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USAID/WEST BANK & GAZA: HEALTH SECTOR REFORM AND DEVELOPMENT FLAGSHIP PROJECT

MID-TERM EVALUATION

DECEMBER 2010

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CONTENTS

ANNEXES

ACRONYMS

ANERA	American Near East Refugee Aid
BCC	Behavior change communication
CBO	Community-based organization
CHCE	Continuing health care education
COGAT	Coordinator of Government Activities in the Territories
COP	Chief of Party
COTR	Contract Officer's Technical Representative
D/COP	Deputy Chief of Party
EBDM	Evidence-based decision-making
EWAS	Emergency Water and Sanitation Project
FCSP	Financial Capacity Strengthening Program
HHA	Health and humanitarian assistance
HIS	Health information system
IDP	Institutional development plan
IDaRA	Institutional Development and Reform Associates
EMAP	Emergency medical assistance program
JICA	Japan International Cooperation Agency
KAP	Knowledge, attitudes, and practices
LDP	Leadership Development Program
M&E	Monitoring and evaluation
MCH	Maternal and child health
MOH	Ministry of Health
NGO	Nongovernmental organization
PA	Palestinian Authority
PACE	Palestinian Authority Capacity Enhancement Project
PHC	Primary health care
PMC	Palestine Medical Complex
PMP	Performance monitoring plan
RFP	Request for Proposal
STTA	Short-term Technical Assistance
TOT	Training of Trainers
QA	Quality assurance
QI	Quality improvement
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNRWA	United Nations Relief and Works Agency
USAID	United States Agency for International Development
WHO	World Health Organization

EXECUTIVE SUMMARY

This report contains the findings and recommendations of the Midterm Evaluation of the Palestinian Health Sector Reform and Development Project (Flagship Project), which began in October 2008. The evaluation team traveled extensively in the West Bank, interviewed dozens of stakeholders at all levels in the health system, and viewed activities at sites in four districts before reaching conclusions about the progress and direction of the program.

The picture of progress and challenges is a mixed one. Impressive accomplishments are already evident in some areas of the Flagship Project's support to the Palestinian Authority (PA) Ministry of Health (MOH) and the nongovernmental organizations (NGOs). These include, for example, the program of activities implemented at the primary health care and community levels, and the commodity procurement system of the project. The team was impressed with both the enthusiasm for project activities that link communities with primary health care clinics and the evidence that those links were producing concrete results in terms of increased utilization of services, awareness of the communities' right to demand high quality care, and understanding of their own responsibility for their health. The community-clinic committees and community-based organizations (CBOs) working in these areas are improving health system governance using a bottom-up approach. The NGO grants have allowed capable institutions to expand their outreach into communities and provide services beyond those covered by the MOH's mandate, such as rehabilitation. Although there are some broader strategic challenges with the equipment procurement and support program, the Flagship's model of coordination, training, and follow up on the correct use and maintenance of the equipment procured is a best practice among USAID projects.

The evaluation also revealed a number of serious problems and issues related to the original project design, the lack of strategic direction on and vision for project outcomes, the lack of rigorous analysis or policy dialogue prior to major investments, some lack of programmatic integration, and a serious problem with partner and donor strategic harmonization in the health sector. Management issues were also identified with the performance monitoring plan, especially with the Flagship Project's reporting to USAID/West Bank and Gaza (USAID/WBG) in terms of the reports' accuracy and usefulness. The evaluation team experienced extraordinary difficulties with developing an accurate view of the accomplishments and challenges of this large and complex project, largely because of the "public relations-oriented" reporting style and lack of substance in the written material.

An extremely tight schedule, which allowed for only two weeks of actual time for interviews and field visits, limited the evaluation process. Project and counterpart staff made themselves readily available during those two weeks, but the Eid al-Adha holidays during the second week posed challenges for verifying and exploring the information gathered earlier. Nevertheless, the team is confident about its findings and recommendations, particularly on the broader issues. Examples are cited to support the conclusions.

The key "take home" message from this evaluation is that the Flagship Project must continue and USAID should expand it to ensure full coverage in the West Bank of the successful elements of the program. However, major changes are essential to ensure the intended impact of activities that are currently deemed weak. USAID needs to restructure certain components of the project to ensure that: (1) there is greater strategic clarity, (2) concrete and measurable outcomes of each program area are developed, and (3) the project supports USAID/WBG's role as health sector shepherd. This restructuring should be led by USAID/WBG but conducted in consultation with the Flagship staff and key MOH counterparts. In addition to this formal

restructuring, USAID and Flagship senior staff need a more honest and communicative partnership in order to share progress and jointly solve problems.

The key recommendations are contained in the final section of this report (Recommendations on Key Strategic, Technical, and Management Issues). Most of the more detailed analyses and recommendations for each of the project's main areas of work are found in Annex 6.

In conclusion, the evaluation team feels that with timely changes, the Flagship Project can make a significant contribution to Palestinian health systems strengthening and health outcomes, particularly if a more coordinated and inclusive approach can be engineered with the other development partners supporting the MOH. In the end, the Palestinian people deserve the best health care possible, and that goal must motivate all parties to maximize benefits from this $86 million investment by the U.S. Government.

I. BACKGROUND

INTRODUCTION

Evaluation Objectives and Rationale

This midterm evaluation aims to assist USAID/WBG in assessing the Palestinian Health Sector Reform and Development Project (Flagship Project). This evaluation will serve as a basis to inform the remaining three years of the program. The evaluation covers all activities implemented from October 2008 to November 2010.

This evaluation is intended to determine progress to date on each project component against overall project goals, targets, and objectives; determine the strengths and weaknesses of the existing program and approach; assess the effectiveness of the project's management structures and partnerships; document lessons learned; and provide discrete management, administrative, and technical recommendations for improving project performance and effectiveness.

Context of the USAID Health Program in West Bank and Gaza

The Palestinian Authority (PA) MOH is responsible for health care provision, legislation and regulation, human resource development, public health activities, health surveillance, and health care financing. Recognizing its public health responsibilities, the MOH envisions the creation of "an integrated health care system that contributes to promoting and sustaining the health status of the Palestinians." The MOH is responsible for ensuring the provision of needed health care services of appropriate quality and emphasizes equitable access, quality of care, community participation, health education, and accountability. An excellent *Lancet* series was published last year that provides a clear picture of the status and challenges of the health system in the Palestinian Territories, and is therefore not repeated in this report (See Annex 3).

SCOPE OF WORK AND METHODOLOGY

Summary of Scope of Work

The objectives of the midterm evaluation of the five-year Flagship Project are to:

- Determine progress to date.
- Determine project strengths and weaknesses.
- Assess effectiveness of management structures and partnerships.
- Document lessons learned and provide recommendations.

Description of Evaluation Methodology

The evaluation team used a variety of methods for collecting and analyzing qualitative and quantitative information and data. The methods used in completing this evaluation included:

- **Document review:** Prior to arriving in country and while in the field, the team reviewed various project documents and reports, as well as studies and documents from other sources. A list of key documents is included in Annex 3.
- **Team planning meeting:** A one-day planning meeting was held during the evaluation team's first day in country. This time was used to clarify team roles and responsibilities, deliverables, development of tools and approach to the evaluation, and refinement of agenda.

- **In-depth discussions with staff from USAID, the Flagship Project, and other stakeholders:** Using a question guide developed during the team planning meeting, the team conducted structured interviews with USAID, project staff, and key partners including the MOH and NGOs, other donors, implementing partners, and other stakeholders.
- **Field site visits:** The evaluation team visited selected project sites across the West Bank (See Annex 2). Meetings were held with MOH representatives, health center staff, NGO representatives, community health volunteers, and community members.
- **Debriefings:** An introductory meeting was held with USAID staff to present a report outline and explanation of the design of the evaluation; a mid-evaluation meeting with the Contract Officer's Technical Representative (COTR) and the Health and Humanitarian Assistance (HHA) Office Director was held to discuss progress and clarify questions; and a debrief with a summary of the findings and draft recommendations was held with USAID and Chemonics staff prior to the team's departure.

The evaluation team intended to use the deliverables of the scope of work and the indicators of the approved performance monitoring plan (PMP) to evaluate the performance and progress of the project to date. (The analytical framework developed for this purpose is attached as Annex 4.) However, early in the course of the evaluation, it became clear that the contracted scope of work was not adequate or conducive to an in-depth analysis of the project and its performance. Instead, the team identified key issues and intervention areas of the project, which paint a clearer picture of where the project has focused its efforts and achievements and the constraints to date.

Limitations on the Evaluation

The evaluation process was somewhat constrained by a tight three-week timeline with a few days to conduct a team planning session, consultations with USAID, and briefings by the Flagship Project prior to two weeks of field trips and interviews. The final week coincided with the Eid al-Adha holidays, posing challenges for exploring the new information generated during the last few days in the field. Fortunately, project and counterpart staff made themselves readily available during the first two weeks for evening meetings, which the evaluation team appreciated. While the evaluation team was not able to explore all areas of work as thoroughly as desired, the team does feel confident about its findings and recommendations, particularly on the broader issues. The report cites examples to support the conclusions.

SUMMARY PROJECT DESCRIPTION

The five-year Flagship Project was awarded to Chemonics International in September 2008 with an estimated cost of $57 million, which was later increased to $86 million. The goal of this project is to strengthen the institutional capacities and performance of the Palestinian health sector, with a special emphasis on building confidence, promoting good governance and effective management practices, and improving the quality of clinical services in the PA MOH. By providing integrated technical assistance and commodity support, Flagship Project's interventions are designed with a sector-wide approach in mind in order to support the PA's reform and development agenda. Targeted assistance for eligible NGOs and health professional training institutions is envisioned to complement the public sector interventions. The project works to achieve this goal through three components: (1) promoting health sector reform and improving management, (2) improving the quality of clinical and community-based health services, and (3) procuring health and humanitarian assistance commodities.

The Flagship Project is supporting the MOH to implement health systems strengthening activities necessary for quality, sustainability, and equity in the health sector. The Flagship Project works on improving the health status of Palestinians in several areas, including mother and child

health, chronic diseases, injury prevention, safe hygiene and water use, and women's health services. Additionally, the Flagship Project works to harmonize health practices and regulations and build effective linkages among the MOH, other health service providers, and the communities they serve.

