td>2003</td>
<td>6,349,134</td>
<td>6,073,200</td>
</tr>
<tr>
<td>2004</td>
<td>2,905,110</td>
<td>3,300,000</td>
</tr>
<tr>
<td>2005</td>
<td>2,053,040</td>
<td>3,018,096</td>
</tr>
<tr>
<td>2006</td>
<td>2,500,000</td>
<td>3,899,760</td>
</tr>
<tr>
<td>2007</td>
<td>476,783</td>
<td>4,300,871</td>
</tr>
<tr>
<td>2008</td>
<td>1,829,232</td>
<td>3,232,440</td>
</tr>
<tr>
<td>2009</td>
<td>2,421,216</td>
<td>3,345,720</td>
</tr>
<tr>
<td>Total</td>
<td>37,165,269</td>
<td>48,058,925</td>
</tr>
</tbody>
</table>

ACTIVITY 3.c) Establish VCT centers within and outside health facilities;
According to NATCoD report of 2009, the number of VCT centres rose from 15 in 2001 to 130 in 2008. Presently in 2010 there are 135 VCT centers. Meanwhile the number of PMTCT centers grew from 3 in 2002 to 93 in 2010.
Of the 237 health facilities in the country, VCT is integrated in the general health care service provision package in 124 health facilities (47%). There are 11 free standing VCT centres. There are 93 PMTCT centres which are all integrated into the ANC and MCH services, (10 hospitals, 47 in health centres, 31 in health stations and 5 MCH). See table 12 below for distribution nationwide.
Table 12: VCT sites by zones and Health Facilities as of June 2009

<table>
<thead>
<tr>
<th>Zone</th>
<th>Hospital</th>
<th>Health Center</th>
<th>Health Station</th>
<th>Free-standing</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maekel</td>
<td>11</td>
<td>5</td>
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<td>DEBUB</td>
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<td>Gash Barka</td>
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<td>3</td>
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<td>1</td>
<td>14</td>
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<td>5</td>
<td>4</td>
<td>1</td>
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<td><strong>47</strong></td>
<td><strong>11</strong></td>
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b. Level of accomplishment of planned activities of the P&D programme component

Activities for P&D Output 1: Strengthened capacity of the NSO and sectoral ministries to generate, analyze and disseminate appropriate population and socio-economic data

i. Output one, activity 1: Improve institutional capacities to collect, analyze and package user-friendly data

Capacity building of the NSO staff was intended to improve competency through training on theoretical and practical application of demographic softwares. As part of the capacity building initiatives, there were twelve different types of training conducted during the period under review. These include:

- Training of NSO staff in visual basic programming, accomplished in 2008
- Training of NSO and other government institutions staff on GIS, accomplished in 2008
- Three-weeks training workshop on CSPro application software for large-scale data processing for a staff in 2009
- Distance education training of one staff from Cartographic division at Masters level in GIS
- Training was provided to 12 NSO staff and also from Ministry of National Development and another from Telecommunication Corporation on “ERDAS IMAGINE” and “ARC Pad”.
- Two staff participated in training workshop on ‘Multiple Custer Indicators Survey (MICS-4) survey methodology abroad.
- Training of fieldwork and data processing staff for the 3rd EPHS
- Training in DevInfo for advanced database management by an external resource person to NSO and other government institutions staff
- Training workshop on basic and advanced Statistical Package for Social Scientists (SPSS) applications given to NSO staff.
- Facilitation of working visits to Kenya and Uganda National Bureau of Statistics.
- In house training on basic sampling methodologies to NSO staff
- Training on HIV-lab testing procedures to National Health Laboratoy Staffs
Moreover, computers to facilitate successful implementation of the activities of the P&D programme component have also been provided.

ii. Output one, activity 2: Undertake national and sectoral surveys and studies

The main survey conducted in 2010 was the EPHS. The survey was based on a random sample of 36,000 households from 900 randomly selected clusters (villages in rural areas and Enumeration Areas in Urban Areas). Of the total, 575 of the clusters were from rural areas. Samples were designed to get reliable estimates of the demographic and health indicators at national, regional, urban-rural levels including HIV prevalence rate in Eritrea using Dried Blood Spot (DBS). The survey was completed and a preliminary report was prepared and submitted to the government for approval. However, the detailed EPHS report has not yet been produced.

iii. Output one, activity 3: Promote the use of disaggregated data for development planning

   ➢ Establishment of national database

   The activity to establish a common national database was part of the Joint program on data for development and necessary preparation was made for its implementation. In the process of establishing the national data base, a limited inventory of available data was planned to be conducted. However due to some technical problems, on the part of the partner, the activity could not be carried out during the planned period.

