ERITREA COUNTRY OFFICE

CENTRAL EMERGENCY RESPONSE FUND 1 AND 2
EVALUATION REPORT

DECEMBER 2006
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Executive summary
The Central Emergency Response Fund (CERF) was allocated to four countries in the Horn of Africa following an appeal to the United Nations. The primary objective of CERF was to address humanitarian needs following a series of droughts.

Prior to the release of the funds the UN agents in close collaboration with the MOH conducted a rapid assessment of the worst affected areas in the 2 drought prone zobas of Northern Red Sea and Southern Red Sea. A number of needs and gaps were identified. Some of these needs were acute and chronic malnutrition, poor sanitation and water provision, poor management of childhood illness and incomplete morbidity and mortality community based data and incomplete district health profiles. Two disbursements of CERF were used to address some of these gaps.

The objective of this study was to document the process of planning, organization, implementation and outcomes of the CERF projects. A team of instructors from Orotta School of Medicine and Ministry of Health were recruited and trained on how to conduct the evaluation. The method used for the evaluation process was that of conducting interviews using open ended questions and direct observation of the results of the funded activities. The interviewees ranged from program officers in the UN agents, managers in the MOH at headquarters, zonal and community level in addition to local government officials in the sub-zones.

The impact of the CERF on disease morbidity and mortality was not measurable because of the short duration of the implementation of the intervention, as result the evaluation focused on the process indicators. These indicators can be grouped into project management and organization, emergency preparedness, morbidity and mortality information, water and sanitation improvements, childhood illness and vaccinations and outreach services.

The planning of the CERF project was jointly done between MOH and UN agencies at the rapid assessment stage including the prioritization of the activities and implementation. MOH were not involved in the process of the sourcing the CERF funds because the determination was not done in Eritrea. The officers in the subzobas and local government were not aware of the CERF however they knew of additional money made available during the period of the CERF disbursement.

Health workers under went training in emergency preparedness and emergency kits were procured. Pertaining to information process indicators, district health profiles were compiled and disseminated as a baseline of the situation analysis. In addition IDSR was strengthened. Prevention of childhood illnesses process indicators included the improved water and sanitation interventions. VIP latrines were constructed, dry waste disposal improved. Health workers were trained on community IMCI and therapeutic feeding strengthened with provision of food. Immunization was supported especially against measles and supplementation of Vitamin A. This was complemented by setting up of SOS for hard to reach areas.

In conclusion the intended contribution of CERF to humanitarian assistance targeted at some gaps was achieved but it is too early to document the impact of the intervention on disease morbidity and mortality. The outcomes could have been enhanced if there was better coordination from the beginning involving all partners from the planning stages.
1. Background information

The drought situation in the Horn of Africa is a major source of concern to the world. The Northern and Southern Red Sea zones of Eritrea are the areas likely to be affected by the consequences of this natural disaster. The Central Emergency Response Fund (CERF) is a special fund allocated by the United Secretary General of the United Nations in response to the humanitarian appeal of four countries in the Horn of Africa including Eritrea. It is in view of this that a special intervention supported by CERF is targeted at these areas. Southern Red Sea Zone is one of the priority areas targeted for special intervention under the CERF project. The area is bordered by both Djibouti and Ethiopia and lowest rainfall pattern in the country. The fund is meant only for a rapid life saving humanitarian interventions in health, nutrition, water and sanitation in such critical time.

Rapid needs assessment surveys were conducted by UN Agencies; the WCO, UNICEF and UNFPA together with their government counterparts in the drought stricken regions.

Key findings of the rapid assessment included:
- Persistent shortage of rainfall, poor water supply, poor sanitation and their related diseases were the major humanitarian problems identified.
- High level of acute and chronic malnutrition including chronic micronutrient deficiencies.
- Routine provision of outreach immunization services did not result in increased coverage and the dropout rates were high.
• Antenatal clinic attendance was low coupled with very poor hospital delivery and postnatal attendance.
• The capacities to provide emergency obstetric services were limited by lack of equipment and expertise.
• Poor reliability of the health facility mortality statistics. With high prevalence of acute global and chronic child and maternal malnutrition, very low immunization coverage, low skilled delivery attendance, poor sanitation aggravated by chronic shortage of rainfall and poverty, high levels of maternal and child mortality would be expected. Yet the health facilities did not report deaths. This was because most of the deaths from the community were not registered.
• Non availability of emergency response plan and emergency drug stockpiles for response was another major area of concern.
• The rocky nature of the area made it prone to injuries, but the health stations lacked dressing set for wounds.
• Poor nature of the shelter in the area exposed the population to bad weather. The results of the assessments were used to identify the worst affected areas and to prioritize the immediate interventions.

The Northern and Southern Red Sea Administrative regions were selected for the intervention. Some of the priority interventions were:
• Establishment of therapeutic feeding centers to improve nutrition services with provision of basic supplies and equipment as well as training,
• Provision of supplementary foods,
• Support catch up immunization campaign by providing some operational cost,
• Establishment of a Sustainable Outreach Services for hard to reach areas,
• Supply a stock of emergency drugs,
• Verify the extent of morbidity and mortality by conducting household mortality and morbidity survey.
• Address the crucial constraints of the health service delivery especially emergency obstetric kits and TBA kits

The period of the intervention was from March 2006 to October 2006. The different United Nations agencies operating in Eritrea namely the WHO which is the leading organization in health related activities, the UNICEF, UNFPA were the direct beneficiaries of CERF through the organization for coordinating humanitarian assistance (OCHA) upon presenting plausible proposals for the purpose.

The CERF funded activities carried out included the following;
• Training of health workers and community health agents in supplementary and therapeutic feeding of malnourished children,
• Training of health workers on integrated case management of childhood illnesses (IMCI) Providing technical and operation costs for immunization activities
• Preparing special strategy to reach hard-to-reach (HTR) areas called sustainable outreach services (SOS) that
  o provided packages of health services such as
    ▪ immunization,
• vitamin A supplementation,
• growth promoting activities,
• treatment of minor ailments,
• antenatal care,
• supplementation of iron to pregnant women.

- Procurement of essential drugs, kits and equipments, provision of special diet called UNIMIX, BP-5, oil and sorghum to
  - needy children,
  - pregnant and lactating mothers
- Survey on District health profiles of the drought stricken regions for use by the government counterparts and the UN agencies.

2. General objective of the project evaluation:
   ✓ The general objective was to assess the contributions of CERF fund in the improvement of emergency health and nutrition interventions in the selected sub-zones.

Specific objectives of the project evaluation:
   ✓ To assess the understanding of health officials at various levels about CERF fund and its contributions;
   ✓ To assess the impact of CERF interventions to address the gaps identified through rapid assessment in the three sub-zones (Shieb, Nakfa and Afabet) in Northern Red sea Zone.
   ✓ To recommend way forward for future CERF fund in the zone.

3. Methodology:
Instructors from Orotta School of Medicine and experienced nurses working in the Ministry of Health all with previous project evaluation experience were recruited and trained to conduct the evaluation. The methodologies used to assess the contributions of CERF fund were interviews with health officials at various levels of Northern Red Sea zone, administration of open and close ended questionnaires and observations in the improvement of health systems and health delivery in the zone and specifically in the three sub-zones assessed.

Photographs were taken for activities implemented using CERF funds and are documented as part of the assessment process.

The project was done in the Northern and Southern Red Sea Administrative Regions (NRSAR and SRSAR), at the Head office of the Ministry of Health, the different UN agencies which have direct relation with the intervention.

The project was conducted by interviewing the respective regional health managers, regional and local administrators, Sub zonal managers, Medical directors of hospitals, and heads of health centers or health stations. Health managers at the head office of the Ministry of Health, different program officers at the WHO, UNICEF, and OCHA were also respondents. Open ended questions were administered to the individual respondents in the areas of planning, implementation, and monitoring and evaluations of the intervention. Coordination of the activities among the partners, community participation, effectiveness and outputs of the intervention were also assessed. Respondents were also asked questions pertaining to the challenges or constraints and the added values of the intervention when compared to the regular modalities of funding.
4.0 Findings

The overall impression from this evaluation is that the implementation of the CERF funded activities was generally successful. The health workers in the periphery were not aware of a fund called CERF presumably because at the district level funds from various sources are disbursed into a common basket from the headquarters. It was possible to see the impact of the intervention in the CERF disbursement period mentioned above. Increase in the number of health workers trained in IMCI and supplementary and therapeutic feeding of malnourished children, increase in the activities of immunization programs thereby increasing the immunization and vitamin A supplementation coverage. A special strategy called sustainable outreach service (SOS) was carried out in some hard to reach areas where the communities were reached with health service packages including immunization, growth monitoring, antenatal care, iron supplementation to pregnant women and treatment of minor ailments. Essential drug supply and different kits were also made available. Solar panels were installed in some health stations, ventilated improved pit (VIP) latrines built in a number of villages. Supplementary feeding was being carried out in selected schools.

5. Coverage of the study

The evaluation was done in the NRSAR and the SRSAR and it includes all phases of the intervention-planning, implementation, monitoring and evaluation, coordination among partners, community participation, outcomes and effectiveness of the intervention and whether there were constraints or challenges.