Component One: Health Sector Management and Reform

The objectives under this component are to improve good governance and management practices in the Palestinian health sector and to strengthen the capacity of nongovernmental organizations to manage quality health care services. The project is responsible for a broad range of technical assistance to the health system to achieve the following:

- Sector-wide reform through the MOH
- Good governance practices within the MOH
- Improved health facility management within the MOH network
- Strengthened capacity for health services management within NGO clinical networks

Component Two: Clinical and Community-based Health

The objectives under this component are to improve the quality of essential clinical services and to support delivery of a quality package of community-based health promotion and disease/injury prevention services.

The project supports the MOH's efforts to improve its quality of care at the primary, secondary, and emergency levels. The project also supports NGOs in their ongoing efforts to provide quality clinical care, especially in the area of rehabilitative care services. The project also supports the delivery of a quality package of community-based health promotion and disease/injury prevention services, including strengthening the capacity of Palestinian health institutions to provide effective outreach services in partnership with local communities for improved health. In addition, the project is responsible for strengthening the capacity of health institutions to effectively promote safer, healthier behaviors.

Component Three: Procurement Support for Health and Humanitarian Assistance

The objective of the third component is to procure essential commodities to help achieve USAID development objectives in health and humanitarian assistance. To effectively manage health care systems, provide quality clinical care, and respond to emergency situations, the project supports the procurement of essential health care commodities, equipment, and humanitarian supplies. All commodities purchased under component three must be linked to components one and two by providing inputs for achieving the institutional development work plans. Under this component, the project must coordinate closely with USAID, the MOH, NGOs, and other donors.

Because USAID-funded commodities donated under this component may result in the generation of medical waste, the project is responsible for implementing mitigation measures to avoid adverse environmental impact. The project also provides technical assistance and monitoring to help beneficiary organizations improve their medical waste management practices.

II. FINDINGS

The findings of this midterm evaluation are divided into three sections. The first section highlights a number of strategic design and other issues that underpin this project. The second presents the evaluation team's findings on program implementation, including progress in each area of work, a summary of key findings, and a set of specific recommendations for that area of work. The third section contains a review and analysis of project administrative and management effectiveness.

STRATEGIC APPROACH FINDINGS: ANALYSIS OF DESIGN AND RELATED ISSUES

USAID Program Design and Conceptual Issues

USAID/West Bank and Gaza set out in 2008 with a very ambitious plan to support the MOH in strengthening the health sector—and not just part of the health sector, according to the statement of work, but the whole sector, across all levels of care, involving not only the MOH but also the NGOs. The endeavor is enormous. The statement of work is organized under three axes that are logically easy to comprehend—management, service provision, and medical supplies—but which, in hindsight, may not have been the most conducive way to move the program toward tangible results. Finally, it must be noted that the large number of deliverables (65 total), many ambiguous or puzzling, has further complicated matters. The Request for Proposal (RFP) deliverables and illustrative activities were transplanted into the Chemonics contract, without sufficient clarity about project outcomes at the end of the five-year period (e.g., some deliverables simply directed the bidders to conduct a series of assessments with few clearly defined outcomes). The problem was compounded in 2009 when the project cost increased by $29 million and a contract modification simply added more deliverables without clarifying the design. This only increased the pressure to check off deliverables from the list, rather than use the many assessments to inform the project's strategic direction.

Overall Strategic Vision about Outcomes

It was clear to the evaluation team that the Flagship Project staff made a real effort early in the project to develop a strategic approach.

They got off to a very good start when using USAID's Health Systems 20/20 model for conducting health systems assessments. The Flagship staff worked with the MOH, supporting them as they undertook the MOH Needs Assessment following the six key areas of health systems strengthening established by the World Health Organization (WHO) in 2007.[1] The Flagship is to be commended for having the MOH do a self-assessment, rather than sending in a team of outside consultants. It was a valuable exercise in terms of capacity building and promoting ownership. During the next phase, the development of an institutional development plan (IDP), the approach of supporting an MOH-led analytical process was still used, but it lacked systematic, focused thinking in terms of the six building blocks of a health system. As a result, the IDP turned into a list of 18 modules that the MOH believed to be its highest priorities, with an expectation that the Flagship would help the MOH achieve those programs. The title "MOH Institutional Development Plan" suggests that it should be an MOH document to which the project contributes in certain areas that are agreed upon by the MOH, the project, and USAID. Instead, it is branded as a Flagship document.

[1] World Health Organization. "Everybody's Business: Strengthening Health Systems to Improve Health Outcomes." 2007.

During the second year of implementation, the Flagship Project also began to conceptualize its work as supporting five areas: institutional development, the health information system (HIS), primary health care, support to hospitals, and procurement. The third year workplan is organized around these key issues and, therefore moves toward a more coherent approach.

Nevertheless, while these activities and the third workplan provide a certain coherence to a number of activities, they cannot compensate for the absence of an overall "vision" that must be set by USAID in consultation with the MOH, clearly delineating areas of the health system that the project would support and those that it would not. This has made the project vulnerable in several ways.

Without an agreed-upon strategic vision, the Flagship fell into the "support the MOH at all costs" mode. It became clear during the evaluation that this impression was omnipresent. The Flagship staff themselves often offered the explanation, "The MOH wanted it." The MOH was happy with the Flagship's high level of responsiveness, though many donors interviewed wondered why the Flagship did not adopt the role of technical advisor. The evaluation team felt that the Flagship should work with USAID to decline support to the MOH in particular areas if there was a strong rationale to do so. Within any healthy partnership, there should be scope to "agree to disagree."

By the same token, without strategic vision the Flagship was also at a higher risk of involvement in areas that were not originally part of the plan, resulting in a "make it up as you go along" mode. The fact that the deliverables gave the Flagship the flexibility to enter new areas of work did little to mitigate this risk. For example, there were deliverables that read: "Other deliverables as specified in the MOH institutional development work plan." Essentially, the contract was flexible enough to justify work in almost any area the MOH identified as a new priority. Furthermore, without a clear definition of the end goal or final outcome of the Flagship's support to the MOH or a reliable plan for measuring the achievement, USAID is in danger of investing $86 million without being able to demonstrate the results of its investment.

Specific examples illustrate the points above:

Design and Implement a Health Facility Accreditation Program (IDP #6)

The issue of accreditation of health facilities was addressed in a Flagship report dated December 2009 and submitted to USAID as a contract deliverable, which delineated the various requirements to establish such a system. In addition to outlining the regulatory, cost, and other issues involved, the report stated that a quality improvement/quality assurance (QI/QA) system should also be in place, as accreditation systems require the ability to monitor the quality of care. While facility accreditation is a worthy goal, it was clear from that report that a substantial amount of preparatory work would be needed to establish the preconditions for an accreditation program. A February 2010 Flagship report did provide recommendations for a reasonable roadmap for developing a quality assurance program at the primary and secondary levels within the MOH,[2] although a follow up report from June 2010 seemed to suggest a more narrow focus on performance improvement and supportive supervision at the primary health care level. Nevertheless, project staff was not able to articulate a clear vision for how they intend to support the development of a QA system (or accreditation), apart from describing specific activities such as supportive supervision or developing the primary health care Standards of Care. Defining what the project could accomplish in the remaining three years by supporting a QA/QI system or moving toward an accreditation program has not been done, nor is there

[2] Arscott-Mills, Sharon, and Maha El-Saheb. "Quality Assurance and Improvement in Primary and Secondary Care." Flagship Project, February 12, 2010.

evidence of a clear plan for *measuring* improvements in quality of care to gauge progress over the next three years.

Institutional and Management Capacity Building (IDP #15)

The assumption appears to be that leadership, financial management, and administrative skills training will enable MOH staff at the directorate and facility level to improve their performance. Some may, but most will not be able to apply their new skills unless there are changes in their work environment and job descriptions that enable them to use those skills. Financial management training for those who do not now have any financial planning or management responsibility—as is still the case in all MOH secondary facilities—cannot result in meaningful change. The specific training and on-site work necessary to undertake the costing of hospital services is an example of how training is more immediately applicable in those facilities where the HIS will soon be installed, as there is a need to feed costing data into the new system (see Implementation Findings in Section Two). Other than the pre-post training surveys to demonstrate the effectiveness of the training, there is little else in terms of follow up or systemic change that leads anyone to believe that this training will have much impact in the long run. The *National Health Strategic Plan* calls for a thorough health manpower needs analysis and health manpower plan, which may suggest the need to revise job descriptions and functions supported by appropriate types of in-service training or skills development. The evaluation team was informed that the European Union is interested in supporting such a needs assessment. This exercise may open a clearer path to health manpower capacity development needs in the future.

Medical Waste Management (IDP #17)

The IDP significantly increased the scope of work in this area for the Flagship Project. Rather than simply ensuring that medical equipment procurements include medical waste management supplies, the Flagship is now expected to address the chronic problem of medical waste at the national level, in a systemic way, managing the coordination minefield among the Ministry of Health, Ministry of Environment, and other government entities. However, the project's in-house staff does not have the technical capacity to address this challenge.

Rigorous Analysis or Policy Dialogue Prior to Major Investments

USAID and the Flagship Project have missed some opportunities to conduct rigorous analytical work or the partner consultations necessary to provide evidence-based policy advice to the MOH prior to engaging in certain areas of work.

Examples include:

Palestine Medical Complex (PMC)

Because this was a priority for the Minister of Health, there was an assumption that the project should support its development. Consultants were asked to "justify the establishment of the PMC" given the "need to organize and provide tertiary care services that will inspire the Palestinian health system to provide high quality services in a complementary fashion."[3] Instead, the project should have flagged the development of the PMC as a tertiary care facility as an important policy issue needing further study, including a critical look at the feasibility and desirability of the investment. A more useful approach could have been to recommend conducting a rigorous analysis of the budgetary and health systems implications of the investment, the availability of alternatives to expansion of MOH responsibility for tertiary services, and present policy options and alternatives. Such an approach should have sought advice and participation by USAID, other development partners, and stakeholders in the

[3] Flagship Project. "Development of a Start-Up Plan for the Palestinian Medical Complex." February 12, 2010, page 7.

dialogue with the MOH on an important and far-reaching policy issue. All this was especially crucial given the importance of the hospitals in East Jerusalem, which would inevitably be affected by the PMC.