   As a demonstration of its capacity to deliver in matters of data processing and management, the NSO provided technical assistance to the:

   • Ministry of Education to undertake the students summer work programme evaluation survey and the 2008 Eritrean Literacy Survey
   • Ministry of Public Works to conduct the Urban Housing Survey in 18 major urban areas of the country.
   • Ministry of Health in conducting Roll Back Malaria Evaluation Survey

c. Level of accomplishment of planned activities of the Gender programme component

i. Activities for expected Output 1: Supportive policies, legislation and other legal frameworks are in place and enforced

Towards achieving this output a variety of activities were implemented during the reporting period and they included;

Activity 1: Training of community judges and law enforcement personnel

Under this activity, trainings were provided to targeted community judges, law enforcement personnel, NUEW and NUEYS kebabi leaders and members of PFDJ. The training was conducted in the NRS and Gash-Barka Zoba’s. Total trainees by the time of
evaluation were 786 comprising of 479 male and 307 female. Topics covered included general gender issues, FGM & FGM proclamation.

A five days training on the methodologies of eliminating VAW was conducted in November 2008. The training was undertaken in 3 sites in the NRS Administrative Region: the first Group from Karora, Nakfa, Adobha and Afabet; second group from Gindae, Dahlak, Massawa and Shieb and third group from Foro and Gelaelo. A total of 418 people were reached of which 196 were women and 222 men.

Activity 2: Assessment of existing laws

- Most importantly, the enactment of the FGM/C Proclamation 158/2007 abolishing the practice was realized through the programme implementation period, thus providing a strong basis for advocacy for change in practices amongst families, circumcisers, law enforcement agents and other policy actors.
- The planned activity to review the NGAP in 2008 was rescheduled to allow the Government Ministries’ development of the gender mainstreaming action plans.
- The study on socio-economic background of women in the Informal Business Sector was conducted to "investigate the overall socio-economic situation of women engaged in the informal business in Eritrea” and a document on “Women in Informal Business in Eritrea” was published by the end of 2008.
- The anticipated assessment of existing laws related to gender in 2010 has not yet been undertaken.

Activity 3: Monitor the implementation of recommendation of the CEDAW committee on Eritrea

At least five (5) of the twenty (20) CEDAW committee recommendations have been implemented during the period under review: namely training of judicial officers (recommendation No. 9); strengthening of the national machinery and provision for its clear mandate (recommendation No. 13); enactment of FGM/C law and awareness raising for cultural perceptions connected with FGM (recommendation No. 19) and ensuring wide consultation on the preparation of the next CEDAW report (recommendation No. 34). This indicates a 25% accomplishment which is half of the expected 50% realization in terms of implementation. However, other CEDAW recommendations have been partially met such as: design and implementation of awareness programmes to create a gender responsive culture/attitude (recommendation No. 15); increase of women in decision making at all levels (recommendation No. 21); integrating gender within the Poverty reduction and Food security strategy (recommendation No. 25) and creation of income generation projects for women in rural areas (recommendation No. 27).

- In addition, towards establishing a legal culture supporting women’s equality and non discrimination amongst law enforcement personnel (No. 9 and 17 CEDAW/C/ERICO/3) NUEW has facilitated various training for 953 law enforcement agents with a view to sensitize them on the provisions and obligations of CEDAW and in accordance with recommendation No 9 CEDAW/C/ERICO/3.
The CEDAW recommendation (No. 31 CEDAW/C/ERICO/3) to have a “comprehensive systems of data collection and assessment of trends in the situation of women” and provide analysis of sex disaggregated data has been constrained due to the delay in finalizing the EPHS report. However the input by the NUEW in designing the EPHS survey assured a chapter on Gender.

A draft CEDAW report capturing the status of implementation on the concluded comments and recommendations of the UN CEDAW committee has yet to be finalized and disseminated.

ii. Activities for expected Output 2: Strengthened institutional capacities for gender analysis and mainstreaming in development sectors
Because of an inadequate incorporation of gender as a cross-cutting concern in the 2\textsuperscript{nd} CP it was proposed that a gender mainstreaming approach be used, which required a consistent institutional collaboration to build capacities for effective gender mainstreaming. In the reporting period, the following activities were undertaken in this line

Activity 1: Build capacity of NUEW

Infrastructural development: With bilateral support of UNDP, the Gender research and resource centre in Eritrea was refurbished with equipment and furniture and is currently being stocked with resource materials in 2010. It is anticipated that the centre will be fully functional in the first quarter of 2011.

- Capacity building and exposure for NUEW

Towards strengthening the national machinery in the delivery of its gender equality mandate, various delegations have participated in regional and international meetings such as “Women Deliver Conference” that saw the elaboration of a road map for maternal and reproductive rights and Beijing +15 Conference

- Training of “NUEW Kebabi Leadership” in the Administrative Regions

To enhance and strengthen the capacity of those who interact in gender empowerment, the NUEW administration and parliament members were given training on: Evaluation of NUEW activities, developing annual activity plan, and formulation of strategic planning from a Gender perspective.

A series of capacity building activities were undertaken at the village level. The skills of NUEW Kebabi leaders were also enhanced so as to ensure that they resonate with the programme agenda of securing gender equality. In 2007 823 females and 18 males were trained.