Planning

Most of the program officers in the different UN agencies interviewed participated in the needs assessment survey and the designing of the planning of the CERF intervention. Some did not participate in the process. The latter suggested that participating in all the processes would have resulted in an even better outcome. The planning could have been strengthened by participation of the program officers in the WHO, the other sister agencies and the main government partners and the Ministry of Health and other relevant government institutions.

Health managers in the MOH who have direct relation with the CERF intervention were invited to the needs assessment survey in each of 3 Subzobas of NRS and SRS administrative Zones. MOH, as the main government counter partner, was not actively involved in the planning process of the CERF intervention and was not even aware of the project at the beginning.

The Zonal and sub zonal health managers, the heads of health facilities had inadequate information of the intervention and most of the activities were planned at the center and forwarded to them for implementation.

Implementation

Almost all the planned activities were implemented. The zonal and sub zonal health managers and the health workers in the health facilities did participate as part of the enhanced activities of their duty. The health managers at the head office of the MOH had participated very well. Almost all the program managers at the different UN agencies did have sound knowledge about and had participated very well in the intervention.
Monitoring and evaluation

Monitoring of interventions was carried out by
- Periodic assessment of the activities done through
  - Field visits by MOH health managers and the UN agency counterparts
  - Reports from the health facilities were other ways of monitoring.

The process indicators used were
- the number of health personnel trained in specific activities like IMCI case management, ETAT etc
- the number of therapeutic feeding centers actually run by trained individuals,
- The number of simplified nutritional guide printed and distributed.
- Proportion of target population reached in immunization which is seen as a function of measles vaccine and vitamin A supplementation coverages.
- proportion of children reached for the first time (% zero dose children reached) during immunization activities
- Degree of community participation.

6. Organization and management.

The different program officers of the UN agencies prepare proposals in collaboration with their government counterparts. Those proposals found to serve the purpose of the CERF interventions would get the grant and planning done. The planned activities were taken down to the zonal and sub zonal level for implementation. Monitoring and evaluation were conducted by both partners.

7. Achievement-inputs, activities and outputs

The different UN agencies and their government counterparts worked together in the areas of health, nutrition, water and sanitation related with emergency situations.

Activities
The activities carried out in health and health related issues included:
- Child health improvement
- Training of health personnel in IMCI case management
- Training of trainers of IMCI case management
- Training of Emergency triage and treatment, ETAT
- Facilitating trainings on nutritional management of children having malnutrition in the Zobas selected for the CERF intervention-the NRS, and SRS and for people living with HIV- AIDS
- Managing feeding centers
- Supplying needy children, pregnant and lactating mothers with nutritious food
- Providing food to school children
- Procurement of essential drug and emergency kits to the drought affected areas
- On job training of health workers on and preparing guide for epidemic response
- Installation of solar panels to health stations as source of electricity
- Building ventilated improved pit latrines.
8. Outcomes

The evaluation team observed nutritional supplies and food processing equipment in operation at a feeding centre in the Northern Red Sea as illustrated below.

*Therapeutic feeding centre, Alfabet, NRS.*

Emergency preparedness especially related to delivery of pregnant women under skilled attendance has been a measure concern identified during the rapid assessment. Some kits have since been procured and below a health worker is preparing such equipment for use in the next delivery.

*Health worker preparing delivery kits for pregnant women.*
Water and sanitation issues are related to increased diarrhea and acute respiratory tract infections. Construction and use of ventilation improved pit latrines was one community based activity implemented through the CERF funds. Below is a part of a village community with VIPs in place.

Ventilated improved pit latrines in Kelhamet, NRS

Systematic disposal of dry waste is another approach that improves sanitation and constitutes a key component of the PHAST strategy in improving hygiene and disease prevention.

Participation of the community in dry waste disposal, Nakfa, NRS.
EPI has been one key activity supported by CERF including the maintenance of the cold chain for vaccines. Below is health facility with solar panels to support solar fridges and emergency lighting for the patient care. The funds were used in the national measles vaccination campaign and vitamin A supplementation campaign with a record coverage of greater that 95%. In addition a SOS for hard to reach areas was conducted for the first tie as a resounding success as detailed below.

![Solar panels in a health facility in NRS.](image)

**9.0 Sustainable outreach Services (SOS)**

A special outreach program called Sustainable Outreach Services (SOS), the first of its kind in the country took place in the Hard-To-Reach (HTR) areas of two sub Zobas, namely, Tio and Foro sub zones.

The team that participated in the SOS was specifically trained for the service and involved both community health workers and health agents. In addition to providing routine immunizations for children and pregnant women, antenatal care services and limited curative services for minor ailments was also carried out. The other important achievement is the finding of children with zero dose vaccinations in the HTR areas. Through the SOS strategy so many pregnant mother could get antenatal care at least once during the period of intervention.
Because of the hard terrain in these areas, camels and donkeys were the preferred mode of transport carrying supplies and health workers to provide services in areas where some inhabitants are predominantly nomadic.

*Camels used for SOS CERF funded activities to reach ‘hard to reach areas’*

*Immunization of a pregnant woman in the hard to reach areas through SOS.*
Summary of the outcomes of the CERF as seen through the evaluation

So many health workers were trained in case management of IMCI, ETAT, supplementary and therapeutic feeding of malnourished children

- The changes on the conditions of the beneficiaries are difficult to see now. But the number of health personnel that are trained in handling common childhood diseases has significantly increased.
- The conditions of the beneficiaries are changed. At least the number of trained individuals on IMCI, ETAT, Nutritional management and etc, has increased. The impact of this is yet to be seen.
- Nutritional guide for peoples living with HIV and with the disease AIDS is prepared in two of the major languages of Eritrea, namely Tigrigna, and Tigre, and is being distributed.
- The CERF has contributed to the capacity of WHO to respond to humanitarian emergencies as it has given the chance of training to some members of the WHO country office on specific relevant activities.
- All the health facilities have all the essential drugs and kits, there are no drugs out of stock
- More people got mosquito bed nets
- Through SOS, services reached the hard-to-reach (HTR) areas; thereby service-community link has improved.
- On job training of health workers in and preparing of technical guide for epidemic response done.
- ANC, iron supplementation and immunization coverage improved.
- Multiple doses is needed to see the actual effect in the community
- SOS is a good strategy to reach HTR areas; hence EPI can take it as an alternative means to reach such areas.
- Through SOS strategy a reproducible experience is gained

10. Facilitating and inhibitory factors

The peoples working in the Administrative regions and the head office could not say any thing about the facilitating factors to the intervention more than having witnessed enhanced health related activities in the period of the intervention.
But, program managers working in the different UN agencies could list factors that contributed to the success of the intervention program. These include:
- The ease with which the fund was available
- Commitment on the side of the WHO staff, the executing bodies mainly the MOH staff, both at the centre and the Zobas and the other partners

The facilitating factors include:
- -readily available fund
- praiseworthy involvement of the government counter part, MOH at all levels, health workers, local government administrations, at Zoba sub Zoba and village levels, community health agents.

Constraints or inhibitory factors for the activities include
- The hot climate was not favorable for the people and for the health workers
• Low number of local experts at all levels including the planning, implementing and monitoring of the intervention program
• Other competing priorities increased the already present human resource shortages
• CERF intervention can be improved by a better and permanent coordination between the partners.
• shortage of fuel
• Limited period of time allotted for the intervention. Especially in CERF 1, almost the first half of the period was passed in introducing the intervention to the main partner, the MOH and in planning.

11. Cross cutting issues: Effectiveness, Efficiency, Relevance, Sustainability and community participation
There was no formal body that coordinates the activities of the different UN agencies and the MOH, but informal ways of sharing information were there. Many of the interventions carried out are relevant, but taking the fact that the people who were supposed to implement the activities were not involved in the planning process makes some of the interventions to be questionable for their relevance for the purpose of the fund and the area in question. Community participation was commendable at the level of implementation. The people were mobilized by the local government and village administrators for the different activities.

Sustainability
As this is an emergency revolving fund, it cannot be sustainable. It is sustainable only when the government takes over. Emergency is a surprise; hence, human resource capacity building is of paramount importance for improved emergency response and preparedness. Sustainable vigilance fund may enhance emergency preparedness

12. Conclusions and Lessons Learnt
Looking at the different interviews done, we can say the CERF intervention was successful. It has added to the general well being of the people in the drought stricken areas apart from solving the immediate problems like nutrition and health. Better coordination would have resulted in still better outcomes. Involving all the partners at all level of intervention can bring about sense of ownership.

13. Recommendations
1. Though the awareness of the health workers as to the source of fund is almost nil, Such Intervention as the CERF must continue as long as there is emergency situation like drought internal displacement due to war, etc..
2. Participation of all the partners at all level of the intervention can result in a yet better outcome. There fore better coordination of the different UN sister agencies and their government partners are very important. To this effect a formal coordinating body is mandatory.
3. Because emergency is a surprise prevention of emergencies by strengthening vigilance, emergency preparedness and response activities must be part of such intervention.
4. Contributing to the building of human resource capacity is very important.

