



WHO COUNTRY COOPERATION STRATEGY 2009-2013

ERITREA



WHO COUNTRY COOPERATION STRATEGY 2009–2013

ERITREA

AFRO Library Cataloguing-in-Publication Data

WHO Country Cooperation Strategy, 2009–2013 Eritrea

1. Health Planning
2. Health Plan Implementation
3. Health Priorities
4. International Cooperation
5. World Health Organization

ISBN: 978 929 023 1356 (NLM Classification: WA 540 HE7)

© WHO Regional Office for Africa, 2009

Publications of the World Health Organization enjoy copyright protection in accordance with the provisions of Protocol 2 of the Universal Copyright Convention. All rights reserved. Copies of this publication may be obtained from the Publication and Language Services Unit, WHO Regional Office for Africa, P.O. Box 6, Brazzaville, Republic of Congo (Tel: +47 241 39100; Fax: +47 241 39507; E-mail: afrobooks@afro.who.int). Requests for permission to reproduce or translate this publication – whether for sale or for non-commercial distribution – should be sent to the same address.

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by the World Health Organization in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by the World Health Organization to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either express or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall the World Health Organization or its Regional Office for Africa be liable for damages arising from its use.

Printed in India

CONTENTS

MAP OF ERITREA	v
ABBREVIATIONS	vi
PREFACE	ix
EXECUTIVE SUMMARY	x
SECTION 1 INTRODUCTION	1
SECTION 2 COUNTRY HEALTH AND DEVELOPMENT CHALLENGES	3
2.1 Political and socioeconomic context	3
2.2 Health status	3
2.3 Development challenges	5
2.4 Key challenges following the implementation of the first CCS	8
SECTION 3 DEVELOPMENT ASSISTANCE AND PARTNERSHIPS	9
3.1 Development assistance	9
3.2 Opportunities and challenges in development assistance	11
SECTION 4 WHO POLICY FRAMEWORK: GLOBAL AND REGIONAL DIRECTIONS ..	12
4.1 Goal and mission	12
4.2 Core functions	12
4.3 Global health agenda	13
4.4 Global priority areas	13
4.5 Regional priority areas	13
4.6 Making WHO more effective at the country level	14
SECTION 5 CURRENT WHO COOPERATION	15
5.1 Financial resources	15
5.2 Human resources	15
5.3 Infrastructure and equipment	15
5.4 Strategies for technical cooperation	16
5.5 Support from Regional Office and Headquarters	17
SECTION 6 STRATEGIC AGENDA: PRIORITIES AGREED FOR WHO COUNTRY	
 COOPERATION	18
6.1 Introduction	18
6.2 Guiding principles	18
6.3 Strategic areas	18
6.4 Priority Area 1: Scaling-up priority programmes	19
6.5 Priority Area 2: Health system capacity and performance	23
SECTION 7 IMPLEMENTING THE STRATEGIC AGENDA	26
7.1 WHO Country Office	26
7.2 Institutional capacity implication	28
7.3 Support from WHO Regional Office and Headquarters	28
7.4 Coordination within UNDAF	29

SECTION 8 MONITORING AND EVALUATION 30

ANNEXES

ANNEX 1: Steps involved in the development of 2nd Generation CCS 31

ANNEX 2: Swot Analysis CCS..... 32

ANNEX 3: WCO Eritrea Organizational Chart **33**

Map of Eritrea



ABBREVIATIONS

ACTs	:	Artesunate Combination Therapies
AFP	:	Acute Flaccid Paralysis
AFRO	:	WHO Regional Office for Africa
AIDS	:	Acquired Immunodeficiency Syndrome
AOW	:	Area of Work
ART	:	Anti Retroviral Therapy
CAP	:	Consolidated Appeal Process
CCA	:	Common Country Assessment
CCM	:	Country Coordination Mechanism
CCS	:	Country Cooperation Strategy
CERF	:	Central Emergency Response Fund
CSR	:	Communicable Diseases Surveillance and Response
DG	:	Director General
DOTS	:	Direct Observed Treatment Short Course
ECHO	:	European Commission for Humanitarian Office
EDHS	:	Eritrean Demographic and Health Survey
EDM	:	Essential Drug and Medicines Policy
EOP	:	End of programme
EPI	:	Expanded Programme on Immunization
EU	:	European Union
FBO	:	Faith-Based Organization
FGM	:	Female Genital Mutilation
GAVI	:	Global Alliance for Vaccines and Immunization
GFATM	:	Global Fund to Fight AIDS, Tuberculosis and Malaria
GPN	:	Global Private Network
GPW	:	General Programme of Work
HAMSET	:	HIV/AIDS, Malaria, STIs and TB
HCW	:	Health Care Workers
HDI	:	Human Development Index
HEC	:	Health Economics
HFA	:	Health For All
HIV	:	Human Immunodeficiency Virus
HMIS	:	Health Management Information System
HQ	:	Headquarters
HRH	:	Human Resources for Health

HSP	:	Health Systems Policy
ICC	:	Inter-agency Coordination Committee
ICST	:	Inter-country Support Team
IDP	:	Internally Displaced Persons
IDSR	:	Integrated Disease Surveillance and Response
IFAD	:	International Fund for Agricultural Development
IHR	:	International Health Regulation
ILO	:	International Labour Organization
IMCI	:	Integrated Management of Childhood Illnesses
IMNCI	:	Integrated Management of Newborn & Childhood Illnesses
I-PRSP	:	Interim-Poverty Reduction Strategy Paper
IUTLD	:	International Union of Tuberculosis & Lung Diseases
IVD	:	Immunization and Vaccine Development
LB	:	Live Birth
MAL	:	Malaria
M&E	:	Monitoring and Evaluation
MDGs	:	Millennium Development Goals
MoND	:	Ministry of National Development
MoD	:	Ministry of Defence
MoE	:	Ministry of Education
MoH	:	Ministry of Health
MoI	:	Ministry of Information
MoLG	:	Ministry of Local Government
MoLHW	:	Ministry of Labour and Human Welfare
MOSS	:	Minimum Operating Security Standards
MoV	:	Means of Verification
MPN	:	Managerial Process for National Programmes
MPS	:	Making Pregnancy Safer
MTEF	:	Medium-Term Expenditure Framework
MTSP	:	Medium-Term Strategic Plan
NATCoD	:	National AIDS and TB Control Division
NCD	:	Noncommunicable Disease
NEPAD	:	New Partnership for Africa's Development
NGO	:	Non-Governmental Organization
NORAD	:	Norwegian Development Agency
NPO	:	National Professional Officer
NUEW	:	National Union of Eritrean Women
NUEYS	:	National Union of Eritrean Youth and Students
OCHA	:	Office for Coordination of Humanitarian Assistance

OSM	:	Orotta School of Medicine
PHARPE	:	Public Health and Rehabilitation Programme in Eritrea
PHE	:	Protection of Human Environment (Environmental Health)
PMU	:	Project Management Unit
POA	:	Plan of Action
RBM	:	Roll Back Malaria
RED	:	Reaching Every District
SO	:	Surveillance Officer
SOS	:	Sustainable Outreach Service
SWAP	:	Sector-wide Approaches
SWOT	:	Strengths, Weaknesses, Opportunities and Threats
TB	:	Tuberculosis
UN	:	United Nations
UN Habitat	:	United Nations Habitat
UNCT	:	United Nations Country Team
UNDAF	:	United Nations Development Assistance Framework
UNDP	:	United Nations Development Programme
UNESCO	:	United Nations Educational Scientific and Cultural Organization
UNFPA	:	United Nations Population Fund
UNHCR	:	United Nations High Commissioner for Refugees
UNICEF	:	United Nations Children's Fund
UNIFEM	:	United Nations Fund for Women
VPD	:	Vaccine Preventable Disease
WB	:	World Bank
WCO	:	WHO Country Office
WFP	:	World Food Programme
WHO	:	World Health Organization
WR	:	WHO Representative

PREFACE

The WHO Country Cooperation Strategy (CCS) crystallizes the major reforms adopted by the World Health Organization with a view to intensifying its interventions in the countries. It has infused a decisive qualitative orientation into the modalities of our institution's coordination and advocacy interventions in the African Region. Currently well established as a WHO medium-term planning tool at country level, the cooperation strategy aims at achieving greater relevance and focus in the determination of priorities, effective achievement of objectives and greater efficiency in the use of resources allocated for WHO country activities.

The first generation of country cooperation strategy documents was developed through a participatory process that mobilized the three levels of the Organization, the countries and their partners. For the majority of countries, the 2004-2005 biennium was the crucial point of refocusing of WHO's action. It enabled the countries to better plan their interventions, using a results-based approach and an improved management process that enabled the three levels of the Organization to address their actual needs.

Drawing lessons from the implementation of the first generation CCS documents, the second generation documents, in harmony with the 11th General Work Programme of WHO and the Medium-term Strategic Framework, address the country health priorities defined in their health development and poverty reduction sector plans. The CCSs are also in line with the new global health context and integrated the principles of alignment, harmonization, efficiency, as formulated in the Paris Declaration on Aid Effectiveness and in recent initiatives like the "Harmonization for Health in Africa" (HHA) and "International Health Partnership Plus" (IHP+). They also reflect the policy of decentralization implemented and which enhances the decision-making capacity of countries to improve the quality of public health programmes and interventions.