In following years, the training sessions were conducted in three phases around the following themes.
Table 14: NUEW Kebabi Leadership training

<table>
<thead>
<tr>
<th>Date</th>
<th>Theme</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Female</td>
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<tr>
<td>2008</td>
<td>Gender, law, human rights, hygiene, cleanliness and ethics</td>
<td>218</td>
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<td></td>
<td>Characteristics of human rights, Gender roles and responsibilities,</td>
<td>198</td>
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<td>Gender stereotypes, Strategies, Challenges and opportunities of</td>
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<tr>
<td></td>
<td>Eritrean Women</td>
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<tr>
<td></td>
<td>Project management, conflict management and advocacy</td>
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<td>2010</td>
<td>Reproductive health rights, CEDAW, CRC, national constitution and</td>
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<td>human rights</td>
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<td></td>
<td>Family law and Eritrean civil code, reproductive health, advocacy</td>
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<td>campaigns and fundraising (for NUEW Diaspora members)</td>
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<td>Nationality and Eritrean women’s movement, CEDAW, gender analysis</td>
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<td></td>
<td>communication, conflict resolution skills</td>
<td></td>
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<tr>
<td></td>
<td>Monitoring and evaluation, planning and coordinating meetings (for</td>
<td>30</td>
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<tr>
<td></td>
<td>NUEW Executive Board members)</td>
<td></td>
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<td></td>
<td>Gender concepts, proclamation on FGM</td>
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<td></td>
<td>Presentation skills, report writing, project management, M&amp;E,</td>
<td>240</td>
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<tr>
<td></td>
<td>finance basic concepts of CEDAW &amp; CRC</td>
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</tbody>
</table>

Activity 2: Build capacity of institutions and partners in Gender and Development

➢ Ministerial gender assessments

With support from international consultants, NUEW conducted a training needs assessment to establish the gender mainstreaming needs and gaps for various Ministries in December 2007. It revealed among others, the gender imbalances in the high positions in Ministries such as Director Generals, Planners and Unit heads. It was based on these findings that appropriate training was modeled.
Gender mainstreaming workshop for Ministries and follow up on the development of gender mainstreaming strategy

The workshop treated gender concepts and models for gender analysis, utilizing the Harvard Analytical Framework. It focused on demonstrating how to mainstream gender during the planning and implementation of their activities. In addition, normative human rights standards on gender equality were shared to appropriately locate the mainstreaming agenda including the various human rights conventions acceded to the GoSE as well as the National gender policy.

Following the workshop and as a way of assuring sustained transformation within the Ministries, commitments to develop gender mainstreaming strategies alongside action plans were made. The workshops saw the participation of about 415 participants (141 females & 274 males) coming from MoE (27), MoH (40), MoA (67), MoLWE (31), Mol (51), MoF (63), MoTC (35), MoTI (24), MoME (45), & MoT (32). There were also other participants from NUEW (18) NSO (4).

Following the training of the various Ministries, NUEW monitoring strategy was through a series of meetings and some follow up workshops to determine the development and the status of their implementation. Between 2008 and 2009, the following Ministries had drafted a Gender Mainstreaming Strategy, namely Ministry of Education (MOE), Ministry of Health (MOH), Ministry of Agriculture (MOA), Ministry of energy and Mining (MOE&M), Ministry of Land, Water and Environment (MOLW&E) and Ministry of Information (MOI).

The MOE strategy of 2008 was piloted and was updated and revised as the Gender Mainstreaming Strategy and Action Plan of the Ministry in 2009. The MOA identified the Planning and Statistics division as its gender focal point to monitor the progress of the Gender Mainstreaming Strategy. Following a review meeting with NUEW, in June 2010 it was resolved that a review of the strategy would be necessary to ensure its compatibility with the Ministry’s goals and targets. MOA has finalized its gender mainstreaming strategy and action plan in 2010. Line ministries including MOH, MOT&C, MOT&I have identified gender focal points.

Sensitization of Policy Makers and Influential actors

A series of workshops were held to sensitize administrators, Ministry representatives, NUEW representatives of the zobas and sub-zobas as well as the PFDJ at regional and sub zoba levels during which:

- Tangible ways in which to mainstream gender during the planning and implementation of their activities were demonstrated.
- Normative human rights standards on gender equality were shared to appropriately locate the mainstreaming agenda, and,
- The substantive element of monitoring and evaluation for gender was taught.

During the period under reporting, all 6 Zoba’s were targeted for knowledge building on gender and human rights. The training demonstrated how these concepts are underpinned within the constitution, transitional codes as well as sectoral policies. There were 524 participants (128 females & 396 males), largely drawn from Zoba officials, Ministry representatives, Zoba Assembly representatives, FGM committee
members, Zoba and sub-Zoba PFDJ Heads, representatives of NUEW and public sector representatives. Towards enhancing gender responsive laws, at least 46 parliamentarians were sensitized on international and regional human rights conventions.

- Production of gender standards at the 30 years anniversary of NUEW
With regards to strengthening capacities around the themes requiring gender mainstreaming, NUEW embarked on undertaking comprehensive research on nine themes as tabulated here below. These research papers were developed and disseminated in 2009 to support the national gender data base. The data will help in the identification of gender gaps and provide a basis of informing the Gender Action Plan for identified ministries. The dissemination was in 7 centres: in the 6 Zoba’s and in SAWA. In each Zoba best practices were shared on the specific sector. In more detail format, the conference papers are indicated in the appendix.

