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EAST, CENTRAL AND SOUTHERN AFRICA - HEALTH COMMUNITY

PERFORMANCE EVALUATION

JANUARY 21, 2016

This publication was prepared independently and produced for the United States Agency for International Development. It was prepared by the Evaluation Team of Evaluation Services and Program Support for International Business & Technical Consultants, Inc.

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DISCLAIMER

ACKNOWLEDGEMENTS

This performance evaluation was a substantial undertaking that would not have been possible without the input and support of many people. IBTCI would like to thank:

- The key informants (ECSA-HC Secretariat, training and research institutes, and ECSA-HC's development partners) for sharing their insights despite competing demands on their time.

- ESPS/IBTCI Kenya staff (Cyndi Scarlett, ESPS Chief of Party; Paul Mwai, ESPS Senior Monitoring and Evaluation Advisor; Dr. Maxwell Omondi, ESPS Public Health Specialist; Rosemary Were, ESPS Program Support Manager; and all ESPS administrative personnel) who provided technical and administrative support to the evaluation team during all phases of the evaluation process.

- The IBTCI Head Office staff (Dr. Joshua Volle, ESPS Project Director; Nikita Ashoka Gurudas, Program Associate; and Tyler Wallace, Global Health Intern) who assisted in the process and review of the report.

- USAID/Kenya, East Africa counterparts—in particular, Dr. Grace Miheso, who offered guidance and support throughout the evaluation.

Lastly, the authors extend their heartfelt appreciation to the ECSA-HC Secretariat, ECSA-HC stakeholders from various training and research institutes, the member state ministries of health and the implementing partners who all worked in collaboration with ECSA-HC on regional policies and implementation.

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Acronyms and Abbreviations

AED	Academy for Educational Development
A2Z	USAID Micronutrient and Child Blindness Project
AMSTL	Active Management of the Third Stage of Labor
ASW	Auxiliary Social Workers
CDC	The Centers for Disease Control
CHAI	Clinton Health Access Initiative
CHAL	Christian Health Association of Lesotho
CHE	Council on Higher Education
CRHC	Commonwealth Regional Health Community
COSECSA	College of Surgeons of East, Central and Southern Africa
CSA	Child Sexual Abuse
DJCC	Directors' Joint Consultative Committee
DHMT	District Health Management Team
EAC	East African Community
ECA	East and Central Africa
ECSA	East, Central and Southern Africa
ECSACON	East, Central and Southern Africa College of Nursing
ECSA-HC	East, Central and Southern Africa Health Community
EDCTP	European & Developing Countries Clinical Trials Partnership
EQ	Evaluation Question
EQUINET	Regional Network on Equity in Health in Southern Africa
ESPS	Evaluation Services and Program Support
FP/RH	Family Planning and Reproductive Health
GBV	Gender Based Violence
GIZ	Gesellschaft für Internationale Zusammenarbeit (German international development)
HMC	Health Ministers Conference
HPN	USAID, Health, Population and Nutrition Office
HRAA	Human Resources Alliance for Africa
HRH	Human Resources for Health
HRIS	Human Resource Information System
HSS	Health Systems Strengthening
HWAI	Human Workforce Advocacy Initiative
IBTCI	International Business and Technical Consultants, Inc
ICAP	International Center for AIDS Prevention
ICT	Information Communications and Technology
Jhpiego	Johns Hopkins Program for International Education in Gynecology and Obstetrics
KII	Key Informant Interview
KM	Knowledge Management
LNC	Lesotho Nursing Council
MCH	Maternal and Child Health
MNCH	Maternal, Newborn and Child Health
MDG	Millennium Development Goals
MOH	Ministry of Health
MOET	Ministry of Education and Training
MOHL	Ministry of Health and Labor
MOLSS	Ministry of Labor and Social Security
MOPS	Ministry of Public Service
MOSD	Ministry of Social Development
MOSW	Ministry of Social Work

MTR	Mid-term Review
NHA	National Health Account
NHTC	National Health Training College
PMTCT	Prevention of Mother to Child Transmission
RCQHC	Regional Centre for Quality of Health Care
RHAP	Regional HIV and AIDS Program
SADC	Southern African Development Community
SIDA	Swedish International Development Cooperation
SOAG	Strategic Objective Agreement Grant
SOW	Statement of Work
SWAp	Sector-wide Approach
SZL	Swazi Lilangeni
TB	Tuberculosis
TPM	Team Planning Meeting
TWG	Technical Working Group
UNISWA	University of Swaziland
USAID	United States Agency for International Development
USG	United States Government
WHO	World Health Organization

Executive Summary

The findings from the East, Central and Southern Africa Health Community (ECSA-HC) Performance Evaluation offer USAID and ECSA-HC information to assess program performance, measure key achievements and determine the way forward for future engagements between USAID and ECSA-HC. The evaluation team used a mixed-methods approach to determine how well the collaboration between USAID and the ECSA-HC has been unfolding and posed a set of questions focusing on three main program areas: regional policy, technical support, and institutional capacity and knowledge management. The evaluation answered three key questions:

1) To what extent has ECSA-HC with USAID support been able to influence regional and country-level policies?
2) To what extent have USAID-supported programs responded to thematic priorities as outlined in ECSA-HC's strategic plans and in other regional strategies (agreed to by member states)? and
3) What have been the key contributions of USAID support to ECSA-HC's institutional capacity strengthening agenda? Elaborating on question 3: to what extent has USAID support helped strengthen ECSA-HC's financial sustainability and management capacity, including its human resources and knowledge management capacities?

To answer these questions, the Evaluation Services and Program Support (ESPS) team brought together an evaluation team of three people: a team leader, an evaluation specialist and a health systems specialist. The team worked over a period of three months to gather, analyze, summarize and report on these key questions. During this time, the evaluation team reviewed over 150 documents and conducted 50 interviews with representatives from 11 countries (the nine ECSA-HC member states, South Africa and the US) and five relevant agencies/partners. This report contains the findings, conclusions and recommendations based on the desk review and the key informant interviews (KIIs) that were conducted.

The finding in response to ***Evaluation Question 1***: ECSA-HC has been able to engage the ministries of health (MOHs), the permanent secretaries, key health experts and decision-makers across many countries to positively influence regional and country-level policies. USAID support played a fundamental role in facilitating this regional success. The agency's positive impact is evident in the many policies, resolutions, training curricula and support systems that have been put in place. Informants noted that the most valuable aspects of USAID support included: financing core ECSA-HC staff; providing technical assistance in key health areas; issuing specific regional development strategies (e.g., food security and nutrition, gender-based violence (GBV); drafting and proposing key policies, guidelines and strategies; and supporting the expansion of programs in the region (maternal child health and family planning).

Informants noted that some of the best practices and successes were: the adoption of Active Management of Third Stage of Labor (AMSTL) policies leading to increased awareness on the devastating effects of post-partum hemorrhage; model national policies on Gender-based Violence; the adoption of food fortification and implementation in East, Central and Southern Africa (ECSA) member states; and cross border disease surveillance using laboratory methods for outbreak investigations.

Some of the challenges ECSA-HC faced included: too many Health Ministers Conferences (HMCs) and HMC resolutions to keep track of; the high ECSA-HC staff turnover; the high MOH staff turnover; the need to secure an ongoing commitment from the MOH for implementation of resolutions; the dependence on USAID support; the lack of funding to implement HMC resolutions from some of the member states; and the inconsistent adoption of policies by member states. The main reason for inconsistency in adoption was the substantial volume of policies and differing priorities. To date, no concrete tracking mechanism exists to identify which policies member states have adopted and whether or how they have implemented these policies.

The findings in response to ***Evaluation Question 2***: From 2006 to 2014 (the review period of this report), ECSA-HC member states analyzed and adopted 19 policies and a number of other promising practices in response to the thematic priorities of member states and of those raised in global health forums. Respondents noted, however, inconsistencies between USAID priorities and those identified by ECSA-HC. While ECSA-HC takes its priorities from member states and global health forums, USAID interacts with the member states and health forums separately from ECSA and the agency sometimes comes to different conclusions about priority areas for intervention.

Furthermore, under the Human Resources Alliance for Africa (HRAA) project that was implemented in Swaziland and Lesotho and that required buy-in from USAID's respective bilateral offices, the USAID regional offices did not always agree with the priorities set by USAID's bilateral missions.

Overall, the support to ECSA-HC did not change its focus over the eight-year period under review. However, reduced funding often forced an alignment shift to direct funds to specific areas of the ECSA-HC strategic plan. These changes did not shift ECSA-HC away from its intention or vision, but small changes in USAID priorities had large ramifications for ECSA-HC's focus. Consequently, ECSA-HC needed to and succeeded in leveraging funds from other donors such as the WorldBank, Rockerfeller Foundation and Global Fund.

The HRAA activity, supported by USAID and ECSA-HC, has had a positive effect in Lesotho and Swaziland and has strengthened their respective health systems, financing, policies and plans. Through HRAA, technical assistance was provided to health training institutes to facilitate the development of strategic plans. Technical assistance also worked to collaborate support for the MOH in Lesotho in costing out the ministry's operational plans for Human Resources for Health (HRH) reforms. Also, HRAA assistance helped develop and cost out the HRH implementation plan for Swaziland. Moreover, with support from HRAA, Swaziland reviewed its need for various donor-funded health worker positions.

HRAA also carried out activities in Lesotho and Swaziland in the areas of: planning and finance; human resource information systems; pre-service education; the Auxiliary Social Work Program initiative; the voluntary health worker profiling and mapping exercise; continuous health education accreditation; and health staff recruitment and retention.

Finally, the findings in response to ***Evaluation Question 3***: USAID support strengthened ECSA-HC's internal process, thus positioning ECSA-HC as a regional implementing organization. USAID also enhanced ECSA-HC's administrative capacity and helped them qualify as a regional implementing partner with USAID and other potential donors such as the Global Fund. Furthermore, USAID support assisted some member states in the process of policy formulation and adaptation and was critical in sustaining HRH as a top priority in the ECSA region and as an ECSA-HC priority in its 2012 to 2017 strategy.

As a direct result of USAID support, ECSA-HC has improved its financial systems and is now in very good standing with its other partners and donors. The ECSA-HC organizational structures, procedures, systems and experience in the region have high prospects for sustainability. Their sources of funding are shifting away from direct reliance on member states to various other development partners such as GIZ, the World Bank, the Rockefeller Foundation and the Helen Keller Foundation.

Historically, ECSA-HC has faced challenges in receiving funds from member states. Funding has been easier to obtain from member states where ECSA-HC is implementing programs. In member states where no ECSA-HC programs exist, funding is less forthcoming. Seeking funds from other partners, therefore, is a sound financial strategy shift. Inconsistent funding also calls into question the member states' intentions: are they committed to working with ECSA-HC? The member states that are funding ECSA-HC increasingly have been providing funds in a lump sum up front rather than raising debts and paying afterward. It's also important to note that the amount of member state contributions has not been adjusted in the last twenty years—since 1995. This means that member state contributions are not keeping pace with the current (and actual costs) of running the ECSA-HC Secretariat.

Based on the evaluation findings and analysis, the evaluation team offers the following recommendations to ECSA and its developmental partners:

USAID regional and bilateral mission engagement with ECSA-HC

1. When designing regional programs, such as HRAA, that require the buy-in of USAID's bilateral missions, USAID's regional offices and other USG-funded offices and programs (such as PEPFAR) should engage the bilateral missions and secure their obligations and commitments to each individual member state. ECSA-HC should function as an implementing partner independent from the USAID bureaucracy. (Responsibility: USAID and/or other donors)
2. The ECSA Secretariat and its developmental partners should ensure the sustainability of HRAA's successes in Lesotho and Swaziland. (Responsibility: ECSA Secretariat, ECSA Developmental Partners)

Research, Knowledge Management and Sharing:

3. ECSA-HC's Information and Communication Technology (ICT) and M&E capacity should continue to be strengthened. This could dramatically improve ECSA-HC's ability to communicate with its partners and with member states. This also would help ECSA-HC serve as a regional health systems policy body to influence the member states. (Responsibility: ECSA and its developmental partners)
4. ECSA's developmental partners should support the ECSA-HC secretariat to increase the organization's efforts to ensure that policies developed at the regional level are available to each member state. A repository (of metadata) from the ECSA-HC resource center should be available online with open access for each member state. This would facilitate systematic information and knowledge sharing (i.e., ICT) in spite of staff and MOH turnover. (Responsibility: ECSA Secretariat, Developmental Partners)
5. Developmental Partners should provide assistance to the ECSA-HC secretariat to establish a policy and HMC resolution tracking system that captures and tracks which member states are implementing which policies and resolutions. The tracking system also should provide links to previous resolutions. (Developmental Partners, ECSA Secretariat)

Support for operations at ECSA-HC Secretariat

6. Member state contributions that have stagnated over the past two decades should be reviewed, taking into consideration the evolution of ECSA-HC's operations, changes in membership and the current economic environment in the ECSA region. (Responsibility: ECSA Secretariat)
7. When supporting multi-state organizations, such as ECSA-HC, developmental partners need to allow enough time for intergovernmental planning cycles especially because regional goals and objectives are captured as project activities. The developmental partners should increase ECSA-HC's and other potential regional awardees' involvement in the work plan and awarding processes to align each organization's timelines. (Responsibility: Developmental Partners, ECSA Secretariat)
8. Developmental partners should continue to support such regional bodies as ECSA-HC because they remain relevant to African health issues and can help synchronize health services (e.g., for successful migration) *among* and *across* several states. (Responsibility: Developmental Partners)

1. Introduction

The East, Central and Southern Africa Health Community (ECSA-HC) is a nine-member (Kenya, Lesotho, Malawi, Mauritius, Swaziland, United Republic of Tanzania, Uganda, Zambia and Zimbabwe) regional intergovernmental organization based in Arusha, Tanzania, and was established in 1974 by the Convention of the East, Central and Southern Africa Health Community to promote regional cooperation in health.

With a mandate to promote efficiency and relevance in health service provision, ECSA-HC is helping the region improve the physical, social and psychological well-being of its people through advocacy, capacity building, coordination, inter-sectoral collaboration and the harmonization of health policies and programs.

ECSA-HC provides a platform for regional consensus-building on health priorities and a forum for reviewing progress on regional and international health targets. The organization also provides technical assistance and capacity building to member states and its institutional partners and facilitates regional health research and surveys.

Under the USAID/Nairobi Transition Plan, USAID/EA's Strategic Objective Agreement Grant (SOAG) with ECSA-HC will transition to USAID/Southern Africa. The Health Population and Nutrition (HPN) Office will continue engaging with ECSA-HC through other mechanisms. Ahead of this transition, the USAID/EA Regional Mission requested an external performance evaluation of its engagement with ECSA-HC to cover an eight-year period, from the signing of the first SOAG in 2006 to date. Therefore, the reference period for assessing ECSA-HC activities and experience is from January 1, 2006, through December 31, 2014. (See Annex I for Statement of Work.)

The two overall objectives of this evaluation are:

1. To highlight the key achievements and challenges of USAID/EA's and USAID/SA's engagement with ECSA-HC, and
2. To provide concrete recommendations for future investments by USAID to improve the regional management of health systems in order to address the key causes of morbidity and mortality in the region.

Under the Evaluation Services and Program Support (ESPS) contract, IBTCI signed a Task Order with USAID on September 16, 2015, to conduct a performance review of ECSA-HC. In addition to documenting the achievements of the USAID and ECSA-HC engagement (including best practices and lessons learned), the findings from this evaluation will influence USAID's decisions on how to best engage ECSA-HC to address priority health challenges in the region.

1.1. Audience and Intended Uses

USAID is the primary audience for this report. The findings offer insight into the ECSA-HC's strengths, weaknesses and opportunities in relation to health programming in the ECSA region. The findings will also help USAID determine how best to engage this mult-state member organization. A secondary audience for this evaluation is ECSA-HC, its member states and other key stakeholders.[1]

1.2. Evaluation Questions

The evaluation questions are grouped into three main program areas*: Regional Policy; Technical Support; and Institutional Capacity and Knowledge Management*, explained as follows: (Note: See Annex II for sub-questions.)

[1] KECSA Evaluation Task Order (2015)

Regional Policy

- Evaluation Question 1: To what extent has ECSA-HC with USAID support been able to influence regional and country-level policies?

Technical Support

- Evaluation Question 2: To what extent have USAID-supported programs responded to thematic priorities as outlined in ECSA-HC strategic plans and in other regional strategies agreed to by member states?

Institutional capacity and knowledge management

- Evaluation Question 3: What have been the key contributions of USAID support to ECSA-HC's institutional capacity strengthening agenda? To what extent has USAID support contributed to strengthening ECSA-HC's financial sustainability and management capacity, including its human resources and knowledge management capacities?

2. Background

2.1. Context of USAID and ECSA-HC Engagement

Weak health systems prevent ECSA-HC member states from offering their citizens universal access to health services. Member state health systems face chronic and acute shortages of skilled health workers, inadequate health facilities and infrastructure, limited access to essential medicines and supplies, and inadequate and unpredictable health financing at the national and local levels. These challenges exacerbate the region's high disease burden and worsen access to quality health services for women and children.

Regional cooperation and collaboration is deemed essential to increase the flexibility and responsiveness of public health systems for improved outcomes. Since 2006, USAID/EA has engaged the ECSA-HC to address these health system challenges and support transnational programming.

USAID/EA's formal collaboration with ECSA-HC began in 2006 with a US$6,534,833 SOAG to promote the adoption and analysis of policies and promising practices that would respond to priority needs in reproductive, child and maternal health and in infectious diseases throughout East and Central Africa. This grant initially focused on seven program areas: 1) prevention and control of infectious diseases, including tuberculosis (TB), malaria and avian influenza; 2) improving child survival, health and nutrition; 3) improving maternal health and nutrition; 4) supporting family planning; 5) addressing other health vulnerabilities; 6) reducing the transmission and impact of HIV/AIDS; and 7) additional support for enhancing health system capacity.

With this assistance, USAID leveraged the political capital of ECSA-HC and its convening power using various forums to elevate health system priorities and advocate for the implementation of high-impact interventions. However, changes in USAID priorities, staffing constraints and pipeline issues have influenced this support as follows:

1. In 2008, USAID's new Foreign Policy Assistance Framework objective was "Investing in People" and due to pipeline issues, the funds focused only on maternal and child health (MCH) issues.
2. In 2009, initiatives focused on a "healthier population in the East and Central Africa (ECA) region achieved through African leadership" and used funds to conduct research and test family-planning delivery models for use in emergency settings.
3. In 2011, USAID's regional objective incorporated a deliberate effort to better understand the synergistic relationship between population, health and the environment. This became an add-on to its support to ECSA-HC, and
4. By 2012, ECSA-HC received USAID funds for six programmatic areas: 1) birth preparedness and maternity services; 2) newborn care and treatment; 3) family planning and reproductive health

(FP/RH), including the synergy between population, health and the environment; 4) policy analysis and systems strengthening; 5) health governance and finance; and 6) other health systems strengthening initiatives.

Starting in 2011, ECSA-HC was the prime implementing partner on the Human Resources Alliance for Africa (HRAA), a regional buy-in mechanism in southern Africa to address Human Resources for Health (HRH) in five areas: 1) workforce planning and financing); 2) human resources information systems (HRIS); 3) pre-service training of health workers; 4) the recruitment and retention of skilled health workers; and 5) health worker regulation and capacity strengthening of health professional organizations. By the end of the 2014 fiscal year, USAID had obligated US$ 9,325,430 to the HRAA out of an award ceiling of US$ 50,000,000.

2.2. The Governance Structure of ECSA-HC

- The Conference of Health Ministers provides policy direction to member states
- The Advisory Committee gives oversight on strategic and administrative matters
- The Directors' Joint Consultative Committee (DJCC)
- The Program Experts' Committee
- ECSA-HC Secretariat provides technical assistance and oversees the following seven program areas: 1) health systems and services development; 2) human resources for health and capacity building; 3) family and reproductive health; 4) HIV and AIDS; 5) food security and nutrition; 6) monitoring and evaluation; and 7) research, information and advocacy.

2.3. ECSA-HC partners

In addition to USAID, ECSA-HC works with various other partners that cover a broad range of thematic areas and offer both technical and financial support in improving health policies and programs. They also help to extend the reach of ECSA-HC's work across the region. These partners include: the Hewlett Packard Foundation, the Academy for Educational Development (AED), the Regional Network on Equity in Health in Southern Africa (EQUINET), the World Bank, Family Health International (FHI360), the Regional Centre for the Quality of Health Care (RCQHC), A2Z–AED, the Commonwealth Secretariat (COMSEC), the Rockefeller Foundation and the European and Developing Countries Clinical Trials Partnership (EDCTP).

3. Evaluation Methodology

In addressing the three key evaluation questions (see Annex III: Evaluation Question Matrix), the evaluation team employed a non-experimental mixed-methods approach that used both quantitative and qualitative elements (desk review and key informant interviews) as described below.

3.1 Data sources

3.1.1 Desk Review

Key documents reviewed include: USAID documents (SOAGs), quarterly reports, amendments, ECSA-HC Secretariat documents, HRAA documents, Health Ministers Conference (HMC) resolutions/recommendations and ECSA deliverables, e.g., guidelines, manuals and the ECSA-HC Mid-term Review. (See Annex IV for a list of the key document types reviewed.)

3.1.2 Key Informant Interviews

The evaluation team conducted key informant interviews (KIIs), either face-to-face or by Skype or telephone, with various stakeholders in the ECSA region. A standardized guide was administered to the respondents. The evaluation team transcribed and coded the interviews according to the three evaluation questions and eighteen sub-questions and then analysed the information by content data abstraction and triangulation.

In most cases the interviews were recorded with the respondent's permission; in several cases, however, permission was denied. IBTCI's ESPS Kenya staff supported all phases of the evaluation process.

3.2 The Selection Criteria and Sample

The ESPS team worked closely with USAID's technical team in designing the sample and weighed methodological rigor against implementation costs. The evaluation employed a purposeful sampling approach as suggested and verified by USAID. The respondents were chosen primarily from the key partners and organizations that USAID and ECSA-HC had identified. They were selected based on their roles and responsibilities and many served as representatives of the target respondent groups. Also, they were often the most informed about ECSA-HC projects. (For a complete list of the respondents for the performance evaluation, see Annex VI: Master List of Completed KIIs.)

Originally, USAID requested that interviews be conducted with 76 representatives from the various key stakeholder partners and organizations from 11 countries (the nine ECSA-HC member states, South Africa and the US). The evaluation team made every effort to organize these meetings either in person or via telephone or Skype. However, 26 of the identified representatives were not available and did not respond to multiple requests to set up an appointment. As a result, across the 11 countries, 50 individuals participated in the evaluation. The following table shows where the KIIs were conducted and the number of individuals that the evaluation team had planned to interview. The individuals who were most likely to refuse participation were representatives within the various ECSA-HC member state Ministries of Health.

Table 1: Qualitative data: Number of KIIs conducted versus the (intended)

Country		MOHs	Training & Research	ECSA & EAC	ECSA Partners	USAID	TOTAL
1	Kenya	1 (2)	4 (5)		6 (8)	5 (5)	16 (20)
2	Lesotho	0 (2)	1 (2)		2 (2)	1 (1)	4 (7)
3	Malawi	1 (3)					1 (3)
4	Mauritius	1	0 (2)				1 (2)
5	South Africa					1 (4)	1 (4)
6	Swaziland	1 (2)	1		1 (1)	0 (1)	3 (4)
7	Tanzania	0 (2)	5 (5)	7 (7)	3 (2)	0 (1)	15 (17)
8	Uganda	0 (2)	1 (3)		2 (3)		3 (8)
9	Zambia	1 (1)	1 (2)				2 (3)
10	Zimbabwe	1 (4)	2 (2)		0 (1)		3 (7)
11	USA					1 (1)	1 (1)
Total		**6 (18)**	**15 (21)**	**7 (7)**	**14 (17)**	**8 (13)**	**50 (76)**

3.3 Data Management and Analysis

For the desk review, the evaluation team reviewed all documents and abstracted their contents guided by the evaluation questions and the three analytical domains (regional policies, technical support, and institutional strengthening and knowledge management). This data then was used to augment the respondent information gathered during the KIIs.

The KIIs were recorded in most instances, but nine out of 50 respondents were not recorded. During all interviews, the evaluation team took extensive notes. As a result, even when recordings were not available the team was able to analyze their responses effectively. All recordings were transcribed and then coded according to the various themes under each analytical domain and grouped across multiple respondents in order to combine responses to questions and to triangulate and fortify responses. Content analysis and triangulation analysis techniques were used to synthesize the findings for this evaluation.

3.4 Approach to Field Work

IBTCI established an evaluation team comprised of a team leader, Dr. Gary Svenson; a senior evaluation specialist, Jack Buong'; and a health systems expert, Dr. Kennedy Manyonyi, to carry out the evaluation process. (See Annex VII: Evaluation Team Members' CVs.) Fieldwork for this evaluation was carried out from October 3 to November 3, 2015. (See Annex VIII: Work plan and data collection schedule.)

All three members of the evaluation team conducted the KIIs. Working as a team they were able to conduct face-to-face interviews in Kenya, Tanzania, Lesotho, Swaziland and South Africa. In addition to the face-to-face interviews, phone interviews were conducted with all other member-state representatives and partners.

Prior to the field work, the evaluation team participated in a two-week document review to read and analyze documents that were provided by USAID and sourced by IBTCI. Then a one-week team-planning phase (October 5 to October 9, 2015) followed to finalize the work plan and data collection tools, to participate in the in-brief meeting at USAID (on October 8, 2015) and to set and finalize other field logistics. Field work was scheduled to conclude on October 30, 2015, however, some follow-up interviews were done on November 3, 2015.

3.5 Limitations

A significant number of documents (covering a span of several years) needed to be reviewed. Increasing this challenge, the team continued to collect documents for review from ECSA-HC and its partners during the interview process. Without an ECSA-HC recording or tracking system, the evaluation team also found it difficult to determine which member states had adopted the resolutions and recommendations put forth during the Health Ministers Conferences. In addition, only 50 of the 76 pre-selected interviewees were available or willing to be interviewed. For those who could not be reached the reasons varied: some were on holiday; others were traveling; poor communication networks interfered with requests; and some failed to respond at all.