**14.0 Interviewees in Hard to reach areas:**

1. Mr. Ukbaab Haileselassie  
   Sheib sub-zoba Medical officer
2. Mr. Mulugeta Habteghiorgis  
   Wekiro Health Station
3. Mr. Abdurahman Mohammed  
   Shieb sub-zoba Local Administration
4. Mr. Tesfai Tsegai  
   Nakfa, Sub-zoba Medical Officer
5. Mr. Hammed Hamid  
   Agraie Health Station
6. Mr. Mohammed Shiker  
   Nakfa Sub-zoba Local Administrator
7. Dr. Yocob Hussen  
   Afabet, Sub-zoba Medical Officer + Hospital director
8. Mr. Habte Negash  
   Afabet, Hospital Administrator
9. Mr. Tsegezeab Mehari  
   Afabet, Sub-zoba Public Health technician
10. Mr. Kidane Andemariam  
    Afabet, MCH Health Center
11. S/r Lemlem Mebrahtu  
    Kamchewa Health Center
12. Mr. Shagray  
    Afabet, Sub-zoba Local Administrator
13. Mr. Said Mohammed Ali  
    Local Administrator of Kebabi Wekiro
14. Mr. Osma Hammid Idris  
    Local Administrator of Kebabi Agraie
15. Mr. Ahmed Omer  
    Local Administrator of Kebabi Kamchewa

**Interviewees in Northern Red Sea Zone**

1. Abraham Yemane  
   NRS Zonal medical officer
2. Dr. Solomon Ghebrezgabhier  
   Massawa S/zoba medical officer
3. Dr. Ghebremeski Dogol  
   Ghindae S/zoba medical officer
4. Mengisteab Tewolde  
   Foro S/zoba medical officer
5. Fana Tesfamariam  
   Massawa S/zoba administrator
6. Mohammed Haji  
   Foro S/ zoba administrator
7. Fatuma Mohammed  
   Ghindae S/zoba vice-administrator
8. Semere Berhe  
   Amatere health centre medical officer
9. Almaz Abraham  
   Nefasit health centre medical officer

**Interviewees for Southern Red Sea:**

1. Dr. Afwerki - Southern Red sea Zonal Medical Officer
2. Mr. Eseyas –Southern Red sea MOH administrator
3. Dr. Tekle- Sub Zoba Assab medical officer
4. Mr. Birhane- Administrator of Assab
5. Mr. Tesfalidet- Administrator of Araeta
6. Mr. Mohammed Nughus_ Araeta sub zoba medical officer
7. Mr. Aman – Gelalo sub zoba medical officer
8. Mr. Dirar- Subzoba Gelalo administration representative.
Annex 1. Report on outcomes of CERF interventions in Northern Red Sea - Zone

Sub-zobas: Massawa
Foro
Ghindae

Introduction
Eritrea is located in the horn of Africa. It has three major geographical Zones, the western Lowlands, the Central and the Northern Highlands, and the Eastern low lands (coastal). Eritrea has six Administrative Zones. The Northern red sea is one of the six zones Which is located in the Eastern low lands (coastal). This zoba has a population of 541,782 and it has 10 Sub zobas.
This region is known for its extremely low rainfall which is less than 200 mm per annum. This causes aridity and a hostile environment for agriculture, grazing and industry. 70% of the population live in the coastal areas and depend on agriculture and fishing as a means of livelihood. Following several years of poor rains and subsequent drought, population of this Zoba is experiencing a severe crisis situation.
The main coping strategy for this population is migration to the high lands in search of pasture and water and food for their animals. Because of these movements and other constraints women and children less than five years do not access to basic health services especially immunization, ANC and emergency obstetric services.

The Zone has a total of 45 health facilities ((Hospitals, Health centers, Health Stations and clinics) out of which seven are private clinics. Massawa Sub Zone has five health facilities with the population of 42,033, Foro three with the population of 56,593 and Ghindae has ten health facilities with a population of 75,778.

The primary causes of morbidity and mortality in this Zoba are acute respiratory tract infection, diarrhea, malnutrition and malaria. HIV/AIDS and tuberculosis are also identified to be important causes of mortality and morbidity. The acute and chronic malnutrition levels amongst women and children less than 5 years are very high.

Even though the health infrastructure and equipment are satisfactory in most of the Sub Zoba there is acute shortage of doctors and nurses across all the 10 sub Zobas. In addition to the shortage of human recourses access to health services are not easy. This due to:
♦ most of the vulnerable groups are not accessing the services because of migratory life style and large and difficult terrain of the land
♦ absence of outreach services due to inadequate and de-motivated manpower and lack of logistics.
♦ lack of either human or material capacity for life saving procedures especially emergency obstetrics care.

Objective of the study

♦ to assess the understanding of health officials of the Sub Zobas (Massawa, Foro, and Ghindae) at various levels about CERF fund.
To assess the CERF interventions in the three sub zones (Massawa, Foro and one activities of the CERF intervention
to assess if there could have better been better ways of doing things to get a still better outcome

**Methods**
The study was done at the head office of the ministry of health of the Northern red sea Zone and the selected three Sub Zobas namely Massawa, Foro and Ghindae. The study was conducted by interviewing the medical directors, the respective regional health managers, regional and local administrators, Sub zonal managers, Medical directors of health centers or health stations. Open ended questions were provided to the individual respondents in the areas of planning, implementation, and monitoring and evaluation of the intervention.

**Findings**

**Implementation and monitoring**
The medical officers were actively participated in planning on the interventions made in health, sanitation and nutrition areas.
The partners were well coordinated in undertaking the activities in the region. Immunization program, provision of sanitation facilities, provision of supplementary feedings and establishment of therapeutic feedings were some of the joint activities carried out in the region
Monitoring of the activities was carried out through regular field visits while interventions are underway and through reports from the Sub Zoba medical officers.

**Northern Red Sea Zonal Medical Office**
The medical officer actively participated in planning on the interventions made in health sanitation and nutrition areas.

The Zonal medical officer participated in the implementation through giving training to a number of health workers and community members in the areas of sanitation, nutrition and reproductive health. 40 health workers and community members have been trained to serve as hygiene promoters. 33 health workers and community members were given training on supplementary and therapeutic feedings. Moreover 30 male community members have been trained to serve as fistula prevention promoters. 42 health personnel were given training on life saving skills. However no training was given on IMCI.

Though there is no full data to talk about the conditions of the beneficiaries on sanitation, immunization and nutrition interventions, it observed that their conditions have improved because there has been an increased demand for sanitation facilities, VIP latrines, and supplementary food items like UNIMIX and Emergency foods rations by the people. Moreover since a number of health workers and community members have been trained in the areas of sanitation, reproductive health and in the provision of supplementary foods, they will play significant role in improving the health conditions of people of the region.
Since there is increased demand for sanitation facilities, the VIP (Ventilated Improved Pit) construction program should be expanded to all sub-zobas of the region. The solar
power supply of all the health facilities of the region are old because many of them were installed before 12 years and some of them are no more functioning, thus efforts should be made to replace them. Moreover continuous supplies of supplementary or therapeutic feedings should be ensured as the region is frequently affected by drought and mothers should be taught on how they can prevent malnutrition using the available type of food staffs.

The expiration date of the foods supplied has to be seen ahead of distributing to the people because they can be the source of new diseases. In addition other areas like sanitation and water supply problems of the sub-zoba specially that of Massawa hospital has to be addressed. Currently the Massawa hospital is getting water through tankers, which is expensive and difficult to find.

**B. Massawa Hospital and Amatere health centre.**

<table>
<thead>
<tr>
<th>Area</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Health</strong></td>
<td></td>
</tr>
<tr>
<td>1. Infrastructure</td>
<td>There is no change in the power supply of the health facilities of the sub-zoba. Massawa hospital does not have back up generator to provide power in case of shortages. The same hold true to the Amatere Maternal Health care.</td>
</tr>
<tr>
<td>2. Supplies</td>
<td>The provision of essential supplies especially of essential medicines was good and there were no out of stock items.</td>
</tr>
<tr>
<td>3. Community based activities</td>
<td>Two health workers were given training on therapeutic feeding but nothing new was done with respect to IMCI services.</td>
</tr>
<tr>
<td>4. Health service provision</td>
<td>Due to the out reach strategy introduced during the immunization period, the Immunization coverage increased significantly. Number of children under one who have got access for BCG, DPT, POV, and Measles are listed below. Unfortunately that of above one and below five is currently unavailable.</td>
</tr>
<tr>
<td>5. Surveillance, Information for evidence based health care, monitoring and supervision</td>
<td>No surveys had been conducted to enrich the baseline indicators data. Monitoring is done mainly through reports and occasional supervisory visits.</td>
</tr>
<tr>
<td><strong>A. Sanitation</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>No intervention was carried out on sanitation though the villages around the Massawa require latrines or public toilets.</td>
</tr>
</tbody>
</table>
B. Nutrition

There was continuous supply of supplementary food staffs and therapeutic feeding. Around 536 under five children and mothers of child bearing age became beneficiaries of the supplementary foods distributed at the sub-zoba health facilities mainly at the Amatere maternal care health and Massawa hospital.

C. Water

The Massawa hospital has severe water supply problem and the toilets have been closed for that reason. Thus it is in need of water provision.