- Capacity building workshops on leadership to enhance Women’s designation
Working in partnership with NUEYS, NUEW facilitated a workshop with the Junior Club members of NEUYS prior to the workers confederation elections in Zoba Maekel. As part of preparing young women workers to participate in the elections, a total of 150 women leaders were involved in a 2 day forum convened to build their capacity for gender analysis as well as enhance their potential for advocacy in terms of gender equality. In addition, they were introduced to the regulations of NUEW that were applicable to young women workers. This workshop enabled them to deepen their understanding on workers’ rights and responsibilities, as well as identifying and categorizing the gender inequalities they experience in the workplace.

Activity 3: Establish mechanisms for tracking gender in MDG
A participatory encounter with a total of 26 NUEW members from 6 Zobas, was organized by NUEW with the support of a consultant, leading to the elaboration of a monitoring and evaluation framework. At the village level, 280 traditional birth attendants, health workers and Kebabi administrators were trained on issues of abuse, violence against children and basic psychosocial care including reproductive health issues associated with FGM/C. The FGM/C indicators were developed and submitted to the MOH to be included in the M&E tool. Moreover, FGM/C component were included into the pre-service training curriculum of associate nurses.

Activity 4: Enhance the ability of girls to enroll and complete education.
The activities undertaken included the production of IEC materials as well as national advocacy campaign on Violence against Women in Anseba Zoba. Towards mobilizing community to support and lead the campaigns ending violence, promoting girls’ education and ending discrimination, over 249 community members were involved in the various programmes in Habero and Asmat in November 2007. The themes during the campaign included: early marriages, school retention particularly for girls, FGM/C and gender equity and equitable distribution of wealth. The International Women’s Day, March 8, has been celebrated throughout the programme life i.e. from 2007 – 2010.)
Orientation programmes on legal matters associated with gender equity were also undertaken amongst college students as follows:

a) In 2008 ten classes of 50 students + 4 (Total 504) of Mai Nefhi College students. The topics covered were legislations of the country regarding women, the role of young women/girls in educational, political, socio-economic life, gender and reproductive health.

b) In 2009, two weeks training for 103 NUEW representatives in SAWA covering Gender Concepts and the Proclamation against FGM/C.

c) In 2010, a workshop on Legal Literacy training was conducted.

iii. Activities for Gender Output 3: Positive socio-cultural values, norms in support of women and girls reproductive rights and female empowerment measures enforced

Activity 1: Community awareness-raising to protect women and children from exploitation and abuse such as GBV and FGM/C

Predominant activities undertaken include:

- Sensitization of all levels of leadership from Ministerial, Parliamentary, Zoba, sub Zoba and Kebabi levels.
- Formation of FGM committees to keep momentum on awareness and monitor compliance to the FGM/C Proclamation 158/2007.
- Production of audio visual materials that were disseminated nationwide as well as translation of the FGM Proclamation in 9 languages to guarantee satisfactory understanding.

Various outreach programmes sensitizing various communities nation-wide were undertaken. The themes covered were mainly:

- Communication, Legal Literacy and Financial Reporting (with 1421 participants all female)
- Training and orientation on consequences of FGM/C (with 489 female & 88 male participants)
- Violence against Women (with 196 female & 228 male participants)

Activity 2: Support to one common community outreach model

- Establishment of a New Micro Credit Program and Preparation of Manuals

A variety of activities were undertaken including:

- Training on micro credit was conducted for credit officers, project coordinators, finance personnel, NUEW Zoba leaders in order to facilitate outreach services in remote rural areas.
- In 2008 training on concept of micro credit was extended to 223 females and skills training to 83 women beneficiaries.
- In 2007, a ‘Village Bank’ was designed and introduced in Gash-Barka.
- Operation and financial manuals prepared with which a training program was then designed and conducted in 2007.
A three day orientation program was also conducted for 200 women beneficiaries on the management of loan, financial record keeping, and running and/or selecting profitable cottages or businesses.

IV. SITUATION OF CP OUTPUT AND OUTCOME INDICATORS

a. Situation Of Reproductive Health Output And Outcome Indicators

i. Status of indicators for RH Output 1

1. The proportion of Health Stations providing BEmOC, with a baseline of 23% and Target of 45%
   According to the RH Unit, 2009 Annual Report 2, it increased beyond target to 46%. Moreover, according to the present evaluation 86% (20/23) of the health stations visited provide BEmOC.

2. Proportion of health facilities that are providing PNC, with a baseline of 0% and Target of 75%
   According to the MOH-RH service, it moved to 29.7% in 2009. Hence, there is an increasing trend though short of the target.

3. The proportion of Health facilities providing ANC with VCT services, with a baseline of 10.5% and Target of 100%
   According to NATCoD it was 47% in 2009, while the findings of the present evaluation, indicates that it is 70%. Hence, there is an increasing trend though short of the target.

4. The proportion of health facilities providing at least three modern methods of family planning with a baseline of 10.5% and Target of 100%
   According to HMIS 2008 it was only 56.6% but according to the present evaluation, it is 100%.

ii. Status of indicators for RH Output 2

1) The proportion of men and women that can mention more than two danger signs associated with pregnancy and child birth with a baseline of 25% and Target of 50%
   According to the present evaluation, it was 75% for women. However, that of men was not measured.