Health Information System (HIS)

The development of the HIS should have followed rather than preceded the kind of process (supported by the WHO) now underway to understand all of the dimensions of the HIS. An investigation of why previous investments in this area were not sustained or expanded and how to benefit from the lessons learned should have come first, before developing the automated system. Issues related to data use and analysis capacity, the overall human resources and training needs of the staff to operate the system throughout West Bank and Gaza, the costs of fully expanding after the end of the Flagship, and other strategic information issues needed to be part of the thinking and discussion. Other donors or partners may have been able to participate in some part of this ambitious effort and buy-in to the new automated system would have been greater. The issue is that the Flagship does not even seem to have attempted a mini-strategic analysis before starting.

Institutional Development Plan (IDP)

Superficial descriptions of the tasks listed in each of the 18 topics of the IDP and the lack of specificity about expected outcomes is another indication of the critical lack of systems analysis and planning. The evaluation team found no evidence of in-depth analysis or credible justification to support or explain the priority topic areas. In many modules, the lack of a clear plan to define specific objectives and implement the necessary decisions and actions is evident.

Where doubts may have existed about the wisdom of choosing a particular path, the evaluation team had no clear evidence that the project engaged USAID for senior level discussions with the Palestinian Authority to raise questions and present analysis on alternatives and policy options. The Flagship clearly did feel under pressure to have "results" as quickly as possible—demonstrating that the money was being spent and submitting "deliverables"—responding to the Minister of Health's directives rather than engaging in a more thoughtful, time-consuming, and evidence-based discussion on the topics.

The only exception to this pattern—and it is worth mentioning—is a summary analysis prepared by the Flagship (no author or date indicated, but it appears to have been prepared in 2010) of the proposed health insurance law based on a World Bank report. It recommended that the Flagship hold off on any work on this issue (see Implementation Findings in Section Two).

Strategic Engagement of Partners and Donors

The current stakeholder environment is difficult for USAID and the Flagship given the high level of resentment among donor partners over the size and scope of USAID's program and the MOH's decision to change the sector "shepherd" role from the Italians to the Americans. Health systems strengthening and reform in West Bank and Gaza are particularly challenging given the problems created by the occupation and the uncertainty about West Bank and Gaza's political future.[4] In this environment, the importance of stakeholders providing strategically harmonized advice and well-coordinated support is especially critical to achieving any progress. The current divisive atmosphere in the health sector is not in keeping with the intent of the Paris Declaration nor is it helpful in the long term to the Palestinian Authority. Furthermore, because the MOH remains so heavily dependent on donor assistance to accomplish its work in strengthening health systems, better consensus among partners will help leverage reform and ensure the best outcome for West Bank and Gaza.

[4] Sabatinelli, Marwan Khawaja, and Tony Laurance."Health in the Occupied Palestinian Territories: Health Status and Health Services in the Occupied Palestinian Territories." Lancet Series, March 7, 2009.

Unfortunately, the MOH seems to see the Flagship as a one-stop shop, which has and gives everything the MOH wants, reducing the need for the MOH to pay attention to any other donors. Although this may not be true in every case, this is how the other donors perceive it. It is not difficult to understand why: it is striking, for example, that the MOH IDP does not include any reference to any other donor or partner as contributing to the 18 priorities. Contrary to extravagant claims in various Flagship reports, little effort has apparently gone into developing a harmonized strategic approach among the other donors and partners on various elements of the IDP, which, if pursued, may have helped bring a more focused and realistic framework to the planning. As the MOH's shepherd and co-chair of the Donor Working Group, USAID—supported by the Flagship—has the responsibility to help guide and advise the MOH on these issues and develop (with the MOH and key partners) a clear vision and a plan for moving forward in each area of health systems strengthening. Engagement by multiple donors has the added advantages of increasing the likelihood of sustainability and reducing the risk of relying too heavily on only one donor.

The project leadership *should* have been alarmed by this and worked proactively with USAID to help bring the broader group of MOH partners into a more consultative mode of operation through the Sector Working Group, which USAID now co-chairs with the MOH. The Flagship, in its operational engagement with the MOH programs, is USAID's strategic partner on the ground to spot problems and provide the analytic and strategic support for USAID to carry out its role as shepherd. Now that it is the sector shepherd, USAID should fully and proactively engage in this role, especially on policy issues at the Sector Working Group and in all relevant thematic groups. USAID should define for the Flagship staff the kind of support and assistance the project should provide to USAID in this effort. Several donors reported to the evaluation team that Flagship staff are most active in the HIS thematic group and when they do attend the other thematic groups they are often silent and rarely contribute substantively to the discussion. Another recurrent complaint on behalf of the donors was that the Flagship would come in, take the materials of interest, and then not be heard from again.

The Flagship is not maximizing its opportunity to advise and influence the MOH's vision of its role and responsibilities within the total health care system (public, United Nations Relief and Works Agency [UNRWA], NGO, private for-profit). This is important particularly because entities other than the MOH are such major service providers in West Bank and Gaza. NGO activities supported by the Flagship could become better linked with, and supportive of, a broadening of the MOH's view and role in the entire health care system. Referral links, training or mentoring sites, sharing evidence-based practices, and taking on roles that are beyond the scope of the MOH are all important avenues for addressing system strengthening activities across the whole health system, but the vision to do so seems to be lacking. UNRWA and NGOs have experience and views that are important for achieving positive outcomes in the areas covered by the Flagship. Using credible Palestinian institutions to weigh in on discussions about these topics should be an important strategy.

Recommendations that the MOH broaden outreach to academic institutions (e.g., Institute of Community and Public Health at Birzeit University) and work with them on establishing the evidence base for specific innovations do not appear in any workplans. Substantive involvement by such stakeholders in the program will help increase understanding, build a local support base for sustained work with the MOH and other partners, and help institutionalize learning from the project.

Working in Gaza

The Flagship Project is expected to also conduct activities in Gaza, focusing on the NGO sector. The scope of work foresees support to NGOs in terms of training to strengthen institutional

capacity and grants to improve the quality of services. These NGOs can be the beneficiaries of grants as well as procurement support.

This is easier said than done for several reasons. Because of the complicated political and humanitarian situation in Gaza, work in Gaza receives several additional layers of scrutiny and approval from various USAID offices, Israeli officials, and others. Following the war in the winter of 2008–2009, the Flagship was instructed to halt activities until further notice. Resuming activities has been slow, and there is some difference of opinion about when the instruction was given to again move forward with activities in Gaza.

It is exceedingly difficult to get anything done because of the many restrictions imposed. The Flagship Project can not only *not* work with the de facto Hamas government in Gaza, it also must proceed with caution when working with NGOs as well. As in the West Bank, NGOs need to be vetted, sign the Anti-Terrorism Certification, and adhere to the other mandatory anti-terrorism clauses in contracts and agreements. In addition, there is the Israeli Coordinator of Government Activities in the Territories (COGAT) to contend with, as it controls all commodity imports as well as access/travel permits into and out of Gaza. The procurement team reported that several of the requests to deliver particular items have been denied. It is also difficult, for example, to work with some NGOs, given that physical access is very limited. This means that regular monitoring visits and hands-on support are impossible; it is also not clear to what extent it will be possible for the project to implement its standard comprehensive procurement approach, including training in appropriate use and maintenance of the equipment procured. The project does have a representative in Gaza, but that cannot compensate for all the obstacles.

The project does try to overcome these obstacles; the grants team is hoping to add several more grants to the current sole Gaza grant it manages, and the procurement team has recently received clearance for a delivery of medical equipment worth $2 million.

IMPLEMENTATION FINDINGS: ANALYSIS OF PROGRESS TOWARD MEETING GOALS AND ACHIEVING RESULTS

As described in the background section of this paper, the Flagship is composed of three major components in the Chemonics contract: health sector management and reform, clinical and community based health, and procurement support for health and human assistance. Many of the activities within these components, however, are highly interrelated in terms of content and activities.

The following section provides summary information based on the findings, analyses, and recommendations of each of the principal areas of work found in the project components. For readability, the material in this section has been condensed to one-page summaries, with greater detail on each topic found in Annex 6. The evaluation team decided to organize this report by areas of work rather than components because it makes for a clearer, simpler presentation and a better understanding of what the project is achieving and what it is not.[5]

The areas of work, listed by the six internationally recognized health systems strengthening categories, include:

Service Delivery

- Primary Health Care
- Community Mobilization

[5] The objectives, contract deliverables, and PMP indicators for each component are listed in Annex 4.

- Behavior Change Communication
- Secondary Health Care – PMC
- Secondary Health Care – MOH Hospitals
- Quality Improvement
- Medical Waste Management
- NGO Grants and Capacity Development

Health Workforce

- Human Capacity and Professional Development
- Emergency Medicine Training and Preparedness
- Medical Training and Licensing

Information

- Health Information System

Medical Products, Vaccines, and Technologies

- Equipment and Pharmaceutical Procurement

Financing

- Health Financing

Governance[6]

Primary Health Care

Contract Scope of Work

The task as described in the contract is to "strengthen the capacity of Palestinian health institutions to deliver a quality package of essential primary care services" (Task 2.1.1). Improving the clinical MOH primary health care system is listed among the IDP priorities.

Progress toward Achieving Results

Improving the quality of health services at the primary health care level is fundamental to strengthening the health system as a whole. Thus, the Flagship Project works with the MOH to strengthen, improve, and sustain the quality of essential primary health care clinical services. To date, the Flagship Project has equipped 83 clinics based on needs assessments received from the MOH and verified by field visits conducted by the project staff in collaboration with district MOH teams. However, the full model of clinic with community interventions has only been implemented in 21 facilities in Nablus. The project is currently expanding the implementation of the model to 15 more facilities in Qalquilia, Bethlehem, and Hebron.