Finally, the second generation CCS documents are synchronized with the United Nations development Assistance Framework (UNDAF) with a view to achieving the Millennium Development Goals.

I commend the efficient and effective leadership role played by the countries in the conduct of this important exercise of developing WHO's Country Cooperation Strategy documents, and request the entire WHO staff, particularly the WHO representatives and divisional directors, to double their efforts to ensure effective implementation of the orientations of the Country Cooperation Strategy for improved health results for the benefit of the African population.



Dr Luis G. Sambo
WHO Regional Director for Africa

EXECUTIVE SUMMARY

This Country Cooperation Strategy is the second to be developed for Eritrea. In spite of the short life cycle of the first generation CCS, some modest accomplishments were registered across the whole spectrum of the programme areas supported by the WHO Country Office. The achievements made during the implementation of the first CCS include: the revision of the draft National Health Policy and other programme-related draft policy documents for Health Research, Health Promotion, Noncommunicable Diseases, Reproductive and Child Health programmes and blood safety. Other achievements are strengthening of health systems, the Orotta School of Medicine, disease prevention and control, especially for the attainment of the Abuja targets for malaria control, sustaining the gains in IDSR and the generation of baseline data for Noncommunicable Diseases, Reproductive and Child Health programmes. Resources were also mobilized to support some of the programmes that were inadequately funded. However, there are still some major gaps, notably lack of an endorsed national health policy, absence of a national health strategic plan, including human resources for health, the non-harmonization of the health information system, weak intersectoral collaboration, absence of updated strategic approaches for sustaining gains in disease control and elimination and updated interventions for the attainment of MDGs 4 and 5.

The second generation CCS (2009–2013) sets out the strategic directions for the work of the WHO Country Office (WCO) in Eritrea in collaboration with stakeholders in the health sector such as the Ministry of Health, UN agencies, development partners and NGOs. It places greater emphasis on sustaining achievements and addressing gaps and challenges identified after the review of the first generation CCS. The WCO strategic agenda includes support to the Government for:

(a) Scaling-up priority programmes

- Prevention and Control of Communicable Diseases;
- Combating HIV/AIDS, Tuberculosis and Malaria;
- Prevention and Control of Noncommunicable Diseases;
- Maternal Health, Child/Adolescent Health and Nutrition;
- Disaster Preparedness and Humanitarian Response;

(b) Strengthening the Capacities and Performance of Health Systems

- Leadership and Governance for Health;
- Health Service Delivery, Information System and Community Participation;
- Human Resources for Health;
- Health Financing;
- Social and Economic Determinants of Health;
- Health System Research;

(c) Partnership and Coordination

These areas were identified after a series of interactions with the national health authorities and partners as well as the strategic orientations and guidance provided by the WHO Regional Office for Africa (AFRO) and WHO HQ. Other domains such as health promotion, monitoring

and evaluation and research are also given due emphasis because of their cross-cutting nature in the achievement of the goals of the second generation CCS.

In order to successfully implement the second generation CCS, the WCO will enhance its partnership with other UN agencies within the framework of UNDAF and support the strengthening of Government coordination mechanisms in line with the principles of the Paris Declaration and the Accra Agenda for Action. The Office will be structured to enable it to accomplish its new mission. The mobilization of resources will be at the forefront. This CCS will reposition the visibility and leadership role of the WHO Country Office in health.

SECTION 1

INTRODUCTION

The CCS outlines the country specific framework of collaboration between WHO and the State of Eritrea. It defines the strategic agenda for the WHO Country Office in Eritrea and aligns it with the national health priorities; priorities and other international health agendas, sub-regional and regional economic blocks including the Millennium Development Goals (MDGs). It also reflects the values, principles and corporate directions of WHO as one Organization and articulates a vision and selective priorities for the work of WHO for health development. The CCS takes into account WHO's commitment to promoting human right to health, gender equity, health-related MDGs, UNDAF, WHO 11th GPW, WHO MTSP 2008-2013, Harmonization of Health in Africa, International Health Partnerships (IHP), International Health Partnerships and Related Initiatives (IHP Plus), and Compact.

The first generation CCS was developed with the spirit of partnerships in the context of the country's overall goal for health and development. It served as a reference document for cooperation between the State of Eritrea and the WHO Country Office for the period 2004–2006. Some of the key achievements recorded include: strengthening the institutional management of the Orotta Medical School; upgrading the teaching curricula of middle level health workers to take into account priority strategies aimed at achieving the health-related MDGs; strengthening the national blood safety and the national essential drug and medicine policy; improving early detection and response to epidemics; improving immunization coverage rates and scaling-up maternal and child health services; conducting a situation analysis on the magnitude of noncommunicable diseases and neglected tropical diseases in the country.

This second generation CCS aims at setting out the WHO strategic agenda, taking into account gaps identified during the 1st generation CCS. It will guide the WHO Country Office support to the State of Eritrea for the five-year period (2009–2013). During the planning stage, the priorities, challenges and strategies set in the first generation CCS were critically reviewed and the achievements, shortcomings and gaps analyzed. The process was participatory and involved broad consultations with stakeholders in the health sector, including the Ministry of Health, UN agencies and development partners. A retreat with all representatives of stakeholders was organized to reach a consensus. The strategic areas identified for the period 2009–2013 fall within the WHO organization-wide Strategic Domains.

These are:

- (a) scaling-up priority programmes;
- (b) strengthening the capacities and performance of health systems;
- (c) partnership and coordination.

Other domains such as health promotion, gender equity, monitoring and evaluation and research are also given due emphasis because of their cross-cutting nature in the achievement of the goals of the second generation CCS.

This second generation CCS helps to streamline and focus the WHO Country Office support in order to optimize the limited resources and ensure complementarity with all development partners and stakeholders based on its comparative advantage. The identified priority areas will be implemented through three consecutive WHO Biannual Programme Budget and Work Plans within the context of the Result-Based Management that aims at accelerating the attainment of the health-related MDGs.

SECTION 2

COUNTRY HEALTH AND DEVELOPMENT CHALLENGES

2.1 POLITICAL AND SOCIOECONOMIC CONTEXT

Eritrea is situated in the Horn of Africa and lies north of the Equator. It has an area of 124,400 km². Administratively, the country is divided into six zobas (regions). The estimated population¹ in 2007 was 3 447 060 inhabitants. There are nine ethnic groups and two major religions, namely, Christianity and Islam. About 80% of the population lives in rural areas and agriculture, including pastoral activities, is the main source of livelihood. The GDP per capita² is US\$ 200. **The country ranked 157 out of 177 countries, with 37% of the population living below the poverty line³.** The fertility rate is estimated at about 4.8 children per woman⁴. Nearly 60% of the population has access to potable water. Access to improved sanitation has increased from 2% to 5%. The country has suffered considerable set back as a result of the border conflict with Ethiopia (1998-2000) and the no-war-no-peace situation still continues.

2.2 HEALTH STATUS

Since independence in 1991, Eritrea has made considerable progress in promoting equitable, accessible and affordable health services for the majority of its citizens with the support of its partners. This is demonstrated by the significant improvement of the health indicators.

The health infrastructure has made considerable progress. Currently, the country has 25 hospitals, 52 health centres, 180 health stations and 113 clinics. Over 60 different medical products are locally produced; key medicines are available in 95% of health facilities and there is no shortage of supplies and equipment. There is a National Drug Laboratory that carries out quality control of drugs produced. Blood for transfusion is screened for transmissible infections, including HIV/AIDS, hepatitis and syphilis. Chronic diseases like diabetes, hypertension, mental health and infectious diseases like tuberculosis, HIV/AIDS and other sexually transmitted diseases are treated free of charge. The Government sustains the payment of all health professionals, maintenance of infrastructure and equipment and other running and capital investments.

The infant mortality rate decreased from 72 per 1000 live births in 1995 to 42 per 1000 live births in 2002, while the child mortality rate decreased from 136 per 1000 live births in 1995 to 93 per 1000 live births in 2002. The MDG targets for infant mortality and child mortality by 2015 are respectively 18 per 1000 live births and 34 per 1000 live births.

¹ Ministry of Local Government.

² (UNDP-2007).

³ (UNDP-2007).

⁴ (Eritrean Demographic and Health Survey, 2002).

Between 1995 and 2005, maternal mortality rate decreased from 998 to 450 per 100 000 live births, with the MDG targeting to reduce it further to 250 per 100 000 live births by 2015. To date, 1015 nurses, midwives and associate nurses have been trained in emergency maternal and neonatal care service provision while 90% of health facilities have at least one basic emergency obstetric care service provider.

Malnutrition⁵ remains one of the major public health problems in the country. The global acute malnutrition rate ranges from 13.1% to 21.0%, well above the WHO cut-off point of 10%. The reasons for this high level of malnutrition include lack of food security due to drought and rare floods, and poor knowledge on good feeding practices. The Gash Barka Region recorded the highest Global Acute Malnutrition rate of 21% among children under 5, exceeding the emergency threshold of 15%.

