External End-of-Project Evaluation:

Health Center Renovation Coordination Project

Final Report

August 2008

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TABLE OF CONTENTS

CONTENTS

ACKNOWLEDGEMENTS 5
LIST OF ACRONYMS 6
PROJECT SUMMARY 7
EXECUTIVE SUMMARY 8
Overview 8
Key Findings 9
General 9
Result 1: Coordination 9
Result 2: Technical Assistance 10
Result 3: Renovation 10
Recommendations 11
I. INTRODUCTION 12
II. PROBLEM STATEMENT 13
III. HCRCP OBJECTIVES AND IMPLEMENTATION PLAN 14
IV. EVALUATION DESIGN AND METHODOLOGY 16
Survey design 16
Data collection tools and techniques 16
Sampling 16
Analysis 17
Expected and unexpected deliverables and work plan progress 17
Site visits 17
Federal and Regional level key informant interviews 17
Document review 17
Limitations 18
Analysis of the health-care component of renovation 18
Composition of the team 18
Document review 18
V. FINDINGS AND CONCLUSIONS 19
Result 1: Coordination and donor leveraging 19
Result 2: Providing technical assistance 20
Result 3: Direct renovation of health centers 21
VI. QUESTIONS POSED TO THE EVALUATION TEAM AND ANSWERS 23
Program Management 23
Implementation 24

Monitoring and Evaluation (M&E) 24
Quality Assurance 25
Capacity Building and Sustainability 25
VII. RECOMMENDATIONS AND LESSONS LEARNED 27
Coordination 27
Technical assistance 27
Management 28
Renovations 28
Monitoring and evaluation 29
VIII. APPENDICES 31
APPENDIX 1) SOW for the evaluation 31
APPENDIX 2) TMG evaluation work plan 48
APPENDIX 3) Topical outline for the small group discussions 49
APPENDIX 4) Photos from evaluation team site visits 53
APPENDIX 5) List of people met and interviewed 69
APPENDIX 6) Description of field guide assessment document 71
APPENDIX 7) Levels of renovations with respect to health care 75
APPENDIX 8) Summary of key project activities with status notes 76
APPENDIX 9) Table of key project activities with status and notes 79
APPENDIX 10) Summary of the results from site visits 85

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LIST OF ACRONYMS

ART	Antiretroviral Therapy
A&E	Architecture and Engineering
CAC	Crown Agents Consulting
CDC	Centers for Disease Control
CTO	Cognizant Technical Officer (USAID)
FGOE	Federal Government of Ethiopia
FMOH	Federal Ministry of Health
FHI	Family Health International (NGO)
GAA	German Agro Action (NGO)
GOE	Government of Ethiopia
HC	Health Center
HCRCP	Health Center Renovation Coordination Project
HH	Household
IP	Implementing Partner
IQC	Indefinite Quantity Contract
KI	Key Informant
M&E	Monitoring & Evaluation
MOH	Ministry of Health
MOU	Memorandum of Understanding
MSH	Management Sciences for Health
NGO	Non Governmental Organization
OJT	On the job training
PEPFAR	President's Emergency Plan for AIDS Relief
PLHIV	People Living With HIV/AIDS
PMP	Performance Monitoring Plan
PPD	Program and Planning Division
PY	Project Year
RHB	Regional Health Bureau
SGD	Small Group Discussion
SNNPR	Southern Nations, Nationalities, Peoples Region
SOW	Scope of Work
STTA	Short-Term Technical Assistance
TA	Technical Assistance
U.S.	United States
USAID	United States Agency for International Development
USAID/E	United States Agency for International Development/Ethiopia
USD	United States Dollar

PROJECT SUMMARY

Project Title & Objective:

Title: Health Center Renovation Coordination Project (HCRCP)
Objective: The three main expected project results were:

- Coordination - Serve as a coordination and synchronization "hub" with national and bilateral stakeholders on health center renovations to support chronic disease;

- Technical Assistance Assessment - provide assistance on renovations to the Federal Ministry of Health (FMOH) and Regional Health Bureaus (RHBs), including technical design, engineering, procurement and logistics support (100 Health Centers [HCs] in total); and

- Renovation - Provide direct or indirect renovation support at selected health centers to support chronic disease management including antiretroviral therapy (ART) (50 HCs in total).

Project Number:	663-C-00-06-00428
Life of Project:	2 Years
Implementing Agency:	Crown Agents USA, Inc.
Contract Number:	663-C-00-06-00428-00
Project Funding:	$3,919,940

EXECUTIVE SUMMARY

OVERVIEW

In September 2006, USAID/Ethiopia awarded Crown Agents Consulting USA (CAC) a contract to coordinate health center (HC) renovations in four President's Emergency Plan for AIDS Relief (PEPFAR) priority regions (Amhara, Oromia, Southern Nations, Nationalities, and Peoples [SNNPR] and Tigray) and Addis Ababa in Ethiopia.

The activity was to provide technical assistance to the FMOH and RHBs for renovation coordination, technical design, engineering, procurement and logistics support. Though not planned, the project also placed short-term technical assistance at the national and regional level to support staffing gaps in support of the Government of Ethiopia (GOE) health facility renovation/construction. The HCRCP was also to assess and renovate selected health centers directly, so that the facilities can better support chronic disease management and HIV/AIDS services, especially antiretroviral therapy (ART). CAC was to undertake these efforts by contracting with local Architecture and Engineering (A&E) and construction companies. The companies were to assist CAC in the assessment, design and renovation of the health centers. CAC was also to coordinate the activities of numerous organizations funded by several different international donors.

USAID requested an end-of-project evaluation to assess the achievements, challenges and sustainability of the program to inform follow-on programming. The evaluation also responded to USAID's questions that focused on:

- Program management effectiveness;
- Implementation: the approach, effectiveness and quality of assistance;
- Monitoring and evaluation: indicators and the use of monitoring and evaluation (M&E) for planning and management;
- Quality assurance: standards and criteria used for renovations; and
- Capacity building and sustainability: strategies, priorities and lessons learned: guidance for implementation.

The evaluation also provided answers to the illustrative questions that USAID included in the evaluation Statement of Work (SOW) Appendix 1.

The evaluation methodology was observational and qualitative with some quantification. It took into consideration both the engineering and health-care aspects of the renovations and incorporated elements of a performance audit. This hybrid methodology was required to fulfill the objectives and answer the broad range of illustrative questions USAID had outlined in the Statement of Work (SOW) for this evaluation. The evaluation included 13 site visits in four of the project's five geographic areas, key informant interviews, small group discussions and comprehensive document review. The sampling for site selection was based on several variables, including: 1) location (north, south, Addis); 2) status of renovation (in-progress and completed); 3) presence of other donors or projects; 4) presence of GOE or other partner contribution (leveraged or not); and 5) convenience. USAID requested that final site selection be made with CAC assistance.

Specifically, the evaluation focused on the following tasks:

- Assessing the progress toward contract targets;
- Assessing the process used to implement the program's three key areas of intervention to meet objectives;
- Assessing the effectiveness of the program's three key areas of intervention;
- Identifying additional achievements and unexpected benefits; and
- Identifying project components that could be scaled up beyond the project agreement in Ethiopia.

KEY FINDINGS

General

- CAC consistently identified challenges, such as inadequate financial resources to renovate the 50 targeted health centers and still assure a reasonable level of quality; a lack of interest in this project by Federal Government of Ethiopia (FGOE); and a lack of available GOE engineering counterparts.

- The first year work plan was not approved by USAID until nearly the end of the first year, even though CAC had submitted the original work plan and its revisions to USAID on time; the second year work plan had still not approved at the time of the evaluation, more than six months into the second (last) year of the project.

- These and other constraints hampered implementation. Some of these challenges were addressed appropriately and others inappropriately by both CAC and USAID. Examples of the constraints are included in the report.

Result 1: Coordination

- The environment in which a health center renovation project was conceived changed between project design in FY06 and project implementation in FY07/08. By the time project implementation began, there were very few NGOs involved in health center renovations, so there was little to "coordinate." Thus, Result One (i.e., to establish an HCR coordination mechanism) could have been replaced and the coordination component of the project could have been simply an activity under Results Two or Three.

- CAC was to have developed a health center (HC) renovation tracking system as part of Result One. If done well, this could have been useful to the GOE for both renovations and new construction. Unfortunately, the tracking system created by CAC was not a "system" and did not track HC renovations. It was a poorly labeled/documented spreadsheet with some charts that predominantly had information about the type of services delivered by implementers rather than information about the status of HC renovations.

- The HCRCP was not implemented in partnership with national government. The evaluation team assessed that this was due to a number of factors. Because there was a major new GOE health care expansion effort requiring construction of ***new*** health centers, there was limited buy-in to the HCRCP project as designed. USAID's management support/response to this changed environment was slow -- slow to initiate dialogue with the FGOE and slow to adapt the project to respond to the current environment.

Result 2: Technical Assistance

- CAC developed excellent tools and guidance for health center assessments and renovations and there is a high probability that these will be adopted by the GOE. These take into account not only the engineering aspects of renovation but also address the health care aspects of renovations comprehensively.

- CAC contracted the minimum required single local architecture and engineering (A&E) firm to undertake HC assessments, renovation design and renovation supervision. Temporary staff hired by the A&E firm were well trained in conducting assessments. However, by the time that this evaluation was conducted, CAC had stopped using the A&E firm and was doing the assessments in-house. CAC stated that this was because the A&E firm was not performing as expected regarding submission of their paperwork. However, the A&E firm stated that this was not the case.

- The environment made it difficult to provide technical assistance (TA), mentor and provide on-the-job training to GOE staff of the Federal Ministry of Health (FMOH), Regional Health Bureaus (RHBs), zonal or district level. Nonetheless, no evidence was found that either USAID or CAC explored opportunities to reprogram the budgeted resources with alternative capacity building mechanisms.

- The model developed by CAC for tendering and contracting the HC renovations was efficient and resulted in a reduced time between tender and start of renovations when compared to the model used by the GOE. During the project period, the procedures used by the GOE were also modified, independent of inputs from the HCRCP, such that there is no longer a significant difference between the FGOE procedures and CAC model.

Result 3: Renovation

- As stipulated in their contract, CAC had introduced a "health" aspect to the renovations, which addressed issues of client comfort (waiting areas, privacy), workflow for increased efficiency, and decreased risk of exposure to infections, as part of the assessment/design processes.

- The funds provided for HC renovations were not adequate to achieve acceptable standards for the renovation of the 50 targeted HC renovations.

- Some of the fixtures and materials used in the renovations were not of acceptable quality. In most of the sites visited, the evaluation team observed problems related to non-functional water supplies, leaking roofing and guttering, and doors that were not hung correctly, although the framing and foundations were of good quality.

- The number and quality of supervision visits of the renovations were inadequate. Even though several sites had been signed-off and reported as being "completed," there were incomplete renovations or long standing problems that had not been addressed, or were sometimes not known by CAC/USAID. This was confirmed during the evaluation team's review of the supervision records, and shown in photographs taken by the evaluation team.

- Though the HCRCP did not have a stated objective to improve maintenance at the renovated sites, CAC did identify this as a serious weakness jeopardizing the longevity and sustainability of the project. They made a nominal effort to incorporate improved maintenance into their activities. Given the potentially available budget if changes were made in Result 1, resources could have been reallocated to increase maintenance-related activities.

RECOMMENDATIONS

- In future projects, additional financial resources should be allocated to assure a standard of quality for the major components of the project, especially technical assistance and renovation. There should be sufficient resources to renovate each HC selected so that a defined standard is assured.

- Strong, consistent management oversight by USAID and the contractor should be provided for successful planning, implementation and monitoring of the project. Clear guidance and the development and monitoring of timely work plans should be used to strengthen the project's management.

- Contracting for assessments and renovations should be conducted by the government, building their capacity to manage larger projects for assessment and renovation. To increase the ability of the technical assistance contractor to improve the ability of the RHB staff, it is suggested that the TA staff be stationed at the RHBs.

- The two high quality handbooks for health center assessment and health center renovation produced by this project should be diffused widely and promoted as a resource for the GOE, other organizations, and other donors.

- It is suggested that strong technical assistance and a significant training program be a part of new projects. Various alternatives should be used to increase the capacity of RHBs and other organizations. In addition to training RHB staff in HC assessments and renovation, a comprehensive training program should be developed for maintenance.

- Establish a minimum renovation package for each site during project design to help establish an appropriate budget and implementation plan. Increase the threshold for what is considered a "minimum package" renovation - after operationally defining a minimum package (e.g., include in all cases covered waiting areas with benches or seats)

- Renovation materials should be of commercial quality and supervision of renovations should be adequate to monitor and assure the quality.

- Finally, contract administration functions and overall control of the assessments should be located in the RHB.

I. INTRODUCTION

The purpose of this evaluation report is to provide information to allow USAID/Ethiopia to assess the USAID strategic objectives and program results of the Health Center Renovations Coordination Project. The SOW for the evaluation included:

- Assessing the progress toward contract targets.
- Assessing the process used to implement the program's three key areas of intervention to meet objectives.
- Assessing the effectiveness of the key project interventions: the approach and activities used by Crown Agents to assist the GOE to improve health center renovation planning, design and operations for HIV/AIDS and other chronic diseases among various institutions, and other cooperating agencies, other donors, HAPCO, the Ministry of Health and other Ministries.
- Identifying additional achievements and unexpected benefits.
- Identifying project components that could be scaled up beyond the project agreement in Ethiopia.

The workplan for the Evaluation team is included in Appendix 2.

There are nine regions and two chartered cities in Ethiopia. Addis Ababa and Dire Dawa are the two chartered cities. HCRCP is located in the city of Addis Ababa and the regions of Amhara, Oromia, Tigray and SNNPR.

1. *Addis Ababa*
2. Afar
3. Amhara
4. Benishangul-Gumuz
5. *Dire Dawa*
6. Gambela
7. Harari
8. Oromia
9. Somali
10. Southern Nations, Nationalities, and People's Region
11. Tigray

II. PROBLEM STATEMENT

The number of HIV positive individuals in Ethiopia was estimated at 977,000 in 2007 and is projected to increase substantially in the next two years (a 30% increase was projected from 2006 to 2010). The projected growth in the total size of the HIV-infected population in Ethiopia means that efforts to strengthen facility-based services will be critical for a successful national HIV/AIDS program. The Government of Ethiopia (GOE) Federal Ministry of Health (FMOH) is decentralizing ART and other HIV/AIDS services to the health center level. HIV/AIDS services at health centers require adequate infrastructure to accommodate the rapid and sizable increase in HIV/AIDS clients at these sites.

The health manpower capacity to engineer, plan and monitor the expansion and renovation of facilities is limited. Following the Paris Declaration, the GOE adopted a plan to achieve universal access to primary health care, including HIV services, by 2010. Under this plan, the MOH has a goal to increase the number of health centers in the country from around 630 in 2007 to 3,153 by the year 2010. This ambitious undertaking to expand the health infrastructure means that the engineering, construction planning and monitoring capacity of the federal and regional health administrations are stretched to the limit. The expansion of PEPFAR caused even more pressure on health facility infrastructure. A recent assessment identified infrastructure deficiencies as a major obstacle impeding sustained progress in achieving ART and PMTCT expansion targets. The poor condition of health facility infrastructure also affects the public's willingness to access services.

When the HCRCP was originally designed, several US Government-funded partners in Ethiopia were engaged in health center renovation. By the time that the HCRCP began, this situation had changed and only one other organization, Management Sciences for Health (MSH), was working on health center renovation. Given the identified deficiencies in health centers and the limited number of other donors and implementing agencies renovating health centers, the need was greater than initially assumed by USAID/Ethiopia (USAID/E).

HCRCP design included the development of a systematic and structured approach for the FMOH/PPD so that it could coordinate its own activities as well as other agencies implementing and/or supporting HC renovation and construction. One of the three main project results was: "Coordination - Serve as a coordination and synchronization "hub" with national and bilateral stakeholders on health center renovations to support chronic disease."

III. HCRCP OBJECTIVES AND IMPLEMENTATION PLAN

As per the Country Operational Plan (COP07), HCRCP was to support the GOE, coordinate the various renovation and construction initiatives for improved HIV/AIDS services in Ethiopia, and carry out selected renovations – filling gaps when other funds are unavailable. This activity links to care and support, antiretroviral drugs, ART and laboratory services. A Family Health International (FHI) 2006 assessment identified infrastructure deficiencies as a major obstacle to reaching ART targets, thereby addressing ART service expansion by increasing health centers' operational capacity to manage ART services, including integration into the health network. HCRCP was to alleviate some of these infrastructure constraints.

HCRCP's three objectives, listed as expected results, are described below.

Result 1: Serve as a coordination and synchronization "hub" with national and bilateral stakeholders on health center renovations to support chronic disease management and to leverage United States Government resources with the Government of Ethiopia and bilateral agency resources.