2) Proportion of men and women who know at least two benefit of modern contraceptives with a baseline of 25% and Target of 50%
   This was not directly measured.

   However in a recent survey conducted by NUEYS in October, 2010 on “Condom availability, quality and knowledge, attitude and practice” sexually active group, 70% of the study population associated the use of condom with the double
protection against pregnancy and STI. The target was 50%. There is an increasing trend that goes beyond the target.

3) The percentage of sexually active young people (15-24) who used a condom at last sexual intercourse with a non-married, non-cohabitating partner, with a baseline of 36% and a target 80%

According to a study conducted by NUEYS in October 2010, this indicator stood at 90% for males and 87.7% for females. There is an increasing trend that goes beyond the target.

iii. Status of indicators for RH Output 3

1. The proportion of sites providing comprehensive PMTC, with a baseline of 36% and a target of 50%

According to NATCoD report of 2009, it stood at 47%. There is an increasing trend and the target is likely to be achieved by the end of the current programme.

2. The proportion of young people aged 15-24 who know at least two ways of preventing HIV transmission” with a baseline of 78% and a target of 100%

According to the MoH and UNICEF KAPS study of 2008 it stood at 80-90% as against 92% according to the present survey. There is an increasing trend though short of the target but it is likely to be achieved by the end of the current programme.

3. The proportion of respondents expressing accepting attitude towards those positively living with HIV AIDS (PLWHA), with a baseline of 16% and target of 100%.

During the current evaluation it was 73% and that there is an increasing trend though short of the target.

iv. Status of indicators for RH Outcome indicators

At the level of the RH outcome the indicators stood as follows:

1) The percentage of births attended by skilled birth attendants, with a baseline of 28.3% and target of 40%

It was stagnant at 28% according to HMIS 2010 and therefore, there was no progress in this regards.

2) The HIV prevalence among young people aged 15-24 years, by sex with a baseline of 2.4% for females and 0.75% for males. The target was 1% for female and 0.25% for male.

This is at 0.88% for female and no data for male according to NATCoD report 2010. However, there was a progress beyond the target.

3) The proportion of service delivery points without stock outs of reproductive health commodities. There was no baseline.
This stood at 95% according to HMIS 2009 and 100% according to the present evaluation.

b. Situation of P&D Output and Outcome indicators

3rd CP Outcome: Quality disaggregated data is available, accessible and utilized in the formulation of polices, national development plans and programs.
P&D Output 1: Strengthened capacity of the NSO and sectoral ministries to generate, analyze and disseminate appropriate population and socioeconomic data.

i. Status of the indicators for P&D Output 1

1. Sector development plans reflecting the use of disaggregated data by age, gender, and vulnerability (Baseline: Education Development target: Plan12 Sector Ministries)
   During this evaluation 12 sector ministries were found to be collecting and collating data relevant to them

2. Functional IMIS available
   The system is not yet in place. The preparations are however at advanced stage, though enactment of the National Statistical Act has been delayed

3. Survey reports disseminated (Baseline 2002 EDHS, target 2010 EPHS)
   The 2010 EPHS was carried out but full report not yet ready and preliminary report not yet approved by the Government

4. Population and Housing Census (Baseline = Nil, Target = 2007/8 Census)
   Not conducted but all ground preparation done.

5. Number of sectors providing appropriate disaggregated data to NSO (Baseline = Nil, Target = 12)
   12 sector ministries can provide disaggregated data as the needs arise, but there is no standard format at the national level.

c. Situation of Gender Output and Outcome indicators

Output 1: Supportive policies, legislation and other legal frameworks are in place and enforced.

In general there was progress in the various indicators particularly with regard to FGM/C. However two of the indicators namely gender related articles in the penal and civil code as well as number of gender based violence cases reported remained stagnant. A great proportion of the output indicators were fulfilled.

i. Status of indicators for Gender Output 1

1. Proportions of gender related articles in the penal and civil codes that are reviewed in line with international instruments;
No review on gender related articles has been done yet. However the constitutional framework provides great impetus for the realization of the gender responsive laws as anticipated. The Eritrean legal system which consolidates all its laws within the civil and penal codes has demanded extensive time investments. Though the Codes are currently in draft, they are yet to be adopted by parliament after the establishment of the institutions.

2. Number of institutions mainstreaming the National Gender Action Plan in their sectoral plans;

Nine (9) of the twelve (12) line ministries targeted for 2011, and all six zobas have accepted mainstreaming as a mechanism to reach the MDG goals and have designed strategies for mainstreaming gender in the respective departments. At least two have developed related action plans, whilst 4 have identified a focal person to follow the mainstreaming process.

3. The FGM/C Law enacted and implemented.

The GoSE publicly denounced FGM/C by issuing the FGM/C Abolishing Proclamation No. 158/2007. The proclamation entered into force on March 20th 2007. This was circulated to all administrative officers in the zobas, line ministries, judges, the police and religious leaders and community members.

ii. Status of the indicators for Gender Output 2

Output 2: Strengthened institutional capacities for gender analysis and mainstreaming in the development sectors

During the 3 CP great investments have been made in capacity building around diverse skills useful for gender analysis, monitoring and communication. The status of the indicators for Output II is as follows.