The country is located within the meningitis belt and lies on the path of migratory birds and is, therefore, prone to outbreaks of major communicable diseases, including meningococcal meningitis and avian influenza. Outbreaks of meningococcal meningitis and cholera occurred, but they were detected and managed timely and appropriately, thanks to the capacity acquired within the context of the Integrated Disease Surveillance and Response (IDSR). In 2007, more than 80% of suspected outbreaks were notified in time; the laboratory confirmed and responded to them with WHO recommended strategies.

The five major vaccine preventable diseases (Poliomyelitis, Measles, Diphtheria, Tetanus and Whooping Cough) no longer pose any major public health problem in Eritrea. The country has eliminated maternal and neonatal tetanus, while Measles morbidity and mortality have been reduced to less than 90% of the 1991 levels. The country is heading towards achieving the Polio free status.

The prevalence of chronic Neglected Tropical Diseases (NTDs) such as Schistosomiasis, Leishmaniasis and re-emerging diseases like Brucellosis and Dengue Fever are not well documented. However, the prevalence of active Trachoma among children aged 1-9 years ranged from 2.4% in Gash-Barka to 14.9% in Debub Zone, whereas the prevalence of Trachomatous Trichiasis in adults above 15 years of age ranged from 1.1% in Northern Red Sea to 2.2% in Debub Zone, according to the 2006 survey⁶. The country is at the level of "Guinea Worm Free" certification.

Noncommunicable Diseases (NCDs), especially Diabetes, Cardiovascular Diseases, Chronic Obstructive Pulmonary Diseases and Cancers are on the rise. Recent survey⁷ shows a prevalence of 16% for Hypertension in the general population; 7.2% of the population smoke daily and 39.6% drink alcohol. The prevalence of "Low Fruit and Low Vegetable" consumption in the population was about 85% and 50% respectively. Nearly 3.3% of the population is obese ($\geq 30\text{Kg/m}^2$) and around 10% was physically inactive. The burden of Diabetes Mellitus, mental health disorders, oral health problems, blindness and cancers is not well documented.

HIV prevalence decreased from 2.41% in 2003 to 1.33% in 2007, PMTCT is estimated at 95%, the ARV coverage is 46%, while VCT services have increased from 3 sites (2003) to over 110 sites (2007). However, AIDS is still one of the major causes of morbidity and mortality in health facilities⁸.

⁵ (National Nutrition Survey, 2006).

⁶ Trachoma prevalence survey 2006.

⁷ Ministry of Health Survey.

⁸ Ministry of Health, HMIS report 2006 and 2007.

With the advent of HIV/AIDS, Tuberculosis has become a public health problem. The Tuberculosis HIV/AIDS co-infection rate is estimated at 35%, and the prevalence of TB is 90/100 000 people⁹. The implementation of the Directly Observed Treatment Short course (DOTS) strategy is on-going and is being gradually expanded country wide. However, further action is needed to improve detection rate from the current 42% to about 70% and treatment success from the current 80% to 85% or above as recommended by WHO. The status of resistance to TB drugs (MDR and XDR) is unknown since there is currently no facility for culture and drug sensitivity test.

Malaria used to be one of the leading public health problems in Eritrea. However, after the introduction of the Roll Back Malaria (RBM) Initiative in 1999, Malaria morbidity and mortality have been reduced significantly to less than 80% of the 1998 levels. According to the 2004 Evaluation Report of the Five-Year Strategic Plan for Malaria Control in the country, the proportion of children and pregnant women sleeping under Insecticide-treated Net (ITN) was estimated at 48.3% and 50.4% respectively.

2.3 DEVELOPMENT CHALLENGES

During the first generation CCS, WHO, in close collaboration with the UN system and other partners, provided technical and financial support to address issues related to health system strengthening, prevention and control of major diseases, sexual and reproductive health, child and adolescent health, environmental health, health promotion and emergency and humanitarian action. The review of the first generation CCS identified the gaps and challenges highlighted below.

2.3.1 Health System Development

2.3.1.1 Health Policy and Strategic Planning

Although there is a Primary Health Care Policy, the overall national health sector policy is yet to be finalized and endorsed by the higher authorities. The current gaps and challenges include finalization of the draft national health policy and development and subsequent implementation of strategic plans for the other programmes within the framework of the Primary Health Care approach adopted by the Government. The draft national health policy had served as a working document. The absence of an office responsible for the planning process within the Ministry of Health and the non-finalization of the national health policy have delayed the development of the National Health Strategic Plan.

2.3.1.2 Human Resources for Health

The country still experiences acute shortage of human resources particularly at the peripheral level of the healthcare delivery system. The current challenge includes the development of health human resource strategic plan linked to the health system staffing norms. This challenge persists because of many factors, including the delay in finalizing the national health policy, the absence of operational definitions for the various levels of health services and the incomplete Human Resource for Health data.

⁹ MoH 2005 Survey.

2.3.1.3 Quality of Health Care and Referral System:

The health service is delivered in a three-tier system in the country. However, the referral system is not adequately followed by the majority of those who attend health facilities. The limited availability of transportation and communication means for referral, coupled with the relatively low health-seeking behaviour, leads to delays in getting appropriate services. These factors contribute to the increase in mortality, especially among the vulnerable segment of the population, including pregnant women, children, the elderly and the nomadic group. The identified gaps include the development and implementation of policies and guidelines on the referral system and resource mobilization for logistics, equipment, and transport facilities. The challenges include human and institutional capacity limitations of the drug quality laboratory, inadequate transportation and communication. These challenges persist because of inadequate budget allocation and unavailability or insufficient supply of fuel on the local market.

2.3.1.4 Health Information Management

Information, evidence and research are essential for strengthening the health system. However, networking for information sharing is still limited¹⁰. The gaps identified include harmonization of the information systems and establishment and utilization of a common database. The capacity to conduct research and utilization of evidence for decision making is limited and further support is needed to train and promote access to scientific information. The challenge is to commit 2% of the national expenditure and 5% of external aid for health projects and programmes for research and research capacity as recommended¹¹. This challenge persists because of competing priorities and limited external aid for health projects.

2.3.1.5 Sustainability of Health Services

The sustainability of the existing healthcare financing scheme poses a challenge. This scheme is to be reviewed in line with the principles of the Government's self reliance policy. Support for operational research, fostering community participation and public/private mix participation are some of the identified gaps. The main priority to be addressed is the intersectoral collaboration between the Ministry of Health, the Ministry of Finance and the Ministry of National Development to finalize the health financing policy. The introduction and application of the National Health Account (NHA) is also another challenge. The concept of National Health Account is not fully understood by most members of the relevant sectors and, as such, the required emphasis for finalization of the health financing policy is not yet obtained.

2.3.1.6 Monitoring and Evaluation

WHO is a member of the national M&E Advisory Committee and Technical Working Group of the Ministry of Health and supported the documentation and dissemination of best practices in health that has been conducted. Fostering the evaluation of policy implementation of priority programmes using performance and impact indicators is a gap to be addressed. Monitoring and evaluation is a relatively new concept at the Ministry of Health. The challenge, therefore, is the creation of a single data warehouse to produce harmonized, timely and reliable information for evidence-based decision-making, taking into account the actual

¹⁰ The Health Information System (HIS) was assessed, using Health Metric Network tools as a first step towards strategic plan development.

¹¹ Algiers Summit of Ministerial Conference on Health Research in the African Region.

structure. This challenge persists because the current structure at the Ministry of Health has encouraged the formation of fragmented data sources, thus making the transition towards a single data warehouse a difficult task.

2.3.2 Prevention and Control of Major Diseases

The country faces double challenges from both communicable and noncommunicable diseases. WHO and other partners supported the scaling-up of cost effective strategies to prevent and control chronic neglected diseases. The actual challenges include sustaining the level of achievements gained for the control of Vaccine Preventable Diseases and disease targeted for eradication/elimination, addressing the NTD as a priority, integration of TB and HIV control interventions, as well as human and financial resources for NCDs. The development of core capacity within the framework of the International Health Regulation (IHR-2005), and integrating it within the IDSR is another challenge. Sustaining the level of achievements persists as a challenge due to competing priorities for resources and the absence of sound strategic approaches. Programme managers differ in their attitudes with regard to the practice of integrated approach for interventions.

2.3.3 Sexual and Reproductive Health

Eritrea is on track towards achieving the millennium development goal aimed at reducing maternal mortality. During the first CCS, WHO, in collaboration with other partners, assisted the Ministry of Health with the development of sexual and reproductive health as well as adolescent health policies and strategies. Gaps identified include the low skilled care attendance during delivery and postnatal period; repositioning of family planning; provision of appropriate transportation and communication facilities; community maternal and neonatal health service delivery; research for evidence based decision-making and monitoring; and evaluation of maternal and neonatal health programmes. Another challenge is the integration of the Prevention of Mother-to-Child Transmission of HIV/AIDS (PMTCT) into reproductive health programmes.