Result 1 was to be achieved by creating a resource hub. As per CAC's proposal and the contract, this hub was to have the following key elements: a) a coordination steering committee; b) an HC renovation tracking/mapping system; and c) coordination workshops. In some documents, there was also mention of setting up a tender committee. It must be noted that although the original proposal and contract stipulated the establishment of a "coordination/steering committee," the approved work plan replaced this with development of a "coordination plan."

Result 2: Provide technical assistance on renovations to the Federal Ministry of Health Regional Health Bureaus including technical design, engineering, procurement and logistics support. Specifically, 100 HC engineering assessments were to be conducted.

Result 2 was to be achieved by either: a) adapting available; or b) developing new GOE HC renovation guidelines and procedures, including tendering and awarding contracts. These guidelines and procedures would then be tested and finalized. The result would be useful tools that the FMOH and RHBs would adopt and use.

HCRCP's technical team was also to identify RHB counterparts and build their capacity in: 1) conducting engineering assessments; 2) supervising HC renovation works; and 3) using the HC assessments, renovation guidelines and other tools.

Result 3: Provide direct renovation support in 50 selected health centers to support chronic disease management including antiretroviral therapy.

Result 3 was to be achieved by the project's technical team identifying and training at least one local A&E firm to conduct these assessments and then to renovate selected sites using these renovations as an opportunity to build capacity of GOE.

HCRCP's health facility renovations were implemented in five regions/cities of Ethiopia which are among PEPFAR/Ethiopia's priority geographic areas: These are Amhara,

Oromia, SNNP, Tigray and Addis Ababa. Within these areas, the HCRCP engineering assessments and renovations were to be done at PEPFAR priority sites.

Activities under Result 1 were to be done largely by the FMOH; Crown Agents Consultants was to provide TA and other support. Those activities related to USG renovating agency coordination was to be done directly by CAC, collaborating with the FMOH. In other activities (under Results 2 and 3), CAC was to lead joint activities working with GOE technicians, NGOs and local A&E firms. Still other activities were to be conducted by the contracted A&E firm, after they had been trained. The total estimated cost of this contract was 3,919,940 United States Dollar (USD) for two years.

IV. EVALUATION DESIGN AND METHODOLOGY

SURVEY DESIGN

The evaluation methodology was observational and qualitative with some quantification. It took into consideration both the engineering and health-care aspects of the renovations and incorporated elements of a performance audit. This hybrid methodology was required to fulfill the objectives and answer the broad range of illustrative questions USAID had outlined in the SOW for this evaluation.

The survey design is a post-test without a baseline. Although the HC assessments documented the HC architectural elements prior to renovations, no baseline measurements of provider behavior, work flow, capacity building, etc was made. The team used historical recall during interviews and small group discussions to estimate a pre-test value for some constructs and used stakeholder perception of future/potential impact to estimate the post-test measure for sites that were not yet renovated. For the architectural and engineering components, the team provides photos of health centers as they existed at the time of the evaluation.

DATA COLLECTION TOOLS & TECHNIQUES

Document reviews, observations, key informant interviews and small group discussions (SGD) with a mix of health center employees were used. HC clients were not interviewed because of time limitations. The topical outline for small group discussions is presented in Appendix 3. Photos and diagrams are presented in Appendix 4.

SAMPLING

Given the time allowed and the scope of the evaluation, the sample size of HCs to be evaluated was limited to 13, including the 2 pre-test sites in Addis Ababa. With this particular qualitative research design and limited sample size, the appropriate sampling method was one that maximizes the variance. To achieve this, we selected using the following criteria:

- Location (north, south, Addis);
- Status of renovation (in-progress, completed);
- Presence of other donor or project (CAC only vs CAC+ other {e.g. other = RPM+);
- Presence of GOE or other partner contribution (leveraged or not); and
- Convenience.

Based on these criteria, and at the request of USAID/Ethiopia, with the participation of Crown Agents in selecting the sites, the following sites were visited:

- **Addis Ababa:** 1) Shromeda, 2) Kotebe, 3) Bole Woreda 17

- **South:** 4) Yergalem (SNNPR) 5) Shashemene (Oromia), 6) Batu (Oromia), 7) Modjo (Oromia)

- **North:** 8) Adet (Amhara), 9) Bahir Dar (Amhara), 10) Dangla (Amhara), 11) Koladiba (Amhara), 12) Addis Zeman (Amhara), 13) Injibura (Amhara)

For the key informant interviews, the team planned to meet the HC Director who had signed the MOU with CAC, and representatives from FMOH, RHB, USAID, Centers for Disease Control (CDC), CAC, and other implementers. Please see Appendix 5 for a list of people interviewed. The team planned to conduct SGDs in all of the HCs visited, but logistic and facility staff workload limited access to staff during the team's visits.

ANALYSIS

Seven summary tools were created to help analyze and interpret the data collected, as described below.

Expected and unexpected deliverables and work plan progress

It is important to know what was expected of the contractor (Crown Agents Consulting) in terms of services and deliverables under the contract. Because many factors can influence what can be achieved, the approved work plans are usually used for this purpose. In addition, to understand the environment, if it has changed and if the response was appropriate, the quarterly and semi-annual reports were reviewed. During the review, the reliability and validity of reported results were assessed. Lastly, as with any project, there are often unexpected services and deliverables; these were also assessed The team prepared a summary table and an expanded table showing the project services and deliverables as defined in different project documents (winning proposal, contact, approved work plans and progress reports) to help in the analysis. The summary table is presented in Appendix 8. The expanded table is presented in Appendix 9.

Site visits

To analyze the results of our site visits, we created two matrices. The first summarized the "health care" component of the visit and the second summarized the "engineering" component of the visit. Interpreters were used, and they took notes. Each site visit was made by a four-person team: the team leader, team member, and interpreters. We met as a team; each person reviewing their notes and looking at the photos taken to complete the elements of the matrices with information from SGDs, Key Informant (KI) interviews and observation. The team then combined the elements of the matrices into a single table summarizing the results across all sites. The summary results of the site visits are included in Appendix 10.

Federal and Regional level key informant interviews

At the federal and regional levels, the interviews were relatively few and did not require a matrix to analyze and interpret the results. The team reviewed interview notes subject by subject, and discussed common themes from the interview information.

Document review

Many documents were reviewed. The four general categories of documents include: 1) contracts/work plans; 2) scheduled and interim/ad hoc progress reports; 3) technical deliverables; and 4) A&E designs and documents. For the latter, the team created a matrix to summarize information relative to the renovation process (i.e., dates) for the 13 sites visited, but was not able to get the all of the information in the time allotted. Therefore, this was not included in the analysis.

Limitations

Time to complete this evaluation was the most limiting factor. The sample of sites visited captured variations adequately. The evaluation team judges that the engineering component of the evaluation (i.e., observation) is a good representation of the entire project. The team was not, however, able to have as many SGDs as intended, which means the information we obtained on the health impact of the project is more limited.

Analysis of the health-care component of renovation

The expected impact of renovations on health care service delivery was analyzed by using the descriptions in the PMP, contract and approved work plan. To aid in the data collection and analysis phases, the evaluation team developed a classification of three hierarchical levels of HC renovation related to health care. A thorough document review to determine which level was expected of the contractor was done. Level 3 renovations included renovations to the HC site's original design and functionality plus reorganization and/or modifications to the architecture design for improved health care delivery. The CAC contract stated that level 3 renovations were expected. These were stated in the first 2 of 17 bullets under C.4. Illustrative List of Renovations, which include:

- Add or demolish wall partitions whenever necessary to ensure proper functions and facilitate patient flow. Install a patient reception counter at the central location of each clinic to facilitate patient flow.

- Covering areas between multiple structures to improve client comfort and client flow to create continuous space for patient counseling rooms, waiting areas, administrative offices or secure storage.

Appendix 7 presents a full description of the three levels of HC renovation.

Composition of the team

Team Leader, Barney Mosley; Team Member, Thomas Scialfa; Team Advisor and Coordinator, Michael Dejene; Logistics Coordinator, Azeb Asmamawaw; and interpreters.

DOCUMENT REVIEW

The evaluation team found significant differences between the expected services/deliverables as stated in the different HCRCP documents being: 1) the approved PMP 2) CAC Contract 3) the PY1 Work Plan. The results of the document review with respect to project implementation are summarized below. Detailed information is provided in Appendix 8.

V. FINDINGS AND CONCLUSIONS

RESULT 1: COORDINATION AND DONOR LEVERAGING

The environment for HC renovations had changed from project inception, and during early implementation. This change indicated the need for adaptation of the first and third key activities/products under Result 1. The HCRCP was designed at a time when there were many more implementers doing various levels of HC renovations and these needed coordination. By the time that the HCRCP began, Result One was no longer appropriate as it was written, with two exceptions: developing a mapping/tracking system which the GOE obviously needs, especially given their new HC scale-up; and USG implementer coordination for those few involved in HC renovation.

The significant change in the environment was identified early in the project's implementation through a survey that CAC initiated. This survey showed that respondents (USG, other donor and FMOH) were not doing renovations and not interested in being part of a national coordination committee/hub. The activity of creating a coordination committee/hub changed to establishing a coordination plan, which had not been completed at the time of the evaluation.

Although the environment had significantly changed, USAID did not negotiate the HCRCP with the FMOH prior to implementation. It was approximately eight months into implementation when USAID completed negotiations and obtained some level of FMOH support for the HCRCP. However, USAID did attempt to set up meetings with the head of FMOH/PPD numerous times without success, and instructed CAC to proceed with Results Two and Three until they could reach an agreement with the FMOH to include the renovation of existing HCs in their focus to build new ones.

Moving forward with activities under Results Two and Three was done with project activities by-passing the FMOH and going directly to the RHBs (without FMOH knowledge) to begin technical assistance and direct renovations. Under Ethiopia's decentralization initiative, the Regional Health Bureaus (RHBs) have the authority to make decisions without the FMOH approval. However, this approach, at least partially, undermined the project's ability to support and provide TA to the FMOH. In the team's discussions with CAC, they stated that, when the time came to begin work in Addis Ababa and they needed FMOH involvement, FMOH became quite angry to learn that activities had already been done in the regions. Project delays in getting FMOH support for the HCRCP contributed to CAC having significant barriers to achieving activities under Result One.

Although considerable budgetary resources were available to achieve Result One and limited coordination needs were evident, project priority was not shifted to develop other activities under Result One, such as development of the tracking/mapping system. The tracking/mapping system that was later developed and delivered was reviewed and assessed to be inadequate. It consisted of a minimal number of MS Excel spreadsheets with unlabeled charts. Further, the charts were unrelated to tracking HC renovations and contained information about services delivered at the sites. This may explain the reluctance of USG agencies, FMOH, RHB and other donors to adopt and maintain the "tracking system."

The third key activity/product under Result One was to help FMOH and RHBs organize and hold coordination meetings. Given decreased need for coordination and the decreased number of donors and activities, this key activity under Result 1 could probably have been replaced with another activity or project product. There were, however, several instances when CAC effectively coordinated with other implementers and directly with HCs so that renovations being financed by implementers were done harmoniously. There were also a few times when CAC was able to successfully leverage additional resources for HC renovations. Due to the changed environment for coordination, CAC coordinated activities to the extent possible.

In summary, the HCRCP did not meet the expectations for Result One, as written. However, the team does not feel that these were realistic expectations (except for the tracking system) because of the change in the environment. The team does feel, however, that the HCRCP requirements should have been modified.

RESULT 2: PROVIDING TECHNICAL ASSISTANCE

Technical assistance was provided primarily through developing a new way to conduct A&E assessments, a new model for tendering bids for renovations, and capacity building through mentoring, on-the-job-training (OJT), other training, conducting assessments/proposing redesign, and the technical review of related documents.

The environment in which CAC's TA was to be delivered was not conducive to regular and significant TA to the GOE (federal, regional and district levels) via mentoring and OJT. This situation was compounded by the incredible amount of construction going on in Ethiopia; not just in the health sector but across all sectors. This difficulty was identified within the first several months of project implementation. However, changes to the HCRCP strategy were not proposed.

To build the capacity of A&E firms, mentoring and OJT was to be provided to one or more A&E firms. CAC did provide mentoring and OJT to one A&E firm. Unfortunately, that A&E firm chose outside consultants to receive OJT and mentoring. This meant that the capacity might not be available for future work. In addition, CAC is no longer using the single A&E firm where they provided TA and mentoring. CAC is now doing the assessments with their internal staff.

The team's review of project TA to the GOE found that few TA, mentoring or training activities were carried out by CAC to the GOE. Providing TA to the GOE in an unsupportive environment was admittedly difficult. However, neither CAC nor USAID actively explored alternatives to achieving some type of capacity building at the GOE.

The team found little or no evidence that the project provided TA to the contractors' staff doing the renovations. This TA could have enhanced the quality of the renovations and safety at construction sites, including the removal of debris and other unused materials to prevent accidents.

The team's review of the Health Center field guide found that TA provided for both the health care service delivery and engineering components resulted in products that are of excellent quality. The Guide is in its final draft form. Given its quality and potential usefulness, there is good probability it will be adopted and used by the GOE.

The Guidelines for HC renovation are also comprehensive and of excellent quality. They are in "final draft" form. There is good probability it also will be adopted after final revision by the GOE.

Project TA also resulted in a model for tendering by prequalification. It was developed, tested and used by CAC under the project, and is of good quality. The team found, however, that the GOE had already made changes to their own tendering approach, and now use their model for prequalification independent of the HCRCP project. Thus, the GOE already has a new model similar to the one that the HCRCP tested and used. There might still be a chance that some of the forms and procedures that CAC developed under the HCRCP will be helpful to the GOE.

It is estimated that at least half of the TA that CAC reported in their semi-annual reports was not TA[1]. (e.g., a phone call was considered a TA incident). Some of the TA reported is not usually considered TA. There is a need for a clarification of operational definitions for TA that is approved, and adopted by USAID. There were, in addition, documented instances where CAC reported TA under the HCRCP and simultaneously under other CAC projects in Ethiopia.

Additional activities were requested of the CAC such as a review of and commenting on Standards of Care for Health Centers, a brief report on health center space requirements, a draft report on storage capacity, Assessment for Ethiopian MOH facilities, a brief update report on seconding short-term technical assistance (STTA) consultants to FMOH and RHB, development of SOWs and job descriptions for the seconded 8 STTA consultants, and other additional tasks. The Team noted these and other additional activities were done by CAC. Details are presented in the Activity Description Appendix (Appendix 8).

Overall, the evaluation team concluded that CAC met expectations with respect to Result 2. Based on the team's experience in similar projects, we feel that CAC/USAID missed many opportunities to involve more A&E firms, to offer more short- and medium-term off-site trainings and work with pre-service and institutions to train more people at multiple levels of HC renovation. The one A&E firm did hire consultants that could be contracted again, if they are still available.

RESULT 3: DIRECT RENOVATION OF HEALTH CENTERS

Overall, the team found that the quality of the fixtures used for renovations was low. Residential grade fixtures were used and presented problems. The fixtures were frequently non-functional in whole or part in most of the sites that the team visited. A rapid assessment of available high quality fixtures found that better quality residential and commercial fixtures are available in Ethiopia.

[1] For example: from CAC's PY1 annual progress report, it is claimed that there are 74 separate "T.A. activities" which is actually one – maybe two –but they counted each follow-up phone call, meeting, etc. for this purpose. USG standards in project monitoring do not count each phone call to each client/partner as an activity.

The installation of fixtures was inconsistent and of poor quality. This was felt to be predominantly due to the fact that the specifications used were not detailed enough. The installation processes for water supply and sanitation were also found to be of poor quality and were installed inconsistently. For example, in some locations, walls were broken out to enclose the pipes, which was problematic. In others they were outside and properly secured, yet in others, they were outside but improperly placed and secured. The water tanks that were used to replace the existing ones were smaller than the originals despite the fact that the renovations actually increased the volume of water needed at the site.

The quality of doors was assessed by the team to be very good, although the installation process was poor (e.g., incorrectly hung doors) and inconsistent. Windows were of good quality and installed correctly. The quality of framing and foundation material, as well as their installation was assessed to be of good quality.

The quality of roofing and gutter materials was inadequate. The team also found that the specifications for these materials were not respected. For example, the locations of the downspouts were not appropriate, allowing rain water to pour onto external passageways.

Given these conditions, the team concluded that supervision was inadequate in assuring the quality of renovations. None of the sites had copies of renovation plans. When the team inquired, the staff had neither the master plans nor the blueprints of the renovations to be done.

Only a minority of the sites had seen the maintenance check list that CAC had developed. Less than half of the sites knew that there was a one-year guarantee on renovations and that they should contact CAC if there were any problems.