The evaluation team used multiple mechanisms to mitigate respondent and interviewer bias:

- **Forced Answers:** The KIIs were implemented using standardized guides rather than a detailed interview guide. This prevented respondents from having to answer questions concerning aspects of projects that they knew nothing about.
- **Recall bias:** Key evaluation questions focused on an eight-year review period. Some respondents had difficulties recalling events from the start of the project.
- **Interviewer bias** was mitigated to the extent possible by training the team to use all the available instruments and by pilot testing the instruments prior to the start of field work. Additionally, daily team briefs were held at the field level and the ESPS team reviewed the instruments as they were completed.
- **Selection bias:** To include the most informed stakeholders in the sample, the proposed methodology adopted a "purposeful selection criteria" for identifying the KII respondents.

3.6 Ethical Considerations

The evaluation team implemented a policy of voluntary, informed consent for all KII respondents. Therefore, all respondents gave their verbal, informed consent to participate regardless of the interview technique. As part of the informed-consent process, target respondents were oriented on: why data were being gathered; confidentiality; the minimal risks and inconveniences associated with participation; and the voluntary nature of their participation in the interview or discussion. All team members certified that they had no conflict of interest on being interviewed. Each member of the evaluation team signed a "Conflict of Interest" statement which is stored at the ESPS/IBTCI office in Nairobi.

Respondents also were assured that the information provided would be kept confidential and would not be linked to any specific person in the final report. The raw data, with identifying information redacted, will be provided to USAID at the end of the evaluation.

4. Findings and Conclusions

4.1. Policy

4.1.1. Evaluation Question 1

Evaluation Question 1: To what extent has ECSA-HC with USAID support been able to influence regional and country-level policies?

A. Overview: ECSA-HC as a regional entity

As a regional intergovernmental body, ECSA-HC has the unique advantage of being able to convene Ministers of Health, Permanent Secretaries, key health experts and decision-makers.[2] Moreover, the organization has linkages with other regional bodies such as the East Africa Community (EAC) and the Southern African Development Community (SADC), and with professional organizations such as the East, Central and Southern Africa College of Nursing (ECSACON) and the College of Surgeons of East, Central and Southern Africa (COSECSA). Thus, ECSA-HC has the unique authority to convene regional decision-makers and experts specific to the field of health. ECSA-HC has the authority to pass resolutions and provide guidance on best or promising practices directed to the member states and to its Secretariat.[3] In addition, ECSA-HC's organizational bodies, including the Secretariat, are linked to global experts and forums such as the Geneva Health Forums. Using ECSA-HC's strong health platform, USAID is well positioned to engage government institutions to address health services challenges and weaknesses in Eastern, Central and Southern Africa in order to transform transnational health programming in the region.

Also important, ECSA-HC is the "spider" in the center of a formal, regional network and decision-making process that includes political and professional institutions in the nine member states and in several observer countries. As the center of this network, the ECSA-HC Secretariat has the potential to gather information, knowledge and lessons learned from a wide range of member states and from regional and global sources. ECSA-HC is in the position to analyze, refine and summarize information and knowledge in the form of promising/best practices, manuals, training modules, software, guidelines and policy proposals. For USAID/EA and USAID/SA this provides the opportunity to facilitate the use of high-impact interventions in the member states to address multi-country or cross-border health issues.

B. ECSA-HC as an implementing partner

USAID/SA funded ECSA-HC to serve as an implementing partner of a southern African HRH initiative, the HRAA. The USAID/SA award was a component of a larger global PEPFAR-funded initiative to fortify Health Systems Strengthening (HSS)/HRH systems in the prevention and treatment of HIV and AIDS. USAID originally intended to issue the award as a Cooperative Agreement, but because ECSA-HC was an intergovernmental body based in Tanzania, it became necessary to change this to a Strategic Objective Agreement Grant (SOAG) with unique provisions. Moreover, a pre-award assessment revealed that first it was necessary to improve and build-up the capacity of ECSA-HC to meet USAID's "Responsibility Criteria."

This capacity strengthening included support and guidance to ECSA-HC as both a Secretariat *and* a USAID implementing partner able to manage all its obligations and responsibilities. This included instituting a head HRAA office with a Chief of Party (COP) and key personnel within ECSA-HC and establishing and managing sub-agreements with partners that were implementing national programs in country offices. The

[2] HMC Resolutions 1974 – 2014
[3] Article 5 and Article 6 of the Convention of the ECSA-HC

original goal for the HRAA award was for ten USAID-PEPFAR bilateral offices to buy in. However, only two bilateral offices, Lesotho and Swaziland, ended up doing so. Nonetheless, the capacity and skill sets of ECSA-HC were significantly improved, and building capacity of host country organizations is a "USAID Forward" goal.

Conclusions

- With USAID support, ECSA-HC as a regional body is playing a highly relevant role today. It enables a higher-level view that supports the harmonization of health policies, training, and general approaches to health services among and across several states.

Question 1a: Has ECSA-HC with USAID support been able to influence regional and country-level policies?

As an intergovernmental body, ECSA-HC has worked closely with its nine member states. This has helped member states learn from each other to better support health programming.[4] Furthermore, ECSA-HC has been able to influence, with USAID support, regional and some country-level policies through multiple channels ranging from USAID financing of core ECSA-HC staff to offering technical assistance in key health areas such as food fortification and maternal and child health.[5] (See Annex IV and V for a listing of all project documents.) Respondents for this performance evaluation lauded ECSA-HC's ability to convene and set health agendas for its member states:[6] "*For me, I do not see any other health-specific organization that would provide this platform for countries as much as the ECSA does in the entire Eastern and Southern African regions*." (KII with a former ECSA Partner)

The following findings on: a) ECSA's technical niche on HRH; b) the adoption of policies and strategies; and c) the expansion and integration of health programs, highlight some USAID-supported, ECSA-HC accomplishments as a platform for regionality.[7]

A. ECSA-HC's technical niche on human resources for health (HRH)

Establishment of Health Workforce Observatories: The 54th Health Ministers Conference generated resolution ECSA/HMC54/R6 on the "Innovative Uses of Health Information Technologies and Systems"[8] with recommendations to strengthen Health Workforce Observatories (HWO) in member states. As a result, ECSA-HC helped member states establish and strengthen these observatories. The role of the HWOs was to support actions that address HRH challenges by promoting, developing and sustaining a stable knowledge base for HRH information that is founded on solid and up-to-date HRH information, analyses and evidence-based use at the regional, district and national levels.[9]

Support for ECSACON: ECSA-HC supports the East, Central and Southern Africa College of Nursing (ECSACON), established in 1990, as a professional body for nurses and midwives in the ECSA region. ECSA-HC, in collaboration with ECSACON, developed the Fistula Training Package with a curriculum and participant handbook. In FY 2012, through USAID support, ECSACON conducted trainings in ECSA-HC member states reaching over 120 staff in Kenya, Zambia, Uganda and Burundi.[10] In the same year, ECSA-HC officially launched the "Fistula Care Curriculum for Nurses and Midwives" in the ECSA region. The aim was to raise the awareness of policy makers, program managers and planners on the prevention and management of fistulas.[11] The USAID/EA FY 2011 obligation included funds to develop tools for the

[4] KII with a former ECSA Partner (Oct, 2015)
[5] KII with ECSA Secretariat; ECSA Partner; Training & Research Institution (Oct, 2015)
[6] KII with a former ECSA Partner; ECSA Secretariat; former ECSA Affliate (Oct, 2015)
[7] ECSA Strategic Plan (2012 - 2017)
[8] ECSA Quarterly Report (Oct – Dec 2011); 54th Health Ministers' Conference - Resolution ECSA/HMC54/R6 and Recommendations, Kenya (2011)
[9] ECSA Quarterly Report (2012, 2013, 2014)
[10] Strategic Objective Grant Agreement (SOAG) Amendment Number Six (2012); ECSA Quarterly Report (Apr– Jun 2012)
[11] ECSA Quarterly Report (Oct – Dec 2012)

management of difficult breathing among newborns as a component of essential newborn care curriculums.[12]

Implementation of HRAA: *In* 2011, USAID selected ECSA-HC to implement the Human Resource Alliance for Africa (HRAA) program. Since ECSA-HC was a regional intergovernmental organization, it was not appropriate to use the standard ADS3 cooperative agreement that USAID usually signs with international Non-governmental Organizations. Moreover, the process of awarding the HRAA to ECSA-HC was complicated and slow due to several administrative factors.[13] USAID first needed to provide ECSA-HC with technical assistance to improve the organization's financial and HR management systems, procurement systems and marketing plan.[14] However, this USAID assistance had a positive effect: it increased the administrative capacity of the Secretariat overall and facilitated implementation of the HRAA.[15]

In the case of ECSA-HC's HRAA, regional and country-level influences on HRH from Lesotho and Swaziland were evident. HRH became a top priority in regional policy making as a direct or indirect result of USAID support. For example, HRH is now a top priority in the region, as stated in the ECSA-HC's 2012 to 2017 Strategic Plan: HRH is prioritized as ECSA-HC's "niche"—evidence of a step forward. In Lesotho and Swaziland, several direct effects on national HRH policies also are evident and are discussed below under Question 2.

Additional findings related to the implementation of the HRAA are hereby deferred to Evaluation Questions 2 and 3.

B. Support for the adoption of policies and strategies in the ECSA region

Food security and nutrition: A 2009 assessment of ECSA-HC's food fortification activity noted a significant increase in the adoption and/or adaptation of standards and regulations in the East Africa region, with Uganda (slightly more advanced) and Kenya leading the way.[16] However, member states' national food policies did not always incorporate the food fortification policy.[17] ECSA-HC, with USAID support, developed the "Food Security and Nutrition" regional strategy with advocacy materials on food fortification to enhance appreciation of the role of fortification. This encouraged member states to initiate and support the fortification of staple foods.[18]

For example, ECSA-HC and USAID supported the harmonization of standards for fortified foods and the procedures of the East African Community (EAC) according to the decisions of the 14th and 15th meetings of the East African Standards Committee held in Arusha, in May 2010 and June 2011, respectively.[19] With support from A2Z, ECSA-HC developed 17 food control manuals for salt, oil, sugar, maize flour and wheat flour.[20] By 2013, significant progress had been achieved throughout the ECSA region. For instance, Kenya, Uganda and Tanzania mandated the fortification of all or some of the staple foods (wheat, vegetable oil, sugar and maize flour). Malawi mandated fortification of the same staple foods in 2014.[21] Uganda passed legislation in 2011 requiring mandatory fortification of vegetable oil (with vitamin A), wheat flour and maize flour (with iron, folic acid, zinc, vitamin A, niacin and other B vitamins). In Kenya, 25 flour millers and six oil industries signed Memoranda of Understanding with the government to comply with East African standards.

[12] Strategic Objective Grant Agreement (SOAG) Amendment Number Five (2011)
[13] KII with ECSA-HC; two USAID personnel; (Oct, 2015)
[14] Ibid
[15] Ibid
[16] ARF/EA Review of ECSA-HC Food Fortification Activity, 2009
[17] Ibid
[18] ECSA Quarterly Reports Oct – Dec 2011; Jan – Mar 2012; Apr – Jun 2012; KII with former -ECSA Secretariat Affliate (Oct 2015)
[19] EAC Secretariat 1st meeting of the working group on food fortification under the technical committee on nutrition and foods for special dietary uses (Kampala, Uganda 2010)
[20] Strategic Objective Grant Agreement (SOAG) Amendment Number Four (2010)
[21] Food fortification in Africa: Progress to date and priorities moving forward (2013)

Legislation and policies on gender-based violence (GBV) and child sexual abuse (CSA): Recognizing that not all member states had comprehensive legislation and policies on GBV and CSA, ECSA-HC, with support from USAID/EA, and in collaboration with member states, embarked on the development of a regional gender-based violence policy. This participatory approach culminated in the development of a prototype policy document and an implementation framework on GBV and CSA—the "ECSA-HC Regional Prototype Policy on Gender-Based Violence and Child Sexual Abuse" (2010).

Resolution ECSA/HMC50/R4 on "Gender-based Violence and Child Sexual Abuse" passed during the 52nd Health Ministers Conference held in Harare, Zimbabwe, in 2010, and advocated for the adoption/adaptation and implementation of the ECSA Regional Prototype Policy on Gender-Based Violence and Child Sexual Abuse. The resolution also vouched for the establishment and/or strengthening of national gender commissions to oversee GBV- and CSA-related interventions, including coordination, advocacy and the establishment of monitoring and evaluation systems.[22] Between 2012 and 2014, ECSA, with USAID support, facilitated the adoption of a GBV/CSA prototype policy and CSA and clinical guidelines in Kenya, Tanzania, Malawi and Mauritius.[23] With funding from USAID, ECSA-HC also led a coalition of member states, development partners and civil society organizations to develop and commission the guidelines for the clinical management of children who are sexually abused.[24]

C. Expansion and integration of health programs

Access to family planning and maternal, newborn and child health: During the review period (2006 to 2014), ECSA-HC worked with USAID support (FYs 2010, 2011 and 2014) to expand access to family planning (FP) and maternal, newborn and child health (MNCH) services at the community level in the region, and these inititatives made a positive contribution. ECSA-HC worked with the ministries of health in five member states—Kenya, Lesotho, Malawi, Uganda and Zimbabwe—to help them access policies, guidelines, financing and training materials and to implement community-based family planning interventions, thereby addressing the Health Ministers Conference resolutions. In addition, ECSA-HC, in collaboration with FHI360, conducted assessments in these five countries, and in 2011 with USAID support, they also sponsored a regional dissemination workshop to share the results of these assessments.

Conclusions

With USAID support, ECSA-HC has been able to:

- Establish itself as a resource in human resources for health (HRH);
- Support and strengthen training institutions;
- Successfully support the adoption and implementation of policies and strategies in the ECSA region—notably the legislation of GBV and CSA policies and the specifications for food fortification; and
- Facilitate the integration of family planning and MNCH services and expand the accessibility of these services at the community level.

Question 1b: Describe some of the key policy documents, guidelines and strategies that have been drafted by ECSA-HC with USAID support.

Documents produced by ECSA-HC during the period under review were classified into three categories: a) ECSA operational documents, b) health programming documents, and c) curriculum and health workers guidelines.

[22] 52nd Health Ministers' Conference - Resolution ECSA/HMC50/R4 and Recommendations, Harare Zimbabwe (2010)
[23] ECSA Quarterly Reports (2012 – 2013)
[24] Guidelines for Clinical Management of Child Sexual Abuse; KII with a ECSA Affliate

A. ECSA-HC's Operational Documents

ECSA-HC Strategic Plans (2008 to 2012 and 2012 to 2017): The 2008 to 2012 Strategic Plan was adopted at the 46th ECSA-HC Health Ministers Conference, in Seychelles, in February 2008, after the evaluation of the 2004 to 2007 Strategic Plan, which previously had guided the organization's corporate and program activities.[25] The 2008 to 2012 Plan was useful in providing strategic direction and guidance on program design and implementation while the 2012 to 2017 Plan seeks to identify practical and relevant solutions and partnerships and collaborations in tackling the region's health priorities. Besides ensuring continued focus on the priorities established in the 2008 to 2012 Plan, the 2012 to 2017 Plan aims to address the five priorities identified during the preceding Health Ministers Conferences and other global and regional declarations. Goals include: 1) repositioning HRH as a niche for ECSA-HC; 2) supporting the adoption or adaptation of innovative policies, strategies and technologies to improve health service delivery; 3) enhancing equity in the work of the Secretariat; 4) enhancing organizational growth and expansion of health programs; and 5) promoting the integration of programs.

Human Resources Manual (2011): This document defines the policies and procedures adopted by ECSA-HC to regulate employment within the ECSA-HC Secretariat and outlines principles of personnel policy, including: 1) the general obligations of the employer to the employee; 2) the obligations of the employee; 3) the values and employment philosophy of ECSA-HC; and 4) the guiding principles of ECSA-HC (e.g., for the Advisory Committee and the administrative staff of the Secretariat).

ECSA Code of Conduct (undated): As part of ECSA-HC's initiative to improve corporate governance, the code of conduct establishes the organization's principles on professional conduct and conflicts of interest. The guidelines address: actual or perceived conflicts of interest; mitigation procedures; consequences of policy violations; reporting of suspected violations; handling of confidential/privileged information; misuse of organizational assets and resources; compliance with contract and grant obligations; and financial transactions and reporting. It also includes an anti-kickback policy.

Procurement Manual (2008): To improve the transparency and accountability of procurement procedures, this manual provides a set of principles and procedures for the procurement of goods and services in a timely, efficient and economical manner. The manual is intended primarily for operations staff at ECSA-HC.

Financial Rules and Procedures Manual (undated): This manual sets out the rules and procedures governing the financial operations of the ECSA Secretariat. It explains the financial and accounting assumptions and policies adopted by the Secretariat; describes and ensures uniformity in the financial and accounting policies and procedures; provides a reference and guide for new staff; outlines procedures to maintain requisite internal controls; and documents the Secretariat's work ethics.

Grants Management Procedures Manual (undated): This manual sets out the grants management policies and administrative procedures within ECSA-HC and provides implementation tools for the general management and maintenance of an accountable grants management system. It also includes guidance on multiple partner regulations.

Healthcare Financing Policies for ECSA-HC Member States Report (2011): This report provides a profile of member states' healthcare financing and identifies the key policy issues and concerns that require attention. It includes: member states' epidemiological profiles; an assessment of key health system challenges; a description of the trends in total health expenditures and their sources (including private, out-of-pocket expenditures); government health expenditures; and external sources of funds. The report also details each member state's healthcare financing situation and context, its National Health Account (NHA) status and its progress towards national health insurance.

[25] ECSA Mid-Term Review 2008; Resolution of the 46th HMC (Mahe, Seychelles, 2008); KII with ECSA – Secretariat (Oct, 2015)

B. Health Programming Documents

Food Fortification and Inspection Manuals (2007): ECSA-HC developed a series of fortification guidelines for the food industry in the region focusing on the fortification of staple foods. The guidelines also include a reference manual for enhancing food inspection standards. Examples of these documents include: manuals for: the internal monitoring of sugar premix containing vitamin A; fortified maize and wheat flour; salt fortified with iodine; and oil fortified with vitamin A. Also included are manuals on laboratory methods for inspecting fortified foods with specified test methods to determine the levels of iron, vitamin A and riboflavin in fortified flours.

Regional Prototype Policy on GBV and CSA (2010): Developed through collaboration with USAID/EA and UNICEF-ESA Regional Offices, this document provides a strategic framework for the prevention of and response to GBV in ECSA-HC member states. Its purpose is to assist stakeholders in the member states to improve and expand their programmatic efforts to prevent and respond to GBV.

Guidelines for the Clinical Management of CSA (2011): This is a comprehensive, regional document that focuses entirely on the clinical management of child sexual abuse. It serves as a useful reference for healthcare professionals, social workers, court witnesses and legal specialists.

Standard Package for Expanding Access to Family Planning and to Maternal, Newborn and Child Health Services at the Community Level (2014): This document gives an overview of the current status of the Millennium Development Goals 4 and 5, addresses the ECSA-region health- sector policies and strategic planning and covers ownership and management of health facilities in the region. The document serves as a reference for policy makers working to improve the quality of health services.

C. Curriculums and Health Workers Guidelines

Continuing Professional Development (CPD) for Nurses and Midwives (2013): This document provides a framework for the continuing professional development of nurses and midwives to help them maintain their professional competence and acquire new knowledge over time.

The Prevention and Management of Obstetric Fistula—A Curriculum for Nurses and Midwives (2012): This curriculum addresses the critical medical issues of fistula, including preventive care, surgical treatment and postoperative recovery. The curriculum also includes information dissimination, education, family and community involvement, counseling, and data collection and utilization.

Nutrition and HIV/AIDS—A Training Manual for Nurses and Midwives (2008): This manual provides support to nursing school instructors and trainers and offers a range of materials and information on how to provide effective nutrition, care and support to people living with HIV and AIDS.

(Please refer to Annex V for a comprehensive list of key documents produced by ECSA-HC during the eight years of USAID/ECSA-HC engagement.)

Conclusions

- ECSA-HC, with USAID support, played a crucial role in the formulation and development of key policy documents, guidelines and strategies. However, these documents are not widely disseminated.

Question 1c: What are the successes/best practices and challenges in moving from an ECSA-HC policy level to country uptake?

A. Best Practices and Challenges

Interviewees mentioned several ECSA-HC successes, best practices and challenges concerning the evolution of ECSA-HC policy uptake in member states. Below are examples of those most often mentioned by various respondents:[26]

- Active management of the third stage of labor (AMTSL)
- Cross-border disease surveillance
- Food classification and fortification program
- Tracking of Millennium Development Goals (MDGs) in member states by the ECSA-HC Secretariat
- Strong HMC resolutions that were taken up in member states on GBV/CSA, MNCH and RH/FP
- Surveillance laboratory methods for disease outbreaks
- Tuberculosis (TB)/Multi Drug Resistance-TB (MDR-TB) co-infection
- Training of surgeons by College of Surgeons of East, Central and Southern Africa (COSECSA)

Informants shared several specific examples:

1. There is evidence of increased awareness in six countries (Kenya, Uganda, Tanzania, Ethiopia, Malawi and Zambia) on the devastating effects of post-partum hemorrhage. This increased awareness resulted in a strategy (being promoted in the region) to reduce post-partum hemorrhage at the community level.[27]
2. Model national policies on gender-based violence have been developed for use at the country level along with advocacy work to prevent GBV in the region.[28] As a result, ECSA-HC has developed an "Implementation Framework for GBV Prevention and Control" to integrate GBV prevention into national health programs. The nine member states have unanimously adopted this framework. (A detailed case scenario of successful implementation of GBV/CSA policies is discussed under Question 1f.)
3. The report on food fortification in Africa—progress to date and priorities moving forward—noted significant progress in food fortification and the harmonization of fortification standards and regulations across the ECSA region.
4. Cross-border disease surveillance using laboratory methods for outbreak investigations was cited as a major achievement in the ECSA region and has raised awareness on the importance of cross-border surveillance and monitoring of diseases.[29]

Based on interviews, respondents noted the challenges in moving from the ECSA-HC policy level to country uptake. These include: the high number of HMC meetings; the numerous resolutions to be tracked; the high turnover of health ministers and key MOH staff; the lack of a tracking system to document the uptake of resolutions at the country level; dependency on USAID and PEPFAR bilateral support; and a lack of implementation funds in some of the member states.[30]

[26] KII with Training & Research Institution; Scientist at Training & Research institution; Director at a Training & Research Institution; PEPFAR IP/ Regional training center; USAID; Director in a national government department; Director within a MOH (Oct, 2015)
[27] AMTSL (Uganda survey, 2007); Kenya: Assessment of health workforce competency & facility readiness to provide quality maternal health services (USAID, 2008); Facility-based AMTSLTanzania - Mfinanga et al (2009); Facility-based AMTSL & Community Perceptions on Post-Partum Hemorrhage (2006)
[28] Kenya: Sexual Offences Act (Cap 62A); GBV training manual, Uganda; GBV in Tanzania: An assessment of services, policies and promising interventions (2008); GBV in Malawi: A literature Review to inform policy (2015)
[29] KII with IP and Training and Research Institutions (Oct, 2015)
[30] Interview with EAC Secretariat; Scientist at Training and research center; Director at a regional training & knowledge center; USAID; Director in a national government department (Oct, 2015)

Conclusions

- The lack of a formal monitoring system to track progress made on policies and directives on health issues recommended by the HMC and ECSA-HC Secretariat made it difficult for the evaluation team to conclusively state the level of success in moving from the ECSA-HC policy level to country uptake.
- ECSA-HC successfully supported the adoption and implementation of policies and strategies in the ECSA region—notably, in the legislation of GBV and CSA policies and specifications in food fortification.
- ECSA-HC seemed to have too many HMC resolutions and lacked a systematic way of linking the new resolutions with progress made from previous resolutions.

Question 1d: Describe some of the USAID/EA-supported best practices, key policy issues and approaches that have arisen from the annual best practice session?

ECSA-HC, through USAID support, held annual theme-based best practices sessions to share selected regional program success stories among the member states. These sessions enabled ECSA-HC to increase its visibility in the region and provided the Directors' Joint Consultative Committee (DJCC) with a forum to make recommendations urging health ministers to enforce key public health policies.[31] Several best practices sessions were held during the period under review. Two are presented in detail (below) to illustrate the best practice process and the effect of USAID support:

A. The 1st Regional Forum on Best Practices in Health Care and the 17th Directors' Joint Consultative Committee (DJCC) meeting

These two meetings (the Regional Forum and the DJCC meeting) were held consecutively in September 2007 in Arusha, Tanzania, with the theme: "Improving the performance of health systems for effective delivery and access to health interventions in ECSA." A total of 42 abstracts were presented at the best practice session covering a broad range of topics, including the scaling up of HRH; strengthening disease control (HIV/TB/malaria and non-communicable diseases); access to essential medicines and drugs; and health-care financing.

a. Key Policy Issues and Approaches

The 46th Health Ministers Conference in Mahe, Seychelles, in 2008, adopted twelve resolutions ECSA/HMC46/R1 to R12 drawing on advice from the First Regional Forum on Best Practices in Health Care (noted above). Two key resolutions are described below:

i. ECSA/HMC46/R1: "Strengthening Health Systems to Ensure Equitable Access to Health Care." This resolution specifically urged member states to engage and encourage partners and stakeholders in the health sector to find the ways and means to protect families from healthcare-related financial constraints. The resolution recommended that member states provide their citizens with universal financial coverage against health risks by the year 2010. It also urged member states and stakeholders to develop policies that would ensure universal access to quality and comprehensive (preventive, promotive and curative) healthcare services at all levels of the healthcare system.

ECSA-HC, through USAID support (FY obligations 2009 to 2011), promoted health governance and financing activities to increase access to maternal and child health and family planning services. It analyzed the financial and economic issues that prevent people from accessing these services and advocated for financing approaches that would make health care more accessible. In 2009, ECSA-HC conducted a regional training for MCH National Health Accounts and an analysis of efficiency in health care.[32] The

[31] ECSA Quarterly Report (Jan - Mar 2013)
[32] ECSA Quarterly Report (Jul - Sep 2009)

ECSA-HC Secretariat profiled healthcare financing in its member states in order to understand healthcare costs and to identify the key policy issues and concerns that required attention. The next step was to design focused and relevant evidence-based activities and to mobilize appropriate technical support for member states.[33]

ii. "Improving Human Resources for Health for Effective Health Care Services." This resolution urged member states (among other actions) to accelerate the establishment and use of the National Health Workforce Observatories (HWOs). The HWOs would improve the quality of evidence and information on health workforces, facilitate informed policy dialogues, and monitor and evaluate human resources for health strategies by 2010.