1. Number of institutions with capacity to undertake gender analysis
   Nine ministries, the National Statistics Office and all six zoba administrative offices have received gender mainstreaming training and have developed action plans for their mainstreaming events. A monitoring and evaluation system was established for gender sensitive analysis.

2. Number of institutions mainstreaming gender in their plans and programmes.
   Nine out of the twelve line ministries targeted for 2011, and all six Zobas have accepted mainstreaming as a mechanism to reach the MDG goals. Gender strategy for mainstreaming in their respective departments has been designed and noted the need for a focal person. The institutions are in the process of appointing focal persons in their respective sectors. The Ministry of Health and Ministry of Education have developed action plans, which focal persons shall monitor.

iii. Status of the indicators for Gender Output 3

Output 3: Socio-cultural values, norms and practices are positively influenced in support of women and girls reproductive rights and their empowerment.
1 Number of Community courts supporting legislation promoting the rights of women and girls

Baseline: Nil and the target is; all functioning community courts (MOV: annual reviews of the community courts).

Status: There is no data available to show the progress

2 Number of GBV cases reported

Baseline: Nil, and the target is, all new cases (MOV: annual reviews of community courts)

Status: There is no GBV baseline study undertaken.

iv. Status of Outcome 5 Indicator

Outcome 5: Enhanced institutional mechanisms and socio-cultural practices that promote gender equality, equity and women empowerment and protect the rights of women and girls

Indicator: Proportion of women in decision making

Baseline: a) Ministers 17% b) Director Generals 20% c) High court judges 12% and the target is; 30%.

Status: There has been a marginal increase in the number of women at decision making level but data is not available.

Indicator: Prevalence of FGM/C for persons under 15 years

Baseline: 73% and the target was; 50%.

Status: There is no data available to show the progress made.
V. MAJOR ACHIEVEMENTS OF THE PROGRAMME COMPONENTS

a. Major achievements of the RH programme component

- Most health facilities visited had adequate number of RH materials, equipments and drugs for FP, antenatal, delivery and postnatal care.
- There was a generally good coverage of the population in terms of RH service provision, medical laboratories etc.
- The timely response of partners like UNFPA to address critical personnel shortage by supporting recruitment of international health personnel to fill the gap while the government is building its institutional capacity.
- The Eritrean Defense Force (EDF’s) use of Change Agents or organizations like NUEYS & NUEW by virtue of their extensive territorial coverage and strong organization was an effective means of affecting behavior change not only within their personnel but also within the communities at large where they are stationed.
- There was a laudable effort to provide health services to the population by use of approaches such as the post partum home visits, the lab in suitcase, and the maternity waiting homes, which greatly helped to extend coverage of the much needed services.
- The introduction of the maternity waiting home particularly helped to timely bring pregnant mothers into the health facilities for skilled attended deliveries.

b. Major achievements of the P&D programme component

- The National Statistics Office, in collaboration with UNFPA and other key partners, has accomplished tasks pertaining to data collection, capacity building for the EPHS; conduct an inventory of the existing national databases, training in the use of DevInfo presentation and dissemination software. However, much of the planned activities of the P&D programme component during the Third Country Program have not been carried out.
- Some NSO staff members have received trainings in-house and abroad. To some extent, this has increased their capacity to take on the onerous task of data generation, analysis and dissemination. Their participation in the 3rd EPHS and LSMS surveys as well as their technical assistances to the MoE surveys are testimonies of their skills.
- The financial and logistic support from the partners like UNFPA went a long way to equip NSO. This included: computers and accessories, photocopiers, software among others. This has strengthened the working capacity of the Office in many ways, notably in the area of production, analysis and dissemination of demographic data.

c. Major achievements of the Gender programme component

- The technical skills on gender mainstreaming inbuilt within the programme as well as monitoring capabilities were enhanced thus increasing the capacity of
NUEW to take on the task of designing and facilitating gender mainstreaming training at policy and community levels.

- The extension of NUEW membership at all levels including those in the diaspora has strengthened the sustainability of the programme component as the sources of resources have been increased and diversified.
- The approach of identifying gender component as a programmatic aspect of the UNDAF has contributed to greater visibility and ability to focus and better influence behavior and practices.
- The use of gender thematic groups is useful to ensure sharing and consistent knowledge on the gender equality work.

VI. AREAS TO IMPROVE ON

a. RH programme component

- Difficulties were encountered in measuring progress of some indicators due to non inclusion of the related data in the HMIS tools and or the absence of a baseline situation, for example Post Partum Care (PPC) - home visits.
- Most of the newly graduated midwives had inadequate experience, exposure and skill in obstetrics and gynecology, and were not very operational on the field as they themselves acknowledged.
- The neonate care unit in all hospitals and health centers visited was not established and equipped to provide basic or comprehensive neonatal care.
- Due to the Ministry of Finance policy, most of the training components and supportive supervision were not conducted in the year 2010 but done in the previous years of the 3rd CP i.e. 2007-2009.
- The level of insanitation of some health facilities was exacerbated by the lack of piped water especially in the health stations, thus the improper use of the latrines, showers and lavatories noticed.
- There is a reduced use of ANC services according to the registers.
- Feedback within the referral system was almost completely absent. This could have served not only in strengthening the referral system but also in improving capacity of staff involved.
- The change agents often had accommodation and transport problems in remote villages that need to be addressed, especially when they have to spend nights out.
- Financial approval process is so slow that it often created unnecessary delays in the implementation of the activities.

b. P&D programme component.