FORO SUB ZOBA

In the sub-zoba there were interventions in health mainly in immunization, in sanitation and nutrition. The sub-zoba administration actively participated in the plan for immunization and sanitation but not in nutrition intervention.

The sub-zoba established immunization sites in collaboration with the local administration and its health personnel administered polio, BCG, measles, TT and DPT vaccines to under five years old children and mothers of childbearing age. In this sub-zoba out reach service was carried out in collaboration with the WHO and in addition to the immunization services, growth monitoring and health education plus small scale curative services were conducted in the hard to reach (mountainous) areas. One health worker and a number of community members have been trained on the construction of sanitation facilities such as VIP latrines. Cement and other construction materials have been provided to the community members so as to start constructing the latrines. Moreover since there is a plan to establish therapeutic center in the Foro health center, one health worker has been trained to run the therapeutic feeding center.

There was good coordination between the WHO and the Ministry of health during the immunization period however the sub-zoba administration does not know who was working in the areas of sanitation and nutrition beside the ministry of health. In the area of vaccination however the sub-zoba medical office has got excellent coordination with the local administration.

Due to the out reach strategy introduced in the sub-zoba, the immunization coverage increased almost by 50%. Thus we believe that the health situation of the local people has improved though we don’t, have figures to demonstrate the current prevalence of the vaccine preventable diseases. Further more, since a number of health workers and community members have been trained in the areas of sanitation and nutrition, they will play significant role in improving the health conditions of the people of the sub-zoba.

The immunization period was conducted during the unfavorable season of the sub-zoba where most of the local communities go to the hard to reach (mountainous) areas. Moreover the supplementary foods supplied to the sub-zoba were not adequate and some
of them were expired. The supplied foods include DMK, Emergency food ration (Norway / BP-5), Unimix(protein), Sorghum and oil.

The Foro health center solar power supply is old and it is not functioning well like the other power supplies of the health stations of the sub-zoba. Thus efforts should be made to replace the old one. The immunization campaign should be conducted during the favorable season of the sub-zoba dwellers which is from October to March.

<table>
<thead>
<tr>
<th>Area</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Health</strong></td>
<td><strong>1. Infrastructure</strong> There is no reserve power supply for the health facilities of the sub-zoba. Foro health center does not have back up generator, the health center get access to the regular supply from 6:00 – 11:00 PM. Hence 11:00 PM on ward it doesn’t have access for power and this is posing a problem on delivery of mothers. Since the existing solar power supply is very old it is advisable to find alternative sources.</td>
</tr>
<tr>
<td><strong>2. Supplies</strong></td>
<td>The provision of essential supplies especially of essential vaccines was good and there were no out of stock items.</td>
</tr>
<tr>
<td><strong>3. Community based activities</strong></td>
<td>One health worker was given training on therapeutic feeding but nothing new was done with respect to IMCI services.</td>
</tr>
<tr>
<td><strong>4. Health service provision</strong></td>
<td>Due to the out reach strategy introduced during the immunization period, the Immunization coverage increased significantly.</td>
</tr>
<tr>
<td><strong>5. Surveillance, Information for evidence based health care, monitoring and supervision</strong></td>
<td>No surveys had been conducted to enrich the baseline indicators data. Monitoring is done mainly through reports and occasional supervisory visits. Moreover, the local administration authorities inform the Foro health center in case there is an outbreak of disease in the remote areas of the sub-zoba.</td>
</tr>
<tr>
<td><strong>A. Sanitation</strong></td>
<td>150 VIP (Ventilated Improved Pit) are planned to be constructed in subzoba of Foro, in the near future. Cement and other raw materials are already disseminated to the concerned individuals. One health worker and about 10 community members are trained to monitor the construction.</td>
</tr>
</tbody>
</table>
### B. Nutrition

There was continuous supply of supplementary foods such as unimix, DMK, Emergency food ration (BP-5), sorghum, and oil. All in all about 200 malnourished children, lactating and pregnant women became beneficiaries.

### C. Water

Even though Foro health centre and town of Foro are getting pipe water from the “Wiea” reservoir, majority of the local administrations didn’t have access for pure water.

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**Foro Health Centre: Ghindae Subzoba:**
According to the information given by the medical officer and subzoba administrator the interventions made were mainly focused on health and nutrition.

In the vaccination campaign carried out from June to October, 2006, the medical officer has played pivotal role in the planning process. In collaboration with the zoba medical officer, he has prepared a macro plan which clearly enlist amount of vaccines, manpower, and transportation, needed, based on the number of target group in need of vaccination.

In case of nutrition, the medical officer also actively involved in identifying the target groups, which are in need of supplementary and therapeutic food supplies such as malnourished children, lactating and pregnant women.

The vaccination campaign was carried out by sound collaboration with Ghindae subzone administrator and local (Kebabi) administrators, who were actively involved in dissemination of informing about the vaccination date and site to the population in each local administration.

With regard to nutrition, supplementary and foods such as unimix, DMK, Norway (BP5), Sorghum, and oil were distributed to malnourished children, lactating and pregnant mothers. Besides these for children who were suffering from sever malnutrition, F-75 and F-100 therapeutic foods were administered in the therapeutic feeding center in Ghindae hospital. Unlike in case of vaccination the involvement of the local administrators in the intervention made in nutrition was limited.

Even though the community hasn’t had any involvement in the planning and monitoring aspects, it makes sound contribution in implementation. Community health agents, such as malaria agents, and TBA, actively participate in advocating importance of vaccination, and even by being part of the campaign. The community in the remote areas also facilitate the vaccination campaign by providing free meals to the health workers who participated in the campaign.

As the medical officer and subzoba administrator pointed out, significant number of children and mothers become beneficiaries of the immunization campaign carried out in the sub zoba. With regard to nutrition, two staff members of Ghindae hospitals are provided training on therapeutic feeding; one therapeutic feeding centre is established in
the hospital, and is providing F75, and F100 therapeutic foods for severely malnourished children. Beside these the Ghindae hospital is providing community based therapeutic feeding for children who are moderately malnourished. According to the information provided by the medical officer and sub zoba administrator, some constraints were observed during the interventions made on health and nutrition. One of them is lack of adequate transportation, and communication, while conducting vaccination in the remote areas. This is attributed to inconvenient geographic location of the intervention sites and shortage of fuel. The other constraint was that the supplementary food supplies were not adequate, and to add insult to injury some of them, particularly the unimix, and sorghum were expired one.

The medical officer and sub zoba administrator provide the following suggestions which could strengthen interventions made in the future. Donating agencies should allocate enough funding on logistics of vaccination. They also should supply healthy and unexpired therapeutic as well as supplementary foods. Since less is done in sanitation and water, the authorities recommend that in the future high priority should be given for these areas.
**GHINDAE HOSPITAL AND NEFASIT HEALTH CENTRE:**

<table>
<thead>
<tr>
<th>Area</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Health</strong></td>
<td></td>
</tr>
<tr>
<td>1. Infrastructure</td>
<td>Both Ghindae hospital and Nefasit health centre didn’t have a reserve generator. Since their power supply is intermittent, they frequently encounter a problem particularly during delivery of mothers at night.</td>
</tr>
<tr>
<td>2. Supplies</td>
<td>The provision of essential supplies such as vaccines is good in all health facilities of the zoba so far, and there were no out of stock items in the past six months.</td>
</tr>
<tr>
<td>3. Community based activities</td>
<td>In Ghindae hospital as well as Nefasit health centre nothing new was done with respect to IMCI services.</td>
</tr>
<tr>
<td>4. Health service provision</td>
<td>The interventions made in health, give good opportunity for children under five years old, to get access to BCG, DPT, POV and Measles vaccinations, throughout the sub zoba.</td>
</tr>
<tr>
<td>5. Surveillance, Information for evidence based health care,</td>
<td>No surveys had been conducted to enrich the baseline indicators data. Monitoring is done mainly through reports and occasional supervisory visits.</td>
</tr>
<tr>
<td>monitoring and supervision</td>
<td></td>
</tr>
<tr>
<td><strong>A. Sanitation</strong></td>
<td>Despite the good job done in health and nutrition, the area of sanitation is not addressed yet. Therefore effort should be made to make an intervention in this area.</td>
</tr>
<tr>
<td><strong>B. Nutrition</strong></td>
<td>Recently two health staffs of Ghindae hospital were provided training on therapeutic feeding. The hospital has one therapeutic feeding centre and it is providing F-75 and F-100 therapeutic feeding treatment for severely malnourished children. Nefasit health center is striving to introduce therapeutic feeding centre.</td>
</tr>
<tr>
<td><strong>C. Water</strong></td>
<td>Even though Ghindae referral hospital has access to pure water the community in the subzoba didn’t. Nefasit health centre have got broken pipe line and like the other health stations and the population in the sub zoba it is looking for sustainable water supply.</td>
</tr>
</tbody>
</table>
Conclusion:

Basically in the Northern Red sea we were informed that there were only interventions in the areas of health, Nutrition and Sanitation. In these interventions the health officials were the ones who had played major role in the planning, implementation, as well as monitoring of the activities. However the local administration had limited role in all the interventions carried out in the subzobas, except that they were involved in the mobilization of the community to participate in the immunization programs. Meaning the sub zoba administration was informing the people where and when the immunization program is going to be conducted through its local (kebabi) administrators. Furthermore the subzoba medical officers claimed that the supplementary food items supplied were not adequate to satisfy the needs of the vulnerable members of the community. Besides some of the foods especially sorghum and unimix, were almost expire by the time they reached the health facilities. Thus when supplying food items, their date of expiry should be considered seriously or efforts should be made to distribute them far ahead of their date of expiry. Moreover continuous and adequate amount of food items should be supplied to the region as the region is frequently affected by drought.
Annex 2. Report on outcomes of CERF interventions in
Northern Red Sea - Zone

Sub-zobas: Shieb, Nakfa and Afabet subzobas

Introduction:

Northern Red Sea Zone is one of the six administrative zones of Eritrea and is located in the coastal area of the country. It is bordered by the Red Sea in the East, Sudan in the north, Anseba zone of Eritrea in the west and Southern Red sea zone in the South. It has a total population of 446,090 and the main sources of subsistence are fishing, trade and agriculture. The area is semi-desert and has an average temperature of 35°C. The zone is also characterized by inadequate public physical infrastructure (like roads and water supply, dams etc.). The population in the rural areas lead a nomadic life style where they sometimes cross to Sudan to look for grazing for their animals. Northern Red Sea Zone is vulnerable to natural emergencies especially drought. Due to low rain fall and less productivity of the land, the agricultural output each year is below subsistence. Due to low productivity people in this region migrate within Eritrea and to neighbouring countries mainly Sudan. The zone has been affected by repeated drought and some outbreaks of diseases in parts of the sub-zones.

The zone has a total of 45 health facilities (Hospitals, Health Centres, Health Stations and clinics) out of which seven are private clinics either owned by individuals or institutions. Shieb sub-zone has only one health centre, Afabet four health facilities and Nakfa sub-zone has three health facilities.

Acute respiratory tract infections, malaria, diarrhoea, tuberculosis and malnutrition are the main causes of morbidity and mortality in Northern Red Sea zone. Eye infection, injury and STIs are also common in some part of the zone. The vulnerable segment of the population especially women and children are mainly affected by the common diseases and malnutrition.

The health service management system in the zone is weak. This is mainly due to lack of adequate trained health workers in zone. There are no management structures for health at all levels, only 30% of the sub-zobas have all management structures and management team and committees.

The health infrastructure in the sub-zones are satisfactory, however there was a drug shortage reported in some of the health facilities in the zone. Comprehensive Emergency Obstetric Care services are limited to major hospitals limited in major cities only. The health information system is available at all levels, but its utilization for decision making at lower level is limited.
There is an acute shortage of doctors, nurse midwives and midwives at all levels of the health care system. For example Afabet Sub-zone has only one doctor for the entire 80,000 population. Access to health services is limited, according to the new standard of the MOH, 1 hospital has to serve for 200,000, one health centre/district hospital for 50,000 and one health station for 10,000 people. Currently one hospital serves to 131,000 populations, one health centre for 64,000 populations and one health station to 18,000 populations. Excluding the hospital, the other health service levels have not met the recommended level as set by the MOH.

The above shortage is complicated by the migratory trend of the people in the zone, lack of human resources for life saving interventions, absence of consistent integrated outreach services and lack of equipments such as cold chain equipments for immunization. Health service utilization is still very low in all sub-zones. For example skilled care attendance during delivery is only 26% in the zone. Immunization services are also among the lowest in this zone. This is due to many reasons some of which are lack of adequately trained man power, lack of logistics for outreach services, poorly maintained cold chain and unmotivated staff.

**General objective:**
- The general objective is to assess the contributions of CERF fund in the improvement of emergency health and nutrition interventions in the selected sub-zones.

**Specific objective:**
- To assess the understanding of health officials at various levels about CERF fund and its contributions;
- To assess the impact of CERF interventions to address the gaps identified through rapid assessment in the three sub-zones (Shieb, Nakfa and Afabet) in Northern Red sea Zone.
- To recommend way forward for future CERF fund in the zone.

**Methodology:**
The methodologies used to assess the contributions of CERF fund were interviews with health officials at various levels of Northern Red Sea zone, administration of open and close ended questionnaires and observations in the improvement of health systems and health delivery in the zone and specifically in the three sub-zones assessed.

Photographs were taken for activities implemented using CERF funds and are documented as part of the assessment process.

**Results:**
**Coping mechanisms for vulnerable groups:**
The coping mechanism of the population still remains migration within and outside Eritrea to neighbouring countries mainly Sudan. CERF has not done much to address the coping mechanisms of the population like micro-credit, modern irrigation and others.
Primary causes of morbidity and mortality

The primary cause of morbidity and mortality in the Northern Red Sea Zone and the three sub-zones still remains the same. These are communicable diseases including ARI, Malaria, Diarrhoea and malnutrition due to repeated draught and poverty among the population. CERF has worked to address the above situations through training of health workers in Integrated Management of Childhood Illnesses (IMCI), training in therapeutic feeding and neonatal care and promotion of breastfeeding and weaning food. The interventions using CERF budget has shown a marked improvement in the health child care.

*A severely malnourished child on admission*  

**BEFORE TREATMENT**
- Wt: 6.4 Kg
- Wt/Ht: < 60%
- Age: 3 Years 7 Months

**AFTER TREATMENT**
- MERHAWIT MELAKE
  - Wt: 10.1 Kg
  - Age: 3 Years 8 Months

*1 month after therapeutic feeding*
**Health services management**
The Zonal Health Management Team is in place, but formation of the replica of the committee in the sub-zones is planned to be done in the year 2007. The formation of different committees at sub-zonal level will strengthen the health management and hence improve the quality of health services provided to the population. This could be the areas which CERF could support as part of the emergency interventions in the sub-zones.

**Health infrastructure equipment and supplies**
CERF budget was not used to improve the infrastructure of the health facilities in the three sub-zones, because of the strict rule of CERF budget to be used for emergency interventions only and infrastructure was not part of it. But emergency medical equipments and drugs (Emergency Kits) were procured and the zone is one of the beneficiaries of the activity.

**Human resources**
Human resources development in the areas of IMCI, therapeutic feeding training have been done using CERF budget. This will have an impact in the improvement of the quality of child health services in the intervention sub-zones. Not much has been done to improve the access to emergency obstetric care including caesarean section. This could be an area where CERF could assist the country to reduce the high maternal and neonatal mortality in the country.

*Emergency Obstetric Care is an area which CERF supported.*

**Access to health services**
The physical access to health services will still remain the same in the three sub-zones because there was no any physical structure built using CERF budget. But the improved quality of health services through training of health workers and provision of emergency equipments and supplies (kits) could have an impact in the access to quality health services in the selected sub-zones.
Health services utilization

There was not much done to improve the access and quality of skilled care attendance during pregnancy and childbirth. The CERF budget should invest more to improve access to basic and comprehensive emergency obstetric care in the selected sub-zones. However immunization services were made available through strengthening the sustainable outreach services (SOS) for immunization in the sub-zones.

Sanitation

Sanitation and safe disposal of medical wastes is still poor in most of the health facilities in Eritrea. The health facilities in the three sub-zones are not an exception. There were no specific activities done in the three sub-zones in relation to sanitation and medical waste management. This could be an area where future CERF funds could help in addressing this critical health system intervention.

Discussions:

The CERF budget was an instrumental in the implementation of activities which were under funded and were unimplemented due to financial constraints. The Zonal medical offices feel that they are adequately involved in the design and implementation of the CERF funded projects. However they feel that the community involvement was weak and needs to be strengthened.

The CERF budget was also a good boost to the human resource capacity building in health and nutrition interventions in the three sub-zones. Training in therapeutic feeding to address the high malnutrition level, immunization to improve access and quality of EPI
services was done using CERF budget. However the support for improving access and quality of basic and comprehensive emergency obstetric care was minimal or non-existent. This should be the priority of CERF support in the future.

Shortage of skilled manpower still remains to be a challenge in executing maternal and child health services in the emergency prone sub-zobas. Adequate emphasis should be given in building human resources capacity in the zone in general and the sub-zones assessed in particular.

Sanitation and medical waste management is still one of the areas which are poorly funded and in adequately addressed. CERF budget should give priority to sanitation and waste management.

Coordination of all the partners in CERF were rated as very good but has to be strengthened through sharing of information using various medias before and after the planning, implementation and evaluation of CERF funded activities.

Recommendations:

1. Improving access to basic and comprehensive emergency obstetric care through training and provision of equipments and medical supplies should be given priority in the future CERF funded projects.

2. Malnutrition among women and children is one of the public health problems in the sub-zones and adequate emphasis should be given to nutritional interventions including provision of equipments, supplies and training of health workers.

3. Sanitation and medical waste management are areas which need urgent attention to reduce communicable diseases and iatrogenic infections to the health staff and population.

4. Communication and transportation problems are sited as critical problems for the low access to health services in the sub-zones. Provision of appropriate transportation and communication facilities is highly recommended.