Through USAID financial and technical assistance, ECSA-HC supported its member states to establish and strengthen the HWO to support activities that would address HRH challenges. This included promoting, developing and sustaining a firm knowledge base for HRH information to be used at the district, regional and national levels and to be founded on evidence-based and up-to-date HRH information and analyses.[34]

B. The 7th Regional Forum on Best Practices in Health

This forum was held in Arusha, Tanzania, in 2013, and brought together senior officials from the ministries of health, health researchers, heads of health training institutes from member states and diverse collaborating partners from in and outside the region. The forum was held to identify policy issues and make recommendations to accelerate and scale up best practices in the ECSA region.[35] The Forum's theme was "Strengthening the Response to Emerging and Re-emerging Health Concerns." Its goal was to identify key policy issues, best practices and evidence-based approaches and to develop recommendations to strengthen the response to emerging and re-emerging regional health concerns.

The sub-themes of the Forum were: 1) "Integration of Non-Communicable and Communicable Disease Programs," 2) "Addressing Adolescent Health Issues"; and 3) "Strengthening Global Health Diplomacy for Equity in Public Health Delivery."

a. Key Policy Issues and Approaches

The above best practices forum was followed by the 58th Health Ministers Conference which adopted ten resolutions (ECSA/HMC58/R1 to R10).[36] Of note, are three resolutions: 1) ECSA/HMC58/R1: "Strengthening Global Health Diplomacy for Equity in Public Health Delivery through Strong Health Systems"; 2) ECSA/HMC58/R7: "Standard Practice Package for Expanding Access to Family Planning, Maternal, Newborn and Child Health Services at the Community Level"; and 3) ECSA/HMC58/R8: "Implementation of the Roadmap for Scaling up the Human Resources for Health in the African Region."

ECSA/HMC58/R1 proposed establishing focal points in each member state to institutionalize multi-sectoral coordination on global health diplomacy. It also proposed engaging with and building domestic expertise and capacities in global health diplomacy and developing related public health tools, including stronger and timely dialogues with parliaments and national non-state actors. The lack of capacity in global health diplomacy was noted as a major gap among ECSA-HC stakeholders during the key informant interviews.[37]

[33] Health Care Financing Profile 1995 - 2009
[34] ECSA Quarterly Report (2012, 2013, 2014); KII with a former ECSA Affliate (Oct, 2015)
[35] ECSA Quarterly Report (Jul - Sep 2013)
[36] 58th Health Ministers' Conference - Resolution ECSA/HMC58/R6 –R10 and Recommendations, Arusha, Tanzania (2014)
[37] KII with a former ECSA Affliate; KII with Leadership of a Training & Research Institution (Oct, 2015)

ECSA/HMC58/R7 directed the ECSA-HC Secretariat to disseminate and support the member states in implementation of the "Standard Practice Package for Expanding Access to Family Planning and Maternal, Newborn and Child Health at the Community Level."[38]

ECSA/HMC58/R8 urged member states to offer their support for the ECSA-HC College of Health Sciences through the allocation of resources, recognition, accreditation of programs and any other means necessary for the operation of the college and its constituent colleges.[39]

Question 1e: What are some key recommendations that have been made to the annual Health Ministers Conference and what are the key resolutions that have come out of these recommendations? What is the country-level ownership of these resolutions?

The Directors' Joint Consultative Committee (DJCC) identified policy issues and made recommendations based on the best practices sessions and other sources. During the period under review, a number of recommendations emerged and were submitted to the HMC for approval and adoption. Select key recommendations and resolutions mentioned repeatedly by key informants are listed below.

A. Select Key Recommendations and Resolutions

a. 46th HMC in Mahe, Seychelles (2008)

Resolution ECSA/HMC46/R10: Nutrition Interventions for Promoting Health and Survival": This resolution advocated for the adoption and acceleration of the implementation of infant and young child feeding policies and guidelines and national plans of action based on a global-level strategy to strengthen coordination among nutrition, HIV and AIDS and PMTCT. It also proposed accelerating child survival and development initiatives and the adoption of and implementation support for the ECSA-HC food fortification guidelines by the end of 2009.[40]

The Secretariat was directed to:

1) Ensure the dissemination of best practices and to support accelerated implementation of several initiatives. These included: "Infant and Young Child Feeding" in the HIV and child-survival context; "Sustained Iodine Deficiency Disorders" to eliminate these disorders and help member states accelerate their progress through universal salt iodization; vitamin A supplementation; and iron and folic supplementation in pregnancy;

2) Support member states to adopt and implement guidelines on food fortification; and

3) Advocate for the scaling up of national food fortification programs.[41]

b. 50th Health Ministers Conference in Kampala, Uganda (2010)

ECSA/HMC50/R1: "Health Insurance and Financing": This resolution urged member states to adopt pro-poor and equitable health insurance schemes tailored to each state's unique demographic, economic and health system circumstances. Member states also were encouraged to integrate these schemes within their state's broader health financing policy. During the same conference, the HMC urged the member states to embrace their stewardship role and develop regulations to govern health insurance schemes that protect against exploitation and promote transparency, equity and financial sustainability.

[38] Findings and Recommendations from a regional Assessment on Expanding Access to FP and MNCH at Community Level (2011); ECSA Quarterly Report (Oct – Dec 2012); Standard Practice Package for Expanding Access to FP and MNCH at Community Level (2014)
[39] Ibid
[40] HMC Resolutions 1974 – 2014; KII with Leadership of a Training & Research Institution; Technical Advisor-in a Training & Research Institution, RCQHC (Oct, 2015)
[41] HMC Resolutions 1974 – 2014

c. 52nd Health Ministers Conference in Harare, Zimbabwe (2010)

ECSA/HMC52/R3: "Maternal Child Health/Reproductive Health/Family Planning": This resolution urged the member states to adopt/adapt the "Model Fistula Policy," translate it into effective programs for implementation and establish multi-sectoral structures, as appropriate. The resolution also urged member states to:

- develop comprehensive training programs at the pre- and in-service levels to address issues of stigma, attitude, client care and quality service provision in light of cultural and traditional concerns;
- accelerate implementation of Resolution ECSA/HMC48/R5 which comprehensively addressed issues of task-shifting concerning unmet family planning needs, unsafe abortion and post-abortion care;
- develop mechanisms for the evaluation and use of cost-effective, long-acting family planning methods;
- develop guidelines and standards for delivery of family-planning services in underserved and hard-to-reach areas;
- link the best-practices identification process with high-impact interventions based on global and regional evidence; and
- strengthen evidence-based, youth-friendly, family-planning and other reproductive health services.[42]

ECSA/DJCC20/R5: "Human Resources for Health Leadership and Management for Quality Health Services": Through this resolution, the HMC urged the member states to:

- accelerate the implementation of the ECSA-HC initiative on supporting strategic leadership in global health diplomacy in the ECSA region;
- provide safe and conducive workplace environments in the spirit of the "Positive Practice Environment";
- mobilize resources and offer competitive benefits packages to attract and retain health personnel in order to improve equity and access to health services especially in rural and remote areas;
- strengthen nursing and midwifery training, regulation, service delivery and the related leadership and management skills to ensure quality health care, especially at the lower levels of the healthcare system; and
- share existing best and promising practices on the attraction and retention of health personnel and also share evidence on the implementation of WHO's "Global Code of Practice" concerning the international recruitment of health personnel in the region.[43]

ECSA/HMC52/R4: "Gender-based Violence (GBV) and Child Sexual Abuse (CSA)": This resolution advocated for the adoption, adaptation and implementation of the ECSA-HC "Regional Prototype Policy on Gender-Based Violence and Child Sexual Abuse." It also recommended the establishment and/or strengthening of the National Gender Commission to oversee GBV- and CSA-related interventions, including coordination, advocacy and the establishment of monitoring and evaluation systems.[44]

Resolution ECSA/HMC52/R6: "Prioritizing Nutrition Interventions": This resolution directed the ECSA Secretariat to support member states to implement known high-impact interventions such as essential nutrition actions, food fortification and other initiatives to accelerate achievement of nutrition-related targets.

[42] Ibid
[43] HMC Resolutions 1974 – 2014; KII with ECSA-Secretariat; a former ECSA Affliate (2015)
[44] Ibid

d. 58th Health Ministers Conference in Arusha, Tanzania (2014)

Resolution ECSA/HMC58/R8: "Implementation of the Roadmap for Scaling up Human Resources for Health in the African Region": This resolution proposed periodic progress reports to document implementation of the "Roadmap." It also asked for member state support for the ECSA-HC College of Health Sciences through the allocation of resources, recognition, accreditation of programs, and any other means necessary for the operation of the college and its constituent colleges.[45]

Resolution ECSA/HMC58/R7: "Standard Practice Package for Expanding Access to Family Planning, Maternal, Newborn and Child Health Services at the Community Level": This resolution urged member states to adapt and implement the "Standard Practice Package" at the appropriate levels of care. This was meant to support the regional assessment on expanding family services at the community level (2011) and was conducted in several countries including Uganda, Zimbabwe, Lesotho and Malawi. The ECSA-HC Secretariat was directed to disseminate and support the member states for implementation of the "Standard Practice Package."[46]

B. What is the country-level ownership of resolutions?

According to the ECSA-HC Secretariat, the member states are at different stages in adapting and implementing the policies and resolutions passed at the Health Ministers Conferences.[47] However, according to the evaluation team (to the best of their knowledge), no effective or formal system exists to track the uptake (adoption) and implementation of HMC resolutions in member states.

The adoption or implementation of resolutions in the member states was found to be dependent on several factors including those presented above. (See Question 3c.) Other factors evident from the interview analysis were: the capacity of ECSA-HC to advocate for member state adoption; the degree of dissemination of resolutions; and the level of support, capability and funding within each member state.[48] One key informant commented that there were too many resolutions each year (six to twelve) and that it was difficult for member states to keep track of these and implement them. For this reason, resolutions in health areas that were also supported as projects at the regional or country levels were most likely to be adopted and implemented.[49]

The findings below demonstrate the level of uptake of key policies among member states.

Health insurance and financing: According to the state of health in the ECSA-HC regional report (November 2011), the total expenditure on health per capita (health financing) varied extensively across member states ranging from between five percent and 12 percent of Gross Domestic Product (GDP), with Lesotho at 12 percent and Malawi at 10 percent. Kenya and Tanzania had the lowest at 5 percent. The report also noted that Kenya and Tanzania are the only two countries implementing national health insurance schemes. Malawi has only a privately owned health insurance scheme, while Swaziland and Uganda insurance schemes were in the developmental stage. In Zambia, a revenue mobilization strategy to support the Zambian social health insurance scheme was drafted in 2012.[50] The strategy noted limited capacity for mobilization of domestic revenues as a constraint to sustaining health interventions. This strategy was followed by an actual assessment (October 2012) for the establishment of a social, health insurance scheme in Zambia. The assessment recommended various scheme options with a 12 percent

[45] Ibid
[46] HMC Resolutions 1974 – 2014; KII with ECSA-Secretariat; a former ECSA Affliate (2015)
[47] KII with ECSA-Secretariat (Oct, 2015); a former ECSA Affliate (Oct, 2015)
[48] KII with ECSA-Secretariat; USAID; Training & Research Institution (Oct, 2015)
[49] KII with a former ECSA Affliate - ECSA-Secretariat (Oct, 2015)
[50] Design of the Social Health Insurance Scheme for Zambia, Ministry of Health, Zambia (Sep, 2012); Actuarial Assessment for Establishment of a Social Health Insurance Scheme in Zambia (Oct, 2012)

projected increase in the number of insured persons to help ensure sustainability in terms of membership coverage, contributions and reserves generated per annum.[51]

These assessment reports and strategies (released after the 50th Health Ministers Conference resolution passed in 2010: ECSA/HMC50/R1 on Health Insurance and Financing)[52] clearly demonstrate the variations in the uptake of healthcare financing across ECSA member states.

Maternal Child Health/Reproductive Health/Family Planning: On the implementation of HMC resolution ECSA/HMC50/R3: "Maternal Child Health/Reproductive Health/Family Planning," ECSA-HC, in collaboration with USAID/EA and other partners, conducted an orientation meeting on "Fistula Care Curricula" for chief nursing officers who play a key role in ensuring that the curricula is incorporated in the Nursing and Midwifery training programs. The participants were drawn from Lesotho, Malawi, Mauritius, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe.

Gender-based Violence (GBV) and Child Sexual Abuse (CSA): On the implementation of HMC resolution ECSA/HMC50/R4: "Gender-based Violence (GBV) and Child Sexual Abuse (CSA)," a report in 2013 on scaling up advocacy for GBV and CSA in the ECSA region noted that knowledge on the status of CSA was still sparse in the region.[53] The report emphasized that multi-sectoral GBV interventions were feasible despite the limitations in many countries. The report also cited "Population Council" reports on Africa's regional sexual and gender-based violence network highlighting multi-sectoral models of care currently in use in Kenya, Malawi, South Africa, Swaziland and Zambia. These models are cited as feasible and effective with potential for scale-up in the ECSA region.

Nutritional Interventions: On the implementation of HMC resolution ECSA/HMC50/R6: "Prioritizing Nutrition Interventions," there was evidence of different levels of adaptation of policies supporting the mandatory fortification of staple foods.[54] For instance, by 2013 Kenya, Uganda, and Tanzania had mandated the fortification of all or some of the staple foods (wheat, vegetable oil, sugar and maize flour). Malawi mandated fortification of the same staple foods in 2014.[55]

Conclusions

- The passing of resolutions based on DJCC and Expert Committees' recommendations was a successful but often slow process taking around two years from formulation to member state uptake. However, the Secretariat was limited in advocating for and ensuring implementation in the member states.
- The ECSA-HC lacks a formal tracking mechanism for the implementation of HMC resolutions in the member states.
- There are far too many HMC resolutions and many were not followed-up on or advocated for at the regional and country levels. Consequently, ECSA-HC needs to increase its focus to follow up on implementation and gather feedback on experiences, challenges and constraints encountered.

Question 1f: How successful have ECSA-HC member states been in rolling out the key policies and resolutions from the HMC, and what methods have been used to disseminate these resolutions?

The respondents' views on the rolling out of key policies and resolutions were mixed. As one ECSA-HC partner stated: "There was a time set for when countries should report on the implementation of resolutions from the previous year. That was an interesting forum because the ministers didn't even know that they were implementing things, but their technical officers knew. The planning sections of the Ministries of Health needed to be sure and to be on top of it so that they [could] prepare the presentation

[51] Ibid
[52] Resolution of the 50th HMC (Kampala, Uganda, 2010)
[53] ECSA-HC, Scaling up Advocacy for Gender-based Violence ad Child Sexual Abuse in the ECSA region, Arusha, Tanzania, Sept 2013
[54] Policy briefs on fortification of oil, sugar and flour in ECSA (Vol.4, No.5, 2012)
[55] Food fortification in Africa: Progress to date and priorities moving forward (2013)

for their minister. In my view, that was one of the useful ways of putting peer pressure among the countries. The planning units within the ministries of health needed to know what was agreed on and to coordinate with the other departments—be it on issues on HIV, reproductive health, or nutrition." (KII with ECSA-HC Partner-Oct, 2015) The language of the HMC resolution was noted as too technical for the actual implementers within the member states.[56] However, there were instances where the roll out of key policies was very successful. The findings below on the implementation of GBV and CSA policies provide a case scenario where such roll out was successful.

A. Successful implementation of GBV and CSA regional policies

Looking at the period under review, three key HMC resolutions on GBV and CSA were passed during the 42nd, 48th and 52nd Health Ministers Conferences. In 2006, during the 42nd Health Ministers Conference, the HMC passed resolution RHMC/42/R8: "Maternal/Reproductive Health, Newborn and Child Health," urging member states to review and strengthen legislation to effectively address GBV and sexual offenses especially those against women and children. This was passed in recognition of the serious and pervasive human rights issues that GBV and CSA raises within ECSA member states and that causes many negative emotional, physical and public health consequences. Of note, Kenya in particular, enacted the Sexual Offences Act (passed in 2006) in response to escalating sexual violence.[57] Through USAID's support, ECSA developed the "Sub-regional Implementation Framework for Gender-based Violence Pevention and Control" (2008-2009) and the "Regional Prototype Policy on GBV ad CSA (2010)." These documents were created to assist member states in improving and expanding their programing efforts to prevent and respond to GBV and CSA.

During the 48th Health Ministers Conference held in Swaziland, in 2009, the HMC passed resolution ECSA/HMC48/R6: "Gender-based Violence," urging the member states to develop and review existing GBV legislation, policies, and strategies. States also were encouraged to ensure adequate resources for multi-sectoral implementation plans by December 2010. The following year, during the 52nd Health Ministers Conference, held in Harare in 2010, the HMC passed resolution ECSA/HMC50/R4: "Gender-based Violence (GBV) and Child Sexual Abuse (CSA)," which urged member states to adapt and implement the ECSA Regional Prototype Policy on Gender-Based Violence and Child Sexual Abuse.

Through USAID's support, ECSA facilitated the implementation of the prototype in various countries including Kenya, Tanzania, Malawi and Mauritius.[58] ECSA, through USAID support, also developed comprehensive guidelines for the clinical management of CSA (July, 2011). This built on the extensive work done by the World Health Organization (WHO) on CSA. The purpose of these guidelines was to standardize the care of sexually abused children. The launch of these "Clinical Guidelines" on the management of CSA was successful in Kenya, Uganda, Tanzania, Zimbabwe, Zambia, Lesotho, Swaziland, Malawi and Mauritius.[59] These guidelines were disseminated through community-wide meetings and skills-building workshops (covering FP/RH and CH, and GBV and CSA policy issues) and at various forums, including during the Health Ministers Conferences.[60] However, the report, in 2013, on scaling up advocacy for GBV and CSA in the ECSA region noted that knowledge on the status of CSA was still sparse in the region.

[56] KII with two Training & Research Institutions (Oct, 2015)
[57] Kenya Sexual Offenses Act (2006); KII with a former ECSA Affliate (Oct, 2015)
[58] ECSA Quarterly Reports (Oct – Dec, 2011, 2012, 2013)
[59] ECSA Quarterly Reports (Oct – Dec, 2011)
[60] ECSA Quarterly Report (Oct – Dec 2011); ECSA Sub-Regional Implementation Framework for Gender-Based Violence Prevention and Control (2009)

B. Successful implementation of food fortification policies

Another notable success in policy implementation was in the adoption of food fortification policies. The report on Food Fortification in Africa (progress to date and priorities moving forward) noted significant progress in food fortification throughout the continent. The report also noted that the harmonization of fortification standards and regulations across sub-regions had facilitated the growth and development of fortification programs by encouraging trade and expanding the size of the fortified food markets. ECSA-HC disseminated food fortification specifications through manuals to industries and in workshops on the harmonization of standards and policy briefs.[61]

C. Dissemination methods

The dissemination of HMC resolutions was carried out through various channels. Resolutions were shared with attendees during the HMC session with the expectation that member state government representatives and others, in turn, would disseminate these among their respective constituencies. ECSA-HC also sent resolutions through its email list and made them available on the ECSA-HC website. However, technical experts and staff at the ministries of health were not always aware of the website nor were they included on the mailing list. In addition, ICT capacities vary across countries; some are weaker than others. The private sector distributed some resolutions (e.g., food fortification) and laboratory networks delivered others. In some cases, a government minister would depend on its MOH Planning Unit to inform him/her about any resolutions, but this did not always occur, and some ministers did not know what they were supposed to be implementing.[62]

Overall, the dissemination of resolutions and information was a challenge for ECSA-HC. USAID/EA recently enhanced its support to ECSA-HC by improving the organization's knowledge management capabilities through K4Health.

Some specific dissemination efforts included:

- Workshops on the guidelines for the harmonization of food fortification (Kampala, Uganda, 2010)
- Policy briefs on food fortification
- Support to Tanzania, Uganda and Ethiopia to disseminate findings on the "Active Management of the Third Stage of Labor" (AMTSL). The findings of AMTSL in Ethiopia and Tanzania were also disseminated during the 42nd HMC meeting in Mombasa. Disseminations also were done in-country by the postpartum hemorrhage working groups in Ethiopia (June, 2007) and in Tanzania (September, 2007). The AMTSL study in Uganda was completed in December 2007.[63]

Conclusions

- There are excellent examples of success in the dissemination of resolutions at the country level. Overall, however, a major gap exists on the systematic tracking of resolution implementation at the country level and in executing follow-up activities to promote and advocate for resolution adaptation.

Question 1g: Has there been real peer review by country on implementation progress and have countries borrowed and adapted policy solutions across borders?

ECSA-HC meetings have served as a peer review forum, giving member states an opportunity to share lessons learned across borders.[64] This includes document exchange, research, and interventions and collaboration through existing networks like the Regional Centre for Quality of Health Care (RCHQC).

[61] Policy briefs on fortification of oil, sugar and flour in ECSA (Vol.4, No.5, 2012)
[62] KII with a former ECSA Affliate (Oct, 2015)
[63] ECSA Quarterly Report (Oct – Dec 2007)
[64] KII with Leadership of Training & Research Institution; Director at a regional training & knowledge center; PEPFAR IP/ Regional training center; Leadership at a Training & knowledge center; Director in a national government department; USAID (Oct, 2015)

An example of such a forum is: a consultative meeting on the lessons learned during implementation of the essential nutrition actions (ENA) held in Nairobi in 2011.

4.1.2. Overall conclusions for Evaluation Question 1

Several conclusions can be drawn from the interviews and document review to address the extent that USAID support has been able to influence regional and country-level policies.

A. Regional-level policies

USAID's support to the ECSA-HC Secretariat was well founded given the Secretariat's convening power and wide political support from the member states. USAID engaged (directly and indirectly) with the ECSA-HC—an intergovernmental body with strong potential to support transnational programming and address the region's health system challenges.

The ECSA-HC Secretariat has had notable successes in passing key HMC resolutions, holding best practices forums and implementing health-related initiatives. These successes, often "project-based," were directly related to USAID support and a component of USAID's development agenda. There are several examples worth mentioning, but those most cited in the interviews included: food fortification, MNCH, RH/FP, GBV, TB/MDR, national accounting systems and HRH. It must be noted that these focus areas were not only addressed by the Secretariat but also by other regional and country implementing partners supported by USAID and PEPFAR. Several of these partners provided technical assistance to the Secretariat bodies and conducted separate in-country and cross-country initiatives.

B. Country-level policies

On the passage of resolutions, best practices documentation and advocacy at the regional and country levels, the ECSA-HC Secretariat's efforts were weak. On these matters, they did not inform effectively the member states or the broad range of partners, implementers, universities and regional networks. This is due primarily to the Secretariat's weak ICT and M&E systems and to a general lack of follow-up.

USAID funding facilitated the passing of key resolutions by the DJCC and the Health Ministers Conferences and supported cross-country fertilization through documents and meetings. However, for the adoption of policies within each member state, success varied and often was dependent on cooperation and support from the member states' ministries of health and on stable governance systems and bilateral support within each country. Neither ECSA-HC nor USAID/EA were able to provide financial support to the member states to implement policy resolutions. It was expected that countries would prioritize the resolutions and include them in their strategic plans to be funded by their respective governments or through general resources raised by partners.

Technical assistance was dependent on either the Secretariat's limited workforce or on collaboration between USAID's regional and bilateral offices. Nonetheless, several key policy changes were made in select countries. Examples include policies and regulations on HRH in Lesotho and Swaziland (HRAA) and the country uptake of resolutions on GBV and food fortification.

4.2. Technical Support

4.2.1. Evaluation Question 2

Evaluation Question 2: To what extent have USAID-supported programs responded over the years to thematic priorities as outlined in the ECSA-HC strategic plans and other regional strategies agreed to by member states?

A. ECSA Thematic Priorities

The ECSA-HC's Strategic Plan 2008 to 2012 addressed the region's disease burden and the priorities identified in the HMC resolutions and from the Health Ministers Conferences. The Plan also considered the recommendations of the Advisory Committee, DJCC and Experts Committees and the priority health

challenges identified during the review of the preceding Strategic Plan (2004 to 2007). The health priorities of the ECSA region then included: 1) attainment of the Millennium Development Goals in the region, specifically MDG4 (Improving Child Health), MDG5 (Reducing Maternal Mortality) and MDG6 (Combating HIV/AIDS, TB and Malaria and Other Infectious Diseases); 2) improving the nutritional status of children, mothers and vulnerable populations; 3) HRH including management, training, capacity building and professional development; 4) development of policy analysis and advocacy; 5) enhancement of health systems and service delivery; 6) research, knowledge management and dissemination; and 7) monitoring and evaluation of policies and programs.[65]

The ECSA-HC Strategic Plan 2012 to 2017 sought to identify practical and relevant solutions, partnerships and collaborations in dealing with the region's health priorities. It also ensured continued focus on priorities established in prior Strategic Plan (2008 to 2012). The current plan addresses five priorities: 1) repositioning HRH as a niche for ECSA-HC; 2) supporting the adoption or adaptation of innovative policies, strategies and technologies to improve health service delivery; 3) enhancing equity in the work of the Secretariat; 4) enhancing the organizational growth and expansion of health programs; and 5) promoting the integration of programs.

In addressing these priorities ECSA-HC proposed the following strategic objectives: 1) to contribute to the development and strengthening of member states' health systems with emphasis on HRH; 2) to strengthen the development of evidence-based policies and programs in member states; 3) to support member states in collecting and utilizing data for decision-making; 4) to strengthen the ECSA-HC governing structures at all levels; 5) to strengthen collaboration and partnerships with member states and other organizations (local, regional and international); 6) to reinforce linkages between the ECSA-HC Secretariat and member states' country programs and activities; and 7) to increase the visibility of ECSA-HC.[66]

B. USAID/ECSA Collaboration

In September 2006, USAID/EA and ECSA-HC signed a Strategic Objective Grant Agreement (SOAG) to collaborate on activities designed to achieve the USAID strategic objective of "a healthier population in the East and Central Africa (ECA) region achieved through African leadership." This came under ECSA-HC's 2004 to 2007 Strategic Plan and its focus included: promoting practices and policies in health and HIV/AIDS in the ECSA region; strengthening (and increasing) local capacity to respond to key health and HIV issues; and ensuring that effective programs targeting vulnerable populations are implemented.