- Some essential activities were not carried out as planned due to the procedural reasons, which took a much longer time than previously thought. The national population and housing census and promulgation of statistical act were among the activities/areas that showed little or no progress during the period.
With regards to EPHS, there were critical shortages of field vehicles (for rural clusters and supervision activities) resulting in the delay of the fieldwork for the rural clusters. Furthermore, due to problems related to the delivery of items for weight and height measurements and DBS collection the survey was delayed.

Because of the absence of the Statistical Act and consequently of the common national data base, sector ministries tend to collate, produce and disseminate and utilize their own data, without reference to the NSO. In such situation, there is no guarantee of the quality of data produced here and there.

c. **Gender programme component.**

- Inadequate sex disaggregated data P&D has hindered the collection of baseline information as well as capture developmental trends that are likely to have different impacts on women and men.
- Slow pace in terms of reforming the decision making profile of women in high positions of power. Whilst it is notable that women are largely visible in the public offices, their positioning is dominant at the middle and lower levels.
- Absence of reporting system hinders successful monitoring trends of the community court and other courts on jurisprudence on gender equality. It is recommended that dialogue with the Attorney General and the judiciary be commenced to identify appropriate means to document court judgments and conduct trends analysis as a tangible means of witnessing the impact of the law enforcement training.

VII. **CHALLENGES**

a. **Common challenges of the programme**

- Since the issue of border demarcation between Eritrea and Ethiopia has not been resolved, one noticeable result of this is that census cannot take place in these conditions.
- The lack of current denominator information on the population constitutes a problem for calculating target population and coverage.

b. **Challenges specific to the RH programme component**

- Shortage of human resource such as doctors, anesthetists, midwives etc.; especially in seven hospitals to make them fully functional for comprehensive EmOC was a serious problem.
- Inadequate transport and communication services including shortage of fuel; which negatively affects the referral and outreach activities.
- The multiplicity of local languages constitutes a barrier to effective Behavior Change Communication (BCC) which makes it difficult for the change agents in addressing various populations and also for the producers of IEC material to produce material that is widely appropriate.
c. **Challenges specific to the P&D programme component**

- Absence of Statistical Act. This is identified as a major constraint to achieving the outcome of the programme component. A draft of this essential tool is yet to be validated and approved by the government.
- Shortage of high level experts. Data management requires in many aspects high specialists that NSO cannot afford thus leading to the call for external Technical Assistance to fill the gap.
VIII. RECOMMENDATIONS

a. Recommendations related to the RH programme component

Besides stressing the need for addressing the challenges and perpetrating the major achievements indicated above, the following recommendations are made for the next programme:

i. To follow up on, document and publish the results of innovative experiences in the current program like, maternity waiting homes, lab-in-suitcase services and post partum home visits and scale them up as a means to extend coverage of the population with essential health services.

ii. To introduce a feedback system within EmOC referral not only as a means of strengthening the referral system but also of improving capacity of staff in obstetric health care service provision.

iii. To consider introducing an EmOC network system which aims more at population coverage than of territorial/administrative coverage as a means of maximizing the use of limited resources to cover the maximum population possible. Some health facilities located in strategic and distant places may have to be upgraded, equipped and staffed to manage all emergency obstetrical and other critical patient care from their surroundings, as against trying to get people to use distant ones.

iv. To improve on the supply of energy as a means of optimizing the use of electrical appliances. Solar power is good as a source of lighting and running the fridges or other light appliances, but not for heavy duty appliances.

v. To improve pipe water supply especially in health stations as a means to improve on general sanitation, proper utilization of the latrines, showers and lavatories or general cleanliness.

vi. To improve on the availability and maintenance of ambulances in all health facilities as a means of enhancing emergency obstetrical care. This implies acquiring more ambulances but within the framework of a network system where a centrally positioned ambulance is made to cover a number of communities and health facilities all equipped with communication systems that can permit them to call the ambulance as needs arise. The practical modalities of how this will operate have to be well thought about taking into consideration the contributions of users (community, Individuals, Health facilities, etc.) in view of the sustainability.

vii. To strengthen the team of obstetrician and anesthetists and assign them to strategically located health facilities (Example Assab, Tio, and Afabet hospitals) to provide cEmOC.

viii. To make an extra effort in order to clear the backlog of fistula cases that urgently need treatment and rehabilitation.

ix. To strengthen and possibly scale up innovative and promising best practices like the post partum care home visits, and maternity waiting homes as a means of bringing services closer to the people. The population is very much pro-actively in support and the program needs to capitalize on the dynamic in place currently.
x. To be more aggressive in stimulating the demand and use for ANC services. The community health workers (TBAs, CHAs etc.) should be organized to sensitize and mobilize mothers for ANC, facility delivery and to have birth preparedness plans.