Health perspective results of the site visits showed that the cleanliness of the inside of the health centers visited was very good. Outside cleanliness was also good. Practical safety precautions were not generally taken, such as in some sites where used needles were left lying around near an incinerator site.

Health service staff indicated that the renovations had not helped them provide better health services to clients, because most of the HCs reported as being “completed” had problems. They stated, however, that if the problems were fixed, it would help improve the quality of their services. At two health centers that had little or no problems, they said it has helped deliver better services, especially changes to delivery room and water supply.

In summary, the team feels that the project did not meet expectations with respect to Result Three.

VI. QUESTIONS POSED TO THE EVALUATION TEAM AND ANSWERS

PROGRAM MANAGEMENT

- Have the resources been effectively managed to achieve program results?
  Although it appears that CAC will achieve Results 2 and 3 of their contract, this was only assessed against the two very general performance indicators (100 assessed; 50 renovated). However, this is not an indication of management's performance. The quality of the renovations of the health centers has been poor and not up to international standards. More effective management of funding and project inputs/resources would have allowed project results to be achieved.

- Has management effectively planned, implemented and monitored the program's key interventions?
  While the planning of the program was good, implementation and monitoring were not effective. The CAC Chief of Party and the Mission CTO were unaware of the poor quality of the workmanship on the renovations. There were not adequate site visits and overall project monitoring. Also, given that the Year 1 Work Plan was approved at the end of the first year and the second year had not been approved more than half-way into the Year Two, combined with the low reliability and validity of the reporting, the team cannot conclude that the project was managed effectively.

- Have the TA resources been identified, managed and supervised adequately?
  TA was a significant requirement of the CAC contract. The project was designed for the CAC to provide TA to GOE personnel at the federal, regional and district levels. With only one exception reported by CAC in one region, no TA was provided to GOE personnel. This was due in part to the massive construction program underway in the health sector which requires the attention of the GOE technical personnel. CAC did provide excellent training to the staff of one local A&E firm that subsequently designed some fifty health center renovations. This kind of project assumes USAID construction, architectural and/or engineering expertise in-house or provided through TDY. Moreover, the work plan format does not contain the necessary fields (information) to monitor the project, and the reporting formats are not conducive to decision-making.

- Has management identified problems in implementation and addressed these appropriately?
  From the renovation/engineering perspective, problems were not identified and addressed appropriately. This is demonstrated by the poor quality of the renovated health centers. CAC had not identified problems with implementation of activities in their reports, but rather identified problems regarding the budget being insufficient to reach the targeted number of renovations (50) and problems with the lack of coordination.

  USAID addressed issues very late in the implementation. At times, poor decisions were made to overcome constraints, creating even more constraints. For example: USAID waited a long time to work with the FMOH to negotiate buy-in to the project so that CAC could start renovations with the FGOE support. When they did, they

indicated to the FMOH that it would likely be possible for CAC to support an activity that was not yet budgeted (paying consultant salaries to be placed at the FMOH).

IMPLEMENTATION

- How effective is this approach/model of coordination, TA and direct renovation for supporting the development of GOE capacity to renovate health centers for HIV/AIDS and other chronic diseases?
  The CAC approach/model was not effective given that it was done in complete isolation of the GOE and has not increased the capacity of the GOE to renovate health centers. If, however, the GOE does eventually adopt, and use the guidelines developed by CAC, this TA will help with renovations for health centers.

- How well is this project assisting the GOE to plan and coordinate the activities of assessments, planning, technical reviews and renovations done by multiple organizations providing health center renovations?
  The isolated approach of CAC in the assessment, design, and renovation of the health centers does not assist the GOE or other organizations to undertake health center renovations.

- Is the "engineering assessments'" approach and their implementation adequate to address both the engineering and health service delivery needs of health centers?
  Yes. Without exception, the most significant contribution by CAC has been the development of the two handbooks; namely, the Health Center Assessments Handbook and Health Center Renovation Handbook. These handbooks serve to support both the renovations and the health service delivery.

- Has the amount and quality of the assistance/resources used for the assessments been adequate and appropriate? Have they been directed at priority health centers?
  Yes. The quality of the assessments done by both by CAC and the local A&E firm has been excellent. However, the appropriateness of CAC undertaking the health center assessments directly is questionable. The trained local A&E firm completed fifty one assessments at less than a fraction of the cost of the assessments performed by CAC. It would have been more cost effective to have the assessments performed by the local A&E firm since the quality of their assessments were comparable to those of CAC.

- Has the direct support to renovate selected health centers been adequate and of sufficient quality to meet program targets?
  No. The specifications for some of the materials did not meet acceptable standards nor did the quality of some of the construction.

MONITORING AND EVALUATION (M&E)

- Has the M&E system adequately tracked the progress using the mandated indicators?
  Yes, technically, because there were only two mandated indicators: the number of HCs assessed, and number of HCs renovated. These do not have definitions and there are no other processes, output or outcome indicators. However, by USAID's own M&E standards, this M&E "system" is inadequate to track progress.

- Has the information from the M&E system been adequately used to plan and manage the program?

No. There is essentially no M&E "system"; nor is there a "monitorable" work plan. The M&E component did not have useful performance indicators.

- What indicators of the quality of renovations can/should be incorporated into monitoring the follow on project? Is there a need to introduce or change Project Results?
  Yes. There are many possible indicators; a list was left with USAID before the evaluation team departed. A few of those provided are: number of change orders required, number and type of repairs needed in the first 12 months, number of contracts for which the retention was paid to the contractor. Yes, there is a need to change the project results.

- What indicators could be adopted to measure the program in the areas of coordination and capacity building, renovation, technical assistance?
  There are many possible indicators; a list was left with USAID before the team departed. A few of those provided are: number of multi-stakeholder joint activities as per work plan, number of A&E firms trained, number of RHBs participating in assessment and supervision training, number of training institutions that offer courses or certificate programs in HC renovation management, assessment & design.

QUALITY ASSURANCE

- Has the Project provided appropriate quality standards as part of the TA provided?
  The handbooks for health center assessment and for renovations provided the standards for the engineering and for health services use.

- Have the Health Center renovations met minimum international quality standards? If not, why not? How can health center renovations be done to meet appropriate standards in the most cost effective way?
  As indicated above, the renovations do not meet minimum international standards. The rationale given for the inferior specifications was budget limitations. The renovations can be done to meet appropriate standards by providing sufficient funding and ensuring that the TA contractor requires the use of international standards. Equally important to ensure that renovations meet international standards is to increase the level of construction supervision.

- Are the criteria for selecting health centers for renovation appropriate?
  Yes. They are USG's priority health centers (with respect to HIV/AIDS).

- Is the selection of health centers to be renovated done according to adequate criteria and based on priorities?
  Yes. See above.

CAPACITY BUILDING AND SUSTAINABILITY

- How effective is the strategy for building the capacity of the GOE to coordinate and technically guide health center renovation?
  The strategy for building the capacity of the GOE has not been effective. Given the involvement of the GOE technical staff with other construction in the health sector, CAC basically stopped attempting to involve the GOE technical staff in the program.

- What has been the increase in capacity of the GOE to implement and sustain these activities?
  There has basically been little or no increase in capacity of the GOE technical staff.

VII. RECOMMENDATIONS AND LESSONS LEARNED

The recommendations presented below reflect lessons learned and are focused on strengthening future health center renovations projects.

COORDINATION

To strengthen the future project for the coordination component, USAID should consider**:**

- Investing time and considerable effort to obtain FMOH and RHB buy-in to a HC renovation project before it is awarded.

- For the new project, it is recommended that the contracting for assessments and renovations be done by the government. It is suggested that the TA staff be stationed at the RHBs. With the assistance of the TA contractor, the staff at the RHBs will improve their skills in contracting administration and supervision. In addition, with the contracts being led by the RHBs, the contracted A&E firms located near the RHBs will have less travel to the sites and the frequency of site inspections should be increased. With the overall contract supervision by the RHBs, the site visits by the RHB staff will also increase. This will increase the supervision and as a result the quality of the work will be improved.

- The USG agencies (USAID/CDC) should lead a coordination effort among USG implementers so that whenever sites are visited and supervision is done, routine HC maintenance and safety is addressed: this is part of total quality management. The USG, and not one of the (many) USG implementers, should lead this effort (but one or more USG implementers may be tasked with assisting and preparing the USG to do this).

TECHNICAL ASSISTANCE

To strengthen the future project for the technical assistance component, USAID should consider:

- Identifying multiple alternatives to capacity building and TA and assess which of them are feasible at the onset of the project.

- Exploring alternative training opportunities such as supporting pre-service and technical training institutions.

- Budgeting and planning to train several different A&E firms so there is a backup when one does not work effectively.

- It is suggested that a significant training program be a part of the new project. With the excellent material developed by CAC for HC assessment, the new project should undertake training programs for both the RHB staff and the local A&E firms on the proper methods of performing HC assessments.

- It is recommended that the new TA contract include a comprehensive program that will assess the overall maintenance requirements of the Ministry, identify the required

maintenance staff, and identify the appropriate sources of training for the required staff. This program should be all inclusive from routine maintenance to the maintenance of the most sophisticated equipment in the national hospitals.

MANAGEMENT

To strengthen the management of future programs, USAID could consider the following recommendations:

- USAID should work with the contractor and approve work plans on time, and document changes including reallocation of resources.

- When not certain about the extent of renovations needed, set the renovation target low for the first year and increase it the second year, based on experience and the environment.

- Give clear guidance to the implementer regarding when and how changes to an approved work plan can be made, being careful to document any changes to this while it is being implemented and showing, when necessary, how budgeted resources are reallocated when activities are added/dropped/replaced.

- Require, as part of the reporting, a simple inventory of travels (within and outside of country) which were financed by the project. For the HCRCP, this would be the CAC staff travel and the travel made by the A&E firm as well as any travel and/or per diem paid to national counterparts. The inventory includes date, destination, persons traveling, and a brief purpose that is identifiable as contributing to one or more expected results.

- Clearly state in guidance that only activities funded from the HCRCP project can be reported as services and deliverables for that project. If the implementer has other funding via subcontracts – or receives other funds from other projects for related HC renovation activities, it cannot report them as achievement deliverables under this project unless the cost was shared by more than two sources, in which case this must be documented when reported and submitted.

- Provide guidance to implementers as to what is an “expected” service or deliverable and what is “unanticipated”. This will largely be developed through a stronger PMP and work plan but USAID may wish to add to quarterly reporting requirement a table of expected and unanticipated deliverables and services. USAID could then review these routinely.

- Consider the level of expertise needed. Engineers and architects are not needed for all aspects of health center renovation, especially when they are simple, single story buildings. The project could consider training and use of entry and intermediate-level personnel for site supervision: this would be more cost-effective.

RENOVATIONS

To strengthen the assessment and renovation component of future projects, USAID should consider the following recommendations:

- Establish a minimum renovation package for each site during the project design to help in establishing an appropriate budget and implementation plan. Increase the threshold for what is considered a "minimum package" renovation - after having operationally defined a minimum package (e.g., include in all cases covered waiting areas with benches or seats, which will keep the passageways clear, which is not the case in all of the sites).

- Increase the amount of funding available for site renovation (per site) so that a minimum package can be offered; factor into the budget small items which "complete" a renovation (such as shelves in a newly renovated administrative room or seats in the waiting area that was expanded and roofed, rather than have clients sitting on the ground).

- USAID, the implementing agency, and the GOE should strategize how to make full use of the excellent assessments done and assure better conformity to the (master) plan including changes in client/provider flow, infection prevention, improving privacy and comfort.

- Add to the project objectives and budget maintenance of the health center; the grounds, the infrastructure and the equipment.

- Improve the specifications for the renovations to show the correct ways to install fixtures.

- Require that the implementing agency make more detailed specifications for the renovations – both for materials to use/purchase and how to install these; use commercial grade material.

- Always include renovation of waiting areas to keep hallways free and to make clients more comfortable; this was done at some sites but not at others that need it.

- If PEPFAR permits, take into consideration (to a greater extent) the needs of the HC personnel when renovating. If the HC operates around the clock, there should be a comfortable place for the providers to rest during the night. Also, showers, separate toilets, etc. should be considered.

- Use commercial grade fixtures, roofing and gutters for renovations instead of cheap residential grade materials.

- Invest some time in training the HC personnel how to do routine maintenance, such as tightening loose screws, cleaning the drain traps, knowing where to turn off the water supply.

- When replacing water tanks, always increase tank capacity when renovations effectively increase water use and volume.

MONITORING AND EVALUATION

To strengthen the monitoring and evaluation of future projects, USAID should consider:

- Adopting some process and outcome level indicators and including these in the PMP. Ensure that the PMP has all components as per USAID guidelines. Provide the implementer with a standardized work plan and reporting formats and instructions for semi-annual reports and ensure that there are operational definitions for all indicators.

- Providing the implementing agency with standardized tools and procedures and the proper guidance for project monitoring and evaluation.

VIII. APPENDICES

APPENDIX 1) SOW FOR THE EVALUATION

Draft Statement of Work (SOW) for End of Project Evaluation of the Health Center Renovation Coordination Project (HCRCP)

(Draft # 5 - 24 April 2008)

PROJECT IDENTIFICATION DATA

1. Project Title: Health Center Renovation Coordination Project (HCRCP)
2. Project Number: 663-C-00-06-00428
3. Project Dates: 09/29/06 to 09/27/08
4. Project Funding: $3,919,941
5. Implementing Organization: Crown Agents
6. Cognizant Technical Officer (CTO): Jamie Browder

I. Identification of the Task

The USAID/Ethiopia (USAID/E) Health, AIDS, Population and Nutrition (HAPN) Office requests technical assistance from the Mitchell Group (TMG), under the USAID/E Evaluation Contract Number 663-C-00-08-00409-00, to design and implement an independent external end-of-project evaluation of the Health Center Renovation Coordination Project (HCRCP). The HCRCP coordinates renovation and construction initiatives to improve HIV/AIDS services in Ethiopia, and carries out selected renovations, filling gaps when other funds are not available. The HCRCP's overall goal is to support the Federal Democratic Republic of Ethiopia (FDRE) to provide improved HIV/AIDS care and treatment services at health centers through the following key objectives: 1) Serve as a coordination and synchronization "hub" with national and bilateral stakeholders on health center renovations, 2) Provide technical assistance (TA) on renovations to Ministry of Health (MOH) Federal and Regional Health Bureau (RHB) offices, and 3) Provide direct renovation support at selected health centers. This external end-of-project evaluation will assess the achievements, impact, and challenges for the project in addressing these three objectives.

The USAID/E HAPN office requests that the evaluation be completed by May 29, 2008 in order that the findings, conclusions and recommendations can be used in the implementation of the planned follow-on project for health facility renovation.

II. Background:

The number of HIV positive individuals in Ethiopia was estimated at 977,000 in 2007 and is projected to increase substantially in the next two years (a 30% increase was projected from 2006 to 2010). The projected growth in the total size of the HIV-infected population in Ethiopia means that efforts to strengthen facility-based services will be critical for a successful national HIV/AIDS program. The Government of Ethiopia (GOE) Federal Ministry of Health (FMOH) is decentralizing ART and other HIV/AIDS services to the health center level. HIV/AIDS services at health centers require adequate infrastructure to accommodate the rapid and sizable increase in HIV/AIDS clients at these sites.

Scope of Work – Health Center Renovation Evaluation

The quality of Ethiopia's public sector facilities providing anti-retroviral therapy (ART) is among the key limiting constraints to increasing enrollment. ART services require adequate infrastructure to support the sizeable increase in clients (up to 200/site) expected at priority health centers. The serious infrastructural limitations of Ethiopia's health facilities are important factors in the low utilization of HIV/AIDS care and treatment services, particularly PMTCT.

An FY06 assessment by Family Health International (FHI) identified infrastructure deficiencies as a major obstacle to sustained progress in achieving ART targets. A subsequent FY07 assessment by Crown Agents of 44 health centers currently providing ART services in the four most populous regions of the country (Oromia, Amhara, SNNPR, and Tigray) and the city of Addis Ababa found that nearly all health centers suffered from serious physical/structural and/or essential function deficiencies (e.g., lack of running water, blocked waste water disposal lines, overflowing dry pit latrines, and/or electrical malfunctions). These facilities also faced space limitations that compromised patient care and the safety of clients and healthcare providers. The report also found that the poor condition of the health centers may also have reduced the shelf-life and quality of valuable HIV/AIDS commodities supplied by PEPFAR, the Government of Ethiopia (GOE) and other sources such as the Global Fund To Fight AIDS, Tuberculosis and Malaria (GFATM). It is noted here that the renovation of pharmacies and laboratories was specifically excluded from the SOW of the contractor, Crown Agents.