USAID's response to ECSA-HC's thematic priorities (and vice versa) has been a two-way street based on a common understanding of regional health needs and priorities. While ECSA-HC's thematic priorities are established by the member states through the Health Ministers Conferences (also considering cues from global health forums), USAID responds to global forums and individual member states, but also has had its own specific priorities, e.g., HRH and MCH.[67]

USAID supported two health priorities (directly or indirectly through the SOAG in 2006 and program elements specified in SOAG amendments): 1) attainment of the MDGs and 2) improvement in the nutritional status of mothers, children and vulnerable populations in the region.[68] Consequently, USAID regional support to ECSA-HC strengthened some of the organization's thematic areas more than others. Moreover, shifts in USAID priorities often seemed to move faster than the ECSA-HC's ability to adapt. In addition, USAID regional office priorities were not always the same as those at USAID's bilateral offices, and this created confusion for ECSA-HC.[69] Despite these challenges, ECSA-HC's member states adopted

[65] ECSA Strategic Plan (2008 - 2012)
[66] ECSA Strategic Plan (2012 - 2017)
[67] USAID/ECSA SOAG (2006)
[68] Ibid
[69] KII with –ECSA & EAC (Oct, 2015)

and analyzed at least nineteen policies and a number of promising practices that responded to priority needs in reproductive, child and maternal health and infectious diseases throughout East and Central Africa.[70] Experts also made recommendations such as expanding access to MNCH service delivery at the community level.[71]

Question 2a: How has the change in USAID priorities over the years affected ECSA-HC's strategic focus and areas of priority?

A. ECSA-HC's strategic focus and areas of priority

Overall, USAID/EA support over the years has been based on the ECSA-HC's strategic plans. As such, USAID priorities have not derailed ECSA-HC from its strategic focus.[72] However, reduced funding levels and changing USAID priorities have caused some disruption of ECSA-HC program plans. For example, when ECSA-HC receives USAID funding, often specific USAID program priorities must be met. While these priorities fall within the list of multiple priorities of ECSA-HC,[73] still such changes require ECSA-HC to shift its focus and to alter and align its work plans with the new USAID priorities. Communication from USAID on program changes has usually been sudden and unexpected and at times has removed and/or introduced new layers of activities or new USAID Technical Officers.

USAID priorities and funding obligations: After the SOAG was signed in 2006, the following years of USAID/ECSA-HC engagement were marked by a shift in USAID priorities and funding obligations. The 2008 SOAG amendment noted the health challenges in the region: the spread of HIV/AIDS, the increasing infection of young women, the resurgence of TB and malaria, falling rates of immunization, and the inability of most national health systems to provide for the increasing health needs of their populations.

The amendment also noted the regional health systems' lack of capacity and resources to respond effectively and the limited cooperation and collaboration among countries on program and resource planning concerning public health issues in ECSA countries.[74] Consequently, USAID/EA focused on increasing the technical and institutional capacity of African organizations and professionals to: transfer information, skills and technologies; strengthen health systems regionally; and undertake policy dialogue and advocacy to sustain these systems.

SOAG amendments in 2008 and 2009 obligated funds to support maternal and child health activities including: birth preparedness and related maternity services; maternal and young child nutrition (and related micronutrients); and health governance and finance.[75] USAID funds following SOAG amendment number 5, in 2011, supported MCH/FP activities, including formulation, dissemination and implementation of regional FP/RH activities. In FY2012, USAID supported MNCH interventions including the scale-up of implementation of focused antenatal care and the "helping babies breath" initiative.[76]

Implementation of HRAA: With ECSA-HC as an implementing partner for HRAA the program goals were very well thought out, but the funding process (and financial planning) was complicated for ECSA-HC.[77, 78] For instance, in 2013, PEPFAR communicated to HRAA that it must realign its goals towards an "AIDS Free Generation" through a higher investment in bio-medical HIV interventions, e.g., scaling up prevention of mother to child transmission of HIV (PMTCT); voluntary medical male circumcision (VMMC), and antiretroviral therapy (ART). This meant ECSA-HC had to increase its HIV and AIDS

[70] Resolutions of the ECSA-HC HMC 1974-2014
[71] ECSA-HC RH Experts Recommendations on Expanding Access to MNCH Service Delivery at Community Level
[72] ECSA Strategic Plan (2008 - 2012); ECSA Strategic Plan (2012 - 2017); Strategic Objective Grant Agreement (SOAG) Amendments Number Two (2008), Three (2010), Four, Five (2011), Six (2012) and Seven (2014)
[73] KII with former– ECSA Secretariat Affliate; ECSA – Secretariat in Arusha (Oct, 2015); Correspondence from Mission Director USAID/SA
[74] Strategic Objective Grant Agreement (SOAG) Amendment Number Two (2008)
[75] Strategic Objective Grant Agreement (SOAG) Amendment Number Three (2009)
[76] Strategic Objective Grant Agreement (SOAG) Amendment Number Six (2012)
[77] Group KII with ECSA (Oct, 2015)
[78] Macarena Garcia letter 25 March 2013 (HRAAD22)

activities while still operating at the current levels of funding. Given this requisite adjustment, ECSA-HC had to reduce planned (and budgeted) activitives in other programmatic areas. [79,80] Shortly after the 2013 notice, the PEPFAR office sent a letter to its partners requesting detailed personnel identification information for all employees receiving PEPFAR-supported salaries. This was needed to create (Lesotho's) PEPFAR HRH database.[81] That same year the "New Amplified Description" clarified USAID's involvement regarding approval of key personnel and travel.[82]

Overall, the change in USAID priorities (and the ECSA-HC's subsequent scaling down of programs) had two main effects: 1) prior promises to member states went unfulfilled and destabilized program implementation and 2) ECSA-HC had to leverage funds from other sources.[83] "Previously, our basket portfolio of donors included only USAID. That shift [in USAID priorities] made us reach out to other donors. If you look at our projection of donors, it has actually increased; we now have World Bank, Rockefeller Foundation, and Hellen Keller Foundation, among others." (KII – ECSA-HC Secretariat)

Conclusions

- USAID priorities did not align exactly with ECSA's priorities. As a result, USAID support may have unwittingly pressured ECSA-HC to drift away from the organization's thematic priorities towards USAID priorities. Consequently, changes in funding and USAID priorities confounded ECSA-HC's work and funding commitments to the member states and often compromised program implementation.
- USAID's focus on some ECSA-HC priorities more than others prompted ECSA-HC's to leverage funds from other partners, thereby increasing its portfolio of donors.

Question 2b: How has HRAA had a positive impact on HRH in Lesotho and Swaziland?

A. Lesotho

In Lesotho, the HRAA activity strengthened the country's health system, health financing, policies and plans, as described below.[84]

Development of Strategic Plans: HRAA provided technical assistance to all six Health Training Institutes and assisted them in developing their respective strategic plans[85] and concept papers contributing to the strategic plan of Lesotho's Ministry of Social Development (MOSD) and to the ministry's Human Resources Retention Strategy.[86]

Operational Plans for HRH Reforms: In collaboration with Abt Associates, HRAA helped the Ministry of Health in Lesotho (MOHL) to cost out the operational plan for HRH reforms in the country.[87] HRAA supported MOSD's HR Management Strategic Plan 2015 to 2017 that charts the process for a shift from social welfare to social development under the new, fully functional ministry. It covers four strategic priorities: 1) HR development, communication and engagement; 2) HR repositioning in MOSD; 3) establishment of HR systems; and 4) the retention of a motivated HR for Social development (HRSD).[88]

[79] Ibid
[80] USAID/SA letter no7 to ECSA-HC 14 June 2013 on new SOW focusing HRAA activities to policy and facilitation within HRH (HRAAD24)
[81] Correspondence from Reuben Haylett, PEPFAR Coordinator Lesotho to PEPFAR Partners 28 May 2013(HRAAD23)
[82] Correspondence from Jennifer Borns, Mission Director USAID/SA (HRAAD25)
[83] Group KII with ECSA (Oct, 2015)
[84] Lesotho HRAA PPT Partners Meeting March 2014 (HRAAD33)
[85] Roma College of Nursing Strategic Plan 2012-2017 (HRAAD45); Roma College of Nursing Strategic Plan 2012-2017 (HRAAD45); Scott Hospital School of Nursing Strategic Plan 2013-2018 (HRAAD41); Maloti Adventist College School of Nursing Strategic Plan 2013-2017 (HRAAD42); National University of Lesotho Strategic Plan 2013-2018 (HRAAD43); Paray School of Nursing Strategic Plan 2014-2019 (HRAAD40); NHTC 2013/14-2017-18 Strategic Plan (HRAAD44); Report on Roma College of Nursing (HRAAD2) - Lydia Keketsi-Mokotso
[86] Report on Roma College of Nursing (HRAAD2)- Lydia Keketsi-Mokotso
[87] Report on operational plan for HRH Reforms in Lesotho, see annex Table 7 (HRAAD21)
[88] MoSD Stakeholders Consultation Workshop to develop HR Strategic Plan on 9-13 June 2014 (HRAAD36)

B. Swaziland

Development and Costing of the HRH Implementation Plan in Swaziland: The HRAA program, led by ECSA-HC, was requested to develop and cost an HRH implementation plan to cover the period of 2013 to 2016. HRAA completed the plan and determined costs with the help of Abt Associates.[89]

With technical assistance from HRAA, the Kingdom of Swaziland reviewed its need for various donor-funded health worker positions (and considered possible funds from SIDA, the Global Fund, Irish AID, USAID and CDC). These positions then would be absorbed into the MOH workforce with involvement from MOF.[90] In addition, HRAA supported an ICT consultant from Botswana to help develop a database of medical practitioners in Swaziland.[91]

Additional findings on the impact of HRAA on HRH in Lesotho and Swaziland are deferred to Questions 2c and 2d below.

Question 2c: What key results or contributions has HRAA had in the following areas of HRH in Lesotho: a) planning and financing, b) human resource information systems, c) pre-service education (social work) and d) recruitment and retention?

A. Planning and financing

HRAA supported the training of all six Nurse Training Institutes (NTIs) with a course on USAID's Rules and Regulations enabling the NTIs to secure direct funding from various donors. As a result, five of the six NTIs received FY2014 funding, built their financial systems, and developed their respective financial standard operating procedures. Subsequently, the training institutions were able to receive and manage donor funds for their training activities.[92] HRAA also provided technical assistance to Lesotho enabling it to meet the conditions established under the Global Fund Round 8 HIV Grant.[93]

B. Human Resource Information Systems (HRIS)

HRAA supported the Directorate of Human Resources to update the "HR Establishment List."[94] The activity supported the development of HRIS for Lesotho and an HRIS policy for Lesotho's Ministry of Health in 2014.[95] The HRAA-supported HRIS has enabled MOHL to make informed HR management decisions and to produce the HRIS Bulletin which facilitates continued engagement with the MOHL's workforce and stakeholders.[96]

Thereafter, HRAA created an improved database for MOHL workers by modifying the MOSD database. It also conducted on-the-job training for HRIS at the central level and disseminated the HRIS usage manual for end users with a rollout to all districts. However, even though the HRIS is now able to produce relevant reports to help inform decisions (staff lists, salary sources and contact information), it has yet to be transitioned to MOH.

C. Pre-service education

HRAA completed an assessment of social work education and practice in Lesotho, in 2013, to determine the capacity of the country's training institutes to train and deploy social workers through MOSD. The assessment also described the country context and developed recommendations to strengthen training

[89] Human Resources for Health Implementation Plan: Operational Planning and Costing 2013-2016
[90] KII with ECSA Partners
[91] KII with MOH
[92] Correspondence from CD ICAP Lesotho (HRAAD1); HRAA Trains Lesotho Health Institutions on Rules & Regulations for Managing USAID Funding 11-13 October 2012 (HRAAD17); Final Report: HRAA USAID Rules and Regulations & Capacity Building Consultancy, Keith Feb 2013 (HRAAD18)
[93] Correspondence from Global Fund Coordinating Unit (dated April 10, 2013)
[94] Report on Roma College of Nursing (HRAAD2) - Lydia Keketsi-Mokotso
[95] KII with USAID Partner
[96] Director of HR, MOHL in HRIS Bulletin (October 2014)

programs in Lesotho.[97] In collaboration with the Maternal and Child Health Integrated Program (MCHIP) and with MOHL, the Christian Health Association of Lesotho (CHAL) and the Lesotho Nursing Council (LNC), the HRAA conducted a nursing task analysis. This produced data for use by the Lesotho nursing and midwifery education leaders for various purposes including the creation of core competencies, the development of nursing and midwifery standards and the review and updating of training curriculums, among others.[98]

In 2011, HRAA provided technical assistance to the National Health Training College (NHTC) to develop training materials for the auxiliary social workers (ASWs) under a program run by MOSW in collaboration with the Global Fund, USAID-PEPFAR and World Bank. This assistance supported the establishment of the Auxiliary Social Work Program at the NHTC.[41] The HRAA also worked with MOH and MOSD to ensure that the initial batch of 40 ASW graduates from NHTC were finally deployed on a permanent basis.[8] When MOHSW launched the ASW initiative, HRAA was applauded as a mechanism for providing technical assistance to MOHL to improve HRH systems[99] and was cited as the only project in Lesotho that was focusing purely on HRH.[100] Later on, HRAA connected the US-based Social Workers without Borders (SWWB) organization with MOSD for a program that would pair an SWWB mentor with an ASW in the field.

HRAA supported the training of three medical students. In addition, the HRAA and MOHL collaboration realized the in-service training of 471 participants (144 males and 327 females) through 16 workshops; plus 563 Health Training Institute graduates from 5 CHAL schools and 2 public institutions in Lesotho in FY2013. Graduates included 154 nurses, 200 midwives, 66 pharmacy technicians, 12 laboratory technicians, 28 environmental health engineers, 17 nutritionists, 46 nurse assistants and 40 auxiliary social workers.[101]

Auxiliary Social Work Program (ASW) Initiative: When MOHSW launched the ASW initiative, HRAA was praised as a mechanism for providing technical assistance to MOHL to improve HRH systems.[102] According to the evaluation findings, it also was the only project in Lesotho focusing purely on HRH.[103] HRAA supported the establishment of the Auxiliary Social Work Program at the National Health Training College (NHTC). As of June 2015, the college had trained 109 ASWs.[104]

HRAA also provided technical assistance to NHTC in 2011 with the development of training materials for ASWs under a program run by MOSW in collaboration with the Global Fund, USAID-PEPFAR and World Bank. By 2014, NHTC had graduated 40 ASWs who were competent to provide protection, care and support services to vulnerable children and the elderly at the community level. This filled a long-standing gap in all ten Lesotho districts and was recognized as a best practice for ECSA-HC. The activity, with cooperation from MOH and MOSD, ensured that all 40 ASW graduates from the NHTC were deployed on a permanent basis.[105]

Village Health Workers (VHWs) Profiling and Mapping Exercise: In 2013, HRAA, in collaboration with MOHL, CHAL, the Flying Doctors of Lesotho (FDSL), Clinton Health Access Initiative (CHAI), District Health Management Teams (DHMTs) and Health Service Areas (HSA), commissioned the profiling and mapping of VHWs across Lesotho. They also offered technical assistance to support MOHL's efforts to revitalize primary health care by assessing and validating its human capital at the community level. The

[97] Assessment Report on Social Work Education and Practice (HEAAD47)
[98] Lesotho nursing task analysis report (2013)
[99] Talking points for PEPFAR Coordinator in Lesotho during launch of ASW initiative (HRAAD12)
[100] Talking points for the US Ambassador to Lesotho during launch of ASW initiative (HRAAD13)
[101] ECSA-HC HRAA Training Data
[102] PEPFAR Coordinator address in Lesotho during launch of ASW initiative
[103] US Ambassador to Lesotho address during launch of ASW initiative
[104] CHE Success Story on working with HRAA 2013-2014
[105] ASW Training Success Story; CHE Success Story on working with HRAA 2013-2014

exercise identified a total of 7,103 VHWs with a mean age of 60 years old and a Volunteer Health Worker-Household ratio (VHW/HH) ratio of 1/40. Ninety percent were active though about 20 percent were untrained or were trained over ten years ago. Eighty percent of the VHW records were incomplete. The report raised key issues that were hampering community-level services.[106]

Continuous Health Education Accreditation: HRAA provided support to the Council on Higher Education (CHE) in 2013 and 2014 to build its capacity (in keeping with its mandate) and to develop quality assurance processes. The training covered: accreditation reporting, self-evaluation and the development of improvement plans, institutional data management, and the preparation of submissions for the registration of private higher-learning institutions. It also discussed the legislative, regulatory and functional challenges entailed in these processes. The activity worked with four CHAL Nurse Training Colleges and NHTC to attain accreditation by CHE. It also supported all five training institutes by paying the official accreditation fees following CHE approval.[107]

HRAA supported a team of six nurses from NHTC to conduct a two-day study tour on best practices in quality assurance at Stellenbosch University, in Stellenbosch, South African, in May 2013.[108] HRAA also sponsored an ASW study tour to Continuing Education for Africa (CEFA) in Cape Town and the Candiz Training Academy in Pretoria; both institutes are registered by the South African Council for Social Sciences.[109]

HRAA collaborated with CHE in its workshop for higher education institutions on the strengthening of internal quality assurance. The 36 participants addressed internal quality assurance (QA) mechanisms in their respective institutional contexts as a preliminary to enable the success of an external QA system.[110] HRAA supported the training of MOET and CHE on the screening of submissions for registration of private higher education institutions on October 22, 2014. The activity clarified the process for registration by MOET and for accreditation by CHE.[111]

D. Recruitment and Retention

HRAA collaborated with MOHL to organize a successful job fair for nurses at Maseru, on March 22, 2013. The job fair created awareness among young people on career opportunities in the nursing profession; motivated nurses to apply for health center positions in line with decentralization; facilitated the recruitment and placement of nurses in the hard-to-reach areas; and advocated for stakeholder support for modern health services.[112]

HRAA supported MOH and SWL to implement an innovative nurse recruitment, placement and retention strategy.[113] Between September 2010 and June 2013, over 180 nursing sisters and 60 nursing officers were recruited. This ensured that all supported health facilities attained the recommended staff complement of five nurse/midwives. Consequently the catchment population in hard-to-reach areas was able to access health services in a timely manner.[114]

Following implementation of the innovative nurse recruitment, placement and retention package, Lesotho MOH recruited 183 nurse/midwives for 46 hard-to-reach health facilities and promoted their retention

[106] Report on VHW Profiling & Mapping Exercise
[107] CHE Success Story on working with HRAA 2013-2014
[108] NHTC Quality Assurance Tour Report (9HRAAD19)
[109] Report on ASW study tour to CEFA and Candiz Training Academy (HRAAD20)
[110] Report on Quality Assurance Workshop at Maseru on October 30, 2014
[111] Workshop Report on Training of MoET & CHE
[112] HRAA Job Fair Success Story
[113] Ibid
[114] Poster for JASHC (HRAAD15)

through mobilization of resources from donors and the government of Lesotho. The benefits package included basic household furnishings, utilities and special allowances.[115]

The ECSA-HC HRAA and MOHL collaboration realized the in-service training of 471 participants (144 males and 327 females) through 16 workshops; plus 563 Health Training Institute graduates from five CHAL schools and 2 public institutions in Lesotho in FY 2013. Graduates included: 154 nurses, 200 midwives, 66 pharmacy technicians, 12 laboratory technicians, 28 environmental health engineers, 17 nutritionists, 46 nurse assistants and 40 auxiliary social workers.[116] The project's achievements also included the next generation indicators, notably: 170 health workers successfully completed in-service training; 20 ASW successfully completed their pre-service training; and two new doctors graduated from pre-service training institutions.[117]

Despite these achievements, the HRAA implementer in Lesotho functioned at a very slow pace concerning the above recruitment and retention activities. However, when a core ECSA-HC staff member was sent to Lesotho last year she stabilized HRAA in the country. For instance, her efforts resulted in a large recruitment drive for HRH and produeced guidelines to streamline the recruitment and management of nurses. This reduced the recruitment time from 250 days to around 30 days. Within a short time, the government hired 157 nurses for rural health facilities including some positions that hitherto had never been filled since independence. It should be noted that Lesotho successes were the result of a synergy created by USAID's HRH specialist combined with the Nursing Education Partnering Initiative (NEPI), Millennium Challenge Corporation (MCC) and the International Center for AIDS Prevention (ICAP) awards. In addition, several changes in government in Lesotho during HRAA (3) complicated matters significantly, e.g., a new ministry of health.[118]

Table 2: Nurses in Post and Vacancies at 76 Public Health Facilities in Lesotho

Cadre	Filled	Vacancy
Nursing Officers	75 (98%)	1
Nursing Sister	136 (90%)	16
Nursing Assistant	144 (96%)	8
Total	**355**	**25**
Staffing Norms per Health Centre: 1 Nursing Officer, 2 Nursing Sisters and 2 Nursing Assistants		

There are currently 96 medical doctors in post against an establishment need of 158. Between October 2013 and March 2014, there was an increase of 10 medical doctors.[119]

Conclusions

- HRAA technical support to Lesotho—especially in pre-service, village health workers' mapping and auxiliary social workers initiatives—was successful and bodes well for sustainability and scale up.

Question 2d: What key results or contributions has HRAA had in the following areas of HRH in Swaziland: a) planning and financing, including the transition of Global Fund positions to the Swazi Government and estimation of HRH needs; b) HRIS; and c) capacity strengthening of social welfare?

A. Planning and financing

HRAA supported the development and costing of the HRH implementation plan covering the period of 2013 to 2016 and prepared the plan for approval by the Swaziland cabinet. HRAA provided MOH with a template for estimating the costs of a set of prioritized strategies and activities in order to support

[115] Director of HR, MOHL in HRIS Bulletin of October 2014
[116] ECSA-HC HRAA Training Data (HRAAD16)
[117] ECSA Quarterly Reports Oct – Dec 2011; Jan – Mar 2012; Apr – Jun 2012; KII with former ECSA Secretariat Affliate (Oct 2015)
[118] KII 46 with USAID Partner
[119] Lesotho HRAA PPT Partners Meeting March 2014 (HRAAD33)

decision-making to carry out the HRH implementation plan. Specifically, HRAA assisted in determining the cost of potential scenarios for the implementation of activities to guide decision-makers in identifying strategies that would provide the most impact for their investment. The total cost estimate for implementing the full prioritized list of strategies and activities in the HRH implementation plan is approximately SZL 30 million distributed across the three strategic focal areas as follows: planning (SZL 3.1 million), development (SZL 10.1 million) and management (SZL 16.8 million).[120] The Johns Hopkins Program for International Education in Gynecology and Obstetrics (Jhpiego) through HRAA is supporting the development and costing of a national, pre-service education strategy and working to increase the capacity of training institutions to provide skills-based learning.[121]

With technical assistance from HRAA, the Kingdom of Swaziland reviewed its need for various donor-funded health worker positions (considering possible funds from SIDA, Global Fund, IRISH AID, USAID and CDC). These positions then would be absorbed into the MOH workforce with involvement from MOF.[122] HRAA also provided technical assistance and guidance to the Ministry of Labor and Social Security (MLSS) and to a team of Technical Working Group (TWG) members to synthesize the "HRH Policy and the Strategic Plan" and prepare a cabinet paper. This was a concise presentation to the cabinet on the two documents and resulted in their unconditional approval.[123]

HRAA worked well in positioning the HRH agenda as a top priority in Swaziland. The country now understands and appreciates the issues of HRH and a dedicated team in Swaziland periodically discusses and works on HRH issues. They consider policies and HRH programming and support ongoing initiatives.[124]

Nonetheless, some aspects of HRAA do not work well and have to do with program coordination. Another issue is the lack expertise or available individuals to champion (and carry forward) the HRH cause in Swaziland. Due to a lack of champions, some activities have died or faded out. [125, 126]

B. Human Resource Information Systems (HRIS)

HRAA supported an ICT consultant from Botswana to help develop a database of medical practitioners in Swaziland.[127] With the support of local, short-term technical assistance, the full handover of the existing HRIS was completed in July 2014, and a web-based HRIS tool was developed. Ten standard HRIS reports were created to cover critical HR management issues such as staff inventory and vacancy tracking. A user manual was developed and the Ministry of Public Service (MOPS), MOH HR and the MOH Strategic Information Department were provided technical assistance in the development and use of the HRIS.[128]

The HRIS system appears to have worked well. The data system is linked with the sub-regions and to the training of clerks. It was a tedious and drawn out endeavor, but Swaziland and Lesotho learned from each other. By 2014, data was being entered and linkages were created.[129] HRAA managed to fully hand over the HRIS to the Government of Swaziland and a web-based HRIS tool was developed that can generate ten standard HRIS reports documenting crucial areas such as staff inventory and vacancy tracking. A total of 127 HR officers from MOH and MOPS were trained in twelve batches on the system and a test run was carried out to ensure full functionality.[130]

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[120] Human Resources for Health Implementation Plan: Operational Planning and Costing 2013-2016
[121] Jhpiego: Swaziland Country Profile
[122] KII with ECSA Partners (Oct, 2016)
[123] HRAA Q2 FY13
[124] SAVINGRAM on launch/roll-out of retention package for nurses in hard to reach health centers (HRAAD14)
[125] KII with USAID Partner (Oct, 2016)
[126] KII with ECSA-HC (Oct, 2016)
[127] KII with MOH (Oct, 2016)
[128] Ibid
[129] KII with USAID Partner
[130] Group KII with ECSA-HC

C. Capacity Strengthening of Social Welfare

The primary contribution to social work in Swaziland was the development of child-friendly courts. One court is now operational, though the government is working to ensure that the number of courts is increased. In addition, trainings for prosecutors and social officers have been held to ensure that children's issues are better handled and that legislation is improved.[131]

Specifically, HRAA supported a pilot project in the Lubombo region to establish a child-friendly court. DSW and the Siteki Magistrate Court received assistance to: improve their documentation and filing systems; develop a child-friendly courtroom; improve court intermediary services, accommodating emergencies and after-hour needs; and establish a social work/child-centered system. HRAA also supported the capacity building of eight prosecutors and two court clerks based on an application from the office of Court Intermediaries Procedures and Legislation in Child Cases.[132]

HRAA collaborated with the Ministry of Labor and Social Security (MOLSS) to conduct a pre-service readiness assessment at the University of Swaziland (UNISWA). This was done to determine the university's basic capacity and resource requirements for providing degrees in social work.[133] HRAA in Swaziland signed a Memorandum of Understanding and set objectives for years one and two to help UNISWA establish a social work program within the Social Sciences Department.[134] In addition, HRAA procured a vehicle for the Swaziland Nursing Council to support the continuing professional development program. They also provided assistance to monitor standards of practice at the facility level and to educate students and others on legislation related to the nursing profession.[135]

HRAA in collaboration with Jhpiego worked to strengthen the regulatory capacity around HR for health and social welfare. Specific interventions included: 1) working with the Swaziland Nursing Council to ensure its strategic plan is operationalized; 2) supporting quarterly nurses' meetings and the Nursing Technical Working Group to address cadre-related HR issues; 3) working with various stakeholders to build consensus on how to best develop the regulatory capacity of the Swaziland Medical and Dental Council; 4) exploring and advocating for the development of a Social Work Council; and 5) compiling the scopes of work for all health cadres, including community health cadres, in preparation for reviews and to streamline the scopes of work.[136]

At the beginning of HRAA in Swaziland, there were several challenges, including the long delay in transferring funds. First, the funding had to route through the ECSA-HC office in Arusha and from there through Swaziland and Lesotho. This led to considerable debate with USAID: USAID claimed under-performance, while ECSA-HC claimed it had received the funds too late to begin on time. This eventually was remedied and the funding arrived in good time, but it should be noted that part of the problem was that the ECSA-HC fiscal year runs from June 1 through July 31 while the USAID fiscal year runs from October 1 to September 30.