Main Findings

In general, the evaluation team found that the work of the project at the primary health care level was proceeding well and achieving tangible results. The project used an already well-established primary health care clinic system achieving good results for maternal and child health (MCH) services as a platform to help introduce prevention and primary level management of chronic diseases. The package of Standards of Care is complete and is being distributed to the

[6] The Flagship contribution to the Goverance category is primarily through the Leadership Development Program (included in the Human Capacity and Professional Development section) and through the Community-Clinic Committees (discussed in the Community Mobilization section).

facilities. Supportive supervision is reported to be increasing the frequency and usefulness of the visits from district managers. The evaluation team witnessed an encouraging level of enthusiasm among clinic staff about the community mobilization activities and how they are positively affecting the work of the primary health care clinics. The team identified some areas for improvement, which are listed in Annex 6.

Key Recommendations

- Because there is a shortage of MOH physicians to provide coverage to all primary health care facilities, the Flagship should advise the MOH to take advantage of the availability of NGO clinics in some places to provide a lower level facility with more preventive services that does not require a doctor to be present more than a few days a week.
- Add a scoring system to the supervisory checklist to help the MOH compare and monitor improvements among facilities.
- The Flagship should help the MOH institutionalize on-the-job training, as this is the most effective way to improve the skills of clinic staff. Mentoring and demonstrating good counseling skills is an example of how MCH services can be improved.
- USAID should lift the prohibition on the Flagship providing assistance in family planning, especially since counseling on the timing and spacing of pregnancies to improve maternal and newborn health is already MOH policy.
- This component of the Flagship should be fully expanded, as it shows potential to have continued positive impact over the next three years. Graduation criteria could be used to complete work in some facilities before moving on to another geographic area.

Community Mobilization

Contract Scope of Work

The Flagship Project supports "delivery of a quality package of community-based health promotion and disease/injury prevention through the provision of effective outreach services in partnership with local communities" (Objective 2.2, Task 2.2.1). Contract deliverables include 1) a situation analysis and needs assessment; 2) national standards, expanded training, and a certification program for community health workers; and 3) support to the MOH to implement and scale up an integrated, multisectoral approach.

Progress toward Achieving Results

The Flagship Project's Champion Community Initiative is a community mobilization program whose aim is to improve knowledge and awareness about key disease areas, encourage uptake of services, and empower citizens and communities to work together with their clinic to find local solutions to identified health needs. The project provided small, one-year subcontracts to support the establishment of 21 community-clinic committees in the Nablus district in year 2. Immediately following this, needs assessments were conducted, trainings were held, and workplans put in place. Community health workers conduct daily outreach activities, and committees are required to conduct five medical days, seven community campaigns, and two first aid courses during the year. Bimonthly committee meetings are held and monthly activity reports are submitted to the MOH and project. Communities are encouraged to mobilize their own resources to further contribute to improved health and wellness. Flagship will reward its "champion communities"—those with the best outcomes and impact—with follow-on, one-year contracts. Activities will be scaled up in Nablus by the Health Directorate in year 3, while the Flagship Project rolls out activities in Hebron and Qalquilia. Flagship staff also worked with Ibn Sina Nursing College to integrate a community mobilization module into the permanent four-year nursing curriculum.

Main Findings

The Champion Community Initiative has realized countless successes already in its first year of implementation, and the project should be commended for achieving both improved community linkages with the MOH and measurable health service utilization outcomes in this short time. While there are too many successes to list here, examples collected from the communities visited fell among four main themes: increased knowledge and awareness, increased service utilization, improved advocacy and coordination with the MOH, and increased ability to mobilize local resources. The challenge will be to monitor the sustainability of this approach over the long term and provide ongoing assistance to communities to encourage them to continue this important work.

Key Recommendations

- Scale up community-clinic committees throughout the West Bank and Gaza
- Complete and distribute the "Champion Community" manual to better enable scale-up.
- Measure sustainability in the coming years.
- Document "best practices."
- Include the community mobilization module in nursing college curricula throughout the West Bank and Gaza.

Behavior Change Communication

Contract Scope of Work

The Flagship Project was asked to "strengthen the capacities of Palestinian health institutions to effectively use communication strategies to promote healthier and safer behaviors" (Objective 2.2, Task 2.2.2). Contract deliverables include (1) a situational analysis and needs assessment of MOH health communications programs, materials, and systems; (2) 15 behavior change communication modules targeting key health knowledge and behaviors; (3) expanded opportunities for health communications training for health care providers and educators; and (4) a feasibility study for creating a youth health outreach program.

Progress toward Achieving Results

A needs assessment conducted jointly with the MOH and other stakeholders led to the strategic identification of 15 focal health areas or "gaps" in MOH Behavior Change Communication (BCC) programming. To date, the Flagship Project has developed or reprinted 12 BCC materials (booklets, leaflets, and coloring books) covering 11 of these health areas, and widely disseminated them through clinics and community workers. The project is in the process of developing two additional brochures, as well as a series of radio spots and TV cartoons. An ambitious number of mass media materials are planned in years 4 and 5. Three of the NGO grantees have also produced printed BCC materials. The project has conducted three trainings in the first two years of implementation (for MOH staff and other health workers, health educators, and media). Other BCC activities being implemented under the project include summer camps for kids, community health days, and—importantly—community mobilization activities. A comprehensive BCC manual is in development.

Main Findings

While the BCC component of the Flagship Project has been very active in producing materials, it does so in the absence of any evidence-based decision-making required to provide strategic direction to the development, implementation, monitoring, and evaluation of its activities. It is unfortunate that the deliverables outlined in the contract do not require the project to measure achievements beyond outputs achieved at the activity level and, furthermore, that the contract tasks the project with the rather onerous and seemingly arbitrary goal of producing 15 BCC "modules." It is troubling that the project has no baseline data derived from a knowledge,

attitudes, and practices (KAP) survey of their target audience and has no end-of-project indicators against which it can measure the success of these interventions. Without such data, it will be impossible to say whether the considerable time and resources invested in BCC activities have had any real impact.

Key Recommendations

- Use evidence-based decision-making (EBDM) to guide all future BCC activities.
- Limit the number of key interventions to two or three disease areas.
- Hire a permanent and qualified BCC expert to manage these activities.
- Capacity building at the MOH is essential for long-term success of BCC activities.
- Collaboration with other donors and stakeholders is urgently required.

Secondary Health Care—PMC

Contract Scope of Work

The tasks in the contract in area of hospital services are fairly general and are aimed at strengthening the capacity of Palestinian health institutions to deliver improved secondary and emergency health care. There is also a contract deliverable on improving management of the PMC.

Progress toward Achieving Results

Once the PMC was opened and the leadership positions were temporarily filled with acting staff, the Flagship began providing technical assistance and support to improve the nursing services and management efficiency of the Complex and medical update seminars for medical personnel. A full-time expatriate hospital administrator was assigned to work with the PMC to provide management and operations advice. Legal documents establishing the PMC are still awaiting ratification.

Main Findings

The MOH conceived the PMC as a tertiary center and intends to develop it as such for the West Bank, but serious issues such as whether the West Bank needs a tertiary hospital were never considered or sufficiently analyzed. One official interviewed by the evaluation team stated that PMC becoming a tertiary facility would constitute the public sector competing with the NGO and private sectors, and that buying the services is a much cheaper and more efficient option. The evaluation team noted that there is no clear vision for the PMC. One highly credible interviewee remarked, "The PMC is a potential white elephant." Others interviewed felt that the MOH would have serious difficulties transforming the PMC into a tertiary care center and should examine alternatives.

Clearly, there are serious questions of policy and the role of the MOH involved in further developments at the PMC. The most important contribution from the Flagship Project could have been to undertake a rigorous and credible analysis of the issues involved, the potential alternatives available for tertiary services, and the long-term costs and benefits for the MOH relative to the role and future of the PMC. Presenting such a study to senior leaders as a way to engage in important reform dialogue is an opportunity lost.

Key Recommendations

- USAID needs to redefine what, if anything, the project will contribute and make it parallel to what the Flagship will do with other secondary hospitals.
- As the only MOH hospital in the Ramallah district, the Flagship Project could:
- Strengthen the administration and financial management of the PMC.
  - Strengthen the QA systems.

- Strengthen the capacity of the PMC to provide quality emergency care services and a training hospital for the ongoing Emergency Residency Program.

Secondary Health Care—MOH Hospitals

Contract Scope of Work

The tasks outlined include strengthening quality improvement systems within Palestinian health institutions to deliver better secondary health care services and increasing the capacity of Palestinian health institutions to provide quality emergency care services (Task 2.1.2 and 2.1.3).

Progress toward Achieving Results

The Flagship Project is providing technical assistance to one MOH secondary hospital in each of three districts. It assessed Rafidia Hospital in Nablus and Alia Hospital in Hebron and drafted action plans to improve the quality of health services at both facilities, providing recommendations on improving emergency and pediatric services, as well as medical staff organization. Emergency protocols were developed and are being translated. The project provided the MOH with recommendations on staffing, distribution, supplies management, and configuration of the layout and placement of equipment and furnishings. At Qalquilia Hospital, Flagship staff has been working to improve its capacity to become a pilot facility for decentralization.

Main Findings

The project lacks a clear vision about the intended outcomes in the hospital sector, and to a large extent its work seems to be based mainly on MOH requests. For example, the project's focus has been veering between secondary hospitals in general and the PMC in particular. In 2010, the MOH decided to move the pediatric department from the old Al Watani Hospital in Nablus to the new location at Rafidia Hospital. This happened during the period when the Flagship staff was not engaged at PMC, so the project responded positively to the request for technical assistance in pediatric medicine and offered recommendations to transform Rafidia Hospital into a child-friendly facility.

Key Recommendations

USAID and the Flagship Project need to develop a clearer plan for its support to the secondary hospital sector, including what hospitals to focus on in the course of the project as well as what elements of hospital operations are mostly likely to contribute to improved secondary care, so that the USAID project can demonstrate a positive impact during the next three years.