2.3.4 Child Health and Nutrition

Advocacy and resource mobilization for expanding the implementation of the IMCI have been pursued by WHO. *The gaps identified are how to refocus the intervention on a strengthened promotion of key family behaviours, especially feeding (i.e. exclusive breastfeeding and complementary feeding) and practice of hygiene (i.e. hand washing and safe disposal of children's faeces).* Strengthening nutrition surveillance system, updating guidelines and standards in nutrition and improving the quality of management of malnutrition are other gaps to be addressed.

2.3.5 Emergency and Humanitarian Action

As part of the Horn of Africa, Eritrea remains vulnerable to impact of wars, population displacement and outbreak of diseases, including meningitis and diarrhoea. The protracted war for independence coupled with the unresolved border conflict has created a humanitarian crisis, which is persisting. The gaps identified include weak institutional capacity for emergency preparedness and response, including planning, early warning system, hazard mapping and forecasting.

2.4 KEY CHALLENGES FOLLOWING IMPLEMENTATION OF THE FIRST CCS

The key challenges facing the health sector, following the implementation of the first generation CCS, include lack of an endorsed national health policy, absence of a national health strategic plan, including human resources for health, non-harmonization of the health information system, weak intersectoral collaboration, absence of updated strategic approaches for sustaining gains in disease control and elimination and absence of updated interventions for the attainment of MDGs 4 and 5. The double disease burden from communicable and noncommunicable diseases is also another challenge to be addressed. The latter persists since the primary focus has been on communicable diseases as opposed to noncommunicable diseases. Although this attitude is now changing, much effort and time would be required to ensure that due emphasis is placed on NCDs.

SECTION 3

DEVELOPMENT ASSISTANCE AND PARTNERSHIPS

3.1 DEVELOPMENT ASSISTANCE

Several development partners, including agencies of the UN system, bilateral and multilateral agencies, national and international NGOs, have been providing assistance to strengthen the health sector. The commitment of the Government and people of Eritrea towards long-term goals as well as accountability in the use of donor funding related to specific programmes or agreements constitutes the drive for donor support. However, there is a need for introducing more comprehensive approaches such as Sector-wide Approaches (SWAPs) and Medium-Term Expenditure Framework (MTEF) for transparency, better planning and coordination as well as efficient use of available funds. There are two categories of development partners in the health sector.

The UN system is one of the major contributors towards development and humanitarian assistance. During the period 2002-2006, eight UN agencies, namely UNDP, WHO, UNICEF, UNFPA, FAO, UNIDO, UNTAD and IFAD supported the implementation of UNDAF by contributing a total of US\$ 66 539 million for development and humanitarian activities. Three UN agencies (WFP, UNHCR and OCHA) contributed US\$ 55 665 million primarily for humanitarian assistance (UNDAF/Eritrea). For UNDAF 2007-2011, the UN agencies hope to mobilize US\$ 116.2million. The development assistance is almost doubling in 2007-2011 compared to 2002-2006 and humanitarian assistance is reducing by more than 90%. During the period 2004-2006, WHO contribution amounted to US\$ 9 593 675 (US\$ 5 172 000 of regular budget and US\$ 4 421 675 of extrabudgetary resources).

The other development partners are the World Bank (WB), and bilateral agencies (Italian Cooperation Agency, EU/ECHO, Norway/NORAD, IUTLD, GAVI, UK/DFID, Japan/JICA, China Development Assistance, and the Global Fund). The World Bank provided loans and grants to the Ministry of Health under HAMSET projects (HIV/AIDS, Malaria, STD and TB), and for Early Childhood Development projects. Since 2000, the WB has provided a total of US\$ 76.5 million in loans and grants (HAMSET).

There are a few international (Oxfam) and local NGOs such as the National Union of Eritrean Youth and Students (NUEYS), the National Union of Eritrean Women (NUEW), Vision Eritrea and Faith-Based Organizations (FBOs). They are mainly implementing partners.

3.1.1 Coordination Mechanisms of Development Assistance in the Health Sector

Over the recent years, the UN has been involved in the process of reform to improve coordination, effectiveness and efficiency in supporting national goals and to reduce

transaction costs for the Government by introducing a coordination mechanism such as Results-Based Management (RBM), joint programming, Common Country Assessment (CCA) and UNDAF. Various mechanisms are in place for the coordination of the support provided by the different partners to the health sector in Eritrea.

UN System Coordination Mechanism

The United Nations Development Assistance Framework (UNDAF), 2002-2006, which was based on the CCA, provided a mechanism for coordinating and channelling the contributions of all UN agencies in order to enhance the effectiveness of development assistance to the country. The new framework is for the period 2007-2011. Under the previous framework, there were five coordinating instruments, namely:

- (i) The UN Country Team (UNCT) that provides an overall coordination of the UN system's humanitarian and development assistance.
- (ii) The Humanitarian Coordination System, supported by OCHA, that works with the Ministry of Labour and Human Welfare on humanitarian activities under five sectors: food security, shelter, water and sanitation, health and education.
- (iii) The UNDAF Steering Committee, which is composed of Heads of UN agencies and the Ministry of Finance, which provides directions at policy level for the implementation, monitoring and review of UNDAF.
- (iv) The Thematic Groups, which are responsible for coordinating the development programmes of UN agencies in collaboration with the relevant ministries and other counterparts. They ensure joint programming, monitoring and evaluation of programmes. There are five thematic groups and six subgroups for the UNDAF implementation process. These are the basic social services, under which there are four subgroups (Health and Nutrition, Education, Water and Sanitation, and HIV/AIDS), Capacity Development, Emergency and Recovery, Food Security, Gender Equity.
- (v) The Interagency Standing Committee (IASC) comprises the HoAs and non-humanitarian partners. It is the primary mechanism for IASC coordination, policy development and decision-making on humanitarian assistance.
- (vi) The Donor Coordination Mechanism facilitates the smooth coordination of relationships between donors and UN agencies.

Government Coordination Mechanism

World Bank Project Coordination: The National HAMSET Steering Committee is composed of four ministries, (MoH, MoF, MoD, MoLHW), the DG of Health Services, Six Zonal Governors, NUEYS and NUEW. This body provides guidance for policy, planning, implementation, monitoring and evaluation of the HAMSET project. At the zonal level, a multi-sectoral coordination committee, including local NGOs, chaired by the zonal Governor, is in place. The committee meets on a monthly basis to plan, review achievements and report to the National Steering Committee.

EPI Programme Coordination: The Inter-Agency Coordination Committee (ICC), chaired by the Ministry of Health, oversees the EPI programme in the country. Its membership includes other ministries, UN agencies, bilateral agencies, as well as national and international NGOs working in the field of immunization.

Global Fund Project Coordination Mechanisms: The “Partnership against HIV/AIDS, TB and Malaria” was established in 2003 in response to the requirements of the GFATM, and as an expansion of the HAMSET Steering Committee. It is composed of the MoND, MoLG, MoLHW, MoE, MoD, MoH, MoI, UN agencies, bilateral partners, the EU, NGOs, the FBO, the private sector and the civil society. Its mandate is to guide, review and approve plans, projects and disbursement of funds. The Minister of National Development chairs the partnership. The Vice-Chair is the Chairperson of the UNDAF Thematic Group on HIV/AIDS, while the Minister of Health is the Executive Secretary.

The Country Coordination Mechanism (CCM) for global fund includes broad representation from high-level government ministries, UN agencies, bilateral and multilateral agencies, the civil society and local NGOs. At the operational level, the CCM Secretariat is established in the Ministry of Health and is responsible for the disbursement of approved budgets, as well as the monitoring and evaluation of implemented activities.

Other Coordination Mechanisms: There are several other technical working groups that bring together stakeholders for specific programme areas, which are either coordinated by the MoH or of which the MoH is a member, such as the Health Promotion Steering Committee, the Reproductive Health Steering and Technical Committee, and the National Avian Influenza Committee.

3.2 OPPORTUNITIES AND CHALLENGES IN DEVELOPMENT ASSISTANCE

Opportunities: There are several opportunities for promoting partners’ interests to participate in health development in the country, namely:

- existence of various partnership coordination mechanisms and tools to avoid duplication and strengthen joint programming (Existence of joint UN programmes);
- partners’ confidence towards appropriate use of available funds by government organizations;
- high commitment of national staff to achieve set objectives;
- availability of committed community volunteers;
- availability of strong community associations (Youth and Women).

Challenges

Aid commitment and disbursements fluctuate considerably over time. In other words, development aids are unpredictable. They also provide uncertain basis for the government to plan expenditure over a medium term. The major challenges identified include:

- the no-war-no-peace situation in the country;
- limited number of partners at the grassroots level;
- limited access to health services in remote areas;
- shortage of transportation and communication facilities;
- decreased resource absorption capacity;
- low level of community participation (to promote ownership and sustainability).

SECTION 4

WHO POLICY FRAMEWORK: GLOBAL AND REGIONAL DIRECTIONS

WHO has been – and is still – undergoing significant changes in the way it operates, with the ultimate aim of performing better in supporting its Member States to address key health and development challenges, and accelerating progress towards achievement of the health-related MDGs. This organizational change process has, as its broad frame, the WHO Corporate Strategy¹.