HRAA was a follow-on from another HRH-focused award involving Swaziland. There had been frustrations working with Swaziland during this previous project and, thus, little urgency to start a new project. Pre-award assessments at ECSA-HC and complex award procedures meant delays. In addition, USAID needed to provide capacity building to ECSA-HC in order to meet USAID's "Responsibility Criteria." ECSA-HC's implementing partner in Swaziland appeared to perform poorly, but ECSA-HC delayed in cancelling its contract with them. Eventually, ECSA-HC did cancel the contract and sent in core Arusha staff to get the

[131] SAVINGRAM on launch/roll-out of retention package for nurses in hard to reach health centers
[132] KII with ECSA-HC (Oct, 2015)
[133] KII with USAID Partner
[134] Ibid
[135] Ibid
[136] Jhpiego: Swaziland Country Profile

program back on track during the last year.[137] In general, a lack of communication between HRAA country programs and the Secretariat in Arusha also hampered progress.

At the end of the day, the Swaziland HRAA program could not be salvaged, and the USAID PEPFAR country program progressively lowered its budgeted support. Yearly financial audits were conducted that questioned the high costs of staff remunerations and benefits.[138]

Overall, the HRAA project brought a new competency to ECSA-HC on several fronts. It may have been unreasonable to expect immediate results due to the various challenges, even considering things beyond the control of ECSA-HC such as changes in the Lesotho Government.[139]

The approach to collaboration taken by USAID/SA was very different compared to that at USAID/EA.[140] The demands of being an implementing partner compared to being a largely policy-focused entity brought new learning. ECSA-HC had to provide in-country technical assistance and management to two of its member states and the attendant dynamics at the country level presented a different experience for ECSA-HC.[141] The different demands from the bilateral offices on the HRAA project left ECSA-HC sometimes feeling more like an observer than an implementer, especially when country-level buy-in mechanisms were involved.[142]

4.2.2. Overall conclusions for Evaluation Question 2

- HRAA was well conceived, but the funding mechanism was initially too complicated initially for an intergovernmental organization that had not met USAID's "Responsibility Criteria" and that was also unfamiliar with a buy-in mechanism.
- HRAA had a lasting impact in Lesotho and Swaziland once the ECSA-HC Secretariat removed its primary implementing partner and seconded core staff to run the country programs.
- There were several serious communication challenges in HRAA between the southern Africa regional office and the Swaziland bilateral office, and between HRAA country offices and the ECSA-HC SA Secretariat in Arusha, i.e., regional vs. country-level entities.
- ECSA-HC's mandate currently has both technical and programmatic aspects. While previously the technical aspect was predominant, currently the evidence from HRAA shows that the programmatic mandate is emerging.
- The HRIS in both Swaziland and Lesotho provides a model of support and knowledge sharing between two countries and has resulted in successful implementation.

4.3. Institutional capacity and Knowledge management

4.3.1. Evaluation Question 3

Evaluation Question 3: What have been the key contributions of USAID support to ECSA-HC's institutional capacity strengthening agenda? To what extent has USAID support contributed to strengthening ECSA-HC's financial sustainability and management capacity including human resources and knowledge management?

A. Institutional Strengthening Agenda

In addressing the institutional strengthening of ECSA-HC, this performance evaluation took into account the fact that ECSA-HC is an intergovernmental entity and, thus, is focused on the following six aspects: 1)

[137] KII with USAID Partner (Oct, 2016)
[138] Ibid
[139] KII with USAID Partner (Oct, 2016)
[140] Correspondence between PEPFAR Coordinator Lesotho to PEPFAR Partners 28 May 2013
[141] KII with ECSA-HC (Oct, 2016)
[142] HRAA Job Fair Success Story

ECSA-HC's legal framework; 2) ECSA-HC's internal process; 3) leadership and governance; 4) ECSA-HC's administrative capacity; 5) policy formulation; and 6) ECSA-HC's role as an implementer.

The legal framework: A legal framework supporting ECSA-HC's establishment is in place and details its mandate and scope within the ECSA region. The Republic of Tanzania has granted ECSA-HC diplomatic status as an international organization based in Arusha.[143]

ECSA-HC's internal processes: ECSA-HC, through USAID support, successfully strengthened its internal processes, evidenced by its various manuals, guidelines and procedures including: the financial rules and procedures; human resources manual; procurement manuals/guidelines; code of conduct/conflict of interest policies; leadership structure; and policy formulations.

Leadership and corporate governance: The previous leadership at ECSA-HC includes the director general assisted by three directorates: 1) Operations and Institutional Development, 2) Finance and 3) the Director of Programs. A revision of the leadership structure was proposed in May 2015. The new structure will have two directorates: a Director of Finance and Administration and a Director of Programs and Research. Under the Director of Programs and Research, four clusters are organized: family health and infectious diseases; non-communicable diseases, food security and nutrition; health system strengthening and capacity development; and knowledge management and M&E.[144] USAID currently supports two positions, the Director of Programs and the M&E Manager.

Administrative capacity: USAID has managed to strengthen or to enhance ECSA-HC's administrative capacity through training on corporate management, accounting, grants management and proposal writing. USAID provided support in the development of ECSA-HC's strategic plan (2012 to 2017) and in building its overall capacity in strategic planning. This has improved ECSA-HC's capabilities and qualifications as a regional implementing partner with USAID and other potential donors including the Global Fund.[145]

Policy formulation: USAID supported the member states in the process of policy formulation and adoption through ECSA-HC's structures. This support includes USAID's financial input and technical support to the Secretariat, Health Ministers Conferences, DJCC, Program Experts' Committees and best practices forums. This support ensured passage of key HMC resolutions and the development of best practices in several key health areas that otherwise may have remained dormant, e.g., MCH and food fortification.[146]

Regional implementing partner: USAID support has strengthened ECSA-HC's capacity in key skill areas enabling it to become a regional implementing organization.[147] This is the result of USAID's capacity building initiatives and the related skills learned. Such skills, for instance, made it possible for ECSA-HC to implement HRAA. In addition, ECSA-HC has been able to meet USAID's "Responsibility Criteria" though these criteria may have changed since the initial training was delivered. USAID support through HRAA has contributed to HRH becoming a top priority in the ECSA region and an ECSA-HC priority in its 2012 to 2017 Strategic Plan.

Conclusions

- ECSA-HC institutional capacity is solid and has the potential to impact the region. This can be seen through its effective internal processes, robust leadership, policy formulation and administrative capacity. This increased capacity has contributed to ECSA-HC's visibility in the region.

[143] Convention of the ECSA-HC; ECSA-HC Headquarters Agreement
[144] ECSA Organization Chart
[145] KII with ECSA-Secretariat (Oct, 2015)
[146] Ibid
[147] KII with a former Leader of a Training & Research Institution(Oct, 2015)

B. Financial sustainability including human resources and knowledge management

For an intergovernmental organization like ECSA-HC, financial viability (revenue streams) has relied on USAID contributions and member state contributions.[148] (See Annex IX for member state contributions.) However, over the years, ECSA-HC has been able to leverage program support funds from other partners such as the World Bank, GIZ, and the Global Fund, among others.[149] Additional findings discussed below, under Questions 3b, 3c and 3d, demonstrate ECSA-HC's financial sustainability and its HR and knowledge management capacities.

Question 3a: Has USAID empowered ECSA-HC to be an independent, self-sustaining institution?

USAID gave ECSA-HC both technical and financial support and funded activities that were agreed on jointly as follows: ECSA-HC would hold a planning meeting with its technical team at the policy level. This team would jointly agree on issues concerning such matters as the strategic plans and annual work plans. Once USAID and ECSA-HC were in mutual agreement, USAID would send the funds to ECSA-HC's financial accounts to support these activities.[150] As discussed above, ECSA-HC, through USAID support, improved its internal structures, its administrative procedures, and its leadership and governance structures.

Currently, ECSA-HC's improved financial systems—built on USAID's manuals and audit requirements—has placed the organization in good standing with its other partners and donors. According to a respondent from the ECSA-HC Secretariat: "There has been a lot of improvement in our processes and mechanisms. We've strengthened the organization's roles, developed HR manuals and procurement manuals. We've overhauled our financial systems which have improved a great deal. Actually, when we signed for the World Bank projects, they accepted our financial system which is based on the USAID manuals. We've just been through the Global Fund assessment; we are signing a grant with them anytime now, and because of these mechanisms (USAID's HR, procurement and financial systems and audit requirements) this gave us a very good rating with other partners." (KII – ECSA-HC Secretariat)

A Global Fund assessment found that ECSA-HC has strengthened its organizational roles. Around the time of submission of this report, ECSA-HC had signed a Global Fund grant of US$ 6.1M over a period of four years. The expected date of launch is scheduled for December 2015 to coincide with the Health Ministers Conference.

Conclusions

- ECSA-HC organizational structures, procedures, systems and experience in the region have high prospects for sustainability.
- As an intergovernmental agency, ECSA-HC sources of funding will always be dependent on contributions from its member states.
- ECSA-HC's ability to leverage funds from other partners demonstrates its ability to continue with its operations even without USAID as its main development partner.

Question 3b: How much independent funding has ECSA-HC been able to raise before, during and after USAID's support and what was the influence of USAID's engagement on this?

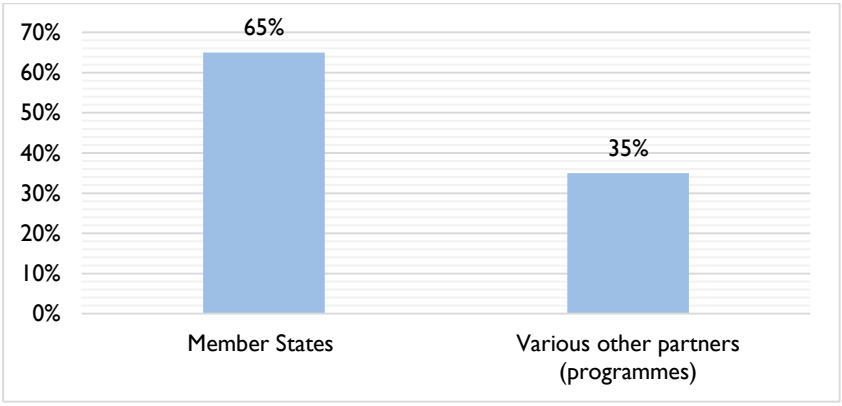
A. Resource mobilization

USAID support has enabled ECSA-HC to increase its resource mobilization, particularly in getting other partners to support ECSA-HC. The data revealed that from 1995 through to 2015 the percent of ECSA funding that comes from non-member state donors rose from 35% in 1995 to 81% for 2015 and beyond, i.e., donor commitments extending into 2016 and after. The data also showed that while USAID provided

[148] KII with ECSA-Secretariat (Oct, 2015)
[149] Ibid
[150] KII with a former ECSA Affliate and current ECSA Partner (Oct, 2015)

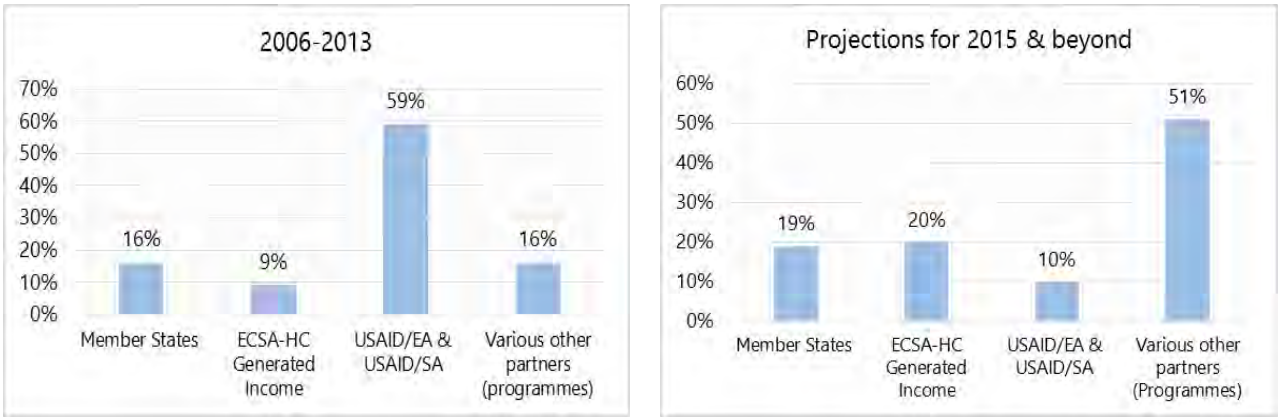
a large portion of this funding from 2007 to 2013 that portion dropped to just 10% of all contributions for 2015 and beyond. The figures below show the trend of funding over the three periods (before, during USAID support and projections beyond 2015).

Figure 1: Average annual leveraging of funds from various sources (1995 to 2006)



Source: ECSA Secretariat (November 2015)

Figure 2: Average annual leveraging of funds from various sources



Source: ECSA Secretariat (November, 2015)

Some member states (South Africa, Namibia, Botswana and Mozambique) became inactive probably due to overlapping mandates that they held with both ESCA-HC and the Southern African Development Community (SADC). Because of this inactivity, the Secretariat sought funding from other partners and developed income-generating activities to meet administrative costs and program implementation costs. Partners such as USAID/EA and later USAID/SA came on board with USAID/SA funding the HRAA project. USAID contributed about 59% of the total budget, while member states and ECSA-HC itself contributed 25%. Other partners included TIDE Foundation, World Bank and Rockefeller Foundation, to name a few.[151]

"*Since our basket portfolio of donors included only USAID, that shift [in resource mobilization] made us reach out to other donors. If you look at our projection of donors, it has actually increased. [Funds from] GIZ, World Bank, Rockefeller Foundation and Hellen Keller came in. We then started responding to RFAs [Request for Applications] which attracted donor funding. A lot of leverage has occurred.*" (KII – ECSA-HC –Secretariat, Directorate of Finance). Moving forward from 2015, it is expected that the Secretariat will continue to vigorously mobilize

[151] Source: ECSA Secretariat (Nov, 2015)

resources through an increased partner portfolio and diversified income-generating activities like consultancies, training, and by hosting and organizing high-level scientific meetings and conferences.[152]

Conclusions

- ECSA-HC has successfully leveraged funds from other developmental partners and it is unlikely to be solely dependent on USAID support in the future.

Question 3c: What is the extent of the ECSA-HC member states' financial and political support to these programs and how can that support be strengthened and mobilized?

A. ECSA member states political support

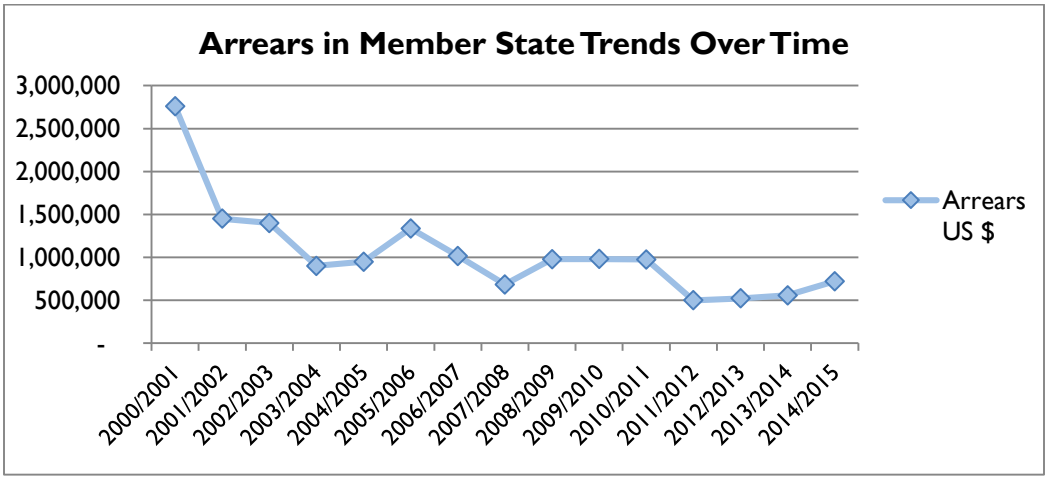
"For us, the highest political office is the health ministers. Many of the USAID-supported programs have gotten political support in the context of resolutions from the health ministers. Where we have programs in the countries, it's much easier for us to go into the country and implement those resolutions—if we are able to get the financial support. The problematic ones are when the countries take up the resolutions, but the countries need to mobilize the funding." (KII with ECSA-HC Secretariat)

B. ECSA member states financial support

In principle, the member states' contributions facilitate the operations of the Secretariat. Funds from the member states and other income generated by the Secretariat cover operational costs including Advisory Committee meetings. Costs for activities like the Health Ministers Conferences, DJCC and best practices forums are leveraged partially from partners and from member states. The levels of member state contributions have not been adjusted in the last twenty years, since 1995/1996.[153]

"Lately, some countries are struggling to make their payments. All of the member states have their own macro-economic issues, but they have demonstrated a commitment to pay. Some are affected by fluctuations in the member states' currency which makes it difficult to determine the actual amounts due. Others are challenged by changes in health ministers. For example, in the last five years, one of the member states has had five ministers of health and four permanent secretaries. Effectively, the member states are contributing less than what they were contributing ten years ago. Now they pay about 40 to 50 percent of their original contributions. Dues established twenty years ago in 1995 have not been adjusted for inflation. These are macro-economic pressures that are beyond ECSA-HC's control." (KII with ECSA-HC Secretariat)

Figure 3: Member states' financial commitment as a contribution to ECSA-HC



[152] KII with ECSA-HC – Secretariat (Nov, 2015)
[153] KII with ECSA-HC Secretariat (Oct, 2015)

The inconsistency in member state financial support to the ECSA-HC is typified in three member states. For example, in 2013 and 2014, Tanzania had been paying periodically, every two months or so (but there was a time Tanzania paid in advance). Then there was a change within the MOH, and the remittance process slowed down. Uganda payments have been bouncing back to the country due to discrepancies and fluctuations in the Ugandan Shilling and USD. The latest installment was paid in September 2014. Swaziland is up to date, but there was a time when they hadn't paid for three to four years.[154] The graph above shows the trend in contributions owed annually by the member states. The drop from 2000/2001 to 2001/2002 is due to four countries (South Africa, Namibia, Botswana and Mozambique) becoming inactive and their arrears clearing.

Conclusions

- ECSA-HC enjoys strong political support from the member states as evidenced by the Health Ministers Conferences and support for policy adaption.
- The level of member state contributions is currently at half the required minimum because their levels have not been adjusted for inflation and because currencies fluctuate relative to the US dollar.
- Arrears in member state contributions have improved (decreased) since 2008. Besides the macro-economic pressures faced by individual member states, it is unclear why contributions are not timely. This may adversely affect the operations at the Secretariat.

Question 3d: Has USAID/EA's involvement in hiring core staff improved the management capacity of the ECSA-HC Secretariat? How can this be improved? Sustained?

A. Management Capacity

The ECSA-HC organizational structure includes the Director General and three Directors: one for Operations and Institutional development, another for Finance and another for Programs. Managers oversee eight technical areas and below the managers are the program officers. USAID was not involved in the direct hiring of ECSA-HC staff at the Secretariat. However, USAID supported the positions of Director of Programs and the Monitoring and Evaluation Manager. Projects such as HRAA also supported some staff.[155]

B. How can this be improved? Sustained?

To improve on its management capacity, the ECSA-HC Secretariat has restructured its administration, specifically establishing a new cluster—M&E and Knowledge Management— which merged its two prior programs: Research, Information and Advocacy and M&E. ECSA-HC expects continued support from USAID for the Director of Programs and the new Manager for M&E and Knowledge Management. Except for these two USAID-funded positions, generally, the member states absorb the staffing and Secretariat costs and USAID funds are used to pay for programs.[156]

Question 3e: What was the impact of pipelines on program implementation and achieving overall goals?

A. USAID Pipeline

The issue of USAID pipeline resulted in missed opportunities for additional funding. In 2009, USAID/EA provided some HIV funds to ECSA-HC, but the persistence of USAID pipeline, though from other funding pockets, prevented the release of additional HIV funds.[157]

[154] KII with ECSA-HC Secretariat (Oct, 2015)
[155] KII with ECSA – Secretariat (Oct, 2015)
[156] Ibid
[157] Ibid

More recently, another way that USAID funding has affected the ECSA-HC program is the transition at USAID/EA which resulted in a decision to channel the large pipeline through USAID/SA. That change now requires a new grant that ECSA-HC is still waiting for. This has resulted in a year's delay in implementing the programs that should have been implemented using the funds that previously had been committed to ECSA-HC.[158]

"You need the money, but you cannot get it. It accumulates and you are accused of not using it. We tried a lot. The team at USAID/EA, especially, was really proactive. There were these quarterly meetings where we would track where ECSA-HC was in terms of implementation, activities and burn rates. You know sometimes the two are not talking to each other just because of reconciliations. (USAID EA) I don't think there were such huge gaps/pipelines. It was just a matter of getting the work done. The team at USAID was very proactive in reminding us that we've not liquidated this." (KII – ECSA-HC Secretariat staff)

Conclusions

- The pipeline issues had a great impact on ECSA-HC programming. The bureaucracies around the inability to access some of the funds as a result of low burn rates seems to have been beyond the ECSA-HC Secretariat's ability to respond.

Question 3f: Did ECSA-HC's capacity to manage a program like HRAA improve after the challenges faced in the first 18 months of the award?

A. ECSA-HC Capacity

ECSA-HC, through HRAA, built up its capacity in several program implementation areas including financing, budgeting, contracting and developing implementation plans. ECSA-HC learned from its HRAA experience: how to be an implementing partner; how to sub-contract to other organizations; and how to support USAID's bilateral missions. "This was a difficult learning situation for all involved."[159] Currently, there is collaboration between ECSA-HC and Jhpiego in the Kingdom of Swaziland to strengthen the country's regulatory capacity around human resources for health and social welfare. Specifically, they are working with the Swaziland Nursing Council to operationalize the Council's strategic plan.

One challenge brought up by an interviewee was that ECSA-HC found itself competing in some countries with international NGOs that were receiving USAID bilateral support. ECSA-HC was not familiar with these types of negotiations and intrigues, which suggests the need for closer collaboration between USAID's regional and bilateral offices. This same need for closer collaboration was found also for the HRAA buy-in initiative.[160]

HRAA in Lesotho has made some significant contributions including: the development and costing of the HRH Implementation Plan (2013 to 2016); the development of the Lesotho HRH strategic plan (2012); the costing and scenarios summaries for Lesotho's rural retention and health systems strengthening (2013); and the success of the Human Resource Information Systems.

Following the exit of HASD and the replacement of HASD HRAA key staff there was a dramatic improvement in implementation of the work-plan activities in both Swaziland and Lesotho. ECSA-HC staff who relocated from Arusha to Manzini and Maseru reported improved skills to manage HRAA despite the delay in program implementation.[161]

Conclusions

- ECSA-HC ability to negotiate with USAID's regional mission and to receive support from USAID's bilateral missions remains challenging. This lack of collaboration and cooperation with the bilateral

[158] KII with ECSA – Secretariat (Oct, 2015)
[159] KII with a former leader of a Training & Research Institution; ECSA Secretariat; HRAA –USAID(Oct, 2015)
[160] KII with former ECSA Affliate (Oct, 2015)
[161] HRAA ; USAID; Former , HRAA Affliate (Oct, 2015)

missions on regional initiatives is likely to affect future programming in the event that the current ECSA-HC Secretariat tenure expires before the stalemate is resolved.

Question 3g: How successful has ECSA-HC been as a regional think tank for health systems issues in the region and how has this been demonstrated?