The plan developed should carefully delimit and justify the USAID support and set forth specific outcomes that are feasible within the remaining period of the project, given investments already made. This will prevent the Flagship from responding too readily to MOH requests without thorough analysis.

Quality Improvement

Contract Scope of Work

Two tasks are listed for strengthening the capacity of Palestinian health institutions to deliver quality primary and secondary services. The deliverables also include a directive on developing an "integrated quality improvement program for delivery of essential package of primary care services" and the same for hospital services.

Progress toward Achieving Results

The Flagship Project succeeded in activating the quality department at the MOH central level. Through different workshops the project introduced the concept of quality and the importance of supportive supervision to enhance the skills and build more understanding of QA. The project

also finalized important documents like the Standards of Care for primary health care services. The MOH appointed a quality control coordinator at each hospital, and gave them an overall orientation about the concept of quality.

Main Findings

Many previous quality improvement activities have not been sustained beyond the period of the donor projects that funded them, which indicates the importance of building a *system* across the levels of health care rather than focusing only on specific tools or committees. The Flagship lost the key staff member assigned to work on quality, which may have caused some setbacks. So far little has been accomplished on the details of a national system for QA other than identifying it as a priority. A systematic plan to building that system in a stepwise fashion is not in place. At the clinic level, the important inputs are now in place for equipment, supplies, and drugs; and the primary health care Standards of Care is awaiting final approval. A promising effort is underway to monitor community feedback on quality of services, including involvement by the CBO in monitoring increases in utilization of selected primary health care services and conducting surveys of clients. Despite these promising activities, a QA/QI system has yet to be fully conceptualized or implemented at the clinic, district, or hospital levels. The Flagship does not currently have enough long-term technical expertise in place, but steps are being taken to rectify this situation.

Key Recommendations

- With Flagship support, the MOH must develop a full coverage QI/QA system that accurately reflects outcomes and monitors progress over time. The primary health care indicators suggested by Dr. Mary Segall, a short-term consultant for the project, are useful.
- UNRWA has an excellent supervision system; that system should be explored to enhance and expand the MOH's supervision system.
- To demonstrate how a QI system affects outcomes, a baseline must be established and the improvements monitored over time. "Self-assessment tools" can also be a powerful way to inculcate the "culture of quality" at the service delivery level.
- The project should focus on a limited number of departments to start the QA system at the secondary hospital level. The unified Protocol for Obstetrics and Gynecology developed with United Nations Population Fund (UNFPA) assistance is an excellent start and could also be used by NGO hospitals. Involvement by academic institutions would also broaden support and buy-in for clinical standards of practice.

Medical Waste Management

Contract Scope of Work

The Flagship Project's mandate for medical waste management was originally linked to the procurement component, and thus quite narrow. That mandate was broadened and moved to Component 2, after the MOH needs assessment and the MOH IDP identified medical waste management as a key priority. The deliverables are (1) waste management assessments for the MOH and beneficiary NGOs, (2) mitigation plans and technical assistance, and (3) monitoring reports.

Progress toward Achieving Results

The Flagship Project has generally included the necessary medical waste management supplies when procuring medical equipment. A total of 17 waste management assessments have been completed according to project staff, the first 7 of which were approved by USAID. There has been no further follow up. The project organized two training sessions at the Augusta Victoria hospital, one for hospital and health care facility staff involved in infection control and one for biomedical engineers.

Main Findings

The broadening of the mandate had raised high expectations that the Flagship Project would improve medical waste management both at the hospital level and at the system wide level. Two years into the project, the prospect of tangible results by the end of the project is dim. The hospital "assessments" reflect a cookie-cutter approach and lack depth; they cannot form a sufficient basis for targeted mitigation strategies and implementation plans. All hospitals visited were dismissive of what the Flagship Project had done so far. For the national level activities, the project contracted a local consultant to develop a proposal; he is reportedly an expert in solid waste management and wastewater, but has no experience in medical waste management. It is unrealistic of the project to believe that this proposal, under development and expected by December, will be able to turn around the situation in a few months, mobilize stakeholders, and enable the foundation of a sustainable system by the end of the project.

Key Recommendations

- Withdraw Flagship engagement from the system wide level activities, given the lack of in-house expertise and the enormity of the task at hand.
- Strengthen Flagship engagement in medical waste management at the hospital level, and then down to the primary health care level, given the importance of proper medical waste management for infection control.
- Make medical waste management an integral part of the project's QA. Medical waste management staff should be firmly anchored in and supervised by the project's primary health care and hospital teams.

NGO Grants and Institutional Development Support

Contract Scope of Work

The project aims to strengthen NGOs that deliver quality rehabilitative care, provide referral services in East Jerusalem, or provide professional training and development for health professionals. The deliverables include: (1) situation analyses of the NGO sector in rehab care and service provision, (2) self-assessments and IDPs for NGO beneficiaries, and (3) on-the-job training.

Progress toward Achieving Results

The project is supporting 12 NGOs through 13 grants of approximately $90,000 each; it has committed 74% of the $1.8 million grant budget foreseen. All but one NGO are based in the West Bank. The situation analyses were done, but only confirmed (rather than informing) the tenets of a grants program that had already started. Based on documents provided by the Flagship, five NGOs in Gaza and seven in the West Bank completed self-assessments as well as IDPs, on the basis of which training was undertaken.

Main Findings

The Flagship has stayed close to the statement of work parameters; grant support is roughly divided between rehabilitative care NGOs (grant focus on service provision and community outreach) and referral hospital NGOs (grant focus on specialized training). The grants program is a success story in the eyes of all NGO beneficiaries interviewed, and Flagship support is highly appreciated. It's an effective mechanism to reach patients in local communities, especially when the Flagship links the grants' outreach and the CBO activities. All NGO beneficiaries interviewed seem committed to sustaining the activities started. Several NGOs have also benefitted from in-depth institutional development support by a Flagship contractor. Regrettably, a disconnect occurred between the grant and the IDP track, resulting in some NGOs receiving institutional development training but no grant, and others receiving a grant but no institutional development

support. Grant support to Gaza cannot realistically represent more than a drop in an ocean of need, because of all the restrictions in place.

Key Recommendations

- Continue or expand the grants program for rehabilitative care and outreach services in close consultation with other NGOs and networks active in rehabilitation.
- Link any future training grant to referral hospitals to a clearly defined strategy for the hospital sector and/or a clearly defined package of priority hospital services.
- Ensure all NGO grantees benefit from the "dual track approach" and receive both grant support and in-depth institutional development capacity support.
- Consider the renewal or continuation of successful grants under the project, in order to build on experiences gained and/or outcomes achieved.
- Continue to systematically link community-based organizations with grant activities, in order to maximize the number of people reached.

Human Capacity and Professional Development

Contract Scope of Work

The project's task is defined as strengthening the capacity of the MOH to implement reforms needed for improving quality, sustainability, and equity in the Palestinian health sector. Deliverables include supporting the development of the IDP as well as training programs in management and finance.

Progress toward Achieving Results

During the second year, when training began, the project reported that 82 MOH participants completed the Financial Capacity Strengthening Program (FCSP) training. As for the professional development programs, the project reported that more than 100 participants were trained under the Leadership Development Program (LDP), and a group of trainers were trained and identified as "change agents." The Flagship reported that professional development occurred as expatriate professionals provided MOH health workers with on-the-job training and lectures.

Main Findings

While the IDP contains an annex that relates the IDP to the six components of the needs assessment, the list of 18 modules is a combination of MOH political imperatives and training needs, with little background analysis to support them. The IDP lost the opportunity to illustrate clearly (so that alternative sources of support could be pursued) the areas in which the Flagship can and cannot support the MOH. The institutional capacity and professional development objective became synonymous with IDP Module 15, a training program in health administration and management.

Administration, management, and leadership training included work at the hospital level on costing and pricing hospital services for the new HIS, training support for a new decentralization pilot in Qalquilia hospital, and the FCSP and the LDP training. Laudable efforts were made with the "change agents" at various levels in the MOH in hopes of institutionalizing new skills and behaviors. Many of those trained as trainers have moved on to other jobs, so continuous development of trainers is needed. The evaluation team concluded that the likelihood of lasting impact would depend largely on trainees using the new skills they acquired. The training, such as that on costing and pricing, will be useful if the new HIS is introduced on schedule and those trainees are deployed to enter the data.

Key Recommendations

- A human resources needs analysis and capacity development plan—as described in the National Health Sector Strategy—is needed and could be an important contribution of the project. USAID and the Flagship should collaborate with other donors who may support the MOH in this effort. The project has valuable experience from the field that could benefit the development of such a plan.
- For the ongoing program, focus on training that is relevant to actual changes occurring (e.g., costing and pricing) and work to institutionalize training capacity.

Emergency Medicine Training and Preparedness

Contract Scope of Work

The contract task states that the project will strengthen the capacity of Palestinian health institutions to provide quality emergency care services and contains a deliverable related to expanding fellowships and training to improve the quality of services.

Progress toward Achieving Results

The Flagship Project worked on transforming emergency rooms into interactive and responsive emergency departments in Hebron's Alia Hospital, Nablus' Rafidia Hospital, and the Ramallah PMC. Triage areas were established in all three hospitals and training conducted in emergency triage as well as in basic and advanced life support. The project also initiated an Emergency Residency Program in the three hospitals in partnership with the MOH, the Faculty of Medicine of Al Najah University in Nablus, and the Palestinian Medical Council. Emergency protocols were developed and are being translated into Arabic before distribution. The process also included the procurement of needed equipment. The project has also been working on emergency preparedness at the national and hospital levels.

Main Findings

Under USAID's Emergency Medical Assistance Program (EMAP) and CARE, emergency protocols were developed and instituted by Johns Hopkins University. Unfortunately, it appears that the Flagship Project did not use the materials or experience from USAID's previous project in the development of its own program. As a result, some emergency staff feel that the new procedures need revision to include some of the better elements from the earlier project. Work in the area of emergency medicine training is ongoing, and short-term consultants are providing useful on-site coaching and mentoring of physicians' work in emergency rooms. The evaluation team did not find a schedule to implement the emergency preparedness plan at other existing secondary hospitals. The Fellowship Training and Visiting Professor Programs mentioned in the contract have not been initiated.