Introduction
Southern Red Sea is one of the six administrative zones off Eritrea and is located in the coastal area of the Red Sea. The country is bordered by the Red Sea in the, with Ethiopia in the. It has a total population of 52,427 and the main sources of livelihood are fishing, trade and animal husbandry. The area is semi-desert and has an average temp 45°C the zone is characterized by inadequate public physical infrastructure. The population in the area migrates from September to February to other part of the southern Red Sea, Ethiopia and Djibouti search of water for their animals. Drought is the main problem; SRS has been affected repeatedly by drought, due to this there was some outbreaks of disease in the Sub-Zones.

Southern Red Sea has a total of 13 health facilities (Hospitals, Health Centers, Health Stations) and Clinics107 Villages and 27 Village administrative areas (Kebabis).

The main causes of morbidity and mortality in the Southern Red Sea are Acute Respiratory Tract Infection, Malaria, Diarrhea, Tuberculosis and Malnutrition, other infections like Eye infection and STI are common in some parts of the zone. The vulnerable parts of the population are women and children mainly affected by Malnutrition.

The health service management system in the zone is weak. This mainly due to lack of adequate trained health workers in the zone. There are no management structures for health at all levels, only 27% of the sub-zobas gave all management structures and management team and committees.

The health infrastructure in the sub-zobas are satisfactory, it had been reported that one of the main problems in the southern Red Sea zone was shortage of electrical supply. Nevertheless, no new progress had been seen in the area thus no change in service output rates had been witnessed. More over, surgical lamps of Assab hospital are out of order which makes emergency surgery problematic.

Community based activities; training was given on sanitation, malaria, IMCI, Reproductive health, Commercial sex workers, HIV/AIDS, Vitamin A, LSS (life saving skills), growth monitoring and other refreshing course. However, the community was ready to provide help with regard to transportation, their extreme poverty coupled with the in hospitable weather and far apart geographical location of the villages retards whatever help the people would have liked to offer.

Health service provision. Immunization coverage for 2005 was BCG 66.1%, DPT3 46%, POV3 46%, Measles 40%.
Immunization coverage for 2006 up to December BCG—80.5%, DPT3—58.8%, POV3—58.8%, Measles—59.2%
No surveys had been conducted to enrich the baseline indicators data. Monitoring is done through SHEMS report and supervisory vistas. For example, a visit was done before a month. Moreover, help is offered by the local administration in cases where there is an outbreak of diseases.

**General Objective:**
The general objective is to assess the output of CERF intervention in the improvement of emergency health and nutrition changes in the selected Sub Zones of Southern Red Sea.

**Specific Objectives:**

- To assess the understanding of health officials at various levels about CERF fund and its impact.
- To assess the impact of CERF interventions in Asseb and Araeta sub-zobas with respect to advancement in infrastructure, supplies, nutrition, water, sanitation.
- To assess if CERF fund has addressed the gaps identified in the rapid assessment done in the zones and Sub zones of Southern Red Sea.
- To recommend way forward for future CERF fund in the Zone.

**Methodology:**
The methodology used to assess the fund was through interviews with zonal medical officers, sub zonal medical officers and Local administrators of Southern Red Sea Zone. Open-ended questioners guided the interview. In addition to the interviews, an observation was made on the present status of the different sub-zobas visited and photographs were taken when deemed necessary.

*Rapid assessment the team visiting a health center*
Constraints of most health facilities include power supply and life saving equipments

Results

- **SOUTHERN RED SEA ZONAL MEDICAL OFFICER:**

  - The progress in the Southern Red Seas Zoba with in the past ten months can be outlined as follows:

<table>
<thead>
<tr>
<th>Area</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Health</td>
<td></td>
</tr>
<tr>
<td>1. Infrastructure</td>
<td>It had been reported that one of the main problems in the Southern Red Sea Zone was shortage of electrical supply. Nevertheless, no new progress had been seen in this area thus no change in service output rates had been witnessed. More over, surgical lamp of Assab hospital is out of order which makes emergency surgery problematic. However, it had been mentioned that the Southern Red Sea Zone had received 6 solar batteries with 80</td>
</tr>
</tbody>
</table>
2. Supplies
The provision of essential supplies especially of essential medicines was good and there were no out of stock items. However, certain items like surgical gown, gloves are scarce.

3. Community based activities
- Training was given on sanitation, malaria, IMCI, Reproductive health, commercial sex workers, HIV, AIDS, Vit. A, LSS (life saving skills), growth monitoring, and other refreshing courses.
- Though the community was ready to provide help with regard to transportation, their extreme poverty coupled with the inhospitable weather and far apart geographical location of the villages retards what ever help the people would have liked to offer.

4. Health service provision
Immunization coverage:
*2005: BCG—66.1%, DPT3--46%, POV3--46%, Measles--40%

*Up to Dec.2006: BCG—80.5%, DPT3—58.8%, POV3—58.8%, measles—59.2%

5. Surveillance, Information for evidence based health care, monitoring and supervision
*No surveys had been conducted to enrich the baseline indicators data.
*Monitoring is done through SHEMS report and supervisory visits. For example, a visit was done before a month. Moreover, help is offered by the local administration incases where there is an out break of disease.

B. Nutrition

<table>
<thead>
<tr>
<th>S/N</th>
<th>Health Facility</th>
<th>Date of arrival</th>
<th>Type of Supp. Food</th>
<th>Amount</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Assab MCH</td>
<td>18/1/06</td>
<td>DSM</td>
<td>83 Carton</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>04/04/06</td>
<td>DSM</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>26/07/06</td>
<td>PSB+UNIMIX</td>
<td>21 Carton</td>
<td>500 quintal</td>
</tr>
</tbody>
</table>

liters of acid very recently.
<table>
<thead>
<tr>
<th>Date</th>
<th>Buyer</th>
<th>Details</th>
<th>Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>7/08/06</td>
<td>Oil</td>
<td>489X4lit</td>
<td>200 quintal</td>
</tr>
<tr>
<td>7/08/06</td>
<td>sorghum</td>
<td>39.2 quintal</td>
<td></td>
</tr>
<tr>
<td>7/08/06</td>
<td>CSB</td>
<td>300 quintal</td>
<td></td>
</tr>
<tr>
<td>25/08/06</td>
<td>BP-5 (Norway)</td>
<td>223.4 quintal</td>
<td></td>
</tr>
<tr>
<td>18/09/06</td>
<td>DMK</td>
<td>50 quintal</td>
<td></td>
</tr>
<tr>
<td>15/11/06</td>
<td>DMK</td>
<td>50 quintal</td>
<td>Vision ERI</td>
</tr>
<tr>
<td>29/11/06</td>
<td>Unimix</td>
<td>100 quintal</td>
<td></td>
</tr>
<tr>
<td>26/07/06</td>
<td>CSB</td>
<td>100 quintal</td>
<td></td>
</tr>
<tr>
<td>20/01/06</td>
<td>DMK</td>
<td>50 quintal</td>
<td></td>
</tr>
<tr>
<td>18/09/06</td>
<td>DMK</td>
<td>50 quintal</td>
<td>Not yet distributed</td>
</tr>
<tr>
<td>15/11/06</td>
<td>DMK</td>
<td>50 quintal</td>
<td>Vision ERI</td>
</tr>
<tr>
<td>29/11/06</td>
<td>Unimix</td>
<td>100 quintal</td>
<td></td>
</tr>
<tr>
<td>26/07/06</td>
<td>CSB</td>
<td>100 quintal</td>
<td></td>
</tr>
<tr>
<td>18/01/06</td>
<td>Unimix</td>
<td>20 quintal</td>
<td></td>
</tr>
<tr>
<td>29/11/06</td>
<td>Unimix</td>
<td>50 quintal</td>
<td></td>
</tr>
<tr>
<td>26/07/06</td>
<td>CSB</td>
<td>100 quintal</td>
<td></td>
</tr>
<tr>
<td>18/1/06</td>
<td>Unimix</td>
<td>20 quintal</td>
<td></td>
</tr>
<tr>
<td>29/11/06</td>
<td>Unimix</td>
<td>50 quintal</td>
<td></td>
</tr>
<tr>
<td>26/07/06</td>
<td>CSB</td>
<td>100 quintal</td>
<td></td>
</tr>
<tr>
<td>18/1/06</td>
<td>Unimix</td>
<td>20 quintal</td>
<td></td>
</tr>
<tr>
<td>15/9/06</td>
<td>DMK</td>
<td>26 quintal</td>
<td>Vision Eri.</td>
</tr>
<tr>
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<td>CSB</td>
<td>100 quintal</td>
<td></td>
</tr>
<tr>
<td>18/1/06</td>
<td>Unimix</td>
<td>20 quintal</td>
<td></td>
</tr>
<tr>
<td>15/9/06</td>
<td>DMK</td>
<td>26 quintal</td>
<td>Vision Eri.</td>
</tr>
<tr>
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<td>CSB</td>
<td>100 quintal</td>
<td></td>
</tr>
<tr>
<td>18/1/06</td>
<td>Unimix</td>
<td>20 quintal</td>
<td></td>
</tr>
</tbody>
</table>

- **2** B/Meskerem
- **3** Rehayta
- **4** ABO
- **5** Beylul
- **6** Wade
<table>
<thead>
<tr>
<th></th>
<th>Location</th>
<th>Date</th>
<th>Supplier</th>
<th>Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Aytous</td>
<td>16/07/06</td>
<td>CSB</td>
<td>100 quintal</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Sorghum 70 quintal</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Oil 22 carton</td>
</tr>
<tr>
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C. Water

It had been reported that supply of clean water was one the neck
bottle problems in the region. Though there is under ground water,
due to lack of transport facilities and generators for water supply
pumps majority of the zone’s residents don’t get pure water and at
the same time they fetch water using donkeys.