ECSA-HC's positive response to the region's health challenges and member state priorities is the result of a range of experience, initiatives and support. This includes the ECSA-HC's strategic plans; its political support from the health ministers; and support from the DJCC and Health Ministers Conferences, especially the health resolutions and recommendations. ECSA-HC's various roles demonstrate its ability to support the member states efforts in coordinating cross-border and regional initiatives and in enhancing regional cooperation in health.[162] Specifically, ECSA-HC has positioned itself as a champion in scaling up human resources for health in the region and advocating for healthcare financing.[163] ECSA-HC's success in policy formulation is demonstrated through: its implementation of sexual and gender-based violence policy; expansion of initiatives in family planning and maternal, newborn and child health at the community level: and curriculum development and regulations in nursing and midwifery. ECSA-HC has developed its skills in strategic planning as a result of HRAA and the capacity building it provided, for example, in developing their 2012 to 2017 strategy.[164]

4.3.2. Overall conclusions for Evaluation Question 3

1. ECSA-HC, through USAID support, has strengthened its internal processes and this has resulted in good ratings from multiple donors and development partners.
2. The capacity and skill set of the ECSA-HC Secretariat in implementing programs has improved considerably due to USAID capacity building and system strengthening. ECSA-HC is now able to compete for grants and other awards from USAID and other donors, e.g., Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM).
3. ECSA-HC has successfully increased its portfolio of donors and consequently succeeded in leveraging funds.
4. ECSA-HC has strong political support throughout the region, but financing and member state payments of annual dues remain an unresolved challenge.
5. The organizational restructuring of ECSA-HC's Secretariat and the new cluster—M&E and Knowledge Management—bodes well for sustainability and for the cascading of knowledge from the regional to the country level.

5. RECOMMENDATIONS

USAID regional and bilateral mission engagement with ECSA-HC

1. When designing regional programs, such as HRAA, that require the buy-in of USAID's bilateral missions, USAID's regional offices and other USG-funded offices and programs (such as PEPFAR) should engage the bilateral missions and secure their obligations and commitments to each individual member state. ECSA-HC should function as an implementing partner independent from the USAID and/or other developmental partners' bureaucracy. (Responsibility: USAID and other developmental partners)

2. The ECSA Secretariat and and its developmental partners should ensure the sustainability of HRAA's successes in Lesotho and Swaziland. (Responsibility: ECSA Secretariat, Developmental Partners)

[162] Resolutions of the ECSA-HC HMC 1974-2014; Strategic Plans (2004 – 20007; 2008-12; 20132- 2017); KII with ECSA Secretariat; former ECSA Affliate (Oct, 2015)
[163] Resolutions of the ECSA-HC HMC 1974-2014; Health Care Financing Profiles 1995 - 2009
[164] KII with a former Leader of a Training & Research Institution (Oct, 2015)

Research, Knowledge Management and Sharing:

3. ECSA-HC's Information and Communication Technology (ICT) and M&E capacity should continue to be strengthened. This could dramatically improve ECSA-HC's ability to communicate with its partners and with member states. This also would help ECSA-HC serve as a regional health systems policy body to influence the member states. (Responsibility: ECSA and its developmental partners)
4. ECSA's developmental partners should support ECSA-HC secretariat to increase the organization's efforts to ensure that policies developed at the regional level are available to each member state. A repository (of metadata) from the ECSA-HC resource center should be available online with open access for each member state. This would facilitate systematic information and knowledge sharing (i.e., ICT) in spite of staff and MOH turnover. (Responsibility: ECSA Secretariat, Developmental Partners)
5. ECSA's developmental partners should provide assistance to the ECSA-HC secretariat to establish a policy and HMC resolution tracking system that captures and tracks which member states are implementing which policies and resolutions. The tracking system also should provide links to previous resolutions. (Developmental Partners, ECSA Secretariat)

Support for operations at ECSA-HC Secretariat

6. Member state contributions that have stagnated over the past two decades should be reviewed, taking into consideration the evolution of ECSA-HC's operations, changes in membership and the current economic environment in the ECSA region. (Responsibility: ECSA Secretariat)
7. When supporting multi-state organizations, such as ECSA-HC, its developmental partners should allow enough time for intergovernmental planning cycles especially because regional goals and objectives are captured as project activities. The developmental partners should increase ECSA-HC's and other potential regional awardees' involvement in the work plan and awarding processes to align each organization's timelines. (Responsibility: Developmental Partrners, ECSA Secretariat)
8. Developmental partners should continue to support such regional bodies as ECSA-HC because they remain relevant to African health issues and can help synchronize health services (e.g., for successful migration) *among* and *across* several states. (Responsibility: Developmental Partners)

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Annex I: Statement of Work

Purpose
The purpose of the evaluation is to assess East, Central and Southern Africa Health Community (ECSA-HC) performance in implementing USAID/East Africa and USAID/South Africa's projects and the contribution to USAID's development objectives.

I. Background

II. Project Information

Basic Project Data

Project Name:	Enhancing Capacity of Regional Health Systems and Financing
Project Duration:	October 1, 2006 to September 30, 2015
Prime Partner:	East, Central and Southern Africa Health Community (ECSA-HC)
Agreement No.:	623-SOAGA11A052-70048
Agreement Duration:	October 1, 2006 to September 30, 2015
Total ECSA Obligation:	US$6,534,833
Activity Manager:	Grace Miheso
Project Name:	Human Resources Alliance for Africa
Project Duration:	April 29, 2011 to April 29, 2016 (to be extended)
Prime Partner:	East, Central and Southern Africa Health Community (ECSA-HC)
Agreement No.:	690-0020
Agreement Duration:	April 29, 2011 to April 29, 2016 (to be extended)
Total ECSA Obligation:	U$9,325,430.00
Activity Manager:	John Fieno

East Central and Southern African Health Community (ECSA-HC)

The East, Central and Southern Africa Health Community (ECSA-HC) is a regional inter-governmental organization based in Arusha Tanzania, with membership from ten countries[165]. The organization was established in 1974 by the Convention of the East Central and Southern Africa Health Community to promote regional cooperation in health. ECSA's vision as defined in the strategic plan is to be the leader in health in the ECSA region, contributing towards the attainment of the highest standard of physical, mental and social well-being of the people in the region. ECSA-HC strives to achieve this vision through advocacy, capacity building, brokerage, coordination, inter-sectorial collaboration and harmonization of health policies and programs. Its mandate is to promote and encourage efficiency and relevance in the provision of healthcare services in the region.

ECSA-HC's core business in fulfilling its mandate is to provide a regional platform for consensus building on health priorities. It also provides technical assistance, capacity building to Member States and institutional partners and, facilitates regional health research and surveys. It further provides brokerage

[165]Botswana, Kenya, Lesotho, Malawi, Mauritius, Swaziland, United Republic of Tanzania, Uganda, Zambia and Zimbabwe

and networking opportunities to diverse health sector players as well as a forum for reviewing progress on regional and international health targets including the Millennium Development Goals.

The ECSA-HC is governed, through five main organs namely; the Conference of Health Ministers which is the supreme governing body that provides policy direction, The Advisory Committee gives the strategic and administrative oversight; The Directors' Joint Consultative Committee is the highest technical body, the Program Experts' Committees and the ECSA Secretariat are the technical arm of the secretariat. Key programmatic areas at the Secretariat include;

- Health Systems and Services Development,
- Human Resources for Health and capacity Building;
- Family and Reproductive Health;
- HIV and AIDS;
- Food Security and Nutrition;
- Monitoring and Evaluation; and
- Research, Information and Advocacy.

Additional program information can be found in the ECSA Strategic documents and at http://www.ecsahc.org/

Context of USAID and ECSA-HC engagement

A significant barrier to achieving universal access to health services in countries in the East Africa region is their weak health systems. Chronic weaknesses in the healthcare system include acute shortage of skilled health workers, inadequate facilities and health infrastructure, limited access to medicines and supplies, and the lack of sufficient and predictable financing to provide quality services at national and local levels.[166] These systemic health sector weaknesses worsen and fuel the region's high burden of disease and low access to quality health service, especially disastrous for women and children. Regional cooperation and collaboration are essential to increased flexibility and responsiveness of public health systems and improved health outcomes. USAID/EA has supported transnational programming by engaging with African inter-governmental institutions such as the East Central and Southern African Health Community (ECSA-HC) to address these health system challenges.

In Southern Africa, ECSA-HC has been the prime implementing partner on the Human Resources Alliance for Africa (HRAA), a regional buy-in mechanism. The award was designed to address issues in Human Resources in Health (HRH) in five areas: 1) workforce planning and financing; 2) Human Resources Information System (HRIS); 3) pre-service education; 4) recruitment and retention of health workers; and 5) regulation including capacity strengthening of professional organizations. During the course of HRAA, Lesotho and Swaziland have bought into the award. As of the end of fiscal year 2014, a total of U$9,325,430.00has been obligated into the award.

USAID and ECSA-HC collaboration

ECSA-HC and USAID/EA began an informal collaboration in 1994 to expand cross-border public health collaboration and joint programming between member states. This partnership was formalized four years later. The first SOAG was signed in 2006 and to date; the total SOAG obligation directly going to ECSA is $6,534,833.

USAID/EA has supported ECSA-HC to lead the development of harmonized policies, standards and guidelines and promising practices that respond to priority reproductive, maternal, newborn, child health and infectious diseases with the overall goal of strengthening the regional management of health

[166] Success Story -- Strengthening Health Systems, USAID/East Africa, 2012

systems. In turn, USAID has leveraged ECSA-HC's political capital and convening power through various fora to elevate health systems priorities and advocate for implementation of the high impact interventions.

At the signing of the first SOAG, the objective was to provide a mechanism to promote the adoption and analysis of policies and promising practices that respond to priority reproductive, child and maternal health and infectious diseases needs through East and Central Africa (ECA). At that time, the programmatic areas of focus had seven components; 1) Prevent and Control Infectious Diseases including TB, Malaria and Avian Flu, 2) Improve Child Survival, Health and Nutrition, 3) Improve Maternal Health and Nutrition, 4) Support Family Planning, 5) Address other Health Vulnerabilities, 6) Reduce Transmission and Impact of HIV/AIDS and 7) Enhance Health Systems Capacity.

By 2008, USAID had a new Foreign Assistance Framework whose objective was "Investing in People" and the funds for that year focused only on maternal and child health (MCH) with the other programs receiving no fund due to pipeline issues. In continuing the efforts to meet the health results objective of "a healthier population in the ECA region achieved through African leadership" USAID under the complementary programs component provided funds in 2009 to conduct research and test family planning delivery models that can be used in emergency settings. In 2011, funding was put aside to engage a partner to support population and health initiatives in the region in line with USAID's regional objective to better understand the synergistic relationship between population, health and environment (PHE). By 2012, the engagement focused on seven programmatic areas 1) Birth preparedness and maternity services; 2) Newborn care and treatment; 3) FP/RH including PHE: 4) Policy analysis and systems strengthening; and 5) Health governance and finance. During this period, funds were also received from HIV/AIDS state funds to support health system strengthening initiatives. Factors that have contributed to the flavors of funds received by ECSA-HC over the years include changes in USAID priorities, staffing constraints and pipeline issues.

III. Evaluation Objectives

As recommended in the approved USAID/Nairobi transition plan, the SOAG with ECSA-HC will be transferred to USAID/South Africa office by January 2015. RHH will continue to engage with ECSA-HC through other mechanisms. Before this is done, the USAID/East Africa Regional Mission intends to conduct an external performance evaluation of its engagement with ECSA-HC from the signing of the first SOAG to date. USAID/South Africa Mission also intends to conduct a mid- term evaluation of the HRAA project that has been implemented since 2011.

The overall objectives of the evaluation will be to highlight the key achievements and challenges of USAID/EA and USAID/SA's engagement with ECSA-HC and provide concrete recommendations for future investments by USAID to improve the regional management of health systems and address the key causes of morbidity and mortality in the region.

IV. Audience and Intended Uses

The primary audiences of the evaluation report will be USAID. For this audience, the evaluation findings will serve to influence decisions on how best to engage ECSA-HC especially recognizing their strengths, weaknesses and opportunities to address key health challenges in the region.

The secondary audiences of the evaluation will be ECSA, its member states and other key stakeholders. The evaluation report will serve to document the achievements of the USAID-ECSA-HC engagement, best practices and lessons learnt.

V. Evaluation questions

The evaluation questions will focus on key components namely policy, technical, institutional management including knowledge management.

Policy

1. To what extent has ECSA-HC with USAID support been able to influence regional and country-level policies?

Technical

2. To what extent has USAID-supported programs responded over the years to thematic priorities as outlined in the ECSA-HC strategic plans and other regional strategies agreed to by member states?
3. What key results or contributions has HRAA had in the following areas of HRH in Lesotho; a)Planning and financing; b)HRIS; c) Pre-service education (social work) and d) Recruitment and Retention
4. What key results or contributions has HRAA had in the following areas of HRH in Swaziland; a) Planning and financing including the transition of Global Fund positions to the Swazi government and estimation of HRH needs; b) HRIS and c) Capacity Strengthening of Department of Social Welfare

Institutional capacity

5. What have been the key contributions of USAID support to ECSA-HC's institutional capacity strengthening agenda? To what extent has USAID support contributed to strengthening ECSA-HC's financial sustainability and management capacity including human resources and knowledge management?

VI. Evaluation design and methodology

USAID seeks the most robust evaluation design and methodological approach that is appropriate for the scope of the project, resources, and audience. A non-experimental evaluation design should be used.

A post-award conference will be held to review the Statement of Work, clarify any questions that may arise, and address any concerns related to the selected contractor's proposal including the evaluation team, methodology, and implementation timetable. The post-award conference may be held via teleconference, as appropriate.

Evidence gathered will be from both primary and secondary sources. Both qualitative and quantitative data will be collected and analyzed for this evaluation. Methodological triangulation is encouraged in this study. A minimum set of possible methods include the following:

a) Secondary data: Key documents

A desk review of key relevant documents (see list below). For example, review of key resolutions and their impact on change of key health strategies and policies. Content analysis of all available secondary data relevant to the evaluation will also be undertaken. Key Documents to be reviewed may include but not limited to:

- Partner Instruments (SOAG, etc.)
- ECSA-HC Strategic plans
- ECSA-HC Annual Work Plans
- ECSA-HC Annual Reports
- Prior year USAID Annual Reports
- Annual Health Ministers Conference and Best Practice meeting reports
- Various Regional policies, strategies, guidelines and training materials developed

- ECSA workshop and meeting reports
- ECSA led training manuals and materials
- Past Evaluations / Assessments even those by other partners

b) Primary data

Interviews will be held with staff from ECSA-HC and the member states, ECSACON and other constituent colleges, EAC, RCQHC, WHO, USAID/East Africa, other donors and development partners. Field visits, and or questionnaires and or telephone interview will be made to a minimum of 4 member states to gather data.

The evaluation team may provide suggestions on data collection methods and analysis approaches that, in their opinion, best accommodate the objectives of the evaluation. The final evaluation approach will be negotiated with the Mission.

Data Analysis Methods

The contractor should propose a clear plan for analyzing and triangulating data from various sources to generate high quality and credible evidence to answer the evaluation questions. The analysis method proposed must be relevant to the data collection tools proposed. Potential limitations of methodologies proposed should be highlighted.

All conclusions made by the evaluation team must be supported by clear, verified evidence. Anecdotal evidence will not be considered sufficient for drawing conclusions.

As a part of the proposal, the contractor will utilize the following table to organize the description of the different methods. Before data collection, the contractor in coordination with USAID will finalize the data collection methods and data collection tools as part of the methodology plan.

Evaluation Questions	Data Collection Method (s)	Data Source(s)	Sampling or Selection Criteria	Data Analysis Method
1.				
2.				
3.				
4.				

Methodological Strengths and Limitations

It is expected that the contractor will discuss the relative strengths and limitations of the methodology proposed within the proposal.

VII Evaluation Team Composition:

The evaluation team will be composed of a Team Leader (TL) and one or two experts with an option of a Research Assistant depending on the need for a specific component. USAID may also propose representatives from USAID/EA to participate in parts of the evaluation and/or travel with the consultant team to site visits. All team members must have relevant prior experiences in Africa, familiarity with USAID's objectives, approaches, and operations and prior evaluation/assessment experience. In addition, individual team members should have the technical qualifications identified for their respective positions. The team should have sufficient relevant experience in organizational development, health, nutrition, health systems strengthening, monitoring and evaluation and knowledge management.

Evaluation Team Leader/Lead Investigator:

The TL is ultimately responsible for the overall management of the evaluation team and the final products. In addition, TL is responsible for coordinating evaluation activities and ensuring the production and completion of an evaluation report in conformance with this scope of work and timelines. TL will

also ensure high quality analysis, writing quality and report integration. S/he is also responsible for quality assurance and timeliness of all deliverables. S/he is responsible for the writing of the final evaluation report and preparing and submitting all Task Order deliverables. S/he will also lead the preparation and presentation of the key evaluation findings and recommendations to the USAID team and other stakeholders.
All team members report to the Team Leader.

The TL should have a post graduate degree in public health or an applicable social sciences field. S/he should have extensive experience in conducting mixed methods (combining quantitative and qualitative) evaluations/assessments in Sub-Saharan Africa and strong familiarity with health, nutrition, health systems strengthening and monitoring and evaluation/knowledge management. Excellent oral and written skills in English are required. The TL should also have experience in leading evaluation teams and preparing high quality documents.

Health Systems Expert:
The health systems expert, together with the team leader, will finalize the evaluation methodology; develop the data collection strategy, instruments, and protocols; direct data collection and compilation; and conduct data analysis.
The Subject matter/evaluation expert should have an advanced degree in public health, health systems management, social science or a related subject. S/he should have several years' experience working in Sub-Saharan Africa. S/he should be knowledgeable in program assessment and evaluation methodologies.

Evaluation Specialist
The Evaluation Specialist will work with the team to finalize the evaluation methodology; develop the data collection strategy, instruments, and protocols; direct data collection and compilation; and conduct data analysis.
The Evaluation expert should have an advanced degree in public health, social science or a related subject. S/he should have five years' experience working in Sub-Saharan Africa. S/he should be knowledgeable in program assessment and evaluation methodologies.

As a lesson learned from previous evaluations, the evaluation needs to be carried out in a participatory fashion, forming a team that, in various places and times, includes a range of USAID staff and relevant stakeholders. The process and findings are expected to enable USAID and its partners to clearly and easily evaluate the quality of programming over the last few years.

All team members will be required to provide a written disclosure of conflicts of interest.

VIII. Evaluation Deliverables

Inception Report: Within seven work days of the contract signing, the contractor must submit a detailed inception report to USAID. The report shall detail the evaluation design and operational work plan, which must include the proposed data collection and analysis methods to address the Key Questions of the evaluation. The inception report shall also include questionnaires and interview protocols.
Preliminary Draft Evaluation Report: Within six weeks of USAID's acceptance of the Inception Report, the contractor must submit a draft evaluation report and a power point version to USAID for preliminary comments prior to final Mission debriefing. This will facilitate preparation of a more final draft report that will be left with the Mission upon the evaluation team's departure.

Debriefing: Within six weeks of USAID's acceptance of the Inception Report, and before the contractor's team departs East Africa, the team must present the major findings of the evaluation to USAID/East Africa, USAID /Southern Africa, ECSA-HC and other partners through a PowerPoint presentation

immediately at the close of fieldwork. The debriefing shall include a discussion of findings, conclusions, and recommendations. The team must consider both USAID/EA, partners and other stakeholders' comments and revise the draft report accordingly, as appropriate.

Interim Evaluation Report: Within 10 work days after the debriefing, the contractor must submit a draft report of the findings, conclusions and recommendations to USAID. The written report must address the evaluation questions; clearly describe findings, conclusions, and recommendations. USAID will provide comment on the draft report within two weeks of submission.

Final Report: Within 10 work days of USAID's comments on the Interim Evaluation Report, and based on the provisions of the USAID evaluation policy, a formal and final evaluation report shall be presented to USAID/EA. The final report shall incorporate the team responses to Mission's comments and suggestions. The format shall include an executive summary (highlighting key lessons learned), table of contents, list of acronyms, evaluation design and methodology, findings, conclusions, and recommendations and lessons learned. The report shall be submitted in English, in both electronic and three bound hard copies. The Final Report must not be more than 30 pages excluding annexes. The report will be disseminated within USAID. A brief summary of this report (the popular version), not exceeding 8 pages, excluding any potentially procurement-sensitive information shall be submitted (also electronically, in English) for dissemination among implementing partners and stakeholders. The report must meet standards out-lined in the evaluation policy[167] .

IX. Evaluation Management

a) Logistics: USAID/EA will provide overall direction to the evaluation team, identify key documents, and assist in facilitating a work plan. The evaluation team will be responsible for arranging meetings with key stakeholders and will be required to advise USAID/EA prior to each of those meetings. The evaluation team is also responsible for arranging logistics within the region. The evaluation team will be responsible for procuring its own work/office space, computers, Internet access, printing, and photocopying. Evaluation team members will be required to make their own payments. USAID/EA personnel will be made available to the team for consultations regarding sources and technical issues, before and during the evaluation process.

USAID/EA will send letters of introduction informing key Ministry of Health (MOH) staff and other high-level partners of the nature, timing, and scope of the evaluation and of the evaluation team members.

Responsibilities: The contractor will coordinate and manage the evaluation team and will undertake the following specific responsibilities throughout the assignment:

- Recruit and hire the evaluation team.
- Make logistical arrangements for the consultants including travel and transportation, country travel clearances, lodging and communications.
- Make logistical arrangements for ECSA-HC staff and key stakeholders including travel and transportation, lodging, and communications.

USAID/EA will provide overall technical leadership and direction for the evaluation team throughout the assignment and will provide assistance with the following tasks:

Before Field Work

- SOW. Respond to queries about the SOW and/or the assignment at large.

[167] http://www.usaid.gov/sites/default/files/documents/1868/USAIDEvaluationPolicy.pdf

- Consultant Conflict of Interest (COI). To avoid conflicts of interest or the appearance of a COI, review previous employers listed on the CV's for proposed consultants and provide additional information regarding potential COI with the project contractors evaluated/assessed and information regarding their affiliates.

- Documents. Identify and prioritize background materials and provide them to the evaluation team, preferably in electronic form, at least one week prior to the inception of the assignment.

- Site Visit Preparations. Provide a list of site visit locations, key contacts, and suggested length of visit for use in planning in-country travel and accurate estimation of country travel line items costs.

During Field Work

- Mission Point of Contact. Throughout the field work, ensure constant availability of the Point of Contact person and provide technical leadership and direction for the team's work.

- Facilitate Contact with Implementing Partners. Introduce the evaluation team to implementing partners and other stakeholders, and where applicable and appropriate prepare and send out an introduction letter for team's arrival and/or anticipated meetings.

After Field Work

- Timely Reviews. Provide timely review of the methodology plan and approval of deliverables.

Mission Point of Contact

Name: Grace Miheso
Position: Activity Manager, ECSA-HC
Mission: USAID/EA
Email: gmiheso@usaid.gov
Phone Number: +254722711466

b) Scheduling: USAID expects this evaluation to take place over a period of six weeks beginning o/a January 2015 until February 2015.

Pre Field-Work (Two Weeks): Obtain key documents, make key contacts and plan for interviews and discussions in Arusha with project staff, DJCC members, and USAID staff as needed. Most of this work will be done through email and Skype. The team will work though USAID, but will ultimately be responsible to set as many meetings and interviews as possible prior to arrival in Arusha, Tanzania. It is expected that the first team planning meeting will occur during this phase and the work plan and methodology will be finalized before departure to the field. The team will begin preparing the first few sections of the final report on the background, setting and previous evaluative efforts related to the set of activities under review.

Field Work – Week One: The focus at the beginning of this period will be on meeting with USAID, ECSA-HC staff, gathering and reviewing data not already available, and solidifying plans for site visits. It is also expected that the evaluation team leader will conduct formal in-briefings with the USAID Mission Director and ECSA-HC officials.

Field Work – Weeks Two, Three, and Four: The focus will be to conduct site visits and interviews with ECSA-HC member states government officials (A sample of senior MOH staff), ECSACON staff, Nursing councils, heads of training institutions, other implementing partners like RCQHC and others who work with or have been impacted by the activities under evaluation. Team members will visit and

assess activities in a sample of intervention sites. The balance of the final report will be drafted, to the extent possible.
Field Work - Week Five: The evaluation team will conduct the required debriefings with USAID/EA. The team will submit a draft of the presentation to the AOR before the debriefing with the Mission. Submission of the completed draft final report is expected before the team leader's departure from the region.
Post Field-Work: The final report will be submitted no later than two weeks following receipt of final comments from USAID/EA.

c) Summary of budget

The estimated budget summary are based off of a calculation using the excel file attached. We will not include this in the Task Order.

Evaluation Criteria

1. Clear Understanding of the Project and its Intent – 15%
2. Evaluation Approach – 25%
3. Qualifications and Evaluation Experience of Proposed Personnel – 20%
4. Past Performance – 15%
5. Sample Previous Evaluation – 15%
6. Sub Saharan Africa Experience – 10%

Summary of Budget: A budget template is attached which must be used for presentation of the proposed budget to USAID.

d) Reporting guidelines

- The evaluation report should represent a thoughtful, well-researched and well-organized effort to objectively evaluate what worked in the engagement with ECSA-HC, what did not and why.
- Evaluation reports shall address all evaluation questions included in the scope of work.
- The evaluation report should include the scope of work as an Annex. All modifications to the scope of work, whether in technical requirements, evaluation questions, evaluation team composition, methodology or timeline need to be agreed upon in writing by the technical officer.
- Evaluation methodology shall be explained in detail and all tools used in conducting the evaluation such as questionnaires, checklists and discussion guides will be included in an Annex in the final report.
- Evaluation findings will assess outcomes and impact on males and females.
- Limitations to the evaluation shall be disclosed in the report, with particular attention to the limitations associated with the evaluation methodology (selection bias, recall bias, unobservable differences between comparator groups, etc.).
- Evaluation findings should be presented as analyzed facts, evidence and data and not based on anecdotes, hearsay or the compilation of people's opinions. Findings should be specific, concise and supported by strong quantitative or qualitative evidence.
- Sources of information need to be properly identified and listed in an annex.
- Recommendations need to be supported by a specific set of findings.
- Recommendations should be action-oriented, practical and specific, with defined responsibility for the action.