4.1 GOAL AND MISSION

The mission of WHO remains “the attainment by all peoples, of the highest possible level of health” (Article 1 of WHO Constitution). The corporate strategy, the 11th General Programme of Work 2006-2015² and Strategic Orientations for WHO Action in the African Region 2005-2009³ outline key features through which WHO intends to make the greatest possible contribution to health. The Organization aims at strengthening its technical and policy leadership in health matters, as well as its management capacity to address the needs of Member States, including the Millennium Development Goals (MDGs).

4.2 CORE FUNCTIONS

The work of WHO is guided by its core functions, which are based on its comparative advantage⁴. These are:

1. providing leadership in matters critical to health and engaging in partnership where joint action is needed;
2. shaping the research agenda and stimulating the generation, dissemination and application of valuable knowledge;
3. setting norms and standards, and promoting and monitoring their implementation;
4. articulating ethical and evidence-based policy options;
5. providing technical support, catalyzing changes, and building sustainable institutional capacity;
6. monitoring the health situation and assessing health trends.

¹ WHO EB 105/3 A Corporate Strategy for the WHO Secretariat.

² 11th General Programme of Work 2006-2015. A Global Health Agenda.

³ Strategic Orientations for WHO Action in the African Region 2005-2009.

⁴ 11th General Programme of Work 2006-2015. A Global Health Agenda.

4.3 GLOBAL HEALTH AGENDA

In order to address health-related policy gaps in social justice, responsibility, implementation and knowledge, the Global Health Agenda identifies seven priority areas, namely:

1. investing in health to reduce poverty;
2. building individual and global health security;
3. promoting universal coverage, gender equality, and health-related human rights;
4. tracking the determinants of health;
5. strengthening health systems and equitable access;
6. harnessing knowledge, science and technology; and
7. strengthening governance, leadership and accountability.

In addition, the Director-General of WHO has proposed a six-point agenda as follows: 1. Health Development; 2. Health Security; 3. Health Systems; 4. Evidence for Strategies; 5. Partnerships; and 6. Improving the Performance of WHO. In addition, she has indicated that the success of the Organization should be measured in terms of results on the health of women and the African population.

4.4 GLOBAL PRIORITY AREAS

The Global Priority Areas have been outlined in the 11th General Programme of Work⁵. They include:

1. providing support to countries in moving to universal coverage with effective public health interventions;
2. strengthening global health security;
3. generating and sustaining action across sectors to modify the behavioural, social, economic, and environmental determinants of health;
4. increasing institutional capacities to deliver core public health functions under the strengthened governance of ministries of health; and
5. strengthening WHO's leadership at the global and regional levels and supporting the work of governance at country level.

4.5 REGIONAL PRIORITY AREAS

The regional priorities have taken into account, the global documents and resolutions of the WHO governing bodies, the health millennium development goals, and the NEPAD health strategy, resolutions on health adopted by Heads of State of the African Union and the organizational strategic objectives, which are outlined in the Medium-Term Strategic Plan (MTSP) 2008-2013⁶. These regional priorities have been expressed in the "Strategic Orientations for WHO Action in the African Region 2005-2009". They include prevention and control of communicable and noncommunicable diseases, child survival and maternal health, emergency and humanitarian action, health promotion, and policy-making for health in development and other determinants of health. Other objectives cover health and environment, food safety and nutrition, health systems (policy, service delivery, financing,

technologies and laboratories), governance and partnerships, and management and infrastructures.

In addition to the priorities mentioned above, the region is committed to supporting countries to attain the health-related MDGs, and assisting in tackling its human resource challenge. In collaboration with other agencies, the problem of how to assist countries source financing for their goals will be addressed under the leadership of the countries. To meet these added challenges, one of the important priorities of the region is that of decentralization and installation of Intercountry Support Teams to further support countries in their own decentralization process, so that communities may derive maximum benefit from the technical support available to them.

To effectively address these priorities, the region is guided by the following strategic orientations:

1. strengthening WHO Country Offices;
2. improving and expanding partnerships for health;
3. supporting the planning and management of district health systems;
4. promoting the scaling-up of essential health intervention related to priority health problems; and
5. enhancing awareness and response to key determinants of health.

4.6 MAKING WHO MORE EFFECTIVE AT COUNTRY LEVEL

The outcome of the expression of WHO's effectiveness at country level will vary from country to country, depending on country-specific context and health challenges. But building on WHO's mandate and its comparative advantage, the six critical core functions of the Organization, as outlined above, may be adjusted to suit each individual country.

SECTION 5

CURRENT WHO COOPERATION

During the first generation CCS, the WCO provided a range of technical support to the Government's national health priority programmes and collaborated and coordinated its assistance with all the partners. The financial resources for programme implementation also increased significantly. The WCO played a critical role in the assessment of health needs, prioritization of its technical support, the implementation of Work Plans (2004-2005 and 2006-2007), coordination and fostering of partnerships, as well as collaboration with stakeholders.

5.1 FINANCIAL RESOURCES

In addition to the regular budget, amounting to US\$ 5 172 000, extrabudgetary resources, amounting to US\$ 4 421 675 were mobilized through grants from CERF (US\$ 2 768 796), ECHO (US\$ 848 147.82), CIDA (US\$ 114 268), Italian Cooperation (US\$ 235 845), Fidelis (US\$ 109 000), Norway (US\$ 275 619) and Sweden (US\$ 70 000.00). The WCO supported the MoH to mobilize resources from the GFATM to support the National Malaria, HIV and TB prevention and control programmes, of which the principal recipient was the Ministry of Health. WHO, as a member of the Country Coordination Mechanism (CCM), has played an important role in supporting the MoH to mobilize resources, specifically for Round 6 of the GFATM (TB) as well as for the GAVI health system proposals, which were both approved.

5.2 HUMAN RESOURCES

The WCO showed a remarkable staff increase (from 4 in 1994 to 42 in 2006) to respond to the increased demand for support to the health care delivery system in the country. Currently, the WCO has 17 technical officers, including 7 international staff. There are 10 National Programme Officers (NPOs), who are responsible respectively for Disease Prevention and Control, Disease Surveillance, Family Health Programmes, Essential Drugs and Medicines, HIV-AIDS, Malaria Control, Information and Communication Technology, Data Management, Emergency and Humanitarian Action, Nutrition, and Management Process for National (MPN) Policies. Two of the NPOs are medical doctors. The WCO has 22 support staff. A total of 5 out of the 17 technical staff and 15 out of the 22 support staff are females.

5.3 INFRASTRUCTURE AND EQUIPMENT

In 2006, the WCO moved out of the UN common premises to its new office located in a self-contained two storey building. The office was connected to the GPN and V-Sat in December 2006. An archives unit and a documentation centre have been established. The office is MOSS compliant with a back-up generator and a solar power system. A security guard service is on duty twenty four hours, seven days a week.

5.4 STRATEGIES FOR TECHNICAL COOPERATION

5.4.1 Health System Strengthening

During the period of the CCS 2004-2006, the WCO supported a wide range of activities to improve the health system. Draft programme policy documents on Blood Safety and Clinical Technology, Health Promotion, Health Care Financing, Adolescent Health and Nutrition were developed. The medical school was supported with the secondment of two professors for 3 years to strengthen the Physiology Department and enhance the Institutional Management. Support was also provided for the training of middle level health staff by upgrading the teaching curricula to include priority strategies aimed at achieving the MDGs. The teachers' skills were updated while in-service training, including distance education of health workers, was strengthened.

The WCO also supported the development of the national blood safety policy and assessment of hospital blood banks in all the zones with the aim of developing a strategy to improve safe blood transfusion services. Guidelines on management of patients, using blood and blood products, standard operating procedures for safe blood transfusion, were produced and health workers trained on their use. The National Drug Policy and Medicines Law were revised and updated. In order to promote the rational use of medicines, support was provided to train health workers, the national drug formulary revised, and drug bulletins produced and widely distributed. To strengthen the local production of drugs, technical guidance and training on good manufacturing practices was provided to staff of the MoH Department of Regulatory Services of the MoH and the local pharmaceutical company.

In the area of health promotion, the WCO contributed to the development of the national health promotion policy and supported its dissemination. Advocacy tools aimed at behaviour change and adoption of a healthy lifestyle targeting policy-makers and communities were produced while the capacity of the national and zonal hospital Focal Points to implement health promotion activities was enhanced.

5.4.2 Health Information Management, Integrated Disease Surveillance and Research

The Health Information System (HIS) was assessed, using Health Metric Network tools as a first step towards strategic plan development. The IDSR system was strengthened to follow-up the 20 priority diseases that are reported immediately or on weekly, monthly and quarterly basis, and support provided to finalize the national research policy. Support was also provided to monitor the IDSR core indicators. There has been a significant improvement in health facility reporting, timely reporting of outbreaks and data analysis at district level. All outbreaks investigated were laboratory confirmed and the response was in line with WHO recommended measures. Technical assistance was provided to conduct drug efficacy studies for anti-malaria drugs to support treatment policy change. In addition, three scientific papers were published in peer review journals. Results of the research were disseminated for evidence-based decision-making.