Ongoing efforts to renovate health facilities: Currently, several bilateral and multilateral agencies, as well as non-governmental organizations (many of which are PEPFAR partners or USG-supported with non-HIV/AIDS funds) are working independently to renovate health centers, hospitals, supply warehouses and other facilities. These include the Japanese International Cooperation Agency (JICA), the German Technical Cooperation Agency Gesellschaft für Technische Zusammenarbeit (GTZ), the U.S. State Department's Regional Procurement Support Office (RPSO), Pathfinder International, Management Sciences for Health, IntraHealth International, and the Packard and Clinton Foundations, all of which have worked and in some cases continue to work independently to renovate hospitals, health centers and other facilities.

Health manpower capacity to engineer, plan and monitor the expansion and renovation of facilities is limited. Following the Paris Declaration, the GOE adopted a plan to achieve universal access to primary health care, including HIV services, by 2010. Under this plan, the MOH has a goal to increase the number of health centers in the country from around 630 in 2007 to 3,153 by the year 2010. This ambitious undertaking to expand the health infrastructure means that the engineering, construction planning and monitoring capacity of the federal and regional health administrations are stretched to the limit. The application of a systematic and structured approach for coordination is urgently needed among the agencies currently supporting renovation and construction, the MOH and RHBs, to rationalize infrastructure improvements at health centers and other facilities. Improved coordination will heighten the impact that facility renovation and construction can have on expanding sustainable HIV/AIDS, chronic diseases and related services across the country. The need for coordination and appropriate technical guidance will become even more acute as the country moves into a major renovation phase supported by GFATM and the Global Alliance for Vaccines and Immunization (GAVI) funding in support of the push for universal access to primary health care services. GTZ has been tasked by the MOH with carrying out much of this construction, which will convert large numbers of existing lower level health stations to health centers.

Scope of Work – Health Center Renovation Evaluation

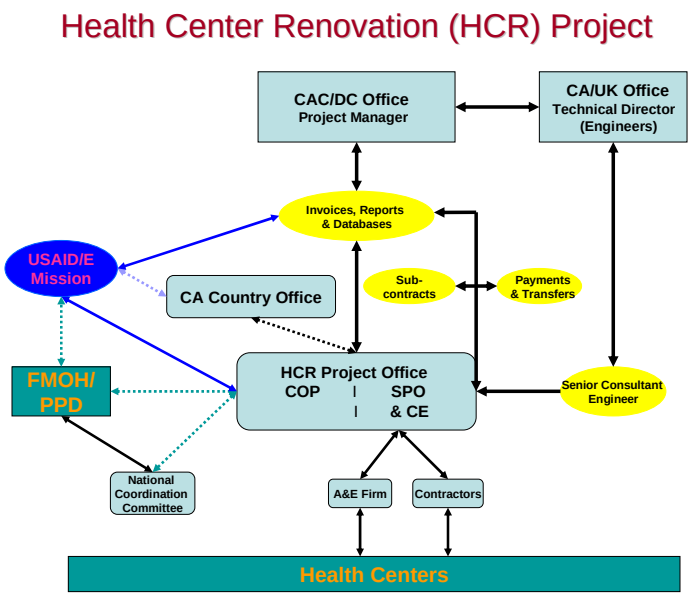
As mentioned above, a number of US Government-funded partners in Ethiopia are currently engaged in health center renovation activities. For example, the Rational Pharmaceutical Management Plus Project under Management Sciences for Health (MSH/RPM Plus) is funded by PEPFAR to renovate pharmacy stores as well as voluntary and counseling testing (VCT) and antiretroviral (ARV) dispensing rooms at 23 health centers. Other key PEPFAR partners involved in limited renovation and refurbishment include MSH's HIV/AIDS Care and Support Project (HCSP). The State Department's Regional Procurement Supply Office (RPSO) renovates hospitals and laboratories in conjunction with four PEPFAR-funded American university partners supported by the Centers for Disease Control and Prevention (CDC). The non-PEPFAR USAID-funded DELIVER project is also carrying out renovation of health center stores. Before the advent of the HCRC Project, systematic overall coordination of these efforts was limited and incomplete.

III. Overview of the Health Center Renovation Coordination Program

Begun in September 2006, the USAID/Ethiopia PEPFAR-funded HCRCP has worked to standardize, synchronize and facilitate proposed GOE and U.S. Government-funded renovations, with a focus on existing health centers. The activity has provided technical assistance to the MOH and RHBs for renovation coordination, technical design, engineering, procurement and logistics support. The project has also placed short-term technical assistance at the national and regional level to support staffing gaps in support of GOE health facility renovation/construction efforts irrespective of funding source. A particular emphasis of these health facility renovation/construction efforts is on the conversion of health stations to health centers. As part of this effort, the HCRC Project has also directly assessed and renovated selected health centers, so that the facilities can better support chronic disease management, and HIV/AIDS services, especially antiretroviral therapy (ART).

Geographic coverage: The HCRCP serves the four most populous regions of the country (Oromia, Amhara, SNNPR, and Tigray) plus the capital city of Addis Ababa, potentially benefiting millions through improved infrastructure for ART services. See Attachment 4 for a map of HCRCP sites.

HCRCP Management and Administration: Management is accomplished via joint oversight by the Chief of Party (COP), responsible for technical and programmatic areas, and the Project Manager, responsible for administrative and financial matters. Figure 1 depicts the organizational structure for implementing and managing the project and diagrams the relationship between the HCR Project office in Addis Ababa and Crown Agents Consultancy, Inc. headquarters in Washington DC; Crown Agents/UK headquarters in Sutton, England; and the Crown Agents Ethiopia country office.



Program Objectives: The HCRCP's overall goal is to support FDRE efforts to provide HIV/AIDS care and treatment services at health centers.

The three main expected project results are:

- Coordination - Serve as a coordination and synchronization "hub" with national and bilateral stakeholders on health center renovations to support chronic disease;
- Technical Assistance - provide assistance on renovations to the FMOH and RHBs, including technical design, engineering, procurement and logistics support (100 Health Centers (HCs) in total); and
- Renovation - Provide direct or indirect renovation support at selected health centers to support chronic disease management including ART (50 HCs in total).

According to the work plan for the first year of activities, the HCRCP had three principal results:

- **RESULT 1** –Establish a National Health Center Renovation (HCR) Coordination Mechanism
    - Identify Key HCR Implementing Agencies
    - Identify HCR Coordination Meeting Participants
    - Develop an HCR Tracking System
    - Develop an HCR Harmonization and Coordination Plan
    - Assist FMOH/Planning and Programming Department (PPD) to conduct a National HCR Coordination Meeting.

Scope of Work – Health Center Renovation Evaluation

- **RESULT 2** - Technical Assistance to FMOH/PPD and RHBs (50 HC assessments per year)
    - Identification of TA requirements
    - Field-based Assistance to RHBs
    - Preparation, Testing and Vetting of Standardized Documents and Procedures
    - Contract Documentation
    - Identification of Engineering Assets

- **RESULT 3** - Renovation of 20 HCs
    - Identification of HCs for Renovation with RHBs and Other Stakeholders
    - Preparation of Standardized Guidelines and Procedures
    - Identification and Procurement of Architect and Engineering (A&E) Firm
    - Pre-Qualification of Works Contractors
    - Health Center Renovation Works (20)

During the first project year (PY1) the HCRCP provided 156 specific technical assistance activities related to Result 1; provided TA on HC assessments under Result 2, involving more than 65 visits to 59 selected HCs located in the four major regions and Addis Ababa; and, under Result 3, provided direct renovation support to 23 selected HCs in the four major regions and Addis Ababa.

HCRCP Strategic Framework: While HCRCP is implemented within the PEPFAR Country Operational Plan framework and targets, it is also considered under the USAID Mission's strategic framework elements and sub-elements, the **USAID Integrated Strategic Plan FY 2004-2008 and the 2007 Foreign Assistance Framework.** USAID/Ethiopia's HCRCP was initiated under the **USAID/E Integrated Strategic Plan (ISP)** for the period FY 2004 to FY 2008 under the strategic objective (SO) ***SO 14: Human Capacity and Social Resiliency Increased*** and ***SO 14.2 HIV/AIDS prevalence reduced and mitigation of the impact of HIV/AIDS increased***. In 2007, the SO14 was incorporated into an alternate **Foreign Assistance Framework (F-Framework)** for the USAID 2007 Operation Plan. The activities under the HCRCP project now fit under the **F-Framework Objective**: *Investing in People*, **Program Area**: Health, **Program Elements**: HIV/AIDS; **Program Sub Elements:** Treatment and Care Services.

Recent HCRCP activities: The actual HCRCP renovations of selected Health Centers (HCs) to support care and treatment services include: Reception/Registration Areas, Client Waiting Areas, Outpatient Delivery, Maternal Child Health, HIV Counseling and Testing, Chronic Care Clinics, stores, latrines and toilets. As mentioned above, under the current cooperating agreement scope of work, the HCRC Project does not support (or report on) renovations to pharmacy or laboratory facilities in health centers. This work is currently covered under separate contracts or agreements.

In the first half of Project Year Two, from September 30, 2007 through March 31, 2008, the HCRCP completed engineering assessments on 22 HCs located in the four most populous regions and Addis Ababa, awarded contracts for the renovation of these 22 HCs, and provided TA to the FMOH and RHBs for the expansion of four HCs and the design of a Hospital's waiting and administration areas. In response to an acute shortage of technical experts within the RHBs,

the cooperating agreement has recently been modified to permit HCRCP to recruit nine Short Term Technical Assistance (STTA) architects and engineers to be seconded to four RHBs and the FMOH/PPD. In addition, the HCRCP has drafted a HC renovation and health services tracking system, and developed a working draft of Guidelines for Health Center Renovation and Expansion and a Health Center Assessment Handbook.

Monitoring and Evaluation (M&E): The two primary indicators for the HCRCP are shown in Table 1 below.

Major HCRCP Indicators	LoP Target	Achieved to date (03/2008)
Number of HCs provided direct renovation support	50	23 (12/07) completed 22 03/08) under contract
Number of HCs provided with TA for renovation planning, assessment and renovation documents	100	81 (as of 03/08)

Other indicators include: Result 1, the number of technical assistance meetings and visits; Result 2, the number of times provided TA to RHB and HC/Woreda Staff; and Result 3, the number of HC engineering assessments completed, and number of HCs undergoing renovation. For a detailed summary table of current HCRCP indicators see Attachment 1.

Emerging Issues: Over the past year, HAPN has noted the following emerging issues for HCRCP program implementation:

Limited availability of RHB/Zonal/Woreda Engineering staff to assist in conducting engineering assessments and other TA activities in four of the five regions and insufficient funding to provide substantial short term TA to address this constraint. The former problem is being addressed by hiring STTA architects and engineers.
Lack of interest in the proposed Health Center Renovation (HCR) Coordination Committee.
Lack of support for leveraging health center renovation resources from non-USG donors.
Need to upgrade PEPFAR priority HCs to a minimum performance standard, coupled with an inadequate funding to implement upgrades.
Delay in official acceptance of HCR Project Statement of Work by FMOH/Planning and Programming Department.

IV. Purpose of the Assignment

The purpose of this evaluation assignment is to implement an independent external end-of-project evaluation of the Health Center Renovation Coordination Project (HCRCP).

The evaluation requires a core team of two experts: 1) a senior expatriate Team Leader trained in civil engineering or architecture with extensive health facility renovation program experience (25 days), and 2) a senior expatriate HIV/AIDS health services expert with prior experience working in Sub-Saharan Africa (22 days). The local TMG sub-contractor will provide all needed logistical support. Additional technical team members may be provided by local and

international stakeholders, potentially including OGAC, CDC/Atlanta, USAID/Washington and GOE staff participation. With about six months remaining in the project, this evaluation will assess the progress of HCRCP implementation and challenges. It will document lessons learned and formulate recommendations for the proposed follow-on program, "Facility improvements to strengthen HIV/AIDS services: capacity building at multiple levels." The evaluation will cover the HCRCP performance period of September 2006 through March 2008. The evaluation report will assist USAID and Crown Agents to address topics of program management, planning and coordination, the provision of TA, quality of services, and sustainability during the time remaining in this project.

This is external end-of-project evaluation will assess program process, document lessons learned, and inform follow-on activities.

This evaluation will:

- Assess the progress toward contract targets.
- Assess process used to implement the program's three key areas of intervention to meet objectives.
- Assess the effectiveness of the three key project interventions: the approach and activities used by Crown Agents to assist the GOE to improve health center renovation planning, design and operations for HIV/AIDS and other chronic diseases among various institutions, and other cooperating agencies, other donors, HAPCO, the Ministry of Health and other Ministries.
- Identify additional achievements and unexpected benefits.
- Identify project components that could be scaled up beyond the project agreement in Ethiopia.

The evaluation will answer the following illustrative questions:

Program Management:

- Have the resources, (human, financial and other) been effectively managed to achieve program results?

- Has the management effectively planned, implemented and monitored the program's key interventions?

- Have the TA resources been identified, managed and supervised adequately?

- Has management identified problems in implementation and addressed these appropriately?

Implementation:

- How effective is this approach/model of coordination, TA and direct s renovation for supporting the development of GOE capacity to renovate health centers for HIV/AIDS and other chronic diseases?

- How well is this project assisting the GOE to plan and coordinate the activities of assessments, planning, technical reviews and renovations done by multiple organizations providing health center renovations? (These include PEPFAR partners such as the CDC

(which supports the Regional Procurement Support Office or RPSO), the Management Sciences for Health (MSH)/Rational Pharmaceutical Management Plus (MSH/RPM Plus), non-PEPFAR stakeholders, such as Gesellschaft für Technische Zusammenarbeit (GTZ) and others as appropriate)

- Are the "engineering assessments'" approach and their implementation adequate to address the both the engineering and health service delivery needs of health centers?
- Has the amount and quality of the assistance/resources used for the assessments been adequate and appropriate? Have they been directed at priority health centers?
- Has the direct support to renovate selected health centers been adequate and of sufficient quality to meet program targets?

Monitoring and Evaluation (M&E)

- Has the M&E system adequately tracked the progress using the mandated indicators?
- Has the information from the M&E system been adequately used to plan and manage the program?
- What indicators of the quality of renovations can/should be incorporated into monitoring of the follow on project?
- What indicators could be adopted to measure the program in the areas of coordination and capacity building, renovation, technical assistance?

Quality Assurance

- Has the Project provided appropriate quality standards as part of the TA provided?
- Have the Health Center renovations met minimum international quality standards? If not, why not? How can health center renovations be done to meet appropriate standards in the most cost effective way?
- Are the criteria for selecting Health Centers for renovation appropriate?
- Is the selection of health centers to be renovated done according to adequate criteria and based on priorities?

Capacity Building and Sustainability

- How effective is the strategy for building the capacity of the GOE to coordinate and technically guide health center renovation?
- What has been the increase in capacity of the GOE to implement and sustain these activities?
- What are the priority areas of capacity that still need improvement?

Lessons Learned

- What lessons have been learned to guide improvement of the program and for the new follow-on program development?
- Identify lessons learned, successful interventions for continuation or replication, best or better practices, and significant products and tools from the HCRCP for consideration for possible dissemination and replication.

V. Evaluation Methods

The evaluation will be carried out by a core team of two independent, external consultants over a three-week period using multiple methods, including review of HCRCP reports, tools, and materials, key informant interviews, field observation, facility assessments, and selected health

provider and client interviews. The two core team consultants may be joined by up to three representatives from the MOH and HAPCO at the national and/or regional level. The evaluation team working with USAID/E, the GOE, RHB's, Crown Agents and others, will identify a representative subset of Health Centers to visit. Activities will include:

- Review of relevant documents.
- Interviews with key stakeholders, government officials, health services staff, representatives of beneficiaries of the health centers.
- Meetings with Crown Agents staff.
- Field visits to selected regions and districts (one combined team will be used to assure that the issues of engineering and of service delivery are addressed in the facility assessments of renovations. The calendar attached shows the major tasks and timeframes).
- Direct observation of assessment process and of renovation (if possible) at selected health centers.
- Assessment of renovated health center facilities.
- Follow-up on the current status of a sub-sample of the earliest renovated HCRCP health centers.
- Visits to one or more HCs that have not been selected for renovation.

Specific evaluation techniques may include: interviews, focus group discussions (FGDs), and technical health facility assessments from both an engineering and health service delivery perspective.

VI. Information Sources

Crown Agents will provide consultants with appropriate background documents in preparation of the assignment. USAID and Crown Agents will identify priority documents if possible from the list. The documents will include but are not limited to:

- HCRCP Cooperative Contract including all subsequent modifications
- HCRCP PEPFAR Semi-Annual Report submissions
- HCRCP 2006 and 2007 Annual Reports
- HCRCP Quarterly Reports
- HCRCP Guidelines
- HCRCP M&E Tools
- Prior assessments and evaluations carried out by HCRCP
- USAID trip reports summarizing past field visits to HCRCP
- GOE Road Map for HIV/AIDS Prevention, Care and Treatment
- Pertinent GOE documents on related programs such as the Health Services Extension Program.