Thus it is not surprising that diarrhea was the first ranking disease
in the region both in 2005 and 2006.

D. Sanitation

It had been described that PHAST had been introduced. As a result
around 37 persons in Berasole and 40 persons in Bilul had been
trained on PHAST strategy from 23/7/06 to 30/07/06.

E. Cross cutting
It had been discussed that the Southern Red sea Region had good
coordination with different UN agencies. To mention some,
training on Iodinated salt use, SOS and Health information system
was given very recently in the region which was conducted through
coordination of the Southern Red Sea and UNICEF.

F. Community Participation
- Though the community was ready to provide help with regard to
  transportation, their extreme poverty coupled with the inhospitable
  weather and far apart geographical location of the
  villages retards what ever help the people would have liked to
  offer.

G. Suggestions
- The topmost issue that the Southern Red Sea region medical
  officer underscores to be resolved very urgently is the crises of lack
  of transportation. It was reported that in spite of the fact that there
  had been scarcity of Ambulances, the lack of fuel worsened the
  already ill-equipped transportation system.
- Moreover, it had been suggested that though there was flow of
  supplementary food aid, the villages are scattered far apart thus if
  therapeutic feeding centers were set up in each village the goal will
  be achieved soon.
- To sum it up, it had been mentioned that an in-depth proposal
  with regard to emergency humanitarian needs had been submitted
  by the Zonal medical officer to the Zonal administration, thus if the
  same is required by any interested body a copy could be obtained
  form the Zonal medical officer.

- ASSAB SUB ZOBA MEDICAL OFFICER AND LOCAL
  ADMINISTRATOR:

  - Hospital Assab receives electrical supply from the city and it the had been
    informed that the energy supply had progressed from 8 hrs to 24 hrs electrical
    supply.
  - As to supply of essential materials, it was discussed that they never had been out
    of stock with regard to medicine. However, there is complaint on shortage of
    sutures, OR gowns, and stationery materials.
  - The immunization coverage in the city Assab is 100%, but out side Assab the
    coverage in very low because of lack of transportation out reach program is
    improbable to be undertaken.
  - With regard to Water, since there is tap water inside the city there is no problem
    of pure water supply in the city. And the same holds true with sanitation, as most
    of the city dwellers have got safe waste disposal system.
- As to supplementary food, they are used to receiving supplementary food and the quantity can be referred from the above table.

- It had been informed that training on IMCI, polio, measles sensitization, infection prevention, avian flu, management of severe malaria, uncomplicated malaria, and data processing had been given to 222 staff members and 80 janitors and health education is given every morning to people attending the OPD.

- It had been suggested that if help is to be offered, the Assab hospital would appreciate the supply of Ambulance, Surgery OR light, OR shoes and gowns, ventilators and conditioners. Moreover, X-ray machine, laboratory furniture and plenty of Stretchers soon.

- The local administrator of Sub Zoba Assab underscored that since the activity in Assab Port, Refinery station, and Salina is almost non-existent the people is badly in need of supplementary food. Moreover, since the city doesn’t have enough garbage carrier cars, it had been ordered for example not to continue the monthly sanitation program because the hoarded garbage stays there forever due to lack of sanitary cars. Moreover, it had been reported that due to lack of fuel there is problem of electrical supply, thus if Solar system could be offered to the city there would have been secure supply of energy. With regard to water, since there is tap water there is no problem of provision of clean water, however since the tubes are very old and mad of asbestos it had been suggested also if some fund could be provided to change the older tubes with new plastic tubes which could safeguard the safety of the population.

1. Introduction.
The Centralized Emergency Response Fund (CERF) is a special revolving fund allocated by the Security Council of the United Nations to the humanitarian appeal of four countries in the horn of Africa including Eritrea. The fund is to be used for a rapid life saving humanitarian intervention in health, nutrition, water and sanitation in crisis situations, due in this case to drought. The regions most affected by drought in Eritrea were the Northern Red Sea Zoba, the Southern Red Sea Zoba and the Gash Barka Zoba and they were therefore selected for the intervention. The period of the intervention was from March 2006 to October 2006 and the available funds were about 1.9 million $.

The UN agencies, which play a key role in interventions related to health, nutrition, water and sanitation in the country (namely WHO, UNICEF, UNFPA and WFP), were the direct beneficiaries of the fund through the organization for coordinating humanitarian assistance (OCHA) and they worked closely with the government counterpart, mainly the Ministry of Health (MOH), for the implementation and monitoring of the interventions.

The activities carried out include:
- Training of health workers and community health agents in supplementary and therapeutic feeding of malnourished children;
- Training of health workers on integrated case management of childhood illnesses;
- Sustainable Outreach Services (SOS): it is a package of health services that include immunization, antenatal care (ANC), iron supplementation, postnatal care, growth monitoring, curative services to minor ailments;
- Procurement of essential drugs, kits and equipments, provision of special food called UNIMIX, BP-5, oil and sorghum to needy children, pregnant and lactating mothers;
- A survey on District health profiles and a Knowledge Practice and Coverage survey in the drought affected regions were also conducted to be used by the government counterparts and the UN agencies.

The following is a report of the interview submitted to several program officers from UN agencies and MOH during the first week of December 2006.

2. Objective of the study.
The purpose of this study is to assess the planning, implementation, coordination, management and monitoring of the activities funded by CERF. Facilitating and inhibiting factors, as well as recommendation for the future were also explored and identified.

3. Methodology
A questionnaire have been administered in December 2006 to several program officers from the MOH and UN agencies who were involved in the coordination, implementation and monitoring of the interventions supported by CERF.
Open ended questions were provided to the individual respondent in the areas of planning, implementation, and monitoring and evaluations of the intervention. Coordination of the activities among the partners, community participation, effectiveness
and outputs of the intervention were also assessed. Respondents were also asked questions pertaining to the challenges or constraints and the added values of the intervention when compared to the regular modalities of funding.

4. Findings

4.1. Interview to Mr. Kazmiro of OCHA

Because of its specific mandates, OCHA played a pivotal role in the designing and planning of the intervention, while the implementation and monitoring activities were performed by other UN agencies.

The facilitating factors for the achievement of the CERF intervention program include good coordination among the partners and readily available money.

There were no constraints or challenges.

As a recommendation for the future, the interventions should be more focused on the target area of emergency situations.

The advantage of such funding modalities is that the money is readily available so long as one presents an appropriate proposal in the area of emergency situation.

4.2. Interview with WHO officers

WHO played the leading role of the CERF intervention carried out in Eritrea from March to October 2006 in the fields of health, and had important role in nutrition, water and sanitation. Several program officers were interviewed about the processes of planning, implementation and monitoring of the intervention and the following is a summary report of what the respondents had to say.

1) Planning

Most of the program officers interviewed participated in the needs assessment survey and the designing of the planning of the CERF intervention. Some did not participate in the process. The later suggested that participating in all the processes would have resulted in an even better outcome. The planning could have been strengthened by participation of the program officers in the WHO, the other sister agencies and the main government partner-the Ministry of Health- and other relevant government institutions.

2) Implementation

The natures of involvement of the different program officers of the WHO are related mainly with health, and include:

- Child health
- Training of health personnel in IMCI case management
- Training of trainers of IMCI case management
- Training of Emergency triage and treatment, ETAT
- Facilitating trainings on nutritional management of children with malnutrition and for people living with HIV-AIDS
- Procurement of essential drug and emergency kits to the drought affected areas selected by the intervention.
- A special outreach program SOS-the first of its kind in the country- took place in the Hard-To-Reach (HTR) areas of two sub Zobas, namely, Tio and Foro sub zones. It is a package of health services that include immunization antenatal care
(ANC), Iron supplementation, postnatal care, growth monitoring, curative services to minor ailments.

**Weaknesses and strengths of the implementation:**

- **Strengths:**

  Strengths of the implementation program were mainly due to
  - The fact that the interventions were result oriented in a very short time and all the partners participated very well.
  - The commitment and participation of all the WHO staff, MOH and the other partners
  - The good community participation, commendable involvement of the government counterparts including the MOH at all levels, community health agents and the local administration up to the level of village administration.

- **Weaknesses**

  Weaknesses of the implementation program result:
  - From shortage of human resource
  - Shortage of time that forces one to prepare a project hastily that may or may not be a priority for the areas selected
  - From the fact that the fund is meant only to an emergency situation that makes it inflexible to use it for other preventive activities.