USAID Evaluation Policy standards, found in the link below, must be met by the contractor throughout the contract.
http://www.usaid.gov/sites/default/files/documents/1868/USAIDEvaluationPolicy.pdf

The findings from the evaluation will be presented in a draft report at a full briefing with USAID/EA. The format for the evaluation report is as follows:

1. **Executive Summary**—summarizes project purpose and background, key evaluation questions, methods, findings, and recommendations. (2-4 pgs.);
2. **Table of Contents** (1 pg.);
3. **Introduction**—purpose, audience, and synopsis of task (1 pg.);
4. **Background**—brief overview of ECSA-HC, USAID program strategy and activities implemented in the SOAG, a description of key partners and purpose of the evaluation (2–3 pgs.);
5. **Methodology**—describes evaluation methods including constraints and gaps (1 pg.);
6. **Findings/Conclusions/Recommendations**—for each objective area; and also include data quality and reporting system that should present verification of spot checks, issues, and outcome (15-17 pgs.);
7. **Issues**—provide a list of key technical and/or administrative, if any (1–2 pgs.);
8. **Future Directions -** to inform the design of future engagement with ECSA-HC(2 pgs.);
9. **References** (including bibliographical documentation, meetings, interviews and focus group discussions);
10. **Annexes**—annexes that document the evaluation tools, schedules, interview lists, interview guides, tables, all sources of information, the evaluation statement of work, statements of differences—should be succinct, pertinent and readable.

The final version of the evaluation report will be submitted to USAID/EA in hard copy as well as electronically. The report format should be restricted to Microsoft products and 12-point type font should be used throughout the body of the report, with page margins 1 inch top/bottom and left/right. The report should be no more than 30 pages, excluding references and annexes.

The evaluation team leader shall incorporate USAID's comments and submit the final report to USAID in electronic format (Microsoft Word) as well as printed and bound copies (five copies in English) no later than 10 working days after the receipt of the comments. Additionally, the evaluation team leader shall submit one either electronic or hard copy to the USAID/EA Program Office

Annex II: Evaluation Questions and Sub-questions

Policy

Evaluation Question 1: To what extent has ECSA-HC with USAID support been able to influence regional and country-level policies?

a. Has ECSA-HC with USAID support been able to influence regional and country-level policies?

b. Describe some of the key policies documents, guidelines and strategies that have been drafted by ECSA-HC with USAID support.

c. What are successes/best practices and challenges in moving from policy level to country uptake?

d. Describe some of the USAID/EA supported best practices, key policy issues and approaches that have arisen from the annual best practice session?

e. What are some key recommendations that have been made to the annual Health Ministers Conference (HMC) and what are the key resolutions that have come out of these recommendations? What is the country-level ownership of resolutions?

f. How successful have ECSA member states been in rolling out the key policies and resolutions from the HMS, what methods have been used to disseminate these resolutions?

g. Has there been real peer review by country on progress made with implementation and have there been instances that countries have borrowed and adapted policy solutions across borders?

Technical

Evaluation Question 2: To what extent has USAID-supported programs responded to thematic priorities as outlined in the ECSA-HC strategic plans and other regional strategies agreed to by member states?

a. How has the change in USAID priorities over the years affected ECSA strategic focus and areas of priority?

b. How has HRAA had a positive impact on HRH in Lesotho and Swaziland?

c. What key results or contributions has HRAA had in the following areas on HRH in Lesotho: a) Planning and financing; b) HRIS; c) Pre-service education (social work and d) Recruitment and Retention

d. What key results or contributions has HRAA had in the following areas of HRH in Swaziland; a) Planning and financing including the transition of Global Fund positions to the Swazi government and estimating HRH needs; b) HRIS and c) Capacity Strengthening of Department of Social Welfare

Institutional capacity and knowledge management

Evaluation Question 3: What have been the key contributions of USAID support to ECSA-HC's institutional capacity strengthening agenda? To what extent has USAID support contributed to strengthening ECSA-HC's financial sustainability and management capacity including human resources and knowledge management?

a. Has USAID empowered ECSA-HC to be an independent self-sustaining institution?

b. How much independent funding has ECSA-HC been able to raise before, during and after USAID's support and what was the influence of the USAID engagement in this?

c. What is the extent of ECSA-HC member states' financial and political support these programs and how can that support be strengthened/mobilized?

d. Has USAID/East Africa's involvement in hiring core staff improved management capacity of the ECSA-HC secretariat? How can this be improved? Sustained?

e. What was the impact of pipelines on program implementation and achieving overall goals.

f. Has ECSA's capacity to manage a program like HRAA improved after the challenges faced in the first 18 months of the award?

g. How successful has ECSA been as a regional think tank for health systems issues in the region and how has this been demonstrated?

Annex III: Evaluation Question Matrix

EVALUATION KEY QUESTION 1: To what extent has ECSA-HC with USAID support been able to influence regional and country level policies?					
REVIEW SUB-QUESTION	**TYPE OF EVIDENCE**	**DATA COLLECTION**		**SAMPLING OR SELECTION APPROACH**	**DATA ANALYSIS METHOD**
		SOURCE	**METHOD**		
1.1 Has ECSA-HC with USAID support been able to influence regional and country-level policies?	Analytical	Project Documents EAC Community; USG Partners; MOHs; ECSACONs; RCQHC; Training & Research Institutions; ECSA Partners; Other DP	Document Review KIIs	As appropriate Purposive sampling	Content analysis of regional and country polices
1.2 Describe some of the key policies documents, guidelines and strategies that have been drafted by ECSA-HC with USAID support.	Analytical	Project Documents EAC Community; USG Partners; MOHs; Training & Research Institutions; ECSA Partners	Document review KIIs	As appropriate Purposive sampling	Content analysis of ECSA-HC policy documents and strategies
1.3 What are successes/best practices and challenges in moving from policy level to country uptake?	ANALYTICAL	Project documents EAC Community; USG Partners; MOHs; ECSACONs; RCQHC; Training & Research Institutions; ECSA Partners	Document review KIIs	As appropriate Purposive sampling	Content analysis of success/best practices

EVALUATION KEY QUESTION 1: To what extent has ECSA-HC with USAID support been able to influence regional and country level policies?					
REVIEW SUB-QUESTION	**TYPE OF EVIDENCE**	**DATA COLLECTION**		**SAMPLING OR SELECTION APPROACH**	**DATA ANALYSIS METHOD**
		SOURCE	**METHOD**		
1.4 Describe some of the USAID/EA supported best practices, key policy issues and approaches that have arisen from the annual best practice session?	ANALYTICAL	Project Documents EAC Community; USG Partners; MOHs; ECSACONs; RCQHC; Training & Research Institutions; ECSA Partners	Document review KIIs	As appropriate Purposive sampling	Content analysis of best practices
1.5 What are some key recommendations that have been made to the annual Conference of Health Ministers and what are the key resolutions that have come out of these recommendations? What is the country-level ownership of resolutions?	ANALYTICAL	Project Document EAC Community; USG Partners; MOHs;	Document review KIIs	As appropriate Purposive sampling	Content analysis of recommendations to annual conference of health ministers and key resolutions
1.6 How successful have ECSA member states been in rolling out the key policies and resolutions from the HMS, what methods have been used to disseminate these resolutions?	ANALYTICAL	Project Document EAC Community; USG Partners; MOHs;	Document review KIIs	As appropriate Purposive sampling	Content analysis of disseminations of resolutions
1.7 Has there been real peer review by country on progress made with implementation and have there been instances that countries have borrowed and adapted policy solutions across borders?	ANALYTICAL	Project documents EAC Community; USG Partners; MOHs;	Document review KIIs	As Appropriate Purposive sampling	Content analysis of inter-state peer review and adaptation of policy solutions across borders

EVALUATION KEY QUESTION 2: To what extent has USAID-supported programs responded to thematic priorities as outlined in the ECSA-HC strategic plans and other regional strategies agreed to by member states?					
REVIEW SUB-QUESTION	**TYPE OF EVIDENCE**	**DATA COLLECTION**		**SAMPLING OR SELECTION APPROACH**	**DATA ANALYSIS METHOD**
		SOURCE	**METHOD**		
2.1 How has the change in USAID priorities over the years affected ECSA strategic focus and areas of priority?	Exploratory and analytical	Project Documents EAC Community, MOH, Training & Research Institutions, ECSA partners, USG partners	Document Review KIIs	As Appropriate Purposive sampling	Content analysis of SOAG strategic objectives and results; ECSA-HC health priorities; amendments to the SOAG
2.2 How has HRAA had a positive impact on HRH in Lesotho and Swaziland?	Analytical	Project documents MOH-Lesotho, Swaziland ECSACON NUL/UOS USAID/Lesotho	Document review KIIs	As appropriate Purposive sampling	Content analysis of HRAA mandate in Lesotho and Swaziland

EVALUATION KEY QUESTION 3: What has been the key contributions of USAID support to ECSA-HC's institutional capacity strengthening agenda? To what extent has USAID support contributed to strengthening ECSA-HC's financial sustainability and management capacity, including human resources and knowledge management?					
REVIEW SUB-QUESTION	**TYPE OF EVIDENCE**	**DATA COLLECTION**		**SAMPLING OR SELECTION APPROACH**	**DATA ANALYSIS METHOD**
		SOURCE	**METHOD**		
3.1 Has USAID empowered ECSA-HC to be an independent self-sustaining institution?	Analytical	Project documents EAC Community; USG Partners; MOHs; ECSACONs; RCQHC; Training & Research Institutions; ECSA Partners	Document review KIIs	As appropriate Purposive sampling	Content analysis
3.2 How much independent funding has ECSA-HC been able to raise before, during and after USAID's support and what was the influence of the USAID engagement in this?	Descriptive and analytical	Project document EAC Community; USG Partners;	Document review KIIs	As appropriate Purposive sampling	Content analysis of alternative sources of funding; USAID influence on ECSA-HC alternative funding
3.3 What is the extent of ECSA-HC member states' financial and political support these programs and how can that support be strengthened/mobilized?	Analytical	Project document EAC Community; USG Partners; MOHs; ECSACONs; RCQHC; Training & Research Institutions	Document review KIIs	As appropriate Purposive sampling	Content analysis of member states political support to programs

EVALUATION KEY QUESTION 3: What has been the key contributions of USAID support to ECSA-HC's institutional capacity strengthening agenda? To what extent has USAID support contributed to strengthening ECSA-HC's financial sustainability and management capacity, including human resources and knowledge management?					
REVIEW SUB-QUESTION	**TYPE OF EVIDENCE**	**DATA COLLECTION**		**SAMPLING OR SELECTION APPROACH**	**DATA ANALYSIS METHOD**
		SOURCE	**METHOD**		
3.4 Has USAID/East Africa's involvement in hiring core staff improved management capacity of the ECSA-HC secretariat? How can this be improved sustained?	Analytical	Project documents EAC Community; USG Partners;	Document review KIIs	As appropriate Purposive sampling	Content analysis of hiring of score staff and management capacity of ECSA-HC secretariat.
3.5 What was the impact of pipelines on program implementation and achieving overall goals?	Analytical	Project documents EAC Community; USG Partners; MOHs; ECSACONs; RCQHC; Training & Research Institutions	Document review KIIs	As appropriate Purposive sampling	Content analysis of program implementation and overall goals
3.6 Has ECSA's capacity to manage a program like HRAA improved after the challenges faced in the first 18 months of the award?	Exploratory	Project documents EAC Community; USG Partners; MOHs; ECSACONs; NUL/ UOS	Document review KIIs	As appropriate Purposive sampling	Content analysis of challenges faced by ECSA implementation of HRA
3.7 How successful has ECSA been as a regional think tank for health systems issues in the region and how has this been demonstrated?	Exploratory and Analytical	Project document EAC Community; USG Partners; MOHs; ECSACONs; RCQHC; Training & Research Institutions; ECSA Partners	Document review KIIs	As appropriate Purposive sampling	Content analysis of ECSA advisory role on regional health systems issues

Annex IV: List of Key Document Types

The following categories of key documents were reviewed.

i. Performance Management Plan
ii. Quarterly and annual reports
iii. Relevant project reports and evaluations
iv. ECSA-HC Strategic Objective Grant Agreements (SOAGs);
v. ECSA-HC Strategic Plans (2008-2012) and (2012-2017);
vi. USG/ECSA SOAG Amendments (2007, 2008, 2008, 2009, 2010, 2011 and 2012);
vii. Rockefeller Foundation/ECSA Agreement (2012);
viii. ECSA-HC Annual Work Plans;
ix. ECSA-HC Annual Reports;
x. USAID Annual Reports;
xi. ECSA-HC Performance Monitoring Plan (PMP);
xii. Annual Conference of Health Ministers (CHM) and Best Practice meeting reports;
xiii. ECSA Workshop and meeting reports;
xiv. Compendium of Regional Health Indicators (2014);
xv. Human Workforce Advocacy Initiative (HWAI) recommendations to CHM (2014);
xvi. Resolutions of Conference of Health Ministers;
xvii. World Health Organization (WHO) resolution on scaling up HRH for improved health service delivery in the African Region 2012-2015;
xviii. WHO African Regional Health Report (2014);
xix. Expanding Access to Family Planning Services at Community Level (2011);
xx. ECSA Mid Term Review Final Report;
xxi. ECSA Regional M&E Expert Core Group Meeting Report (2010);
xxii. Directors' Joint Consultative Committee (DJCC) Meeting Recommendations (2009) on Improving Quality Health Care to achieve MDGs;
xxiii. East, Central and Southern Africa College of Nursing (ECSACON) final recommendations.

Annex V: Listing of Key Documents Produced by ECSA-HC

No.	FILE NAME	DOCUMENT TITLE
1	ECSA-HC Evaluation SOW	Statement of Work to Evaluate the Performance of USAID's engagement with ECSA-HC
2	1423119733-EBOLA-TABLE-TOP-SIMULATION-EXERCISE-BETWEEN-THE	JOINT EBOLA TABLE TOP SIMULATION EXERCISE "EAST AFRICA PUBLIC HEALTH LABORATORY NETWORKING PROJECT (EAPHLNP), MEETING REPORT, 30TH SEPTEMBER TO 02ND OCTOBER, 2014"
3	EAIDSNett Bulletin_Nov2014_Vol4_final2	EAIDSNett Bulletin November 2014 Volume 4 Issue 1
4	ECSA-HC Compendium of Reg.CORE Indicators 2nd Edition-2014	ECSA-HC Compendium of Regional Core Indicators, Second Edition, 2014
5	Health Care financing Profiles 1995-2009	Health Care Financing Profiles of East, Central and Southern African Health Community Countries, 1995–2009
6	integrated_strategic_plan_for_hiv-aids_tb_id	HIV/AIDs and TB and other Infectious Diseases Integrated Strategic Plan 2013 - 2018
7	National Symposium for Scaling up Advocacy for Universal Health Coverage - Uganda June 2014	National Symposium for scaling up advocacy for universal health coverage in Uganda – June 2014
8	Monitoring and Evaluation Framework for Universal Health Coverage	Monitoring and Evaluation Framework for Universal Health Coverage
9	report_of_the_pmdt_mission_kenya	PROGRAMMATIC MANAGEMENT OF DRUG RESISTANT TB (PMDT) MISSION TO KENYA 15-19 July, 2013
10	report_of_the_pmdt_mission_lesotho_	PROGRAMMATIC MANAGEMENT OF DRUG RESISTANT TB (PMDT) MISSION TO LESOTHO 6-10 May 2013
11	Report_of_the_pmdt_mission_to_tz	PROGRAMMATIC MANAGEMENT OF DRUG RESISTANT TB (PMDT) MISSION TO TANZANIA 30 September – 4 October, 2013
12	Technical RPF_ April 2008 Report	Technical Report of the Regional Pharmaceutical Forum and Antimicrobial Resistance Meeting, Kampala, Uganda: April 28–30, 2008

No.	FILE NAME	DOCUMENT TITLE
13	Technical RPF_report_nine - May 2014	REGIONAL PHARMACEUTICAL FORUM Technical Report of the 9th Meeting of the Regional Pharmaceutical Forum 5th -6th May 2014 - Nairobi, Kenya
14	Technical_RPF_report_seven - March 2011	Technical Report of the 7th Meeting of the Regional Pharmaceutical Forum – Lusaka, Zambia, 9th – 11th March, 2011
15	DOC2ECSA Regional Core Indicators Final http://me-ecsahc.org/	Definitions of ECSA Regional Core Indicators February 2011
16	ECSA CORE INDICATORS http://me-ecsahc.org/	CORE INDICATORS
17	ECSA Targets, FY2013 & 2014	A. SUMMARY OF KEY ACHIEVEMENTS IN FOURTH QUARTER, JULY - SEPTEMBER 2013
18	ECSACON Final Recommendations	ECSACON Pre-Conference Recommendations August 10, 2013.
19	Report on Nairobi ENA Meeting	ECSA/RCQHC CONSULTATIVE MEETING ON THE LESSONS LEARNT DURING THE IMPLEMENTATION OF THE ESSENTIAL NUTRITION ACTIONS (ENA)
20	Food Fortification Review FINAL_508 1 15 10	ARF/EA–REVIEW OF ECSA-HC FOOD FORTIFICATION ACTIVITY December 2009
21	The ECSA Regional FF Program	PRESENTATION: The ECSA FF Initiative and the Process of Development of ECSA guidelines on food fortification standards
22	Trip Report - ECSACON Pre-Conference 2013	TRIP REPORT The ECSACON pre-conference meeting: Present the FP-integrated Fistula Care initiative and role of nurses and midwives.
23	Trip Report HMC 46- RHMC Feb 2008	Trip Report: 46th Health Ministers Conference 25-29 February 2008
24	Quartely_Report_October___December_2006[1]	QUARTERLY REPORT: OCTOBER - DECEMBER 2006
25	QUARTERLY REPORT-Jan -March 07	QUARTERLY REPORT: January - March 2007
26	Quarterly Report July - Sept 2007_Revised4	QUARTERLY REPORT: JULY - SEPTEMBER 2007
27	Quarterly Report Oct - Dec 2007	QUARTERLY REPORT: OCTOBER 01 – DECEMBER 31, 2007

No.	FILE NAME	DOCUMENT TITLE
28	ECSA Quarterly Report Jan - March 2008	QUARTERLY REPORT: JANUARY 1 – MARCH 31, 2008
29	Quarterly Report April - June 2008	QUARTERLY REPORT: APRIL 1 – JUNE 30, 2008
30	Quarterly Report July - September 2008final	QUARTERLY REPORT: JULY 1 – SEPTEMBER 30, 2008
31	Quarterly Report October - December 2008	QUARTERLY REPORT: OCTOBER 1 – DECEMBER 31, 2008
32	Quarterly Report Jan - March 2009	QUARTERLY REPORT: JANUARY 1 – MARCH 31, 2009
33	QUARTERLY REPORT April - June 2009	QUARTERLY REPORT: APRIL 1 – JUNE 30, 2009
34	Quarterly Report July - Sept. 2009final	QUARTERLY REPORT: JULY 1 – SEPTEMBER 30, 2009
35	Revised Quarterly Report October - December 2009 - FINAL	QUARTERLY REPORT: OCTOBER 1 – DECEMBER 31, 2009
26	Revised Quarterly Report January - March 2010	QUARTERLY REPORT: January 1 – March 31, 2010
37	Revised Quarterly Report April -June 2010	QUARTERLY REPORT: APRIL 1 – JUNE 30, 2010
38	Revised Quarterly Report -July -September 2010	QUARTERLY REPORT: July 1 - September 30, 2010
39	ECSA Quarterly Report, October - December 2010 Final	QUARTERLY REPORT: OCTOBER 1 – DECEMBER 31, 2010
40	ECSA Quarterly Report, January - March 2011 Final	QUARTERLY REPORT: JANUARY 1 - MARCH 31, 2011
41	ECSA Quarterly Report, April - June 2011	QUARTERLY REPORT: APRIL 1 – JUNE 30, 2011
42	ECSA Quarterly Report, July - September 2011 Final	QUARTERLY REPORT: 1 JULY - SEPTEMBER 30, 2011
43	ECSA Quarterly Report, October - December 2011	QUARTERLY REPORT: 1 OCTOBER – 31 DECEMBER 2011
44	ECSA Quarterly Report, January - March 2012 Final	QUARTERLY REPORT: 1 JANUARY – 31 MARCH 2012
45	ECSA Quarterly Report, April - June 2012 Final	QUARTERLY REPORT: 1 APRIL – 30 JUNE 2012
46	ECSA Quarterly Report, October - December 2012 Final	QUARTERLY REPORT: 1 OCTOBER – 31 DECEMBER 2012
47	ECSA Quarterly Report 2, January - March 2014	USAID QUARTERLY REPORT 1ST JANUARY – 31ST MARCH 2014
48	ECSA Quarterly Report 3, April - June 2014	USAID QUARTERLY REPORT 1ST APRIL – 30TH JUNE 2014
49	ECSA Quarterly Report 4, July - September 2014	USAID QUARTERLY REPORT 1ST JULY – 30TH SEPTEMBER 2014
50	USAID EA Programme April 2012 (1)	Programme for ECSA-HC/USAID EA QUARTERLY METING 17th - 18th April 2012 – ARUSHA
51	ECSA Strategic Plan October 2008	ECSA STRATEGIC PLAN FOR THE PERIOD 2008 – 2012 October 2008
52	ECSA-HC Strategic Plan 2012-2017_ FINAL Signed	STRATEGIC PLAN 2012 – 2017

No.	FILE NAME	DOCUMENT TITLE
		Innovation, Growth and Equity in the ECSA Region May 2012
53	ECSA MTR Final Report (2)	Mid-Term Review (MTR) of the ECSA strategic plan 2008-2012 Final Report
54	CN #71 EAST AFR REGIONAL (Regional Program Narrative-FY 2013) (1)	REGIONAL PROGRAM NARRATIVE FY 2013 / 2014
55	CN #123 EAST AFRICA REG'L (Regional Program Narrative)- (1) (1) dated August 1, 2012	REGIONAL PROGRAM NARRATIVE FY 2012
56	ECSA Amplified Description Feb 2014	Strategic Objective Grant Agreement (SOAG) No. 623-SOAGA11A052-70048 Amendment Number Seven Amplified Description
57	ECSA SOAG Feb 2014	USAID Amendment Number Seven to SOAG between USA and ECSA-HC February 24, 2014
58	ECSA SOAG Sept 06	STRATEGIC OBJECTIVE GRANT AGREEMENT (SOAG) BETWEEN THE UNITED STATES OF AMERICA AND COMMONWEALTH REGIONAL HEALTH COMMUNITY (CRHCS/ECSA) DATED: September 15, 2006
59	FY 2011 Activity Description	Strategic Objective Grant Agreement (SOAG) No. 623-SOAGA11A052-70048 Amendment Number Five Amplified Description
60	FY 2012 Activity Description Sept 18	Strategic Objective Grant Agreement (SOAG) No. 623-SOAGA11A052-70048 Amendment Number Six Amplified Description
61	revised annex 1 CRHC- 2008	Strategic Objective Grant Agreement (SOAG) Amendment Number Two Amplified Description
62	Revised annex 1 CRHC-ECSA 2009	Strategic Objective Grant Agreement (SOAG) Amendment Number Three Amplified Description
63	SOAG Activity Description Annex 1 July 2006	Strategic Objective Grant Agreement (Agreement) Amplified Description
64	2013 BPF-DJCC Recommendations (1)	7th Regional forum on Best Practices and 23rd Directors' Joint Consultative Committee (DJCC) Meeting: Draft Recommendations of the Forum Best Practices 12th-14th August 2013
65	DJCC Recommendations 2009	Improving access to Quality Health Care to achieve the Millennium Development Goals.

No.	FILE NAME	DOCUMENT TITLE
		Recommendations of The 19th Directors' Joint Consultative Committee Meeting (DJCC) 14-18 September 2009
66	DJCC	
67	50TH ECSA HMC RESOLUTIONS	Resolutions of the 50th East, Central and Southern African Health Ministers' Conference 15th – 19th, February 2010
68	Resolutions of the 46th ECSA HMC _ Feb '08_	46th ECSA Health Ministers' Conference 25th - 29th February, 2008 Resolutions
69	RESOLUTIONS OF THE 52nd HMC	Resolutions of the 52nd Health Ministers' Conference 25th - 29th October, 2010
70	A2Z Work plan Activity Matrix-ECSA-REV2-10-0907_1	A2Z-ECSA WORKPLAN: ACTIVITES, TIMELINE AND ESTIMATED BUDGET FOR ACTIVITIES
71	ECSA work plan narrative-20100830-REV- 10-0907_1	ECSA/REGIONAL EAST AFRICA – FOOD FORTIFICATION FY10-11 Work plan Narrative August 10th, 2010.
72	ECSA-USAID EA Revised Implementation 2013-14-Revised Version 5	ECSA/USAID REVISED IMPLEMENTATION PLAN JULY 2013 - SEPT 2014
73	ECSA-USAID EA Work plan-FY 2012-2013-FINAL - 05Nov2012 (3)	EAST CENTRAL AND SOUTHERN AFRICA HEALTH COMMUNITY SUMMARY OPERATIONAL WORKPLAN OCTOBER 1, 2012 – 30 SEPTEMBER 2013
74	ECSA-USAID Work Plan 2010-2011(Nov29)2	East Central and Southern Africa Health Community Summary of Work Plan for the Period October 1, 2010 to September 30, 2011
75	II 11 Revised work plan, 22 August_0	
76	USAID EA Consolidated Work Plan IL - 22 August 2014	
77	USAIDEA SAOG WORKPLAN FOR 2009-2010Rev	East Central and southern Health Community (ECSA-HC) Work plan for the period October 1, 2009 – September 30, 2010
78	ECSA ANNUAL REPORT 2010-2011 Oct. DN	ANNUAL REPORT 2010-11

No.	FILE NAME	DOCUMENT TITLE
79	ECSA ME ExpGp Report FINAL COPY	1st Regional Monitoring and Evaluation Expert Core Group Meeting Report 12-16 July 2010
80	ECSA MTR Final Report	(ECSA-HC) Mid-Term Review (MTR) of the ECSA strategic plan 2008-2012 Final Report
81	ECSA PARTNERS	ECSA PARTNERS (list not contacts)
82	ECSA STRATEGIC PLAN 2008-2012	ECSA STRATEGIC PLAN FOR THE PERIOD 2008 - 2012
83	List of participants - DJCC 2012	ECSA STAKEHOLDERS LIST OF PARTICIPANTS (with contacts)
84	Report on Nairobi ENA Meeting	ECSA/RCQHC CONSULTATIVE MEETING ON THE LESSONS LEARNT DURING THE IMPLEMENTATION OF THE ESSENTIAL NUTRITION ACTIONS (ENA) 28-30 JUNE, 2011
85	Strategic Plan - Swaziland0001	MOH National Health Sector Strategic Plan Strategic Thrust and outcome Framework
86	Strategic Plan - Tanzania0001	HSSP III Implementation
87	UHC_Grant Agreement Rockefeller	Rockefeller Foundation 2012 THS 330 Grant Agreement
88	Quantitative Performance Results - ECSA draft 09	Part III: Quantitative Presentation of Performance
89	USAID Quarterly Report January - March 2013 Final (1)	QUARTERLY REPORT: 1 JANUARY – 31 MARCH 2013
90	USAID Quarterly Report October - December 2014 final (1)	USAID QUARTERLY REPORT 1 OCTOBER – 31 DECEMBER 2014
91	SOAG amendment three Sept 09	AMENDMENT NUMBER THREE TO THE STRATEGIC OBJECTIVE GRANT AGREEMEN DATE: September 28,2009
92	SOAG Amendment Four, September 23, 2010	Amendment Four to Strategic Grant Objective DATE: September 23, 2010

A.