VII. Tasks to be accomplished:
Below is a list of the specific tasks to be accomplished by the consultant team, with an estimated level of effort for each task. See Attachment 2 for a Planning Calendar for the proposed dates for these tasks.

Key activities	Level of Effort in Days
Team reviews background documents, initial discussions with TMG Coordinator, reviews methodology and field visit and interview schedule.	3
Team Planning meeting at TMG –DC. Review evaluation methodology, conference calls to CA HQ, develops outline of report, develops draft work plan that is sent to HAPN for review prior to departure for Ethiopia.	2
Travel to Ethiopia	1
In country in-brief consultation with CTO, Evaluation Coordinator and HAPN. Team discusses and submits Draft Work Plan to USAID/E. Work plan approved based on HAPN comment.	1
MOH and other stakeholders meetings, key informant interviews	3
Full team TPM	2
One Team conduct field visit, facility assessments and interviews	6
Full team analysis and report writing	2
Core team analysis, report writing, and debriefings	4
Travel from Ethiopia	1
USAID/ Review of draft report	
Report - Response to USAID/E comments Team leader (2) T. member (1)	2-
TMG edits final report	

Total LOE – 25 days of LOE for Team Leader and up to 22 days for the Team Member. A six-day work week is authorized for work in Ethiopia.

VIII. Team Composition and Participation

The Mitchell Group will provide two key core team members, 1) an expert with civil engineering and/or architecture expertise and experience in health center renovation and 2) an expert in health services delivery needs. Their qualifications are listed below. In addition, the two consultants may be joined by representatives from the MOH and HAPCO at the National and

regional level and/or other development partners involved in renovation. Local Evaluation Team Logistics will be provided by the local sub-contractor hired by TMG.

1. The Team Leader will be an international consultant with training in civil engineering or architecture as well as extensive health facility renovation program experience. S/he will lead the evaluation process in three or more weeks, spending two weeks in-country. The Team Leader will lead the team's efforts, which will include conference calls with team members and USAID/E representatives, in-brief USAID/E on arrival, debrief USAID/E and HCRCP on evaluation findings, and develop a draft report to be left with USAID/E prior to departure, followed by a final report for USAID/E.

The Team Leader will:

- Discuss the team Work Plan for the assignment with USAID/E and finalize the work plan based on USAID/E comments.
- Define assignment roles, responsibilities, and tasks for team members.
- Oversee logistics arrangements in the field.
- Participate in the TMG Team Planning Meeting (TPM).
- Lead the preparation of and coordinate team member input, submitting, revising and finalizing the report.
- Lead team meetings.
- Coordinate and support the team on tasks and ensure that team works effectively.

Team Leader qualifications:

- An advanced degree (in civil engineering or architecture) pertinent to work with health center renovation.
- **Minimum 10 years** of progressively responsible experience with recognized organization(s) in the design, implementation and evaluation of civil engineering programs, especially for renovation projects related to HIV/AIDS, TB, chronic diseases, and other PHC services at the health center level.
- Demonstrated strong analytical, managerial and writing skills.
- Leadership in coordinating activities; the ability to assign the team the appropriate responsibilities, and expert communication and interpersonal skills.
- Ability to interact effectively with a broad range of internal and external partners, including international organizations, host country government officials, and NGO counterparts.
- Fluency in English and proven ability to communicate clearly, concisely and effectively both orally and in writing.
- Must be able to produce a succinct quality draft Final Report that gives direction and facilitates improvement for the HCRCP program.

2. The senior level expatriate team member will be a health services delivery expert with (optionally) health services renovation experience with prior experience working in Sub-Saharan Africa. The consultant will assess the health services needs for HIV/AIDS and other chronic diseases to identify the appropriateness of the design, renovation and use to meet service delivery needs. S/he is responsible for writing sections of the report. The consultant will develop assessment tools to be used during site visits and analyze data.

Consultant qualifications:

- MD, BSN, MA, MS, or BA in Medicine, Public Health and/or behavioral or social sciences related to HIV/AIDS and other chronic disease services, and related MCH and PHC service needs related to health center renovations .
- **Five to 10 years** of progressively responsible experience in the design, implementation and evaluation of service delivery needs in HIV/AIDS and other chronic diseases and related MCH and PHC programs related to structural and renovation of health centers.
- Strong analytical, managerial and writing skills. Ability to interact effectively with a broad range of internal and external partners, including international organizations, host country government officials, and NGO counterparts.
- Fluency in English.
- Proven ability to communicate clearly, concisely and effectively both orally and in writing.

Evaluation Logistics: Evaluation Logistics will be provided by the local sub-contractor hired by TMG with support staff who are fluent in Amharic, with a demonstrated: ability to be resourceful and to successfully execute complex logistical coordination; ability to multi-task, work well in stressful environments and perform tasks independently with minimal supervision; ability to work collaboratively with a range of professional counterparts. The local sub-contractor will be responsible for logistics, coordination and administrative support, and ensuring the evaluation are carried out seamlessly. TMG's local sub-contractor staff will assist the Team in facilitating meetings, coordinating logistics and organizing site visits. As needed, the local sub-contractor will collect and disseminate background documentation to the evaluation team. TMG will be responsible to manage and direct the efforts of local sub- contractor.

IX. Schedule and Logistics

The in-country phase of the evaluation will be conducted in May with an in–country desired start date on or about 6 May 2008. See table above for Level of Effort and Attachment 2 Planning Calendar for the schedule. The local TMG Evaluation Logistics sub-contractor, *in collaboration with the Mitchell Group in Washington and USAID/E Evaluation Coordinator and HCRCP,* will arrange the partner meetings, site visits and debriefings in advance. Associated travel and per diem costs for non-USAID staff will be covered by TMG under the technical directive with USAID/E.

X. Period of Performance

Work is to be carried out over a period of approximately seven to eight weeks, beginning on or about (o/a) April 15, 2008 and concluding o/a May 29, 2008 (not including approx four weeks time for USAID/E (up to ten days) comment and completion of final editing of the Draft Evaluation Report by TMG (3 weeks).

XI. Financial Plan

A budget agreement between the USAID/Ethiopia and TMG will be reached and USAID/E will approve the evaluation activity by the TMG under the USAID/Ethiopia Evaluation Program.

XII. Deliverables

Prior to arrival (preferably two weeks): Team leader will develop a Draft Work Plan with evaluation methodology and field visit and interview schedule in consultation with the USAID/E CTO and USAID/E Evaluation Coordinator. The Draft Work Plan will clearly present roles and responsibilities, a planned interview schedule, and an analysis plan of who will be responsible for writing various sections of the report.

Three days after Team arrival: Team meeting and in-briefing with USAID/E. USAID/E HAPN technical staff to review and comment on evaluation methods. The Draft Work plan will be presented and discussed with Mission Staff to ensure the assessment is on track and can be met on time. After agreement, the Draft becomes a Final Work Plan.

Prior to departure: Team makes presentation to USG PEPFAR staff, a separate presentation to HCRCP partners, and Team Leader submits a draft report in the format specified by the USAID/E Evaluation coordinator (See separate MS Word file for TMG Evaluation Report Guidelines) to USAID/E CTO - two hard copies and one electronic copy on CD ROM or flash drive.

After departure: Team leader submits final draft report content to USAID/E within one week of receiving comments from USAID/E. The report (not including attachments) will be no longer than 30 pages with an Executive Summary, Introduction, Methodology, Findings, Conclusions, and Recommendations in English in a format specified by the USAID/E Evaluation Coordinator in consultation with TMG.

Upon final approval of the content by USAID/E, TMG will have the report edited and formatted within three weeks. The final report will be submitted electronically to USAID/E CTO and Contract Officer.

TMG will make the results of its evaluations public on the Development Experience Clearinghouse and on its project web site unless there is a compelling reason (such as procurement sensitivities) to keep the document internal. Therefore, TMG will request USAID/E confirmation that it will be acceptable to make this document publicly available. If there are certain restrictions regarding specific parts of the report that should be removed from a public version due to procurement-sensitive information, TMG will produce a second version suitable for public availability.

Attachment 1: Summary of Results 1-3 Technical Assistance/Activities (by quarter)
(Source: Table 4 on page 7 of the Project Year Two Semi-Annual Progress Report**)**

Technical Assistance/Activities	Q1	Q2	Q3	Q4	Q1+Q2
RESULT 1					
1.1. Conduct technical assistance meetings and visits with FMOH/PPD and RHBs	11	18			**29**
1.2. Conduct follow-on meeting with USAID-Partners, USG and non-USG organizations or other donors	13	16			**29**
1.3. Assist FMOH/PPD and/or RHB develop HC renovation and health services tracking system	5	6			**11**
1.4. Assist FMOH/PPD and/or RHB implement HC renovation and health services tracking system					
1.5. Assist FMOH/PPD plan nation HCR Coordination meeting	3	1			**4**
1.6. Assist FMOH/PPD conduct national HCR Coordination meeting with RHBs and other stakeholders					
1.7. Assist RHBs leverage resources for HC renovation	8	19			**27**
1.8. Assist FMOH/PPD and HSD draft HC Renovation and Expansion Manual and HC Assessment Handbook	5	11			**16**
TOTAL (Result 1)	**45**	**71**			**116**
RESULT 2					
2.1. Provide TA to (or mentor) RHB and HC/Worde staff	22	35			**57**
2.2. Orient RHB technical staff (e.g., engineers) to updated HC renovations guidelines and other materials	5	9			**14**
2.3. Mentor RHB technical staff making engineering and supervision visits to health center(s) under renovation	3	44			**47**
2.4. Provide assistance in using the HCR and health services tracking system					
2.5 Conduct annual workshop in project priority regions with RHB/Worde staff and other stakeholders involved in HCR					
TOTAL (Result 2)	**30**	**88**			**118**
RESULT 3					
3.1. HC engineering assessment completed	18	4			**22**
3.2. HC construction on-going	17	22			**22**
3.3. HC renovation completed and approved					

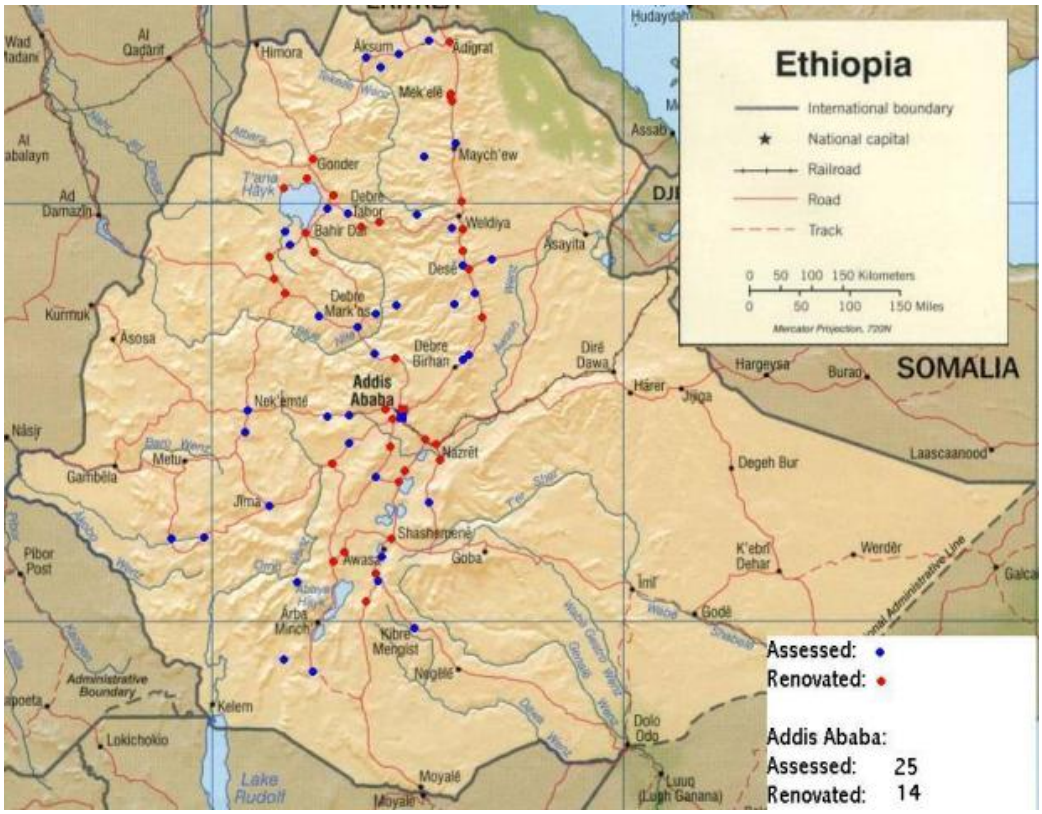
Attachment 2: Planning Calendar

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
	April 1	**2**	**3**	**4**	**53**	**6**
7	**8**	**9**	**10**	**11**	**12**	**13**
14	15	16 **Document review 3 days**	**17**	**18**	**19**	**20**
21	**22**	**23**	**24**	**25**	**26**	**27**
28	**29**	**30**	**May 1** **TPM at TMG/DC**	**2** **TPM at TMG/ DC**	**4**	**5** **Travel**
5 **Holiday**	**6** **Start in Addis** Stake holder meetings Continue tools development	**7** **Mission in brief** **Stakeholders meetings** **Key informant interviews**	**9** **Full team TPM** **Site visits in or near Addis**	**10** **Full team TPM** **Present work plan to USAID** **Site visits in or near Addis**	**10** **Refine tools**	**11** **Rest** **Travel to Asawa**
12 **Field work** **One team** **HC near Awasa**	**13** **Field work** **One team** **HC near Shashemene**	**14** **Back to Addis** **Travel to Bahia** **Regional office** **Bahir Dar – HC near Bahir Dar**	**15** **Field work** **One team** **HC near Bahir Dar**	**16** **Field work** **One team** **HC near Bahir Dar**	**17** **Full Team analysis and writing**	**18** **Rest**
19 **Full Team analysis and writing**	**20** **Core team writing**	**21** **Core team writing** **Debrief USAID**	**22** **Debrief MOH, stakeholders, partners** **Core team writing**	**23** **Core team writing**	**24** **Travel**	**25**

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
26	**27**	**28** **Holiday**	**29**	**30**	**Later** Response to USAID comments Expat T Member 1 Team leader 2	**Total LOE** **Team leader 26** **ex pat expert 25**

Scope of Work – Health Center Renovation Evaluation

Attachment 3: Map of HCRCP Activity Locations in Ethiopia



Scope of Work – Health Center Renovation Evaluation

APPENDIX 2) TMG EVALUATION WORK PLAN

Tulane INDV 410/660 Fall Semester 2007

work plan template

The Mitchell Group Inc. Evaluation of HCRP Ethiopia (DRAFT May 6th)

	Activities	Pre field wk 1	Pre field wk 2	Pre field wk 3	Arrive Day 1 Field	T 6th Day 2 Field	W 7th Day 3 Field	H 8th Day 4 Field	F 9th Day 5 Field	S 10th Day 6 Field	Sun 11 Day 7 Field	M 12th Day 8 Field	T 13th Day 9 Field	W 14th Day 10 Field	H 15th Day 11 Field	F 16th Day 12 Field	S 17th Day 13 Field	Sun 18 Day 14 Field	M 19th Day 15 Field	T 20th Day 16 Field	W 21st Day 17 Field	F 22nd Day 18 Field	Depart Day 19 Field	Post field wk 1	Post field wk 2	Post field wk 3	STATUS (select from drop down list)	Person Responsible on TMG team
Pre-field work		S																										
	SOW reviewed with USAID in Ethiopia, consultants, other stakeholders (Evaluation coordinator visits Ethiopia)	S	F																								Completed; On schedule	Rose, Lane, Jenkins
	Consultants, agency sub-contracts signed	S						F																			Completed; Behind schedule	Jenkins, Alex
	HCRP related documents needed for evaluation are identified and collected	S						F																			Completed; On schedule	Rose, Barney, Tom, others
	Initial review of available documents related to HCRP for strategy and methods development	S			F																						Completed; On schedule	Rose, Barney, Tom, others
	Regions where health facilities to be visited are chosen	S		F																							Completed; On schedule	Rose, Others
	Logistics for team's stay in Ethiopia are completed (hotels, airfare, transport addis, payments, etc)	S						F																			Completed; On schedule	Rose, Mike, Lane, Alex, Azeb
	Pre-field Team Planning Meeting in DC held (2 days)		S/F																								Completed; On schedule	Rose, Barney, Tom, others
	Workplan for the evaluation developed and approved by USAID			S					F																		Completed; On schedule	Barney, Tom, Rose, Mike, et.al.
	Tools for evaluation are drafted (but not finalized)			S				F																			Completed; Behind schedule	Barney, Tom
	Evaluation methodology drafted			S			F																				Completed; Behind schedule	Rose, Barney, Tom, others
Field work in Ethiopia																												
	Meetings in Addis with USAID, Mitchell Grp residence agency, other as needed					S																F					Completed; On schedule	Rose, Barney, Tom, Mike
	List of key informants to be interviewed is completed		S						F																		Completed; On schedule	Barney, Tom, Mike
	Lists of sites (all HC, PEPFAR priority HC, USAID priority HC, etc) is obtained; site selection criteria is adopted and sites selected.			S				F																			Completed; Ahead of schedule	Barney, Tom
	additional HCRP documents obtained and reviewed				S																			F			Completed; Behind schedule	Barney, Tom, Mike, Rose
	Protocol for the evaluation is finalized and adopted by USAID					S			F																		Completed; On schedule	Barney, Tom