5.4.3 Priority Health Interventions

Scaling-up priority health interventions is among the priorities set up by the Ministry of Health.

WHO provided assistance for the adoption of the road map for accelerating the reduction of maternal and neonatal mortality rates. As part of Making Pregnancy Safer initiative, capacities of health care workers to provide quality maternal and neonatal health services at all levels of the health care delivery system were scaled-up. Nurses, midwives and associate nurses were trained in emergency maternal and neonatal care services to ensure that every health facility has at least one basic emergency obstetric care service provider. Other support included the development of maternal and perinatal death audit guidelines and forms to document every maternal and neonatal death. FGM/C elimination is pursued and a proclamation against FGM/C has been made by the Government.

WHO, in close collaboration with UNICEF and USAID, has also contributed towards the expansion of IMCI, including community IMCI. A C-IMCI pilot project was evaluated and later expanded in 4 zones. Technical assistance was also provided for the revision of the guidelines, modules and charts to include neonatal health issues into IMCI. Other support included revision of the CAH policy to include PMTCT and other issues such as nutrition surveillance, building capacity in the areas of young infant feeding and management of severe malnutrition, developing guidelines and standards for nutrition and initiation of nutrition surveillance. *A KPC Survey conducted with WHO support, identified health priorities in order to allocate resources in a more targeted manner during the expansion of community-based programmes. In the pilot intervention area, there is an improvement in management and health-seeking behaviour related to diarrhoea and acute respiratory infections, probably due to the presence of community health workers in close proximity to the communities.*

The WCO supported the strengthening of the national immunization against vaccine preventable diseases, maternal and child health, HIV/AIDS, malaria control. The support also included the development of policies and technical guidelines for the prevention and control of various diseases, including HIV/AIDS, STI, TB and Malaria. The national plan to reach the “3 by 5” target was developed. The national routine immunization programme was strengthened and NIDs organized in collaboration with other partners. A situation analysis conducted for NCDs and NTDs with WCO support, elucidated the risk factors for NCDs, especially for Diabetes and Hypertension, which are prevalent in the country as well as the high prevalence of Trachoma.

5.5 SUPPORT FROM THE REGIONAL OFFICE AND HEADQUARTERS

The WHO Regional Office and Headquarters supported the WCO through the provision of consultants and staff missions. This extra technical assistance to the MoH was focused on policy and technical guidance, advocacy, resources mobilization, development of plans, information sharing and capacity building. Support was provided for the eradication of Polio, Communicable Diseases Surveillance and Response, Immunization against Measles and Malaria. The Regional Office also provided support for mental health, prevention of injuries and disabilities, blindness prevention, IMCI, nutrition and other noncommunicable diseases programmes.

SECTION 6

STRATEGIC AGENDA: PRIORITIES AGREED FOR WHO COUNTRY COOPERATION

6.1 INTRODUCTION

Priority areas for the second generation CCS were identified following a detailed review of the previous CCS and extensive discussions with MoH and other health-related line ministries, UN agencies, NGOs and other partners in health. It takes into account the technical challenges identified from the previous CCS and addresses them in the strategic areas. The implementation will take place within the context of the major government achievements of the health-related MDGs and the WHO paradigm shift from a resource-based to result-based approach.

6.2 GUIDING PRINCIPLES

- The strategic agenda reflects national health policies, strategies and plans as discussed and agreed with the Ministry of Health during the preparation of this second generation CCS.
- The strategy is guided by the Millennium Development Goals, the WHO Eleventh General Programme of Work, the Medium-Term Strategic Plan 2008-2013, the Strategic Orientations for WHO Action in the African Region and WHO Global and Regional Resolutions.
- The WCO will concentrate on its core functions as a normative technical agency, leader in health and work with the Government and partners within the framework of the principles of the Paris Declaration and Accra Agenda for Action.
- The WCO, in its capacity as leader of the UNDAF Health and Nutrition Cluster and Humanitarian Health Cluster, will work closely with the UN Country Team and other stakeholders to harmonize the contributions of the UN and partners towards effective response to national health needs.

6.3 STRATEGIC AREAS

The priority strategic areas are aligned with the 13 Strategic Objectives identified under the WHO MTSP 2008-2013. While the WCO will focus on areas listed below, other domains such as health promotion, gender equity, monitoring and evaluation as well as research will be given due emphasis because of their cross-cutting nature in the realization of the goals of the second generation CCS.

(a) Scaling-up priority programmes

- Prevention and Control of Communicable Diseases;
- Combating HIV/AIDS, Tuberculosis and Malaria;
- Prevention and Control of Noncommunicable Diseases;
- Maternal Health, Child and Adolescent Health and Nutrition;
- Disaster Preparedness and Humanitarian Response;

(b) Strengthening Health System Capacities and Performance

- Leadership and governance for health;
- Health services delivery, information system and community participation;
- Human Resources for Health;
- Health Financing;
- Social economic determinants of Health;
- Health System Research;

(c) Partnership and Coordination

6.4 PRIORITY AREA 1: SCALING-UP PRIORITY PROGRAMMES

6.4.1 Prevention and Control of Communicable Diseases

Important achievements have been registered by the Government in the control of communicable diseases. These include improvement in the immunization coverage rates for vaccine preventable diseases, and a strong surveillance system leading to the early detection and reporting of epidemic-prone diseases. However, there is need to sustain these gains and appropriately address the gaps. The WCO will support the MoH in strengthening the prevention and control of epidemic-prone diseases, as well as chronic and neglected tropical diseases by:

- building core capacities at community, zonal and national levels for preparedness and timely response to epidemics;
- operationalizing International Health Regulation (2005);
- conducting situation analysis to document the magnitude of Neglected Tropical Diseases (NTDs);
- developing and implementing policies, strategies and guidelines for the prevention and control of NTDs;
- developing advocacy package to increase awareness on NTDs;
- developing/updating the advocacy package to increase awareness on epidemic-prone diseases;
- revising IDSR guidelines and strategic plan to incorporate International Health Regulation (2005) and noncommunicable disease surveillance;

- strengthening the Reaching every District approach integrating immunization services with other maternal and child services, including integrated outreach services, especially scaling-up the integrated outreach services for hard-to-reach population groups that are traditionally missed by routine health services.

6.4.2 Combating HIV/AIDS, Tuberculosis and Malaria

The country has made significant progress towards the attainment of MDG 6. HIV prevalence was halved between 2003 and 2007, while mortality and morbidity due to malaria has reduced significantly to less than 80% of the 1998 levels. However, Tuberculosis remains a major public health problem. WHO will support the Ministry of Health to sustain the achievements gained in HIV/AIDS and Malaria control and scale-up interventions aimed at reducing morbidity and mortality due to tuberculosis. Specifically, WHO will support the MoH to:

- develop/update the National Strategic Plan on HIV/AIDS and Sexually-Transmitted Infections with evidence-based information for decision-making and comprehensive health care for people living with AIDS, including home-based care;
- review the existing National Malaria Strategic Plan, develop and implement an updated malaria elimination strategy;
- conduct situation analysis of the magnitude of STIs and implement integrated interventions for reducing their impact;
- enhance integration of PMTCT into Sexual and Reproductive Health (SRH) and to Child and Adolescent Health services;
- strengthen early diagnosis and treatment of STIs, HIV/AIDS and Tuberculosis, including development of the Road Map towards the attainment of Universal Access to ARTs, opportunistic infection treatment, increased access to ACTs for Malaria and increased coverage of the DOTS strategy;
- strengthen surveillance (within the framework of IDSR), monitoring, research and evaluation of HIV/AIDS, Tuberculosis and Malaria;
- strengthen laboratory capacity, including networking, Quality Assurance and Quality Control, surveillance of drug resistance for TB (MDR, XDR), Malaria and HIV/AIDS;
- implement strategies aimed at scaling-up the national TB programme to address MDR-TB and TB transmission and prevention.

6.4.3 Prevention and Control of Noncommunicable Diseases

The country has moved towards epidemiological transition with an increase in the burden of noncommunicable diseases. One of the major priorities of the Government is to prevent and reduce disease disability and premature death from chronic noncommunicable conditions, mental disorders, violence and injuries. Therefore, key priority interventions should aim at preventing and reducing risk factors for health conditions associated with tobacco, alcohol, drug and other psychoactive substance use, unhealthy diets, physical inactivity and unsafe sex. Specifically, WHO will support the MoH to:

- conduct situation analysis to document the magnitude of NCDs;
- develop policies, strategies, guidelines, manuals and tools for prevention and control of NCDs;

- strengthen the human and institutional capacity for the control of NCDs;
- advocate for the adoption of healthy lifestyles among the population;
- develop and enforce appropriate legislation such as Tobacco;
- implement integrated package for control of NCDs within the PHC framework;
- strengthen research and integrate surveillance of NCDs into IDSR for evidence-based integrated planning, monitoring and evaluation;
- develop policies, strategies, guidelines, manuals and tools for strengthening the human and institutional capacity for injury prevention and management.