Annex VI: Master List of Completed KIIs

Country	Position/Organisation
1. Kenya	Consultant, KNCV TB Foundation
2. Kenya	Technical Director, Clinical & Diagnostics, AMREF
3. Kenya	In Country Project Director, CDC/Emory University KHW Project
4. Kenya	Deputy Director, USAID/Kenya and East Africa
5. Kenya	MCH/FP Specialist, USAID/Kenya and East Africa
6. Kenya	Finance Specialist, USAID/Kenya and East Africa
7. Kenya	Regional Director, Eastern, Central and Southern Africa Helen Keller International ILRI Campus, Nairobi, Kenya
8. Kenya	HIV/AIDS Specialist from the Bilateral office
9. Kenya	Comms & Policy Engagement, APHRC - Africa Population Health Research Cente
10. Kenya	Senior Public Policy Officer, EGPAF
11. Kenya	Senior Technical Advisor, Intrahealth International
12. Kenya	Director General, National Council for Population and Development
13. Kenya	CEO, Kenya Medical Practioner & Dentist Board
14. Kenya	Director, KEMRI
15. Kenya	Chief of Party, Cross-Border Health Integrated Partnership Project (CB-HIPP)
16. Kenya	Regional Legal Advisor (for HRAA focus), ECRHS&F, USAID/Southern Africa
17. Lesotho	Health System Advisor, USAID/Lesotho
18. Lesotho	Chief of Party, JHPIEGO
19. Lesotho	Dean, Faculty of Health Sciences National University of Lesotho, Southern Africa
20. Lesotho	ex-President ECSACON
21. Malawi	HR Planning Specialist, Ministry of Health
22. Mauritius,	Director Health Services, Ministry of Health & Quality of Life
23. Swaziland	Prof and Dean, University of Swaziland
24. Swaziland	Former Country Director, HRAA
25. Swaziland	Director, Health Services, Ministry of Health
26. South Africa	Activity Manager, HRAA, USAID/South Africa
27. Tanzania	Director General, ECSA Secretariat
28. Tanzania	Regional Contracts and Finance Manager (gp KII,),--1gp, 3,4, gp Human Resources Alliance for Africa
29. Tanzania	Acting Country Director HRAA Manager for Human Resources for health & capacity Building ECSA-HC
30. Tanzania	Director of Finance, ECSA Secretariat
31. Tanzania	Director of Operations and Institutional Management, ECSA Secretariat
32. Tanzania	Principal Health Officer, East African Community
33. Tanzania	Medical/MO, Ministry of Health
34. Tanzania	Management Consultant, ESAMI
35. Tanzania	ASRHO, EAC Secretariat
36. Tanzania	former Senior Technical Officer - ECON, FHI360 ROADS
37. Tanzania	Dean, Muhimbili University
38. Tanzania	Senior Research Scientist, Ifakara Health Institute
39. Tanzania	Team Leader, Policy Translation, Ifakara Health Institute

40. Tanzania	Director of Research Coordination and Promotion National Institute for Medical Research (NIMR)
41. Tanzania	Quality Improvement Advisor, University Research, Dar es Salaam
42. Uganda	Executive Director African Center for Global Health and Social Transformation (ACHEST)
43. Uganda	Regional Director, PPD ARO
44. Uganda	Ag. Director, Regional Centre for Quality of Health (RCQHC) Child Health and Nutrition Technical Advisor/Deputy Executive Director, RCQHC Makerere University School of Public Health
45. USA	Senior Health Adviser, Africa Bureau, USAID/Washington
46. Zambia	Director, Public Health & Research, Ministry of Health
47. Zambia	Director MCH - Ministry of Community Development Mother and Child Health,
48. Zimbabwe	Director, TARCS/EQUINET
49. Zimbabwe	Director Nursing Services, Ministry of Health & Child Welfare
50. Zimbabwe	Dean, University of Zimbabwe

Annex VII: Evaluation Team Members' CVs

GARY SVENSON **Nationality:** American **Affiliation:** IBTCI

Position: Team Leader **Labor Category:** Health/Population Analyst

Education:

Doctor of Medical Science in Community Medicine, Lund University	2002
Master of Science in Psychology, Lund University	1988
Master of Social Work, San Diego State University	1979
Bachelor of Arts in Psychology and Pre-medicine, Sonoma State University, California	1973

Relevant Experience:

Dr. Gary Svenson is a senior-level technical advisor, researcher, team leader and manager with a multidisciplinary background and experience in 30 countries in the fields of HIV & AIDS, sexual and reproductive health (SRH), adolescent and youth health, key populations, and health systems strengthening (HSS). His responsibilities have included leading research, evaluations, assessments, comprehensive SBCC programs, national and regional strategy development, multi-national networks, and ICT and media interventions. Dr. Svenson has strong leadership, teamwork and partnership skills in developing, managing, and budgeting regional and country-level initiatives within the United Nations, PEPFAR/USAID, EU, national/regional governments, and NGOs. He has served as Team Leader for Situation Analysis of HIV/SRH Youth Peer Education Standards in Eastern and Central Asia Region, and as Lead consultant to develop the National M&E Framework for HIV Risk Reduction Strategy for Most-at-Risk Adolescents, UNICEF Bangladesh and GOB National AIDS/STD Program (NASP). Dr. Svenson holds a doctorate in Community Medicine and Master Degrees in Psychology and Social Work and Master of Science and Social Work. Other training includes USAID Certification as COR/AOR, Programming Foreign Assistance (PFA), Program Design and Management (PDA), and TOT in Medical Research Ethics (FHI 360). Dr. Svenson's primary personal qualifications are the ability to bring state-of-the art evidence and research to bear to lead, implement and guide effective interventions and studies adapted to local contexts particularly for young people.

Professional Experience:

August 2012 – Present, Owner & Director/Primary Consultant, Heights (PTY) Ltd, Botswana - Designated as Senior Immunization Advisor for UNICEF GAVI HSS consultant roster. Served as Team Leader for Situation Analysis of HIV/SRH Youth Peer Education Standards in Eastern and Central Asia Region (18 countries), UNFPA EECA regional office; and Lead Consultant to develop the National M&E Framework for HIV Risk Reduction Strategy for Most-at-Risk Adolescents, UNICEF Bangladesh and GOB National AIDS/STD Program (NASP). Led Mid-term review of the Netherlands' Regional HIV/AIDS/SRH Program for Southern Africa, Embassy of the Kingdom of the Netherlands', Pretoria, South Africa. Served as Lead Consultant to develop and write Policy Briefs on Young People's Health in Vietnam (HIV & AIDS, sexual and reproductive health, mental health), WHO Vietnam. Worked as lead technical advisor and editor for UNICEF Bangladesh and NASP on National HIV Risk Reduction Strategy for Most-at-Risk Adolescents and Especially Vulnerable Adolescents, Comprehensive Mapping of Children Infected/Affected by HIV, National AIDS Spending Assessment, and HIV, Syphilis and Hepatitis B prevalence Survey among Pregnant Women. Held Lead Consultant role for, development of Portuguese National Youth Peer Education Health Programme, University of Coimbra/ Portuguese Association of NGOs for Development, Portugal, 2006; and development of youth peer education training manual for CEE, CIS & Baltic States region, UNDP Latvia, 2000. Participated in Independent Expert Peer Review Panel on research protocols and Expressions of Interest (EOI) for Regional Research and Innovations Fund (RRIF) for HIV Prevention in Southern and Eastern Africa, Mott McDonald for DFID, SIDA, NORAD & HLSP.

September 2009 – July 2012, Senior Regional Technical Advisor for HIV/AIDS Prevention, Regional HIV/AIDS Program, USAID Southern Africa via Global Health Fellowships Program (GHFP), Southern Africa - Provided regional technical expertise in the development, awarding, implementation, management, and evaluation of PEPFAR/USAID programs throughout southern Africa at the country and regional levels in the areas of HIV and AIDS, SRH and TB–HIV co-infection. Served as interim Senior Knowledge Management Advisor for 2 years. Lead USAID Technical Advisor and Activity Manager for, IOM's regional 'HIV and Migration' assessment in 7 southern African countries; and Future Institute's 'SADC regional HIV/AIDS Policy Assessment'. Functioned as Senior Technical advisor for PEPFAR Country Operations Plans (COP), Requests for Assistance (RFA) and Programs (RFP), and Technical Evaluation Committees for, Swaziland five-year Combination Prevention Program ($25 M); Lesotho five-year Sexual HIV and AIDS Prevention Program ($25 M). Served as USAID representative on southern Africa regional 'Drug Use/IDU and HIV' Technical Working Group. Performed role of South Africa Regional Technical Advisor to PEPFAR consultation 'HIV Prevention, Care and Treatment for MSM in Africa', Johannesburg.

July 2007 – March 2009, HIV/AIDS Program Specialist – Senior HIV Advisor, United Nations Population Fund, Botswana - Served as Senior HIV/AIDS Advisor to Botswana Government and UN Country Team (UNCT) on HIV prevention, strategy and policy development, BCC, HSS and national programing within the National AIDS Coordinating Agency (NACA), UNFPA Country Office and as Convener of the UN Prevention Working Group within the Joint UN Team on AIDS (JUTA). Held role of Team leader for the development and implementation of the UN Country Office's HIV prevention work plan focusing on young people and its alignment and harmonization with GOB. Provided HIV and AIDS technical expertise to 10 Botswana government committees and technical working groups (TWGs) at NACA, MoH, MoF, NGOs, CSOs and GFATM recipients. Contributed as senior advisor to the development and implementation of: National Operations Plan on Scaling up HIV Prevention (2008-2010); National HIV Strategic Framework II (2009-2015); 3rd national HIV/AIDS Impact Survey (BAIS III); and National HIV & AIDS Knowledge and Skills Resource Package.

October 2002 – October 2006, Principal Investigator and Team Leader, YouthNet Program, Family Health Institute (FHI 360) - Designed and managed a 4-year research study on the effectiveness and cost-effectiveness of facility-based youth peer education (YPE) for SRH, HIV prevention and youth-friendly health services in partnership with governments of Zambia and the Dominican Republic. Performed research protocols, designs, tools, data collection and analyses, budgets, partnerships, and reports. Led the design, management and analysis of formative research by teams in Zambia and Dominican Republic; developed YPE assessment checklists for global dissemination by UNFPA. Led the design, management and analysis of youth component of one national and 6 district household surveys in Zambia. Headed the design, management and analysis of 7 clinic-based studies measuring the impact of YPE and youth-friendly health services on use of RH and HIV & AIDS services using biomarkers and case controls (Zambia). Led the development of a framework, tools and guidelines for assessing & monitoring YPE programs for global dissemination. Wrote and disseminated research papers.

1997 – 2001, Coordinator & Manager, Department of Community Medicine, Lund University, Sweden - Led and managed national needs assessments on YPE in 15 European countries. Led the qualitative analyses of 24 best-practice YPE programs in 11 European countries in partnership with five universities, five national HIV/AIDS coordinating bodies, and the International Planned Parent Federation (IPPF). Led and directed Phases 1 & 2 of the research-based European Joint Action Plan on Youth AIDS Peer Education (Europeer) that consolidated 16 European countries, WHO Europe, and UNAIDS in a joint action to support and promote evidence-based youth HIV/AIDS prevention and SRH in the European Union. Led and authored the development of the 'European Guidelines on Youth AIDS Peer Education'. Co-led a needs assessment with recommendations on YPE in Central & Eastern Europe (CEE), the Community of Independent States (CIS), and Baltic States for UNICEF and UNDP. Contributed technical leadership to the development of the UNFPA 'Y-PEER' network in Eastern Europe and Central

Asia and to the Caribbean HIV/AIDS Youth Network (CHAYN). Led the development of the EU Europeer grant proposal and work plan that resulted in Phase 2 being awarded to University of Exeter, Child Health Division.

1989 – 1995, HIV/AIDS Psychologist – Principal Investigator, Department of Infectious Diseases, Lund University Hospital, Sweden - Provided clinical services in the form of outpatient counseling and psychotherapy to PLWHA and injecting drug users. Served as member of HIV/AID medical team; provided psychological support to PLWHA and medical staff; conducted neuropsychological and psychiatric assessments. Led, implemented and evaluated a 5-year clinic-based HIV/SRH outreach program and research study on a university campus (n=32,000) based on community mobilization and use of opinion leaders. Led and conducted the neuropsychological component of a 3-year cohort study on HIV encephalopathy that included clinical assessments, MRI and Single Photon Emission Computed Tomography (SPECT). Conducted capacity building and support to numerous governmental organizations, clinics and NGOs on HIV/AIDS/STI including prevention, home-based care and LGBTI throughout southern Sweden. Conducted training and consultations on community mobilization and use of BCC and media at the regional, national and international levels; hosted a weekly edutainment radio program HIV/AIDS/STI prevention, SRH and sexuality.

1996 & January 2002 – July 2002, Research Fellow, Department of Community Medicine, Lund University, Sweden - Conducted the analysis, documentation and course work necessary to complete a Doctorate Degree in Medical Sciences with specialty in Community Medicine/ Preventive sciences; completed graduate coursework at Harvard Univ.

1989, Clinical Psychologist, Department of Psychiatry, Lund University Hospital, Sweden - Provided counseling and psychotherapy to injecting drug users living with HIV/AIDS and clients with drug dependencies including detoxification; contributed to the development of a syringe-exchange program at the Department of Infectious Diseases and a methadone clinic.

Languages:

English, Swedish, Norwegian

References:

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Ronald Goldberg
Coordinator, Regional HIV/AIDS Programme for Southern Africa
Embassy of the Kingdom of the Netherlands, Pretoria, SA
Email: Ronald.Goldberg@minbuza.nl
Mr. Goldberg recently tranferred to the Foreign Minister in The Netherlands. Mr. Svenson worked with him as a colleaque and as supervisor when he was a team leader for the Dutch southern Africa MTR.

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Jack Amayo Buong **Nationality:** Kenyan **Affiliation:** IBTCI

Position Title: Social Scientist Expert **Labor Category:** Social Scientist/Other Technical Advisor

Education:

Masters in Community Health and Development (MCHD)
Great Lakes University of Kisumu (GLUK), Kisumu, Kenya 2007
B.Ed. Moi University, Eldoret Kenya 1999

Relevant Experience:

Mr. Jack Buong is a community health and development specialist with 11 years' experience in strengthening health systems, health institutions, community health strategy, research and training. He possesses extensive hands on experience in; capacity building in leadership development and health systems, community health and strategy development, research, OVC programming and development. Mr. Buong has broad knowledge in HIV/AIDs prevention, care and control and has participated in researches, surveys and evaluations.

Selected Professional Experience:

2002-Present **Consultant**
International Business & Technical Consultants Inc. **Team Member**
June 2015 – August 2015: APHIAPlus Rift Valley end-term evaluation
Functioned in the role of Social Scientist, assisted in the design of instruments, methodology and data analysis. Conducted KIIs and FGDs. Participated in the analysis of data and provided input in the draft final report.

Kenya School of Government **Trainer**
2015: Trainer of Trainers-Health Systems Strengthening (HSS)

Management Sciences for Health (MSH) **Team Member**
2014: Consultant on Leadership, Management and Governance (LMG)

Management Sciences for Health **Leadership Management & Governance Tech. Advisor**
2012-2014: Enhanced collaboration between LMS/Kenya and APHIAplus and identified Leadership, Management and Governance (LMG) priorities in the assigned region (Kakamega, Vihiga, Bungoma and Busia counties).

Great Lakes University of Kisumu USAID Funded OVC Program **Program Coordinator**
2009-2012: Coordinated the community based support program funded by USAID in the four technical intervention areas namely: nutrition, early childhood development, HIV/AIDS (OVC care) and microfinance in 4 districts.

Great Lakes University of Kisumu (GLUK) **Partnership Coordinator**
2005-2006: Coordinated TICH-MOH-Community and other partners' capacity building of manpower for community strategy, trainings for Community Health Workers (CHW's), Community Health Extension Workers (CHEW's) and Community Health Committees (CHC's).

Kenya Italian Debt Development program (KIDDP) **Team member**
2009: Designed, trained and carried out a community assessment survey on the contribution of Community Strategy on Health outcomes a quasi-experimental research. Conducted feedback workshop to District stakeholders on the findings, guided action plan on key areas and follow up.

APHIA II-Western -World Vision **Team Member**

2007: Conducted quality assessment aimed at exploring the roles, knowledge, skills and performance of community volunteer service providers, also called Home Visitors (HV) and derived lessons for enhancing their training, supervision and support.

WEMOS –Netherlands, Lusaka Zambia **Researcher**

2007: Participated in a study titled, 'The Effect of Externally Funded programs on Human Resource for Health (HRH) a multi-country study in Kenya and Zambia'.

CARE-Kenya **Facilitator**

2002-2003: Facilitated the Ministry of Education/CARE-Kenya Peer Education Programme.

AMREF **Team Member**

2005: Facilitated baseline survey, AMREF MAANISHA Programme on Knowledge, Practice and Coverage (KPC) on HIV/AIDS in Suba district.

SIMAVI **Team Member**

2005: Participated in the assessment of District Health Systems for improvement towards achieving the Millennium Development Goals.

Languages:

English (Fluent); Kiswahili (Fluent); Luhya and Luo

Kennedy A. Manyonyi **Nationality:** Kenyan **Affiliations:** IBTCI

Position Title: Public Health Expert **Labor Category:** Health/Population/Nutrition/HIV-AIDS Analyst

Education:

Diploma in Palliative Medicine (DipPallMed), University of Wales	2001
DLSHTM, London School of Hygiene & Tropical Medicine	1996
Diploma in Tropical Medicine & Hygiene (DTM&H), Royal College of Physicians of London	1995
MSc Infection & Health in the Tropics, (Tropical Medicine & HIV), University of London, UK	1995
MB ChB (Bachelor of Medicine & Bachelor of Surgery), University of Nairobi, Kenya	1989

Relevant Experience:

Dr. Manyonyi has over 20 years' experience in conceptualizing, establishing, managing, monitoring and evaluating health programs in diverse rural areas and informal urban settings in Eastern Africa. He is familiar with the requirements of various donors and is comfortable with most of the commonly employed rapid assessment approaches as well as program monitoring and evaluation methodologies with an excellent command of the English language and report writing skills. Dr. Manyonyi is a diligent and versatile clinician who has ably managed high performance teams.

Selected Professional Experience:

Afya Na Uzima **Team Leader**

2014: Designed and established a one-stop comprehensive and affordable outpatient health service targeting low-and-mid-income earners in the informal sector.

AMREF, Kenya **Chief of Party, APHIAPlus Northern Arid Lands**

2012-2013: Led and oversaw the establishment and implementation of an integrated support package for HIV/AIDS, TB, Malaria, RH/FP, Maternal, New born and Child Health, alongside interventions addressing the social determinants of health (Nutrition; access to safe Water; improved Sanitation and Hygiene Education; Livelihoods; plus Household Economic Strengthening) in the eight counties of Kenya's arid north.

Jhpiego, Kenya **Senior Technical Advisor**

2011-2012: Guided various teams to develop and apply technically robust approaches in their respective projects, and instilled a spirit of innovation, as well as a culture of teamwork with attention to key details.

Jhpiego, Kenya **Deputy Project Director, APHIA II Eastern**

2007-2010: Managed Jhpiego's first major implementation project that was also the pioneer of health development project in the former Eastern Province of Kenya. Many remarkable achievements of the innovations undertaken by this project inspired the development of the APHIAplus program.

Gedo Health Consortium **Medical Coordinator**

2002-2007: Established, led and managed Somalia's first ever primary health care system and shared the lessons with various players through technical working groups (TWG), for improved program implementation in Malaria, Communicable Disease Control, EPI, TB, HIV, Hospitals development, RH, Lab development, Nutrition & HIS under the auspices of the Somalia Aid Coordination Body (SACB).

AAR Health Services **Head Physician**

2000-2002: Spearheaded the pioneer rescue services in the East African Region, establishing the first three modern medical centers and overseeing service quality assurance for the franchised model of outpatient care.

The Nairobi Hospice **Senior Medical Officer**

1996-1999: Successfully introduced and established Palliative Medicine as a recognized speciality in Kenya and incorporated it into the training programs of Kenya Medical Training College and University of Nairobi.

Medecins Sans Frontiers, Holland **Volunteer Physician, Dadaab Refugee Camps**

1992: Led the team of Kenya Ministry of Health personnel at Dadaab, the largest refugee camp in the world at that time, in attending to the high influx of refugees fleeing civil strife at the height of the Somalia Crisis.

St Mary's Hospital, Mumias **Medical Officer**

1991-1994: Led the Faith Based Facility's health services and pioneered in community based health care in response to emerging health challenges such as HIV/AIDS, malnutrition and non-communicable diseases.

Languages:

English (Fluent); Kiswahili (Fluent); French (Fluent), Luhya (Native)

Annex VIII: Work plan

Timeline	Activity	Consultant responsible
Pre-fieldwork in Kenya		
Sept. 14 – 24, 2015	Document Review	TL, HSS Expert, Eval. Specialist
Sept. 24 – Oct. 2, 2015	Team Planning Meeting	TL, HSS Expert, Eval. Specialist, ESPS Team
October 1, 2015	Submit in-brief PPT to USAID	ESPS team
October 2, 2015	In-brief at USAID	Eval Team and ESPS Team
Fieldwork in Tanzania		
October 3 - 4, 2015	Team travels to Tanzania	TL, HSS Expert, Eval. Specialist
October 5 - 7, 2015	KII with ECSA stakeholders in Tanzania	TL, HSS Expert, Eval. Specialist
October 8, 2015	Team travels back to Nairobi	
October 9, 2015	Team reviews KIIs conducted in Tanzania	TL, HSS Expert, Eval. Specialist
Fieldwork in Lesotho and Swaziland		
October 10, 2015	Team travels to Maseru (Lesotho)	TL, HSS Expert, Eval. Specialist
October 12 - 13, 2015	Conduct KIIs in Lesotho	TL, HSS Expert
October 14, 2015	Team travels to Manzini (Swaziland)	TL, HSS Expert
October 15, 2015	Conduct KIIs in Swaziland	TL, HSS Expert
October 15, 2015	Team travels to South Africa	TL, HSS Expert
October 16, 2015	Conduct KIIs with USAID/SA staff	TL, HSS Expert
October 16, 2015	Team travels back to Nairobi	TL, HSS Expert
Fieldwork in Kenya		
October 12 - 16, 2015	Conduct telephone interviews with ECSA stakeholders (while TL and HSS Expert are in Lesotho & Swaziland)	Eval. Specialist
October 17, 2015	Conduct telephone interviews with ECSA stakeholders	TL, HSS Expert, Eval. Specialist
October 19 - 24, 2015	Conduct telephone interviews with ECSA stakeholders	TL, HSS Expert, Eval. Specialist
October 21, 2015	Mid-brief at USAID/KEA Office	Eval Team and ESPS Team
Post Fieldwork in Kenya		
Oct. 22 – Nov. 1, 2015	Data analysis and synthesis of finding	TL, HSS Expert, Eval. Specialist
November 3 - 14, 2015	Report writing	TL, HSS Expert, Eval. Specialist
November 14, 2015	Submit 1st draft report to IBTCI	TL, HSS Expert, Eval. Specialist
Nov. 14 - 19, 2015	Review of 1st draft report	ESPS Team
Nov.r 14 - 19, 2015	Respond to IBTCI comments	TL, HSS Expert, Eval. Specialist
November 20, 2015	Submit draft report to USAID/KEA	ESPS Team

Annex IX: Member State Contributions

	Country	Annual contribution payable (USD)
1	Kenya	$179,445
2	Lesotho	$46,632
3	Malawi	$55,683
4	Mauritius	$76,933
5	Seychelles*	$60,209
6	Swaziland	$51,354
7	Tanzania	$173,346
8	Uganda	$102,906
9	Zambia	$115,105
10	Zimbabwe	$28,485
	Total	$990,098

Source: ECSA-Secretariat: Directorate of Finance
*Seychelles has been an inactive member since 2011

Annex X: List of Target Groups

1. USG Partners- USAID/EA, USAID/Kenya,USAID/Lesotho, USAID/South Africa, USAID/Tanzania

2. EAC Community (including the EAC Secretariat)

3. Member states (MS)-Botswana, Kenya, Lesotho, Malawi, Mauritius, Swaziland, United Republic of Tanzania, Uganda, Zambia and Zimbabwe

4. MOH of (Botswana, Kenya, Lesotho, Malawi, Mauritius, Swaziland, United Republic of Tanzania, Uganda, Zambia and Zimbabwe)

5. ECSACON (Uganda, Kenya, Tanzania, Zambia and Malawi)

6. RCQHC (Uganda)

7. Training & Research Institution - University of Dar es Salaam, Muhimbili University, National University of Lesotho (NUL), University of Swaziland (UOS), University of Zambia, University of Zimbabwe, University of Mauritius, Moi University of Nairobi, AMREF, RCQHC, ECSACON, Tropical Disease Research Centre, APHRC, Ifakara Health Institute, KEMRI

8. ECSA Partners – EDC CHAI, FHI360 ROADS II, Intrahealth, Pharmaccess, ESAMI, HRAA, ACHES,Strides/MSH, EGPAF, GSG, Hellen Keller International, Kenya AIDS NGO Consortium, KMPDB, IPAS Africa Alliance, KNCV TB Foundation, Population Council, Riders for Health, JPIEGO, and World Vision