S = Start
F = Finish

TMG workplan Evaluation HCRP Ethiopia May2006 approved 09may06 by USAID updated 26June2006.xls
1
6/27/2006

The Mitchell Group Inc. Evaluation of HCRP Ethiopia (DRAFT May 6th)

	Activities	Pre field wk 1	Pre field wk 2	Pre field wk 3	Day 1 Field	Day 2 Field	Day 3 Field	Day 4 Field	Day 5 Field	Day 6 Field	Day 7 Field	Day 8 Field	Day 9 Field	Day 10 Field	Day 11	Day 12	Day 13	Day 14	Day 15	Day 16	Day 17	Day 18	Day 19	Day 20	Post field wk 1	Post field wk 2	Post field wk 3	STATUS (select from drop down list)	Person Responsible on TMG team
	Logistics for field work completed (data collection component)			S						F																		Completed; On schedule	Mike, Azeb
	Key informant (stakeholders) interviews are conducted				S																F							Completed; On schedule	Barney, Tom
	Sites in Addis Ababa are visited & data collected						S		F																			Completed; On schedule	Barney, Tom
	Tool revised as needed based on use in Addis Ababa								S		F																	Completed; Behind schedule	Barney, Tom
	travel to sites around Awasa & near Shashemene are visited & data collected										S		F															Completed; On schedule	Barney, Tom
	travel to sites near Bahir Dar are visited & data collected													S		F												Completed; On schedule	Barney, Tom
	Data analysis - Engineering component including comparision of templates (GOE vs CAC) and review guides, procedures																S		F									Completed; On schedule	Barney
	Data analysis - Health service delivery component including comparision of archit. Design before & after for health service enhancments																S		F									Completed; On schedule	Tom
	Data synthesis; all elements at sources																			S	F							Completed; On schedule	Barney, Tom
	report writing and preparation of presentation																		S			F						Completed; On schedule	Barney, Tom
	Telcon with TMG team in DC															?					?							Abandoned	TMG team
	preliminary results presented; feedback solicited from USAID																			S/F								Completed; On schedule	Barney, Tom
	draft report is presented at stakeholder meeting																											Abandoned	Barney, Tom
Post-Field work and head-quarters back-stopping during field work	A3																												
	Headquarters backstopping				S																						F	Completed; On schedule	TMG team DC
	TMG conference call to debrief on results																							S			F	Completed; On schedule	TMG team DC
	Feedback from stakeholder meeting is integrated into report																									S	F	Completed; Behind schedule	Barney, Tom
	report formated, finalized and submitted to USAID																										S	In-Progress; Behind schedule	Rose, TMG team DC

S = Start
F = Finish

APPENDIX 3) TOPICAL OUTLINE FOR THE SMALL GROUP DISCUSSIONS

HCRCP-Ethiopia Topical Outline for Small Group Discussion at H.C. May 2008

I. Preparation:

A. when first arrive on site, when with HC director, ask if we can arrange for a small group session and when this would be most convenient, set it up.

B. while doing the site visit and viewing the renovations (engineering and Health perspective)

- Find or draw a picture of the external general layout/design of this Health Center (H.C.)
- Determine which USG funded agencies support this site and for what purpose.
- Determine if there have been any recent or current construction/renovations.

II. Introduction to the group:

Hello, I am (we are) here to conduct a needs assessment for the USG (United States Government) to help design a new project for Ethiopia 2009-2011. We know that this HC has been recently renovated or is now being renovated. In the new project 2009-2011, other HCs – similar to this one - will be renovated.

We want your input – your ideas – regarding these renovations and if the design and function of this health clinic is meeting your current (and will meet future) health care needs in here and in Ethiopia in general. By design and function, we mean the buildings, rooms in the building of the H.C. where they are located, their size, how they are used and equipped. Where and how do you work in these buildings and rooms? Where do your clients come to get the H.C. services?

- ⇨ Show your diagram of this H.C. direct the group to the different buildings/ blocks including the toilets, incinerator, storage, admin, waiting areas (this orients the group to ALL aspects of the H.C…name only the blocks. Not each room within the block.)
- ⇨ POINT OUT THE RECENT OR CURRENT RENOVATIONS.

We want to know if this design/layout of this H.C. has been improved both externally and internally. This could be something as simple as fixing or adding a sink, or adding a roof over the waiting area. It could be changing the location of the toilets or reorganizing some services. It could even be adding a new building.

Today, we will ask for your ideas as an employee – a service provider – at this H.C. Also, we imagine that you, your family, your friends and neighbors come to this H.C. for prevention and treatment so we'll ask you to think and respond as a client.

Thank you for taking time out of your busy day to talk to us.

III. May we now start by asking you your names and what you do as an employee at this H.C.

- ⇨ List names and their title/position here

1) _____
2) _____
3) _____
4) _____
5) _____
6) _____
7) _____
8) _____

IV. Please describe to us of any changes in the design and function of this H.C. in the past 6-12 month – or any changes which are in-progress. (Let group respond.)
NB: If the group does not spontaneously identify recent or current construction/renovations, prompt them by saying "we see what looks like a new addition, building ….or we see there is construction going on here (point to diagram).

V. [<u>for H.C. where has been – or is currently – construction/renovation ask question IV, if not skip to V</u>]

- ➢ V-A. Were any of you involved in the recent, current changes to the design and function of this H.C. By "involved, we mean "did anyone ask for your input/ideas about what is needed before these changes were started/made? (Let group respond. If anyone says yes, ask them when & how.)
- ➢ V-B. What do (will) these changes mean to you as a provider – an employee performing your duties. For example, does it make your job easier or harder, safer or less safe, more or less efficient, more or less private, etc? (let the group respond)

NOW THINK OF YOUSELVES AS CLIENTS, think of your family, friends and neighbors as they come here for health care. This could be to get vaccinations for your child, get pre-natal care, give birth here, visit the TB clinic, get treatment when someone is "sick", etc.

- ➢ IV-C What do (will) these changes mean to you as a client? For example, does it make you feel more or less comfortable, your waiting time shorter or longer, your privacy better or less, more likely to come here to give birth, etc. (let the group respond)

VI. Shat - or what other - changes to the design and function of this and similar H.C. would you suggest be made and why

Vi-A. as an employee (let the group respond)
Vi-B. as a client (let the group respond)

VII. <u>*(if time permits and not already covered, if already covered, skip to VIII.*).</u>
Now let's look a just a couple of the specific situations/services to make sure we didn't miss anything. What changes do you suggest be made. (Go one by one and let group respond.)

VIi-A. waiting to be seen (before and after registration) - as provider; as client
VIi-B. waste/needle/blood disposal and incinerating - as provider; as client
VIi-C. coming for ART services - as provider; as client
ViI–D. coming for Tuberculosis (TB) services - as provider; as client
VIi-E. coming to give birth - as provider; as client
VIi-F. Other – anything you feel is important - as provider; as client

VIII. are there international organizations working with you to construct/renovate this particular H.C. or to help you improve the quality of your services? if yes, which ones and what do they do. (let the group respond)

IX. Pass around a copy of the maintenance checklist and ask the group if they have ever seen this or anything like it. Translate and read some of it to them…e.g. "daily" and read the 1st two items, then "monthly" and read the 1st 2 items, etc.

IX-A. <u>If anyone has seen this or something like it</u>, ask "do you use this? Do you do these activities on this schedule, etc.?

IX-B. <u>if no one has seen this or anything like it</u>, ask "would a list like this (translated) be of any use to you? To whom specifically? How?

X. Thank everyone for their time.

APPENDIX 4) PHOTOS FROM EVALUATION TEAM SITE VISITS

Schromeda (Addis Ababa). Renovation in progress; very good work thus far and coordination with MSH/RPM+; HC Admin officer excited about renovation, 2nd story being added on which will allow admin/finance to move out of areas which should be and will soon be for service provision. Would have been better to include shelter for clients waiting (none planned); could have had workers cleaning mud and debris off steps as a safety measure. Administrator who signed MOU had not seen CAC maintenance form and did not have copy of the renovation blue print nor HCRCP's master plan on site.	View of 2nd story going up over existing building; this is the only 2nd story addition observed.
Good construction!	Would have benefited from some safety measures – cleaning mud and debris from steps to 2nd floor
Client waiting still a problem; blocking corridors.	A view from the addition of a 2nd story admin/finance.

Koteba, (Addis Ababa). Renovation in progress; very good work thus far! Service provision building where clients were previously waiting will improve/increase services to HIV & AIDS clients. Adding new pit latrines – very welcome to both clients and providers! Would have been better to include shelter for clients waiting; could have had workers cleaning mud and debris off steps as a safety measure. Administrator who signed MOU had not seen CAC maintenance form and did not have copy of the renovation blue print nor HCRCP's	Renovation in progress; very good work; would have benefited from some safety measures & covered client waiting area.

master plan on site.	
This major renovation adds exam rooms where client waiting used to be; very welcome and will increase/improve service provision.	New Pit Latrines – very welcome!
Work in progress	Improved access will be welcome.

Bole 17, (Addis Ababa). Small renovation completed (waiting room/records and added sewage lines which were missing. This complemented MSH/RPM+ and Clinton Foundation work. Worked looked very good Upon arrival found a new building being built that was not on HCRCP master plan that was developed. We were asked to leave because CAC had not informed them in advance of our visit: we could not complete the observations.	CAC renovated waiting room and records room

Sewage added	MSH/RPM+ and Clinton's contribution
New building was done but it is not clear by whom and for what principal purpose; it is not part of HCRCP master plan	Clean incinerator but would be better if fenced in to keep passers-by safe from accidental exposure.

Yergalem. Renovation completed. Done at site where MSH/RPM+ had added storage. New washing sink added but not functional because no drain. Staff did not know of guarantee; did not know to contact CAC for problems. Did not initiate contact with district. They did not have a copy of the renovation blue print nor HCRCP's master plan on site. From SGD information about half of clients state they are happier with cleaner/painted walls, covered waiting and sink; other half stated there was no notable change.	A cover to the client waiting area was added at this site.
Added a covered passageway	New sewage canals; could have been better construction.

A new washing sink (top) was added but is not functional so it can't be used ; The old sink is still being used.	A sky-light of appropriate technology added.
Ceiling construction with poor quality material	
The site staff would have liked that the toilet and shower to be renovated and functional.	New water tank
Still a problem with access to water.	Water was leaking into this room for which the HCRCP project had installed the guttering improperly

12/05/2008		

Shashamene. Renovations completed. Coordinated with MSH/RPM+ and even added ventilation windows in the storehouse. Added covered waiting area outside records room; unfortunately, this is not where clients wait so they still block corridors and are waiting in sun or rain. New divider in delivery room in place for more privacy. Faucets and sinks incorrectly installed with poor fixtures. Water not running at sinks near toilet. Placenta pit open (no cover); damaged ceiling from leaks.	Employees quite happy with renovated records room, though they wished that new shelves had been part of the renovation.
New cover for waiting area would be welcome but clients wait in front of the doctor's offices.	Would have been better to extend roof where clients wait to protect from the sun and rain
Ceiling damage from faulty roof/gutter installation.	New Pit latrines also a welcome to the employees, but sinks don't work.
No running water at faucets installed at latrines (and fixtures not installed correctly) so cannot wash hands.	New privacy wall in maternity gives more privacy.

The placenta pit has no cover	Water not running in the lab due to improperly installed sink and faucets.

Batu. Renovations completed. A sheltered waiting area added; would be more useful if some type of seating was included. Some sinks installed do work but hazardous exposed electrical wires are nearby. Sinks at toilets not functional; installed incorrectly. Flooring added of poor quality and difficult to clean; new toilets but no water supply. Sinks installed incorrectly and of poor quality.	a
Showers and sink installed in maternity but never used because contractor had not turned on water: no one knew there were shut off valves	A
A	a

Comment [U1]: The next series of photos and captions is unintelligible due to formatting problems.

Modjo. Renovation in progress.	water, drain lines not being installed correctly
Improper installation	Improper installation and no water

Shaded waiting area extended.	Site management & maintenance (not HCRCP responsibility); needles lying around on ground.
But at the time, the incinerator was not repaired and not used (staff were told because of USG restriction)	Sink drain not installed correctly.

Adet. Renovation completed but with problems. Staff knew of guarantee at this site.	New covered waiting area.
Outside flooring poorly installed and cracking.	No water at sinks

No water at sinks near new toilets.	Ceilings of poor quality material and construction.

Bahir Dar. Completed but with many problems.	Welcome new renovations to maternity area.
Storage shed built to free up service delivery area.	Did not repair walk after cutting out for water lines.
Placenta pit repair not done well and cracking already.	Sewage system not functional
Doors knobs not installed well	New water tank but not functional/connected

Large pit left open and incomplete for more than six months where septic tank was to go.	Sink not working.
Faucets and sinks not installed correctly	Damage to ceiling where roof repair and gutter not installed correctly.

Poor quality construction material	

Koladiba. Renovation in progress; early work looks good, better than average. MSH/RPM+ building on site as well; HC taking responsibility for site safety by having staff move material out of the way. Extension and renovation of maternity ward will be very welcome.	
Water and drain installed properly	
	Site staff working.

Addis Zemen. Renovation completed but many problems.	
Inside floors are difficult to clean.	Doors hung poorly; don't lock; HC had to bring in someone for alternative mechanism to lock
Water available but fixtures and sinks not installed correctly.	
Windows welcome and installed well	Renovated walls cracking
MSH/RPM+ cut a key water line for their renovation, leaving site without water in places.	This sink not functioning for some time so back up water supply used.

Sink installation at site.	Water not connected to toilet (but it was to shower)

Injibara. Renovation completed but still some problems.	
New toilets are welcome.	No water to sinks and installed incorrectly.

Nice sewage. 	Nice roof construction but the downspout was put right through the center without flashing so water drips through.
Installed new water tank and stand which is nice. Project put a smaller water tank. 	