6.4.4 Sexual and Reproductive Health, Child and Adolescent Health and Nutrition

Considerable efforts are being made towards the achievement of MDG4 and MDG5. However, maternal mortality remains high. Improving maternal health and reducing maternal and neonatal mortality is one of the priorities of the Ministry of Health. WCO will, therefore, provide support for implementation of strategies like High Impact Rapid Delivery (HIRD), Road map for reduction of maternal mortality and interventions aimed at improving child and adolescent health. Specifically, the WCO will support the MoH to:

Sexual and Reproductive Health

- develop/update and implement the sexual and reproductive health strategy;
- develop/update and implement the Road Map for reduction of maternal, newborn and child morbidity and mortality;
- conduct research for evidence-based decision-making in sexual and reproductive health;
- advocate, in collaboration with relevant partners, including religious leaders, the civil society and the Ministry of Women and Social Affairs, for repositioning of family planning (as an essential element for maternal mortality reduction), the elimination of FGM and violence against women;
- integrate specific interventions on HIV/AIDS/STIs into sexual and reproductive health;
- strengthen community Making Pregnancy Safer, including scaling-up of skilled attendance during pregnancy, delivery and postnatal period.

Child and Adolescent Health

- develop/update and implement the child health strategy;
- strengthen institutional capacity and expand community intervention to address IMNCI and management of severely sick children, including improvements in quality of care at first and referral levels through Emergency Triaging and Assessment;
- develop and utilize standards and guidelines for implementation of adolescent health in close collaboration with other sectors;
- strengthen the promotion of key healthy behaviour in relation to child and adolescent health at the community level;
- develop/update and implement a comprehensive package that addresses tobacco, alcohol and substance abuse, risky behaviour, injury prevention and safety among adolescents.

Nutrition, Food Security and Food Safety

- develop/update strategies, guidelines and standards on nutrition, including micro-nutrient supplementation and de-worming;
- strengthen the nutrition surveillance system within the framework of IDSR and conduct periodic national nutrition surveys;
- develop/update the food safety strategy and guidelines, including detection and response to food-borne diseases within the framework of IDSR;
- develop and promote a comprehensive package that addresses child nutrition at the community and household levels and is integrated into child health services;
- enhance national capacity on environmental health interventions related to nutrition, food security and food safety within the framework of the 2008 Libreville Declaration.

6.4.5 Disaster Preparedness and Humanitarian Response

Eritrea is located in the driest part of the African continent and is, therefore, vulnerable to drought. The country has also suffered considerable setback as a result of border conflicts and the persisting no-war-no-peace situation. The main objective is to reduce the health consequences of emergencies, disasters, crises and conflicts and minimize their social and economic impact. WHO will specifically support the MoH to strengthen the health sector programme for preparedness, response and recovery through:

- development/adaptation of norms, standards for national health disaster preparedness, response and recovery integrated in PHC;
- disaster risk assessment, hazard mapping and development of national health disaster preparedness and response plan;
- development of norms, standards and capacity building for provision of timely health response to disasters associated with natural hazards and conflict-related crises;
- development of norms, standards and capacity building for needs assessments and for planning health interventions during the transition and recovery phases of conflicts and disasters;
- strengthening of the control of communicable diseases in natural disasters and conflict situations;
- enhancement of national preparedness for re-stabilizing alert and response mechanisms for food safety and environmental health emergencies;
- strengthening of effective communication, building partnerships and coordination with partners;
- timely and effective implementation of acute, ongoing and recovery operations;
- Resource mobilization in support of humanitarian interventions;
- provision of curative, preventive and promotional health and nutritional interventions to communities affected by emergencies;
- facilitating the development of health facilities that are safe and secure from hazards.

6.5. PRIORITY AREA 2: HEALTH SYSTEM CAPACITY AND PERFORMANCE

There is continuous effort to make health systems strengthening a reality. The health system is gradually being transformed into a decentralized system and there is high political commitment to ensure equity. The Government pursues self-reliance as a guiding principle and places human resource development at the centre of all development agenda. The country health sector strategies are based on the PHC principles, namely equity, comprehensiveness, appropriateness, community involvement, self reliance, intersectoral approach, decentralization and quality assurance. The implementation of PHC in the country is part of a continuous effort to make health system strengthening a reality. The Ministry of Health is committed to addressing the gaps identified. The WCO will, therefore, support the MoH to specifically:

Leadership and Governance for Health

- provide a clear strategic direction for health development by updating and adopting the national health policy in line with the PHC approach and regional strategies;
- develop and implement National Health Strategic Plans;
- update the public health acts and laws in line with the PHC approach;
- foster human rights principles for health to ensure community participation, accountability, gender mainstreaming and equity.

Health Service Delivery and Information System

- build capacity for the provision of comprehensive, equitable and effective essential health services in line with the PHC approach;
- implement integrated management of comprehensive essential health services package, including community empowerment and participation;
- strengthen and expand the introduction of hospital autonomy, standards and quality of care in referral hospitals;
- develop/update a strategic plan for essential medicines and drugs to improve the access, quality and rational use of essential medicines;
- develop/update and implement a National Health Information Strategic plan for evidence based decision-making.

Human Resources for Health

- develop/update and implement the health workforce policy and strategic plan;
- scale-up training of appropriate health workers to meet the staffing norm needs at different levels of the service delivery points;
- strengthen workforce management systems,
- generate evidence for HRH planning and implementation and increase investments in HRH development, including career path and retention mechanism to improve coverage and quality of service delivery;
- establish and manage the Human Resources for Health Observatory;
- strengthen the training institutions to meet the needs of health services;

- update the staffing norms and harmonize it with the package of services at the different levels of the health care delivery system.

Health Financing

- provide clear strategy for health system financing development;
- ensure efficiency in the allocation and use of health sector resources;
- secure the level of funding needed to achieve the desired national health development goals and objectives in a sustainable manner;
- ensure that people are protected from financial catastrophe and impoverishment as a result of using health services.

Social and Economic Determinants of Health

- conduct situational analysis of the social and economic determinants of health;
- develop the capacity of the Ministry of Health to take the lead and network on the social and economic determinants of health with other sectors;
- develop tools and strategies to monitor the impact of the social and economic determinants of health.

Health System Research

- develop/update the stewardship and governance role of national research and information systems;
- build institutional capacities to promote research for health, including ethics;
- improve the dissemination and use of research to institutionalize its application;
- implement the Algiers Declaration on health systems research.

Priority Area 3: Partnership and Coordination

Using the WHO comparative advantage as an international agency, leader in health, the WCO will engage all partners in dialogue on WHO global resolutions and regional strategies on health. Partners will be regularly briefed on the implementation of WHO MTSP strategic directions and local and, international developments. The WCO will advocate for increased resources for the health sector and in line with the Paris Declaration and the Accra Agenda for Action, will work to contribute to the practical action-oriented road map to improve the quality of aid for health and its impact on health development in the country. The Global Fund to Fight AIDS, Tuberculosis and Malaria provides opportunity for the country to finance its national priorities for these diseases. The WCO will work to support such resource mobilization for evidence-based interventions.

The WCO will support the strengthening of intersectoral collaboration between the Ministry of Health and health-related sectors such as Finance, Development, Agriculture, Education, Water and Sanitation for setting norms and standards, for gender and right to health, food security, environment, occupational health, water and sanitation, health financing, as well as the social determinants of health to promote healthy setting initiatives. The civil society and private sector will also be involved. The principles of social determinants for health will be featured in the planning and implementation of projects and programmes. The WCO will support the development of policies and strategies that improve the environment and promote private sector participation and public-private partnership for improved access to health care.

Within the framework of the UNDAF, UN Reforms and Humanitarian Reform, the WCO, as lead for the health and nutrition cluster, will work with UN agencies to coordinate efforts that address similar priority health concerns. In addition, the WCO will advocate and promote joint planning and programming and play a pivotal role in humanitarian health cluster and the Inter-agency Standing Committee to advocate and promote health sector priorities.

SECTION 7

IMPLEMENTING THE STRATEGIC AGENDA

The CCS is the essential reference document for strategic planning for the WCO and will have important implications for programming and budgeting at the country, regional and headquarters levels.

For the next 5 years, the WCO will aim at catalyzing change through provision of technical support and stimulating partnerships in health programmes where joint action is needed. This will enable the WCO to better play its role as a broker and an advocacy agent for health, thus increasing the Organization's visibility.

7.1 WHO COUNTRY OFFICE

The CCS provides a medium-term framework for cooperation between the MoH and WHO, focusing on strategic areas. The strategic agenda reflects the programmatic shift from a resource-based management to a result-based management approach. The strategic focus affects the office staffing, management and operations.

7.1.1 Management

The WCO will develop Biennial Work Plans 2008-2009, 2010-2011 and 2012-2013 in the light of the CCS. Semi-annual consultations with MoH Programme Managers and annual review with the MoH will take place. The WCO will be reorganized to operate with 3 clusters so as to be in line with the Regional Director's orientations and requirements of the GSM. A new organizational chart (attached) will change the staffing pattern of the WCO. This organizational chart includes the three clusters, namely Programme Support Coordination, Policies and Systems Coordination and WHO Presence Coordination. Each cluster will be led by a designated coordinator to meet the requirements of the GSM. The components of the clusters are as follows:

Cluster Programme Support

- Disease Prevention and Control;
- Vaccine Preventable Diseases and diseases targeted for eradication and elimination;
- Integrated Disease surveillance and Response;
- International Health Regulation (2005);
- prevention of chronic and neglected tropical diseases;
- HIV/AIDS, Tuberculosis and Malaria;
- Noncommunicable Diseases;
- Emergency Preparedness and Humanitarian Response.