The Emergency Residency Program could potentially have substantial long-term impact. The program had actually been started long before the Flagship Project by the Palestinian Medical Council with the Universities of Lille France and Al Najah in Nablus. The evaluation team learned that when the Flagship Project became involved in the Emergency Residency Program, a new curriculum of the Loma Linda emergency residency program was introduced. This angered Lille University, which then pulled out of the program.

Key Recommendations

- The Flagship Project must coordinate all medical specialization training activity with the Palestinian Medical Council. Short-term training visits in the Residency Program are useful but they need to fit into the existing program.
- Schedules for assisting with emergency preparedness plans at other existing Palestinian hospitals should be planned and approved.

- A decision is needed on whether to proceed with the plan for Fellowship Training and the Visiting Professor Program for the emergency preparedness plan, as the time left on the project may pose constraints and the added value of these programs was not clear to the evaluation team.

Medical Training and Licensing

Contract Scope of Work

The mandate in this area is not clear from the contract, but it does seem to include continuing health care education for professionals and expanding opportunities for specialized medical education. The topic of licensing is included in the IDP.

Progress toward Achieving Results

The project reports that it supported the MOH activities for the planning of licensing and re-licensing of health care professionals according to internationally accepted standards. These standards require health care professionals to engage in continuing health care education (CHCE), which keeps them current on evolving best practices for clinical and administrative work in health care. With the MOH, the project claims to have developed a licensing/re-licensing framework for 13 professional fields. Priority areas for fellowships were identified and shared with the Minister of Health. So far, two orthopedic surgeons from Makassed Hospital are in long-term training courses at academic institutions in Germany and Australia through a grant to Makassed. The hospital also sponsored the first Visiting Professionals Program trainee.

Main Findings

The Flagship Project has not analyzed past training programs supported by previous USAID projects, other donors, UNRWA, or NGOs to apply lessons learned. The evaluation team felt that the training programs lacked specific goals, follow up, or definition of expected outcomes. As a result, what these training opportunities are likely to accomplish is not clear. On the other hand, the Palestinian Medical Council is developing the system for CHCE programs and re-licensing of health professionals in cooperation with the different professional bodies, medical schools, and the MOH. Support for this program should institutionalize higher quality medical and health practitioners. The project has only contributed with one workshop on developing CHCE methodology. The system needs at least another year before it can be applied.

Key Recommendations

- The Flagship Project should reexamine its training programs and determine the most cost-effective approach to achieving the goal, given the time left on the project, especially for any overseas training. Valuable lessons are likely to emerge from looking at training work under previous USAID-funded projects, UNRWA, and the various donors.
- The Flagship Project should work closely with the Palestinian Medical Council on CHCE programs and re-licensing of health professionals, with emphasis on targeted needs linked to the CME and re-licensing program (e.g., capacity building of the Council members).

Health Information System

Contract Scope of Work

The HIS work is described by a single deliverable that reads, "Upgrade the HIS capacities of the Palestinian Authority MOH." The HIS development is second module listed in the IDP.

Progress toward Achieving Results

The HIS is a very important priority for the Minister of Health and other senior managers who recognize the value of access to comprehensive data about the health care system. Reportedly, consultations were held with stakeholders and presentations made to describe the proposed

system. After a tendering procedure, the contractor was selected to modify and translate software developed in Turkey. The main data center, data recovery center, and hardware are either installed or being procured for the main data center, five hospitals, and nine clinics selected by the MOH as pilot sites for the Flagship Project work.

Main Findings

Many MOH managers interviewed by the evaluation team were enthusiastic about the new HIS. While most of the donors expressed support for the idea of strengthening the HIS as a high priority, many of them felt that the Flagship effort had been driven too much by excitement over the sophisticated software systems and not enough by practical issues of feasibility, ability of the MOH to expand it beyond the Flagship-targeted facilities, and concerns about whether the human resources and training requirements had been properly anticipated.

The evaluation team found very little written information about the HIS; only the most general—often repetitive—information about the total number of anticipated beneficiaries was presented in the quarterly and annual reports. No comprehensive study was undertaken to analyze alternatives, determine long-term costs to the MOH, or identify other such influential factors. The evaluation team was also concerned about whether the training and mentoring needs for accurate data entry and use by facilities has been correctly assessed. The HIS system as envisioned is extremely ambitious and highly sophisticated if it works as envisioned. The Flagship has taken on what is essentially a pilot effort. The responsibility for expanding this throughout the West Bank and Gaza within the MOH system and paying for the remaining equipment or recurrent costs will rest with the MOH and its partners.

Key Recommendations

- Improving the HIS is an important priority and, given the commitments already made, it cannot be substantially altered. The project must take all necessary steps to ensure that the rollout is phased in ways that help ensure effective use of the system and provide for the needed staff support and training. The Flagship should also conduct the analyses necessary to help the MOH plan for the future expansion of the system once the project ends.
- Bring all partners into the picture and engage proactively with the WHO strategic assessment. Assist with moving recommendations forward as they relate to the work of the Flagship to help ensure that the HIS is used and becomes a viable planning and monitoring tool.

Procurement Support and Beyond

Contract Scope of Work

The Flagship Project's marching orders are (1) procurement in support of the Flagship Project, (2) procurement in support of other USAID projects if warranted, and (3) emergency procurements. The deliverables for each task include a procurement plan for the beneficiaries (MOH or NGOs) and the actual delivery of quality products.

Progress toward Achieving Results

Procurement Categories	Value per Category	Medical Equipment Beneficiaries	Total Value
MOH Support			
Pharmaceuticals	$1,249,467	n/a	$7,649,158
Medical Equipment—Primary HCF	$913,052	83 MOH PHCFs	

Procurement Categories	Value per Category	Medical Equipment Beneficiaries	Total Value
Medical Equipment—Secondary HCF	$5,486,639	10 MOH Hospitals	
NGO Support			
Medical Equipment—Secondary/Tertiary HCF	$4,829,664	5 NGO Hospitals in East Jerusalem & Bethlehem	$4,829,664
HIS			
HIS Hardware and Systems	$4,219,058	n/a	$4,219,058
Grand Total			Total = $16,697,880

Note: Status as of November 2010

Main Findings

From a technical viewpoint, the Flagship's procurement provides a "best practice" model on how to ensure that the procurement is needs based, coordinated with stakeholders, and transparent; and that the equipment procured is maintained effectively (through preventive maintenance provisions and training) and used appropriately (through organization of clinical trainings). On the other hand, the lack of a clearly articulated strategic vision on how the project aims to improve health care provision and what the priority areas are has left the project vulnerable to accusations of being a "medical equipment only" project. Questions were raised about ECGs being delivered to several primary health care centers in the Nablus district but none to the MOH hospital in Jericho, which was in dire need of one.

Key Recommendations

- Link any future procurements for hospitals to a clearly defined strategy for hospital sector support. Shift focus on improving the quality of care using the equipment procured. Continue to train and monitor clinical staff in the correct use, and technical staff in preventive and corrective maintenance, of the equipment.
- Provide support to the MOH in the writing, passing, and implementation of relevant procurement rules and regulations, based on lessons learned from Flagship procurement.

Health Financing

While health financing is an important part of health systems strengthening, the Flagship should be clear with the MOH that its mandate from USAID does not cover this area. The Flagship Project produced a useful summary analysis (no date or author) of the current situation regarding health insurance reform in the materials provided to the team. Potentially useful consultant reports and recommendations have been generated, but it is not clear whether the Flagship has actually shared any of this material with the MOH or other partners. Flagship staff seem to recognize that they must await further consensus among all stakeholders about new health insurance laws before any work can be useful, despite the statements in the IDP.

The Flagship as currently staffed has little to offer in this area. There is no real capacity in the project apart from bringing in short-term consultants. The project should definitely not be pressured by MOH into engaging in this in the absence of donor and other stakeholder consensus on a clear path forward. Dabbling in this area could be dangerous, resulting in extremely negative outcomes. The Flagship might play a supportive role in the future (such as doing costing work) that would facilitate health insurance reform but should not take the lead.

Recommendation

The Flagship Project should not begin any work on financing reforms or health insurance other than the efforts already underway on costing and pricing. Other organizations are better equipped to support this effort with the MOH. USAID should discuss this with the MOH and other donors to help garner support and participation of others in this technical area.

MANAGEMENT FINDINGS: EFFECTIVENESS OF ADMINISTRATIVE AND MANAGEMENT SYSTEMS

Strategic Management and Integration/Linkage among Activities

Given the lack of overall strategic vision, the evaluation team was not too surprised to also find a lack of vision across some major components and among the staff working on related elements. This in turn translated into various "teams" working too independently of each other. The primary health team seems to have the best overall sense of how the various streams of work fit together and how they can support the team's primary health care work (e.g., using the service quality improvement activities, equipment purchases, supervision and support systems, and community mobilization activities). Other teams, such as the medical waste management team, appear to be working more independently without a sense of how their activities fit with other activities and contribute to the whole.

Performance Management and Monitoring

The evaluation team concluded that the PMP, revised and approved in March 2010, is not useful for monitoring or managing the program with the exception of monitoring some inputs and simple outputs such as numbers of people trained and numbers of facilities assisted in some fashion. The finding may also be indicative of the overall lack of strategic direction and the confusion and lack of clarity about the ultimate outcomes expected in each component of the project. Most of the five impact level indicators listed in the PMP probably cannot be measured, except for those that deal with the increase in client and provider satisfaction with the quality of services since the project has been using client/provider surveys. While this is an inadequate tool on its own for measuring quality change, at least it can be quantified and monitored, as is being done.

At the component level, again, the indicators largely report only number of participants in training programs or number of policies or guidelines developed; however, the numbers per se are not meaningful for project management. For example, indicators such as "percentage of target audience in project-assisted communities reached by BCC messages" merely indicate the number of people reached, not the impact of these activities. The PMP does not reflect any plans to measure whether BCC messages have resulted in increased knowledge or changes in attitude or behavior, which would be useful information. If the project is trying to institutionalize the capacity in the MOH to plan and implement BCC activities, it should be a priority to enable the MOH to demonstrate how such programs can actually influence the population.