APPENDIX 5) LIST OF PEOPLE MET AND INTERVIEWED

EVALUATION TEAM MEETINGS			
DATE	LOCATION	ATTENDEE	TITLE
5/6/2008	USAID	Marie-Claire Sow	CO
		Michael Rossman	CO
	MOH/Addis	Sampson	D/Chief PPD
5/7/2008	USAID	Omer Ahmed Omer	D/Team Leader/HIV
		Xerses Sidhwa	
		Sam Clark	HAPN/BES
		Marie-Claire Sow	CO
		Meri Sinnitt	Health Office Chief
		Cynthia Shartzer	CO
		Kassahun Deneke	SIA/Health Team
5/8/2008	CROWN AGENTS	Paul Wolstenholme	ENGINGEER
		Sallehunae Merahi	ARCHITECT
		Zelalem Tiwneh	ENGINEER
		Efrem Tiruneh	ENGINEER
		Noel McIntosh	Chief of Party
	MOH/PPD	Rik Nagelkerke	PPD
		Alemayehu Shewarega	PPD
5/9/2008	USAID	Sam Clark	HAPN/BES
		Melissa Jones	HIV Team Leader
		Kibru Mamusha	PRM
		Muluken Chanie	PRM
	GTZ/IS Log. Office	Scott Saarlas	GTZ/ARCH
5/10/2008	Hotel	Rob	HSDPIII/ENG
5/12/2008	Awasa RHB	Ato Gizachew Kebede	D/Dir. RHB
		Ato Dereje	PPD Head
	Yirgalem HC	Sr. Abebech Yacob	Health Center chief
		Tadesse (nurse)	EPI Coordinator
		Hibist	MOH Coordinator
		Endrias Lemma	Security guard
		Beyenech Ayele	Janitor
		Yoseph	ART
		Fantaye Teshome	Finance and Admin.
		Mintwab	Sanitation
5/13/2008	Shashamene HC	Ato Tadesse Jubira	Nurse
	Batu HC	Mame Tura	HC Director

EVALUATION TEAM MEETINGS			
DATE	LOCATION	ATTENDEE	TITLE
	Mojo HC	Ato Amare	HC Director
		Sr. Arefa Adem	Nurse
		Sr. Senait Tasew	Nurse
5/14/2008	Bahir Dar RHB	Dr. Asrat Genet	Dir. RHB
	Bahir Dar HC	Ato Mengistu Kebede	HC Director
	Adet HC	Ato Melkamu	HC Director
		Asmamaw Adamu	Pharmacist
		Dires	Finance and Admin
		Abiyot Birhane	Laboratory
5/15/2008	Kola Diba	Ato Habtamu	HC Director
	Addis Zemen	Ato Ademe Asrat Alemu	HC Director
		Ato Muluye Zeleke	Druggist
5/16/2008	Dangela HC	Ato Hussein	HC Director
		Sr. Yeshi Kassa Wubishet	Nurse
	Durbete	None	
	Injabara	Ato Aragaw	Head Nurse
		Sr. Selam	Nurse
5/21/2008	USAID	Omer Ahmed Omer	D/Team Leader/HIV
		Sam Clark	HAPN/BES
		Marie-Claire Sow	CO
		Meri Sinnitt	Health Office Chief
		Cynthia Shartzer	CO
		Kassahun Deneke	SIA/Health Team
5/23/2008	USAID/CAC	Sam Clark	HAPN/BES
		Marie-Claire Sow	CO
		Cynthia Shartzer	CO
		Paul Wolstenholme	ENGINEER
		Sallehunae Merahi	ARCHITECT
		Zelalem Tiwneh	ENGINEER
		Efrem Tiruneh	ENGINEER
		Noel McIntosh	Chief of Party

APPENDIX 6) DESCRIPTION OF FIELD GUIDE ASSESSMENT DOCUMENT

Stage One – Arrive at the Health Center
Upon arrival, introduce yourself (and the team members) to the HC in-charge and the woreda health officer. This should also include meeting available professional staff – nurses, midwife (and doctor if it is a large HC). As part of the introductions, explain the purpose of the visit, how the HC was selected and expected results of the assessment.

During the discussion, collect basic HC data (e.g., age of buildings, population served and range of healthcare services currently being provided and planned). Record this data on the **Health Center Assessment and Renovation Works Summary Report** form. Also, ask about any problems or issues the HC staff consider important and note this on the **Health Center Data Collection** form (**A.2**). Once this task is completed, request the HC in-charge, or her/his designated representative, and the woreda health officer to accompany the assessment team on an initial (preliminary) walkthrough of the HC compound.

Stage Two – Do Initial Walkthrough
The objectives of this walkthrough are two fold:

1. To allow the HC in-charge (or designated representative) to show the assessment team the major problem areas and to discuss other issues

2. For the team to learn what each building is used for and the location of all departments or units at the HC (e.g., administration, registration and waiting areas, and outpatient department as well as other rooms/areas such as labor and delivery or antenatal care, the pharmacy[s] and special stores)

During this initial walkthrough, make a quick sketch detailing the layout of buildings and the activity/function of each room (e.g., labor room, sluice room or laundry area). It is important to gain access to each and every room, especially those identified as stores, which invariably are locked.

Specific tasks that should be undertaken during this initial walkthrough include:

- Take photographs of those rooms that have been unlocked during the tour (or may be locked immediately after the HC-in charge has left the room) because access may not be available later on. (Preferably use a digital camera with a wide-angle lens to document the findings.)
- Identify those areas/rooms/buildings that require attention/renovation or where there is significant deviation from the current FMOH HC standards
- Observe and record the relationship between HC staff and patients as well as the general treatment of patients (e.g., friendly and helpful) offered by the HC staff on the **Health Center Data Collection** form**)**.

Stage Three – Conduct Detailed Walkthrough and Take Measurements
On completion of the initial walkthrough, a second more detailed walkthrough is required. Generally, only the assessment team members, accompanied by the RHB engineer, if available, are involved in this walkthrough. The objectives of this second walkthrough are to:

- Upgrade the initial sketch(es) of the HC compound noting the location of all buildings, walk ways, access road(s) and out buildings (e.g., dry pit latrine), water storage tank, septic tank and placenta pit;
- take relevant measurements (dimensions) of all buildings;
- identify physical (structural) problems or damages, including those buildings damaged beyond repair (e.g., burned out or old, mud-walled buildings) that should be destroyed;
- locate water pipelines, the waste water disposal network and sanitary systems (toilets, dry-pit latrines, septic tank[s] and placenta pit) and fire box;
- determine potential areas within the HC compound for future expansion (e.g., site for dedicated general stores); and
- check patient, healthy client and staff flow patterns relative to various HC functional areas (i.e., registration, cashier, waiting area[s], preventive and clinical services, pharmacy, dispensary and administration).

During this walkthrough:

- Take additional photographs of damages, problem areas and areas where alterations are needed. (Be sure to include general shots [15-20] of the HC compound, including access to the HC and any space available for future expansion.) At all HCs, take specific photographs of the labor room, delivery room(s), and sluice and clean rooms (if present).
- Using the **Damages Assessment Checklist**, identify the appropriate repair method for the observed damages and record the damages on the **Damages Assessment Report** sheet and **Damages Assessment Take-Off sheets**. Cross-reference the room title on the floor plan layout sketch with the damage checklist according to the following sequence:
  a) Ancillary facilities and external works, including manholes and pavement around the buildings
  b) External walls, roof and overhanging parts, with particular attention to any structural damage to foundations, ground beams, columns, tie beams and load bearing walls
  c) Windows, noting on the back of the checklist their size and type
  d) Doors, noting on the back of the checklist their size and type
  e) Fixtures and built-in cabinets or cupboards, noting on the back of the checklist their size and type
  f) Location of central water supply to HC (e.g., ground and elevated water tank)
  g) Location of sanitary fixtures (e.g., sinks and drains, toilets and utility drains, and septic tank[s])
  h) Location and type of electrical fixtures
  i) Walls, floors and ceilings finishings
- Take additional notes detailing such items as the condition of the access road, any access restrictions for construction deliveries or heavy trucks, and any space or site conditions that could limit potential expansion. (Attach another sheet if all the space is taken up by notes on doors, windows and other items.)

- Take two water samples from an outlet closest to the point of entry to the HC or from the storage tank (reservoir); one sample will be used to identify possible bacterial contamination (48 hour test) and the second to measure lead levels (10 minute test).

Finally, throughout this walkthrough observe patient, healthy client and staff flow patterns to identify crowded and high traffic areas. As part of this process, note distances between registration and waiting areas, OPD, examination and treatment rooms, cashier and pharmacy. Where possible estimate the number of patients waiting at each area in order to identify actual/potential bottle-necks. Of particular importance, observe where HIV/AIDS and TB patients are examined and treated (e.g., near the entrance to HC or buried within HC compound).

Then, based on these observations and the data collected produce the following:

- A detailed set of sketches ("as built" drawings) of the entire the HC compound (external buildings and inter-building dimensions) based on the preliminary sketches made during the walkthroughs. This drawing should include the perimeter boundary, land levels and any natural factors that potentially could affect renovation recommendations. The sketch of each building should include the major dimensions and locate fixtures, such as sinks or built-in cabinets, desks or other fittings, and electrical outlets on the appropriate schematic sketch sections. Label the rooms (including verandas and corridors) and designate all windows and doors separately.
- A floor plan layout sketch with at least one elevation for each building. The drawn floor plans, sections and elevations should be sufficiently detailed to define the floor finishing, areas of damage and elevations.
-

Stage Four – Review Data Collected for Completeness

Prior to departing the HC, it is essential that the assessment team leader:

- spends time discussing the findings and observations with the other team members;
- conducts a through review of all data collected on the various forms, checklists and work sheets;
- goes over the sketches and reviews all measurements for completeness;
- scans the digital photographs to ensure that an accurate and complete representation of the HC "as built" has been obtained;
- is satisfied the major damages and problems have been identified;
- develops and/or reviews the preliminary set of recommendations with the team members; and
- has a clear picture of what is needed to improve the function of the HC based on revised clinical (patient, healthy client and staff) flow patterns as well as recommended hygiene practices and environmental health control measures.

Stage Five – Debrief and Depart the Health Center

Before exiting the HC, the assessment team should meet with the HC in-charge, or designated representative, and woreda health officer (if available). The purpose of the debriefing is to summarize the key findings (problems and deficiencies) and suggest any immediate actions that

could be implemented to improve patient flow and patient/staff safety (e.g., open windows and doors and/or re-arrange furnishings to improve cross ventilation). (See **A.6, Environmental Health Control Guidelines for TB,** for details.**)** In addition, the team leader should briefly discuss those repairs or renovations that will most likely be in the final set of recommendations (e.g., leaking roof over OPD rooms or no water to examination or treatment rooms.) In addition, it should be explained to, and accepted by, the HC in-charge that re-allocation of space use (e.g., changing the location of services within the HC compound to improve patient and staff safety) will be a major consideration in the final set of recommendations.

As part of the exit debriefing, the team leader also should review the content of a sample memorandum of understanding (MOU) with the HC in-charge and woreda health officer (if available) putting special emphasis on the potential availability of:

- matching funds from the RHB or woreda health office, and/or
- in-kind contributions by the HC (e.g., provide new benches, desks or shelving and/or labor for moving furniture).

As a final discussion topic, the **Health Center Maintenance Management Checklist** should be reviewed. Gaining acceptance of the need to implement the simple maintenance activities in this checklist is most important. Without benefit of routine maintenance, improvements to the water supply, waste water disposal, sanitation and electrical systems will be lost in a short time (sinks are again plugged and latrines overflowing).

Stage Six – Consolidate Data and Write Reports

As clearly indicated from the above the contractor has prepared required documents to undertake the assessments which can be utilized in the future. The reports, forms, checklists, and template formats developed to assist the HC assessment team collect and record data in a systematic way, simplify the data collection process and provide consistency in data collection are listed herewith.

A.1 Health Center Assessment and Renovation Works Summary Report Form
A.2 Health Center Data Collection Form
A.3 Damages Assessment Checklist
A.4 Damages Assessment Sheets
A.5 Damages Take-Off Sheets
A.6 Environmental Health Control Guidelines for TB
A.7 Sample Health Center Memorandum of Understanding (MOU)
A.8 Health Center Maintenance Management Checklist
A.9 Drug Destruction Certificate
A.10 Sample Health Center Assessment Site Visit Report

APPENDIX 7) LEVELS OF RENOVATIONS WITH RESPECT TO HEALTH CARE

For the purposes of this evaluation, one must understand how the HCRCP differs from other types of renovation. In addition to the health-care component, it is renovation and therefore different than new construction which can be done at fixed cost within several variations. This is necessary because the language of the HCRCP drew the link between the HC renovations and improving the quality of the health care delivered at the site. Though the HCRCP did not adopt performance indicators to measure this, the SOW for evaluation asked to assess this. Thus, we have identified three levels of HC renovation - with respect to health care delivery - in which to assess the contribution of the HCRCP. The lower levels are subsets of (and therefore included within) each subsequent higher level).

Level 1: From the health care perspective, the most basic renovation would be to restore a given site to its' original design and functionality. That is, there is no change in the design; water and sinks where placed should work as originally designed, roofs repairs, walls repaired, toilets repaired.

Level 2: includes all of level 1 but adds to this "reorganization" of the health care delivery within the limits of the existing architectural layout of the buildings. Thus, switching the services in one location to another location so that patient flow, privacy, infection prevention and management is improved. This is particularly important because PEPFAR is one of the primary vehicles (with national governments, WB/MAP and GFATM) for adding ARV and TB services where they have not previously existed through either mainstreaming or integration.

Level 3: includes level 2 but adds "modifications" to the equation. Modifications can included changing/adding walls, doors, expanding building capacity (building up or out on an existing structure), covering waiting areas, increasing water availability (volume and location), etc.

Although there are no performance indicators for this project other than (a) assess 100 HCs and (b) renovate 50 sites, it is clear from the contract that level three assessments and renovations are expected. In the contract, the first 2 of 17 bullets under the heading [C.4. Illustrative List of Renovations] are:

- Add or demolish wall partitions whenever necessary to ensure proper functions and facilitate patient flow. Install a patient reception counter at the central location of each clinic to facilitate patient flow.
- Covering areas between multiple structures to improve client comfort and client flow to create continuous space for patient counseling rooms, waiting areas, administrative offices or secure storage

APPENDIX 8) SUMMARY OF KEY PROJECT ACTIVITIES WITH STATUS NOTES

Activity description	Expected as per 1=PMP; 2=contract, 3= work plan	Unexpected	Status
PROJECT MANAGEMENT ACTIVITIES			
PMP approved	1,2,3	No	Completed (and approved although it is insufficient)
Existence of a project strategy	1,2,3	No	Completed (and approved)
Work plan approved	1,2,3	No	Completed (and approved for PY1; not for PY2)
Semi-annual progress reports	1,2,3	No	Completed
Quarterly reports with budgetary and expenditure information	1,2,3	No	Unknown
Direct renovation 50 HC (20+30)	1,2,3	No	In-progress
T.A. to 100 HC assessments including other PVO and donors	2,3	No	In-progress
RESULT 1 (COORDINATION MECHANISM) ACTIVITIES			
Establish a coordination, planning and synchronization "hub"	1,2,3	No	Details provided below
Set up and preside over a coordination committee; a tender committee	1,2	No	Replaced by Coordination "Plan"
Develop a consensus HC renovation harmonization and coordination plan	3	No	Unknown – assumed in progress
HC mapping/tracking system (a common and simple HC tracking system that can be adapted for other uses (e.g., tracking progress in the conversion of health stations to HCs)	1,3-PMP	No	In-progress
Conduct national coordination meeting PY1	3	No	Completed
Conduct a survey in preparation of the donor coordination meeting	3	No	Completed
Conduct (5 regional) workshops	2,3	No	Not started
RESULT 2 (TECHNCIAL ASSISTANCE) ACTIVITIES			
Engage 1 or more A&E firms to assist with general design	1,3	No	Completed
Identify T.A. requirements to FMOH/PPD and RHBs and agree on TA program	3	No	In-progress
Mentor RHB technical staff making engineering and supervision visits to HCs (part of T.A.)	3	No	In-progress
Other T.A. to FMOH/PPD, other agencies, RHB, Woreda level, HC personnel	2,3	No	In-progress
RESULT 3 (RENOVATION OF HEALTH CENTERS) ACTIVITIES			
Revised Guideline for FGOE HC standards	3	No	In-progress

Activity description	Expected as per 1=PMP; 2=contract, 3= work plan	Unexpected	Status
Inventory of engineering assets	3	No	Unknown
Procurement and contract management processes document	3	No	(see below)
Guidelines[2] for HC renovation and expansion	1,3	No	In-progress
Health center assessment handbook (field guide)	1,3	No	In-progress
Road map (to support development of standardized approach)	1,2	No	Unknown
Skills transfer to local sub-contractors through mechanisms such as on-the-job training	1	No	Not started
Project safety officer; regular safety promotion meetings	1	No	Not started
A common approach to HC renovation being used by the RHBs	3-PMP	No	In-progress;
An A&E firm with at least 10 engineers experienced in use of the approved engineering assessment guidelines and other HC renovation materials; and	3-PMP	No	In-progress (will not be completed)

[2] The guidelines for renovation and expansion includes all of the following elements, each of which was developed or adapted for this project:

Contracts and Contractual Tools

Pre-qualification documents for works contractor selection (adapted from FGOE standard)
Tender document for contracting with A&E firm (adapted from FGOE standard) Tender document for construction works (adapted from FGOE standard)
Tender document for construction works (adapted from USAID)
Sample contract agreement (adapted from FGOE standard)
Master bill of quantities (BoQ) document
Normal BoQ document
Memorandum of Understanding for Regional Health Bureaus
Memorandum of Understanding for Health Centers and Woreda Health Offices

Checklists and Forms

Health Center Maintenance Management Checklist (self-administered)
Damage Assessment Checklist
Reporting Forms

- Progress (Supervision) Report
- Health Center Assessment Site Visit Report

Construction Works Certificates and Forms

Health Center Data Collection Form
Health Center Site Handover Form
Damage Assessment Checklist
Damage Take-off Sheet Form
Initial Payment Certificate
Final Payment Certificate
Provisional Acceptance Certificate
Final Acceptance Certificate