xi. To support the implementation of the MPDA forms, particularly at the community level, in order to identify the causes of maternal and newborn deaths in the community so as to take appropriate corrective measures.

xii. To strengthen RH Commodities Security to ensure the minimum 3 optional FP methods in the health facilities. Special care is to be given to condom given its dual protection of HIV and pregnancy especially given the increasing demand noticed in the field.

xiii. To strengthen the human resource for the provision of quality RH services, with focus on training of midwives, Ob/Gyn specialists, anesthetists and LSS training. There is an urgent need to introduce apprenticeship training for general practitioners on major gynecological and obstetrical surgical procedures so as to improve on the cEMOC coverage.

xiv. To introduce the more personal and intimate behavior change communication strategies as a means of sustaining and fostering the impetus given to risky behavioral change that has been accomplished so far by mass communication, e.g. VCT in school settings or in youth centers.

xv. To better target and give attention to young girls and women getting into sex work for various reasons, but who unfortunately do not identify themselves as CSWs, and as such do not benefit from related BCC strategies and activities.

xvi. To support the community to construct habitable and more durable maternity waiting homes.

xvii. To ensure adequate and timely release of fund annual work plans should be prepared as early as December to make sure all necessary approvals are gotten in view of an early start of disbursements in January of the next budgetary year.

xviii. To strengthen the capacity of the focal person at the MOH in order to enable the person to follow up the financial documents for the RH program on a more regular basis.

b. Recommendations related to the P&D programme component

The P&D sub-program, as a pivotal component of the 3rd CP, should be strengthened further in order to mobilise demographic and socio-economic data for comprehensive development policies in Eritrea. The following recommendations will contribute to achieving this:

i. Approval and promulgation of the ‘National Statistics Act’ should be of strategic importance as this provides the legal framework for data collection and utilization at all levels.

ii. The issue of a National Population Policy should also be given priority attention.

iii. In-house training and study tours abroad should be enhanced to further contribute to the capacity building of NSO and other sectoral Ministries at a
higher expert level. More advanced trainings should be planned and provided for all NSO and ministries staff who deal with data issues.

iv. Census should be rescheduled as soon as internal and external conditions are favorable.

v. The need to implement CP review recommendations is paramount, so that the problems associated with specific issues do not continue to crop up or multiply the consequences of non-implementation.

c. Recommendations related to the Gender programme component

The gender programme component is an integral part of assuring meaningful and efficient development interventions. It enables the comprehensive delivery of the 3rd country programme by capturing the breadth of intervening socio-cultural factors that undermine development, particularly maternal mortality and advances in the reproductive health arena. Thus, it should be strengthened as a vehicle to deliver on GSE goals set out in NGAP and commitments to its internationally stated obligations particularly MDG’s. These are some of the recommendations:

i. NUEW should be strengthened to monitor and report on progress made on improvements on women’s decision making status. The threshold of 30% should be implemented at all levels of decision making and that this affirmative action provision should not be viewed as the maximum but rather as the bare minimum to fulfill gender equality.

ii. As reporting on legal cases is yet to be instituted, it is recommended that monitoring visits to the community courts are made to determine changes in behaviour and management of accused persons by the community judges.

iii. Efforts to have baseline surveys around the themes of the programme will significantly strengthen the programme particularly in targeting necessary interventions.

iv. Activities that contribute to outputs 1 and 3 should be harmonized.

v. There is a need to intensify activities targeting young people at school.

The approach to work in the rural areas and adopt a bottom up approach is successful as shown in the case of FGM campaigns, thus there is need to have the programme expanded to all the rural settings and allocate enough transport facilities and running costs.

IX. CONCLUSIONS

The United Nations Development Assistance Framework (UNDAF) for Eritrea aims at realizing the national priorities and contributing to the country’s achievement of the Millennium Development Goals (MDG). To this end, the Government of the State of Eritrea (GSE) has identified the strategic areas which need to work with the UN Systems. Within this framework, the reproductive health, gender and Population and Development programme components have been put in place to contribute to the national priority of the Government in strengthening the capacity at various levels. The overall performance of the 3rd country program is very satisfactory in relation to its design, relevance, effectiveness, efficiency, sustainability, and implementation. In its design the program was found to be in line with the national priorities as defined in the
strategic documents reviewed in the evaluation. It was found to be in line with the orientations in the UNDAF and CPAP documents. There was a high level of accomplishment of planned activities. The review revealed that most of the envisaged tasks had been accomplished successfully while others are partially done. In RH, significant efforts were made in strengthening service provision and soliciting its demand. In some of the components there has been some innovative and promising initiatives, which need close follow up, documentation and subsequent scaling up to ensure total coverage of the population. The gender mainstreaming is taking root in line ministries and national institutions. The NSO is well-equipped and now skilled to undertake activities related to data collection, analysis and dissemination. The preliminary report of the 3rd EPHS has been prepared and is being assessed by the government. The program results (output and outcome levels) were largely met. Of course there are still areas for improvement and some major challenges to address in order to optimize the results of the country program.