Unfortunately, because a useful PMP was not developed early on, only three years remain on the project to demonstrate solid quantifiable outcomes from some of the work undertaken by the project. Nevertheless, if the project is restructured and outcomes better defined at this juncture, a simple set of indicators to measure progress can be put in place to capture improvements in service quality over the next three years.

Health systems strengthening indicators are available to help guide the project to develop a revised PMP.[7] The evaluation team suggests that Chemonics hire someone with experience developing M&E plans for health systems strengthening programs to assist the project staff in thinking through and developing a simple set of indicators that will help the project and USAID monitor the program, both at the process and outcome level. Persuading the MOH to adopt new approaches will depend on being able to demonstrate that they can achieve results. That cannot be done, however, until the project itself has better strategic direction and well-defined outcomes.

Project Reporting Issues

The evaluation team's work was greatly complicated by the array of public relations- oriented reporting documents that had little specific information on actual accomplishments and progress. In particular, the first day's briefings about the project to the evaluation team were disjointed and focused more on public relations events rather than on substance.

The evaluation team spent an enormous amount of time trying to triangulate information to check the accuracy of extravagant claims in quarterly and annual reports. Instead of acknowledging previous work and building on it, the Flagship chose to represent almost all activity as new and unique. For example, the Emergency Medicine Residency Program existed prior to the advent of the Flagship Project, but consultant reports refer to the Flagship as establishing this program for the first time. The reports lead the reader to believe that more has been accomplished than is actually the case. As a result of this trend, the evaluation team began to have serious doubts about the accuracy of all reports of Flagship accomplishments.

In conclusion, the detail and level of analysis of progress, challenges, and problems needs to improve dramatically. ***The public relations type of reporting must end***. USAID must have an honest assessment of the project's real accomplishments in order to understand how previous investments are being built upon, what problems and challenges have impeded progress, and what USAID should do specifically to support the project. In a partnership, a less than forthcoming partner can have a serious impact on getting the work accomplished.

USAID Project Oversight

The past year has been difficult for the USAID HHA office due to gaps in office leadership and understaffing. With a restructured project, the interactions between USAID and the Flagship need to be formalized and systematized with product approvals in writing and substantive leadership on important issues. While informal communications are important, a written record of notable communications is critical to protecting USAID's interests and ensuring that communications are clear and well documented. With the arrival of permanent HHA office leadership, the team is confident that many of these management issues will be resolved. This will also ensure that there is no further Flagship taking the place of USAID.

[7] U.S. Agency for International Development. "Measuring the Impact of Health Systems Strengthening: A Review of the Literature." November 2009.

III. CONCLUSION AND RECOMMENDATIONS

MAJOR CONCLUSIONS

Despite the initial challenge posed by the design weaknesses, the Flagship Project made a concerted effort to launch this massive health systems strengthening and reform program in a logical way. Using a highly participatory and sound tool, the Flagship supported an assessment of the health system that produced the MOH Needs Assessment. The IDP was a subsequent attempt, admittedly somewhat flawed, to move to the next level of strategic thinking by relating what the Flagship Project could do to support the MOH's priorities. Unfortunately, as the specific program areas were identified, the strategic leadership process seems to have weakened. This left a vacuum for guiding the Flagship staff to identify the specific outcomes to be achieved. The pressure grew, especially during the second year, for the contract to begin reporting on the deliverables, most of which were difficult to interpret. The project staff were eager to be responsive to the MOH and did not take the time for the necessary analyses prior to launching major initiatives. The large infusion of additional resources in the second year further pressured the project and distracted from a more thoughtful process.

In spite of these challenges, the project gained traction in certain areas such as primary health care and community mobilization, with good results even in a two-year period. Small amounts of money were given to CBOs, who helped establish community-clinic committees to oversee and support the MOH clinics. Communities mobilized their own resources and facilitated new outreach programs for breast cancer screening and other awareness campaigns for noncommunicable diseases. These efforts also served to increase demand for the traditional maternal and child health services. The Flagship was able to improve the management of primary health care services through various project initiatives. The model, which began in the Nablus district, is now being expanded to Hebron and Qalquilia, using Nablus change agents to lead the process. This kind of work must proceed unimpeded. Other successful work includes the NGO grants and capacity development training as well as the equipment procurement and maintenance program.

In other areas, the Flagship lost its way due to a variety of factors. The poor PMP was a direct reflection of the weak strategic leadership and lack of vision. The situation can be salvaged but it will take a concerted effort by USAID/WBG and the Flagship to refocus the effort and carefully negotiate with the MOH the specific ways in which the project **can and cannot** provide support in the six key areas of health systems strengthening. Strengthening health systems is only a means to an end; therefore, concrete and measurable outcomes need to be agreed upon and pursued by the MOH with support from the Flagship Project.

RECOMMENDATIONS ON KEY STRATEGIC, TECHNICAL, AND MANAGEMENT ISSUES

Broad Stroke (Re)-Design Recommendations

1. The evaluation team strongly recommends continuing the project, with changes. While there are significant problems, halting the project would mean the loss of several interventions and approaches that are worthwhile.
2. USAID/WBG should use the midterm evaluation, the change of leadership at the Flagship, and this evaluation as opportunities to amend the project in order to better define expected outcomes, maintain or restructure priority areas of work, and eliminate areas of work that are not likely to produce concrete results (see Key Recommendations below).

3. As USAID and Flagship go through the process of consolidating the project, use the WHO's six components of health systems strengthening to organize activities and define outcomes. This will allow USAID, Flagship, and the MOH to relate the chosen areas of work to the priority reforms identified in the MOH Needs Assessment (which also follows the six areas, based on the Health Systems 20/20 tool) and the resulting MOH IDP. It will further help conceptualize how the Flagship is promoting health systems strengthening and the areas where it is making a contribution. Finally, it may also help in the reformulation of outcome deliverables and in communicating concretely to other stakeholders what the Flagship Project aims to achieve.
4. Once the new structure is defined, the project deliverables should be redefined in terms of measurable outcomes that a well-designed program can achieve. By the same token, the PMP should be revised to better reflect the information and data needed for decision-making, with outcome indicators and targets for the end of the project. (Refer to the WHO, HS 20/20, and other USAID references for indicators that reflect health systems strengthening.) The project could also work with the MOH Health Planning Department, using tools such as the Health Systems Dashboards that help benchmark country health systems across regions.

Key Recommendations

Project Areas of Work Identified as Priority

The evaluation team considers the following areas of work feasible and likely to produce outcomes, even within the current constraints of the MOH and the political context.

Primary Health Care and Community-level Work

There have been good results and evidence of progress to date (although PMP needs to capture better the progress in this area). Keep strengthening and expanding region-wide best practices at this level.

There is an opportunity to build on the existing and well-performing primary health care system to increase focus on noncommunicable diseases, as well as nutrition and birth spacing, which are lagging indicators. Focus on developing effective counseling for healthy timing and spacing of pregnancies as part of maternal health within the primary health care package specified for the four levels. The specific prohibition against working in family planning in the contract should be lifted as birth spacing counseling in the context of improving maternal and newborn health is MOH policy and not controversial.

Work with UNRWA and solicit suggestions for improvements based on their experience since they are the other major primary health care service providers (and the MOH may someday inherit that network).

Community work offers opportunities to work beyond health care service provision on important behavior change activities.

The Flagship can make a unique contribution to governance of the health system with community involvement and community-clinic committees. Another best practice in this regard is the concept of the "change agents." The Flagship has reached some tangible, if small-scale, results by training and guiding mid-level staff to take on a small-scale improvement project and follow it through.

Quality Improvement and Quality Assurance Systems across Health Care Levels

- Understand and use resources developed to date. Seek out experience in UNRWA and NGOs to conceptualize a system with input from those who have been working on this in the past. Using the recommendations in the Flagship February 2010 Quality Assurance and Improvement report (Arscott-Mills and El-Saheb), develop specific plans with the MOH and relevant partners on a step-by-step process that institutionalizes a QA system at the central, district, and service delivery levels. Define clearly what the project can help accomplish during the next three years.
- Work at both primary and secondary levels building on tools already developed in earlier USAID projects and other programs in the private and public sector.
- Include a system, beyond mere client surveys, to measure and monitor quality outcomes. Provide the MOH with international best practices in this area to urge moving forward. Ensure tools and QA systems are part of the MOH system, not Flagship protocols.

Medical Equipment

- Use the remaining equipment procurement budget strategically in support of the redefined priority areas. Adhere to the equipment lists the project helped develop for the various levels of primary health care services.
- Continue cooperating with the primary and hospital health care teams to provide staff training according to protocols in clinical use, as part of quality assurance.
- Monitor the implementation (and hopefully impact) of the preventive maintenance provisions introduced by the program and work toward institutionalization of maintenance and repair at the MOH and throughout the health facilities.

NGO Support Program

- Continue and, if possible, expand the support to NGOs active in rehabilitation.
- Regarding the grants to East Jerusalem NGO hospitals, limit the "training grants" to identified areas of priority for MOH hospitals or areas identified as priorities within the overall strategic approach to hospital strengthening.
- Give NGO grantees a second round of capacity strengthening support that has proven to be effective and appreciated.

Project Areas Of Work In Need Of Redefining

The evaluation team considers the following areas of work feasible and likely to produce outcomes, provided the scope is redefined.

Health Information System

- Continue with HIS development, but take a deep breath first. Develop a realistic timetable on how to roll out the HIS in the West Bank—from the pilot in Rafidia to other hospitals and primary care facilities during the project.
- Bring all partners into the picture and find roles for each as feasible. In particular, engage proactively with WHO strategic assessment and assist with moving recommendations forward as they relate to the work of the Flagship. USAID could consider giving funds to the WHO for activities related to HIS following the assessment currently underway (data use training, epidemiology capacity development, etc.).
- Assist in developing a phased plan that does not require the system to be "live" at all sites immediately or introduces various components in different phases.