Activity description	Expected as per 1=PMP; 2=contract, 3= work plan	Unexpected	Status
Approximately 10 private-sector construction companies located throughout the country with experience conducting HC renovation works consistent with the approved guidelines.	3-PMP	No	In-progress
ADDITIONAL ACTIVITIES REQUESTED			
Review and comments on Standards of Care for Health Centers	1,2,3 - at request of Dr. Kessetebirhan	No	Completed
Brief report; Health center space requirements for 2008		Yes, At request of USAID CTO	Completed
Primary HC assessment findings from 3 regions		Yes, At request of USAID CTO	Completed
Mapping and Capacity Building Report	Not applicable because it is a proposal to USAID for additional funding		
Report on Storage Capacity Assessment for Ethiopian MOH Facilities	1,2,3	No	Draft
Brief update report: Seconding STTA consultants to FMOH/PPD and RHB		Yes, At request of USAID CTO	Completed
Reviewed the design being used to convert 262 health stations (HSs) to "nucleus" HCs in Oromia region,.	1,2,3 At the request of the Oromia RHB/PPD,	No	Completed
Developed master plans for leveraging additional resources to renovate three HCs – Shromeda (Gullele) and Arada (July 2007).	1,2,3 Addis Ababa City Administration and the respective Sub-Cities	No	Completed
Developed a master plan for pharmaceutical stores at HCs.	1,2,3 (In collaboration with MOH/IST and RPM+)	No	Completed
Develop ToR and job descriptions & contracts for the (seconded) STTA (8 total)		Yes, At request of FMOH/PPD & RHB.	Completed
Review resumes and jointly interview candidates for STTA (8 total)		Yes, At request of FMOH/PPD & RHB.	Completed
Two-day orientation workshop for STTA before posting. (8 total)	If done, will be part of expected TA	No	Completed (as per USAID)

APPENDIX 9) TABLE OF KEY PROJECT ACTIVITIES WITH STATUS AND NOTES

Description of Key Project Activities	Status	Status Explanation and Notes
PMP approved	Completed (and approved though insufficient)	Even though there are only 2 performance indicators (# sites assessed and # sites renovated), there are no operational definitions for these. On this alone, the PMP should not have been approved (but it was). Furthermore, the contract states "The Contractor will utilize standard PEPFAR indicators and propose additional indicators for assessing performance of activities accomplished". CAC did this by reporting "summary of TA activities" as done in their PY1 annual progress report. This indicator should have been operationally defined either in the PMP and/or report but it was not done. The evaluation revealed that no standard definition was applied rendering these data (# of TA activities) incomparable and not able to be interpreted.
Existing strategy	Completed (and approved)	The existing strategy presented with the PY1 work plan does present elements of a strategy and it is as good as could be expected since it was presented within the first 60 days of the contract start date. USAID should have asked for a revised, full strategy at start of PY2.
Work plan approved	Completed (and approved for PY1; not for PY2)	Work plan outline with description was presented to the team though it is indicated that an MS project work plan was regularly provided to USAID by CAC with all the detail needed to monitor HCRCP progress: the evaluation team did not see these. More importantly, CAC submitted the PY1 work plan on time but it went through 3 more revisions with the final being submitted 9 months after HCRCP began (June07) and USAID approving this at the end of PY1 Sept 2007 (Sept07).
Semi-annual progress reports	Completed	CAC went beyond their requirement in reporting on their progress. Not only did they include extra analysis, tables and explanations in their reporting, but they submitted interim reports all of which are highly commendable. However, the reliability of the data in the reports is not satisfactory for some of key reporting elements (see below); furthermore there is discordance between certain reports making it difficult to track true progress.
Quarterly reports with budgetary and expenditure information	Unknown	Not provided to evaluation team; probably because it contained predominantly budget and expenditure information. This was not critical to the evaluation, though it does make it difficult for the team to attribute weights to the expected outcomes and deliverables especially for Result One. For example, if only 3% of the total budget for Result One was allocated for the "mapping and tracking" system, the product would be assessed differently than if 50% of the budget were attributed to it.

Direct renovation of 50 HC (20+30)	In-progress	Recently reduced from 50 to 45 health centers due to inflation increasing the cost of material and transport. Yet the report (September 29, 2006 to March 31, 2008) states that 45 HCs located in the four regions and Addis Ababa have been renovated with the remaining 5 to be renovated by/before July 2008 (50 total). We visited sites that were not completed and for the same time period, the combination progress reports covering Q1-Q4 PY1 + Q1-Q2 PY2 states that (0+23) only 23 have been completed. There a discordance in results reported and observed.
TA to 100 HC assessments including other PVOs and donors	In-progress	Project Activities Report (September 29, 2006 to March 31, 2008) has an annex (table) stating 100 "completed as of March 31st; but the executive summary states that 81 were completed. Combining tables on page 9+11 and other reports show 81. This makes the reporting data unreliable.
Establish a coordination, planning and synchronization "hub"	See elements below	It is only indicated on the 1st page of #3 as part of introduction, but is not found further in the document nor in the outline of the work plan. From the documents, the 3 key components of the "hub" were 1) steering/coordination committee(s), 2) mapping/tracking system and 3) meetings and workshops.
Set up and preside over a coordination committee; a tender committee	n/a (replaced with below)	Sometimes referred to as a "steering committee", replaced with developing a coordination plan.
Develop a consensus HC renovation harmonization and coordination plan	Unknown – assumed in progress	Described as a "harmonization consensus" document. See above consensus HC renovation harmonization and coordination plan (below)
HC mapping/ tracking system (a common and simple HC tracking system that can be adapted for other uses (e.g., tracking progress in the conversion of health stations to HCs);	In-progress	Also the Progress Report of October 1, 2008, were to have completed in PY1. Sometimes this was called a renovation tracking system and/or a leveraging system which was confusing because it leads the reader to believe they are different products.
Conduct national coordination meeting PY1	Completed	The evaluation team has not seen the report of this meeting
Conduct a survey in preparation of the donor coordination meeting	Completed	Analyze and present results. See "Leveraging Donor Resources for HC renovation in PEPFAR priority regions" (could have been more appropriately titled "Results of survey; GOE, Donors, Implementers interest in establishing a HCR coordination and resource leveraging hub")

Conduct 5 regional workshops	Not started	For Result Two, TA ("at least 1 in the contract", committed to 5 in work plan. Was to orient groups to guidelines and show how to use the tracking system. Review work plan and progress for PY2 when available.
Engage 1 or more A&E firms to assist with general design	Completed	There is a need to train the firm(s) in their approach to assessment. This was done for one A&E firm.
Identify TA requirements to FMOH/PPD and RHBs and agree on TA program	In-progress	T.A. was finally provided with the extra money available to CAC in Dec. 07 due to a revised (reduced) indirect cost-recovery (NICRA) rate. With this money, STTAs were hired and placed with the RHB and FMOH/PPD. This was later changed and some of these STTAs where retained at the FMOH level.
Mentor RHB technical staff making engineering and supervision visits to HCs (part of T.A.)	In-progress	This is an implied output indicator. The number of RHB staff mentored during assessments and supervision visits (distinguish). CAC identified in early reports that their visits to the RHB, Zonal and Woreda found HR scarce and overloaded with work such that they would not be able to be counterparts for mentoring on any regular and significant basis) This should have been abandoned and replaced (reallocate the budgeted resources). For example, develop and promote other types of short term training.
Other TA to FMOH/PPD, other agencies, RHB, Woreda level, HC personnel	In-progress	This is presented in the reports in summary tables as # of TA/activities by quarter; because there is no operational definition for TA nor of a "T.A. activity". These tables are unreliable. For example, in PY1 year report, there were 74 reported "T.A. activities which were follow-up to the survey for coordination purposes – not TA.
Revised Guideline for FGOE HC standards	In-progress	In work plan indicated under "preparing, testing and vetting "standardized documents and procedures (Result Two)"
Inventory of engineering assets	Unknown	To develop recommendations on engineering assets and present to the coordination meeting
Procurement and contract management processes document	(see below)	In work plan indicated under preparing testing and vetting "standardized documents and procedures (Result Two)".
Guidelines[3] for HC renovation and expansion	In-progress	Indicated as tools and procedures for standardization in the proposal. Tools and procedures for standardization of pre-design, design, renovation, and post-renovation stages including service-delivery concepts and materials utilization by stakeholders and maintenance. As of May 20, 2007, needs only final editing and submission to FMOH/PPD; great quality.

[3] The guidelines for renovation and expansion includes all of the following elements, each of which was developed or adapted for this project:

Contracts and Contractual Tools

- Pre-qualification documents for works contractor selection (adapted from FGOE standard)
- Tender document for contracting with A&E firm (adapted from FGOE standard)
- Tender document for construction works (adapted from FGOE standard)
- Tender document for construction works (adapted from USAID)
- Sample contract agreement (adapted from FGOE standard)

Health center assessment handbook (field guide)		Indicated as tools and procedures for standardization in the proposal. Detailed planning of individual projects selected for improvement, emphasizing sanitation and infection-control systems, including availability and proper function of sinks and toilets, hot water in clinical service areas, and function of maternal and child health, OPD and chronic-care service areas, and the reception and waiting area. As of 20May07, needs only final editing and submission to FMOH/PPD; great quality.
Road map (to support development of standardized approach)	Unknown	In contract, this is related to regional TA workshops. The team did not see anything called a "road map".
Skills transfer to local sub-contractors through mechanisms such as on-the-job training	Not-started	Have not found evidence that A&E (or CAC) has worked with the local subcontractors through OJT to improve their skills.
Project safety officer; regular safety promotion meetings	Not-started	Found no evidence of this.
A common approach to HC renovation being used by the RHBs	In-progress	Not adopted/used by the RHBs although CAC did document very early that there is a lack interest in this regard, because GOE now focused on massive scale up of new HCs.

Master bill of quantities (BoQ) document
Normal BoQ document
Memorandum of Understanding for Regional Health Bureaus
Memorandum of Understanding for Health Centers and Woreda Health Offices

Checklists and Forms
Health Center Maintenance Management Checklist (self-administered)
Damage Assessment Checklist
Reporting Forms
- Progress (Supervision) Report
- Health Center Assessment Site Visit Report

Construction Works Certificates and Forms
Health Center Data Collection Form
Health Center Site Handover Form
Damage Assessment Checklist
Damage Take-off sheet form
Initial Payment Certificate
Final Payment Certificate
Provisional Acceptance Certificate
Final Acceptance Certificate

An A&E firm with at least 10 engineers experienced in use of the approved engineering assessment guidelines and other HC renovation materials; and	In-progress (will not be completed)	There are only 3-4 engineers trained and experienced from one A&E firm, and they are not permanent employees of the A&E. At this stage, there is still a possibility of training additional people but CAC has not planned/budgeted for this.
Approximately 10 private-sector construction companies located throughout the country with experience conducting HC renovation works consistent with the approved guidelines.	In-progress	By end of the project, will be reached.
Review and comments on Standards of Care for Health Centers	Completed	Listed by CAC as an unexpected activity but clearly this is the type of TA that is expected of them as per all documents.
Brief report; Health center space requirements for 2008	Completed	CAC lists this as an "unexpected deliverable" because it states that the USAID/CTO requested it.
Primary HC assessment findings from 3 regions	Completed	Interim report; information was also presented in the semi-annual reports. It documents that they need an average of $39K per HC for minimum renovations using GOE HC Standards of Care as basis for this and material cost and renovation data available from CAC's site engineer prior work with Intrahealth.
Mapping and Capacity Building Report	n/a	This is a proposal for an additional $1.5M to add GIS mapping to the expected HC Renovation Mapping/tracking system.
Report on Storage Capacity Assessment for Ethiopian MOH Facilities	Draft	Not sure if this can be counted as it was done for JSI/Deliver: CAC is a sub-contractor to JSI/Deliver. USAID should verify funding source as they should do with all the reported "products and services" (in light of the fact that the team identified 3 instances when CAC reported to the evaluation team a product of HCRCP that we verified was paid for out of another project's money).

Brief update report: Seconding STTA consultants to FMOH/PPD and RHB	Completed	Vital given this was not in the PY1 work plan/contract, although it could be included in PY2 work plan. It should have another update because the STTA are now primarily supporting the PMU at FMOH/PPD.
Response to Services and Deliverables Issues posed by Evaluation Team		In section 2&3: Direct & Indirect TA to 100 HC including PVOs and donors, there are 12 agencies/projects listed as having received TA from CAC under HCRCP. But we found that several of these TA assignments were paid for by other projects and cannot be reported; others can.
Reviewed the design being used to convert 262 health stations (HSs) to "nucleus" HCs in Oromia region	Completed	This might be an expected deliverable but USAID must verify that CAC was not paid from another project for this activity.
Developed master plans for leveraging additional resources to renovate three HCs – Shromeda, Gullele and Arada (July 2007)	Completed	This might be an expected deliverable but it USAID should verify that CAC was not paid from other project for this activity. USAID discussed that the Department of Defense is expected to renovate this and two other sites in Addis assessed by Crown. When this happens, CAC will have leveraged $660,000.
Developed a master plan for pharmaceutical stores at HCs	Completed	This design was to be piloted at Mojo HC in the Oromia Regional State and Nefasilk No 2 HC in Addis Ababa USAID should verify funding source as they should do with all the reported "products and services".
Develop ToR and job descriptions & contracts for the (seconded) STTA (8 total)	Completed	See report Seconding STTA Consultants to FMOH/PPD and RHB Report: Brief Update January 28, 2008
Review resumes and jointly interview candidates for STTA (8 total)	Completed	See report Seconding STTA Consultants to FMOH/PPD and RHB Report: Brief Update January 28, 2008
Two-day orientation workshop for STTA before posting. (8 total)	Completed	Reported as planned in the Seconding STTA Consultants to FMOH/PPD and RHB Report: Brief Update January 28, 2008; the report that this was completed was provided by USAID; we have no documentation of this.

APPENDIX 10) SUMMARY OF THE RESULTS FROM SITE VISITS

(n=13) via observations, interviews and, in some cases, small group discussions

results from site visits to 13 HCs

Construction Safety at site?	No: Practical safety precautions were not taken at renovation sites.
Inside cleanliness of HCs visited	Overall was very good.
Outside Site cleanliness at HCs visited	Overall very good, excluding areas near the incinerator at which some sites had needles lying nearby (see pictures). Note: this was observed as part of helping USAID identify intervention areas for the follow-on project, not as a measure of CAC performance under the current project as it is not part of their contract to intervene in this area).
# sites in-progress & completed	3 of the 13 sites visited by the evaluation team were in progress (under construction).
# times HC director was present during site visit	8
# time other providers were interviewed during site visit	8
Number of sites evaluated	13
# HC which contacted Woreda, RHB, about problems with renovations when exist	In north, it was very common for the HC to contact the Woreda (for problems); in the south, none contacted the Woreda even if problems with CAC and/or contractors occurred. For Addis (pre-test) we didn't assess this.
# HC which contacted CAC about problems when exist	Northern sites contacted CAC, Southern sites didn't know they could contact CAC. We don't know in Addis; didn't ask during pretest: the sites were under construction.
# HC that contacted the contractor about problems when exist	Most of the sites which had problems said they had tried to contact the contractor; there was no difference between the sites in the north and south (We don't know in Addis which were pre-test sites).
# HCs which knew of the one year guarantee on renovations	Most knew of the one year guarantee but some HCs which had problems and did not know of this said that they would have reported the problems had they known of it (Addis sites are unknown).
# HC where person who signed MOU present during interview	About one-half.
# HC where anyone interviewed was present when the HC assessment was done	At all sites, there was someone present during our interview who was also present during the time when the HC assessment was done, though in a few of these cases, that person was not part of the decision making and could not tell us any details about the assessment or renovations.
The renovation has helped service providers deliver better quality services	Because most of the HCs reported as being "completed" had problems, they indicated that the renovations had NOT helped them provide better services But, If the problems are fixed, they felt it would help improve the quality of their services. For 2 HCs visited which had little or no problems, they said it has helped deliver better services, especially changes to delivery room and water supply. NB: Most indicated more things could have been done, such as roofs over waiting area, benches, shelves, showers, living quarters for staff, etc. (This latter point is not used to evaluate CAC. It is there to give USAID ideas regarding the follow-on project.)

Renovations help clients; comfort & privacy	Same as above.
Were problems with the renovations identified?	In all sites reported as completed, there was at least one problem of quality. In most sites there were multiple problems, some very serious. At most of the completed sites reported as complete, some or all of the water and sanitation system was not working (see photos).
HC service providers have seen the CAC maintenance form distributed with CAC-HC MOU	Providers had not seen the form at sites visited.
The HC was left with a copy of the renovation blue print	HC renovation blueprints were not left at sites visited.
HC had a copy of assessment?	A copy of the assessment was not left at sites visited.
Other organizations were working with the HC?	Yes, most frequent is MSH/RPM+ but also, in a minority of sites visited, MSF, Intrahealth, etc.
HC provider attitude about the HCRCP renovation.	For sites visited which were yet to be completed (still in progress), they were all very pleased, Those sites visited which were reported as completed varied from indifferent to very displeased.