Cluster Systems and Policies

- Health Promotion;
- Delivery of Health Services;
- Health Financing;
- Human Resources for Health;
- Social and Economic Determinants for Health;
- Sexual and Reproductive Health;
- Child Adolescent Health;
- Nutrition and Food Safety.

Cluster WHO Presence

- Administration and Finance;
- Information Communication and Technology;
- Human Resources Management;
- Logistics Support;
- Secretarial Support;

7.1.2 Human Resource Implication

The current level of staffing stands at 42. Currently, the WCO has 17 technical officers, including 7 international staff. There are 10 National Programme Officers (NPOs), who are responsible respectively for Disease Prevention and Control, Disease Surveillance, Family Health Programmes, Essential Drugs and Medicines, HIV-AIDS, Malaria Control, Information and Communication Technology, Data Management, Emergency and Humanitarian Action, Nutrition, and Policy Process for National (MPN) Policies. There is a total of 22 support staff.

In order to fully implement the priorities set in the second generation CCS, an updated human resource plan is required. Some essential strategic programmatic areas such as HIV/AIDS, TB, Malaria and Nutrition are without programme managers. This human resource plan will also take into account the new dawn created by the GSM. The WCO will go through the process required to be GSM compliant. This process includes staff re-profiling and matching. The functions of national professional officers will be reviewed and re-adapted to the new strategic agenda. Some job description done ten years back will be updated to reflect the needs of the second generation CCS. Existing competencies will be pooled to facilitate first-line efficient and timely response to the needs of the country, particularly in issues relating to surveillance, outbreak investigation, HIV/AIDS and Emergency Response.

The WCO will increasingly rely on international technical support, as requested by the Ministry of Health. Technical support from the East and Southern Africa Inter-Country Support Team will be requested more frequently. WCO support to the MOH will be strengthened by missions from the Regional Office and HQ. National and international short-term consultancy will also be provided, depending on needs.

7.1.3 Financial Implication

Adequate funding is critical for implementation of the strategic agenda. There are presently two financial sources, the Accessed Contribution (AC) and the Voluntary Contributions (VC).

For the biennium 2008-2009, the total amount of AC allocated is US\$ 2 451 000 and the staff cost is US\$ 2 076 000. This represents 84.7% of the total AC allocated for this period. With a zero growth of the AC and a projected staff cost of US\$ 2 419 000 for the biennium 2012-2013, the staff cost will represent 98.7%. The total AC allocated for this period will, therefore, be used solely to cover staff cost. This excludes office running costs.

In view of the above, there is no doubt that the WCO will be challenged to provide sufficient technical staff for implementation of its work plans and have a reliable reserve of funds to support office running costs while at the same time supporting the implementation of identified priority programmes.

There will, therefore, be a need to review the current human resource plan and develop an aggressive strategy for resource mobilization to fill the funding gaps. This resource mobilization will also take place within the WCO. The need to develop strategies to raise funds locally cannot be over-emphasized.

7.2 INSTITUTIONAL CAPACITY IMPLICATION

All staff members have access to personal computers, internet/email, while laptops are provided to NPOs. The office equipment will be strengthened to cater for possibility of telephone conference calls in the short term and video conference in the longer term. The library service will be strengthened with the installation of workstation and electronic library facilities.

Training needs assessment will be conducted and human resource plans developed. Staff coaching and training, particularly in programme management and resource mobilization, will be a priority.

Within the framework of the GSM, equipment will be upgraded to meet IT requirements and staff capacity building will be ensured.

7.3 SUPPORT FROM WHO REGIONAL OFFICE AND HEADQUARTERS

7.3.1 Intercountry Support Teams

Eritrea belongs to the group of countries under the East and Southern Africa Inter-Country Support Team, based in Harare, Zimbabwe. Support to be sought from the Inter-Country Support Team (IST) will be technical support, organized in sub-regional settings to support the implementation of WHO Programmes at country level. The IST has been established to improve the quality and cost-effectiveness of support by leveraging a broader pool of expertise to assist countries on a timely basis, as identified in the CCS.

7.3.2 Regional Office

The WHO Regional Office for Africa (AFRO) will support the implementation of the strategic plan and facilitate the WCO organizational change. It will play a key role in strengthening and updating the technical and managerial capacities of WCO staff.

Technical support from AFRO will also be required to assist the MoH with the implementation of activities identified as priority areas in the CCS.

7.3.3 WHO Headquarters

In line with the principle of “One WHO”, Headquarters will work with AFRO and the Country Office to mobilize and provide resources to strengthen technical programmes. Headquarters will continue to assist WCO with the implementation of the strategic agenda by developing guidelines and standards. It will also facilitate the sharing and dissemination of lessons learnt in specific programmatic areas. A sustainable working mechanism between HQ, the Regional Office and the WCO will be developed to strengthen the WCO capacity to deliver.

7.4 COORDINATION WITHIN UNDAF

The United Nations Development Assistance Framework 2007-2011 aims at contributing to the achievement of the MDGs, as stated in the Millennium Declaration. It provides an opportunity for joint programming, coordination among partners and for increasing resource mobilization in the areas of reproductive health, nutrition, water and sanitation, HIV, gender equity and emergency response. The WCO, as a lead agency of Health and Nutrition cluster, will strengthen its capacity to lead and fully participate in the joint UN projects with parallel funding. WCO will also support the Government to coordinate the multiple agencies that participate in the health sector.

SECTION 8

MONITORING AND EVALUATION

The CCS formative mid-term review will take place after one and half years. The level of implementation of biennial plans will be monitored continuously through the Global Management System (GSM). Periodic reviews of implementation of the biennial plans will be conducted through the semi-annual monitoring (SAM), mid-term review (MTR) and biennial evaluation.

A final evaluation of the CCS will be conducted at the end of 2013 in conjunction with the health partners to measure the level of implementation and achievement of targets.

ANNEX

ANNEX 1: STEPS INVOLVED IN THE DEVELOPMENT OF THE 2ND GENERATION CCS

- The formation of a broad-based CCS Development Committee comprising of MoH officials, representatives of line ministries, UN agencies, bilateral and multilateral organizations, civil society, private sectors, and local and international NGOs, was the first step in the development of the second generation CCS in Eritrea. This was followed by the formulation and approval of the Terms of Reference of the Committee.
- The Committee reviewed the first generation CCS. The achievements, challenges and gaps were identified. This review involved a series of consultations and interviews with various stakeholders, particularly those of the MoH and UN agencies.
- Identification of the priority areas for the next five years. This process included a series of interviews with MOH authorities, UN agencies and NGOs. This step was followed by the formulation of the zero draft.
- In order to expedite the process, a local consultant was hired to improve on the draft document. A final draft document was then presented to the CCS Development Committee in a retreat for comments and endorsement. The CCS Committee endorsed the draft document and submitted it for editing by WCO staff.
- The final endorsement of the CCS document took place after a consensus building workshop involving all stakeholders. In this workshop, the comments from HQ on the e-guideline for the development of the 2nd generation CCS were considered. The draft was then submitted to AFRO for review and comments.
- Printing and distribution of the document is the last step.

ANNEX 2: SWOT ANALYSIS CCS

Strengths:	Weaknesses:
<ul style="list-style-type: none"> • High level of technical knowledge. • Access to extensive international network of expertise and know-how. • Neutrality on public health advocacy and policy issues. • Good partnership with health and development actors. • Strong commitment and dedication of staff. 	<ul style="list-style-type: none"> • Long administrative procedures, e.g. for contract renewal, procurement, recruitment of external consultants. • Country Office short of capacity to monitor and evaluate the impact of the implemented activities. • Significant proportion of funds still used for long-term routine activities. • Inadequate capacity in some areas of work e.g. environmental health, HIV-AIDS, organization of health services . • Insufficient funds made available for some areas of work: e.g. HIV-AIDS, TB, Malaria, Human Resources for Health (WHO).
Opportunities:	Threats:
<ul style="list-style-type: none"> • Country level staff strengthened and made more accountable and responsible. • Good relationship with the MoH at all levels. • Political commitment and dedication of MoH staff. • Major actors in the health sector acknowledge the technical leadership role of WHO. • Environment conducive for the development of policy and guidelines. 	<ul style="list-style-type: none"> • No-peace-no-war situation. • Macroeconomic growth stagnant and its repercussions on the health of the population and incidence of poverty-related diseases. • Inadequate quantity and quality of human resources. • High level of attrition. • Insufficient management staff of MoH experienced in M&E. • “Donor fatigue” and inadequate sustainability of global initiatives.

ANNEX 3: WCO ERITREA ORGANIZATIONAL CHART