3) **Monitoring**

  Monitoring of interventions is carried out by
  - Assessing activities done in a certain period of time, like 30, 60, or 90 days.
  - Morning meetings of the WHO country office staff members,
  - Field visits by the WHO country office staff
  - Feedbacks from the executing bodies, partners and counterparts were useful
  - Reports from the executing bodies and field supervisory visits.

  The indicators used were
  - the number of health personnel trained in the different activities like IMCI case management, ETAT trained health workers, etc
  - the number of therapeutic feeding centers actually run by trained individuals,
  - The number of simplified nutritional guide printed and distributed.
  - Proportion of target population reached in immunization which is seen as a function of measles vaccine and vitamin A supplementation coverage.
  - proportion of children reached for the first time (% zero dose children reached) during immunization activities
  - Degree of community participation.

  As the SOS is done only in one round practical indicator is very important.

  Positive feedback came from health workers and the Zonal health offices suggesting
  - that the communities were happy
  - that it is the best approach so far to reach hard-to-reach (HTR) areas with such packages.
  - That such strategies can be used in other areas.
4) Community participation.
The community participation was not the same for the different activities and different program officers had different opinions related to it. In particular, Dr Eyob referred that community participation was commendable and local administrations of the areas where SOS was carried out, community health agents and others participated in the planning of the implementation. Village administrators also played a good role in social mobilization and supporting the teams.
On the other hands, program officers involved in the facilitation of training courses (Dr Ghirmay and Dr Chiara) referred that the community was not involved at all levels of the intervention-planning, implementing and monitoring activities. According to them, this may be due to the nature of the fund that it is an emergency fund which runs only in a specified period.
All suggested that community participation can be enhanced in the future.

5) Coordination and partnership in administration of CERF.
The following are different answers of respondents to the question of coordination and partnership between the sister UN agencies and the government counterpart
➢ The interventions were well coordinated between the different partners although a permanent form of coordination is important.
➢ The CERF intervention program was coordinated from the WHO office by Dr. Usman and it was done very well.
➢ The coordination of the intervention program was good. The partners were working together in harmony
➢ There is good coordination among partners and the counter partners.
➢ There is no formal body that coordinates all the activities of the partners, though information sharing was done among partners informally.
➢ The coordination of the implementation program is adequate and there were briefings about the activities in each morning meetings of the staff
➢ Coordination with the other partners especially the MOH was initially not impressive as the intervention was of a new kind, but eventually it came to be very good.

6) Effects/Outputs
It is too early to assess the impact of the activities carried out, but it is possible to refer to indicators. The number of health personnel that are trained in handling common childhood diseases, malnutrition and emergency situations has significantly increased. Nutritional guide for peoples living with HIV and AIDS has been finalized in two of the major languages of Eritrea, namely Tigrigna, and Tigre, and has been distributed.
The CERF has contributed to the capacity of WHO to respond to humanitarian emergencies as it has given the chance of training to some members of the WHO country office on specific relevant topics.
The effect of the intervention on the line of procurement of essential drugs and supplies is yet to be seen, but it will definitely be good.
Through SOS, services reached the hard-to-reach (HTR) areas; thereby service to community link has improved. ANC, iron supplementation and immunization coverage
has also increased. Multiple doses of the latter are needed to see the actual effect in the community. SOS is a good strategy to reach HTR areas; hence EPI can take it as an alternative means to reach such areas. Through SOS strategy a reproducible experience is gained

7) Facilitating factors
Factors that contributed to the success of the intervention program include:
- The ease with which the fund was available
- Praiseworthy involvement of the government counterpart, MOH at all levels, health workers, local government administrations, at Zoba sub Zoba and village levels, community health agents

8) Constraints/Challenges
- The season was not favorable for the people and for the health workers
- Constraints include low number of local experts at all levels including the planning, implementing and monitoring of the intervention program
- Other competing priorities increased the already present human resource shortages
- CERF intervention can be improved by a better and permanent coordination between the partners.
- Shortage of fuel
- Limited period of time allotted for the intervention. Especially in CERF 1, almost the first half of the period was passed in introducing the intervention to the main partner, the MOH and in planning.

9) Recommendations for the future
The CERF intervention can be improved in the future by:
- More community participation at all level of the intervention- planning, implementing, and monitoring
- Giving adequate time so that priority areas are set and proposals developed. Allocating a certain amount of money to be spent in a certain period of time on a project that is going to be prepared may lead in to competition and overlapping of activities by partner agencies.
- Including other target areas or activities that need to be focused such as on maternal health. This may include adequate staffing of remote health facilities, improving the means of communication and transport.
- Extending the time allotted for the project and to making the funds flexible so that it would be used in preventive interventions before emergencies.
- Including areas affected by the last war like Gash Barka and Debub where the aftermath of the war has created lot of problems.

4.3 Dr. Magdi, UNICEF
UNICEF was active in child health especially immunization, nutrition through additional food supply and water sanitation.
It has participated in the designing of the planning of the CERF interventions. The joint assessment among the sister organizations and the government counterpart was good, but the joint planning and coordination was not as good and could be improved. The main weakness during the implementation program was the absence of official updating of the activities done by the other sister organizations. There were informal ways of sharing information between the sister organizations but there was no formal body that coordinated the activities. There should be official sharing of ideas and information at the level of heads of agencies meeting. The community participation was not good in the planning activities. Monitoring of the interventions was done through field visits with the government counterpart. The indicators used include

- Measles immunization and vitamin A supplementation coverage,
- The number of families who received impregnated mosquito bed nets,
- No of children who received additional food supply and etc.

The indicators were good enough to monitor the activities and the feedbacks were very useful both from higher levels and the partners. The measles immunization and vitamin A supplementation coverage has increased, more people got mosquito bed nets and more children got supplementary food supply in the intervention areas. The effects of the intervention is yet to be seen. The organizational capacity of UNICEF has now improved to address emergency situations. The strength of the CERF intervention fund was mainly due to the complementing effects of the activities of the organizations. The most important factor that facilitates the success of the intervention is that the fund is readily available it is an additional fund and is used more efficiently. The most important constraint was that the money was less than required for UNICEF for implement the activities. For the future increasing the fund and the time for fund utilization is very important. Because procurement of supplies is usually done offshore, it may not be of use when the items are needed.

**4.4 Ministry of Health**

*Dr. Goitom*

Although his office was invited to the needs assessment survey in each of 3 Subzobas of NRS and SRS administrative Zones, MOH, as the main government counter partner, was not involved in the planning process of the CERF intervention and was not even aware of the project. He feels that he was not sufficiently involved in the planning process of the intervention. The planning for the CERF intervention can be strengthened by involving the main partners from the very beginning.

The nature of his involvement in the implementation process was preparing and selecting essential drugs and procurement lists without knowing the actual objective. The weakness of the implementation program on his side was related to the fact that he was not aware of the activity sufficiently enough to participate adequately.
The monitoring was done through reports from the health facilities. The reports were not specific to the CERF intervention though. There was no joint monitoring done with all the partners. The indicators used were the same as the ones that the MOH uses for the monitoring of its activities. These include vaccination coverage, growth monitoring, availability of cold chain, presence or absence of latrine, epidemic response etc…

-Community participation
Community participation was good with measles campaign, but not with the other activities. There was good coordination among the partners in the vaccination campaign.

**Effect/out put**

- Measles campaign done
- Essential drugs procured
- Capacity was built in human resource by on job training of health workers and preparing technical guide of epidemic response
- Procurement of laboratory equipments,
- Facilitating factors

There was reservation on the side of the MOH and himself whether CERF was a success as there was little knowledge about the intervention, and no objective, no indicators set ahead.

But, the availability of the money was a positive factor.

**Constraints/Challenge**

- There was no transparency regarding the amount of funds available.
- Responsibility was not clearly defined

**Recommendation for the future:**

- Planning should be done jointly
- Objective must be clearly defined.
- Indicators should be identified ahead of time
- Tasks, responsibilities, accountability must be clearly defined.
- There must be transparency

**The added value of CERF**

- The money is easily available, there seems to be flexibility in using the fund
- It was filling gaps.

**Mr. Fili**

Mr. Fili and his office have not participated in the designing and planning of the CERF intervention. But have participated in the implementation of the sustainable outreach services (SOS) in Foro and Tio and measles campaign monitoring and supervision.

- He does not know what CERF is and how much money was allocated for the project.
- He had technical assistants from the WHO who helped him prepare proposals for implementation.
- SOS was carried successfully. And he feels that there was big lesson learnt from such activities.

The monitoring of the activities was done through the routine ways of reports from the executing health facilities, field visits and supervisions.

Indicators used were:
- Degree of community participation.
- Proportion of target population reached which is seen as a function of measles vaccine and vitamin A supplementation coverage.
- Proportion of children reached for the first time (% zero dose children reached)

The community participation was commendable
There was good participation amongst the partners.

5. Discussion.
In summary, the interviews with the program officers involved in the planning, implementation and coordination of CERF-related activities demonstrated that the intervention has been successful in Eritrea and that the overall management and coordination of the activities were good. Nevertheless some major constraints and recommendations have been identified:
- A better involvement of the MOH in the planning of the activities is advisable in the future;
- An involvement of the community and administrators at all level at an early stage is useful;
- There should be a formal coordinating body for the activities implemented by the UN agencies and MOH.