- Conduct the analyses necessary to give the MOH concrete information on the capital investment, recurrent costs, and training efforts needed to expand the system to all public facilities after the Flagship Project ends. The MOH can use this information to seek buy-in from other donors and partners for future expansion.
- Include UNRWA and other NGOs beyond Al Makassed hospital in discussions during the pilot phase to increase understanding and potential buy-in from those groups in the future.
- Consider running a pilot at Al Makassed more or less concomitantly with Rafidia hospital. The NGO hospital is readying itself and eager to introduce HIS in its facility. It may also create a healthy competitive drive for HIS introduction. Introduction at an NGO hospital may also increase the chances of a success story.

Public Sector Hospital Work

- Define the work of the project in secondary care more narrowly, but continue to expand geographically, among the following:
  - Emergency medicine residency program.
  - Establishing the HIS in pilot facilities and associated training on costing, computer software, and use of information for improving hospital management.
  - Using any available clinical protocols or related materials, develop a QA system (working with hospital QA committees) in a limited number of departments to demonstrate how such a system works (e.g., infection control, emergency, OB/GYN, and pediatrics/neonatal intensive care departments). Measure changes in nosocomial infection rates, case fatality in neonatal ICUs, rates of compliance to clinical protocols (e.g., use of magnesium sulfate to treat eclampsia), and so on to show concrete outcomes for quality improvement. Compare and publicize results among hospitals.

Behavior Change Communication

- Conceptualization of the BCC work needs a serious overhaul and better in-house, long-term expertise (rather than relying only on consultants). Work with MOH health education staff to develop a well-planned, evidenced-based BCC program and tighten the focus to NCDs. Don't reinvent what already exists if the materials are good. Link with CBOs at the community level. Focus on youth for behavior change. Help the MOH learn how to measure program impact.

Institutional and Management Capacity Building

- Consider assistance to the MOH in the area of human resources needs analysis and development of a capacity development plan. Define a focused strategy in institutional capacity building that is geared toward clearly identified roles of the MOH. Stop widespread training of people who will not make immediate use of new skills.
- Limit training in leadership, financial management, and decentralization to those institutions that are being prepared for the HIS or decentralization, as appropriate.
- Shift emphasis to helping supervisors provide on-site coaching and mentoring that is likely to be sustained.

Project Areas of Work Recommended for Elimination

Palestine Medical Complex—Redefine what the project will contribute and parallel this with what the Flagship will do with other secondary hospitals.

National Medical Waste Management System Building—Do not spend energy on this hugely complex issue; limit medical waste management support to activities within the health facilities; explore which organization may be willing to support strategic level activity.

Health Insurance—No further work. The project is not well positioned or sufficiently staffed for work on this topic.

Project Management Recommendations

1. USAID should work with senior project staff to develop and implement an overall strategic overview and approach, which will—among other things—ensure better integration of the various elements of the project**.** Develop work teams so that staff are aware of each other's activities and how they contribute to a common set of goals and objectives.
2. The project's PMP must be redesigned to become a more useful tool for monitoring and managing program progress and outcomes.
3. USAID, Flagship, and the MOH should convene the Steering Committee regularly and use it to guide the project**.** It should be the forum for policy discussions, as well as a place for reviewing challenges and problems and improving accountability for performance. The Steering Committee, for example, could be useful in ensuring correct engagement with other donors and strengthening the shepherd role.
4. USAID should crack down on inaccurate reporting and demand transparency and accountability in all reporting.

ANNEX 1. STATEMENT OF WORK

1.364 USAID/WEST BANK AND GAZA HEALTH SECTOR REFORM MIDTERM EVALUATION

Global Health Technical Assistance Project, Task Order No. 01
GH Tech
Contract No. GHS-I-00-05-00005-00
Statement of Work

(Revised: 07-1-10)

I. TITLE

USAID/WBG: Midterm Evaluation of International Palestinian Health Sector Reform and Development Project (The Flagship Project)

Contract No. 294-C-00-08-00225-00

II. PERFORMANCE PERIOD

The in-country evaluation shall be conducted during an approximately four-week period in October–November 2010.

III. FUNDING SOURCE

USAID/West Bank and Gaza.

IV. PURPOSE

This midterm evaluation is to assist USAID/WBG (USAID/WBG) and the Palestinian Authority (PA) Ministry of Health (MOH) in assessing the Palestinian Health Sector Reform and Development Project (Flagship Project). This evaluation is a required action under the Contract signed in September 2008 and will serve as the basis to inform the remaining three years of the program. The evaluation will cover all activities implemented from October 2008 to November 2010.

This evaluation is intended to:

- Determine progress made on each project component in relation to planned activities outlined in the contract and progress against the goals, targets, and objectives of the project.
- Determine the strengths and weaknesses of the existing program and approach.
- Assess the effectiveness of the project's management structures and partnerships.
- Document lessons learned and provide discrete management and administrative and technical recommendations for improving overall performance and effectiveness of the project.

The project's performance will be evaluated not only by successful implementation of the workplans, but by measurable improvements according to performance indicators to be tracked through the project performance management plan (PMP).

As a monitoring tool, this midterm evaluation should provide information that can be useful in determining strengths and weaknesses of the program and its various components and help direct future program activities.

V. BACKGROUND

A major foreign policy objective for the United States is the realization of a "two state solution" to resolve the Palestinian-Israeli conflict. This vision seeks to establish a democratic Palestinian state living side-by-side with Israel in mutual peace and security. Such a state must be functional, self-sufficient, and capable of meeting the needs of its people, including effective mechanisms for ensuring the delivery of essential public health services.

The Palestinian Authority Ministry of Health (MOH) is responsible for health care provision, regulation and legislation, human resource development, public health activities, health surveillance, and health care financing. Recognizing its public health responsibilities, the MOH envisions the creation of "an integrated health care system that contributes to promoting and sustaining the health status of the Palestinians." The MOH is responsible for ensuring the provision of needed health care services of appropriate quality and emphasizes equitable access, quality of care, community participation, health education, and accountability among its guiding principles.

The Flagship Project was awarded to Chemonics International in September 2008. The total estimated funding for the five-year contract is $86 million. The overall goal of this project is to strengthen the institutional capacities and performance of the Palestinian health sector, with a special emphasis on building confidence, promoting good governance and effective management practices, and improving the quality of clinical services in the PA MOH. By providing integrated technical assistance and commodity support, Flagship Project's interventions are designed with a sector-wide, strategic approach in mind in order to support the PA's reform and development agenda. Targeted assistance for eligible nongovernmental organizations (NGOs) and health professional training institutions will complement the public sector interventions. The project works to achieve this goal through three components: (1) promoting health sector reform and improving management, (2) improving the quality of clinical and community-based health services, and (3) procuring health and humanitarian assistance commodities.

The Flagship Project is supporting the MOH to implement health sector reforms necessary for quality, sustainability, and equity in the health sector. By addressing key issues in governance, health finance, human resources, health service delivery, pharmaceutical management, and health information systems, the Ministry will strengthen its dual role as a regulator and main health service provider. The Flagship Project focuses on improving the health status of Palestinians in priority areas to the Ministry and public, including mother and child health, chronic diseases, injury prevention, safe hygiene and water use, and women's health services. Additionally, the Flagship Project works to harmonize health practices and regulations and build effective linkages between the MOH, other health service providers, and the communities they serve. The Project's Results Framework is found in Annex 4.

Flagship Project Components

Component One: Health Sector Management and Reform

The objectives under this component are (1) to improve good governance and management practices in the Palestinian health sector and (2) to strengthen the capacity of nongovernmental organizations to manage quality health care services. The project is responsible for providing a broad range of technical assistance at various levels of the health system to achieve the following:

- *Sector-wide reform through the MOH* (i.e., referral networks, accreditation of health facilities, planning and licensing for new health care facilities according to needs and resources, national standards for health professional education).

- *Good governance practices within the MoH* (i.e., more transparent and efficient procurement systems, application of managed care principles to MOH practices, improved financial and budget planning and management, strategic approaches to human resources planning).
- *Improved health facility management within the MOH network* (i.e., standardized administrative and operational policies and procedures for MOH hospitals and clinics, devolution of decision-making authority, improved maintenance of facilities and equipment).
- *Strengthened capacity for health services management within NGO clinical networks.*

As a first step, the project assessed current health administration and management systems and practices in the MoH and selected NGOs at the central and peripheral levels. These assessments form the basis of institutional development workplans which will strengthen the management capacities at these institutions.

Component Two: Clinical and Community-Based Health

The objectives under this component are (1) to improve the quality of essential clinical services and (2) to support delivery of a quality package of community-based health promotion and disease/injury prevention services.

The project supports the Ministry's efforts to revitalize its quality improvement efforts at the primary, secondary, and emergency care levels. The project also supports NGOs in their ongoing efforts to provide quality clinical care, especially in the area of rehabilitative care services. Under component two, the contractor supports the delivery of a quality package of community-based health promotion and disease/injury prevention services. This includes strengthening the capacity of Palestinian health institutions to provide effective outreach services in partnership with local communities for improved health and safety outcomes. In addition, the project is also responsible for strengthening the capacity of health institutions to effectively use communication strategies to promote healthier and safer behaviors.

Component Three: Procurement Support for Health and Humanitarian Assistance

The objective of the third component is to procure essential commodities to help achieve USAID development objectives in health and humanitarian assistance. To effectively manage health care systems to provide quality clinical care and respond to emergency situations, the project supports the procurement of essential health care commodities, equipment, and humanitarian supplies. All commodities purchased under component three must be linked to project components one and two by providing inputs for the achievement of the institutional development workplans. Under this component, the project must coordinate closely with USAID, the MOH, NGOs, and other donors.

Because USAID-funded commodities donated under this component may result in the generation of medical waste, the project is responsible for the implementation of mitigation measures to avoid adverse environmental impact. The project also provides technical assistance and monitoring to help beneficiary organizations improve their medical waste management practices.

Roles and Responsibilities of the Flagship Project Prime Contractor and Subrecipients

- **Chemonics International** has the ultimate responsibility for successful management and implementation of this project. Chemonics is responsible for compliance with USAID rules and regulations, provides most long-term and administrative technical staff, and draws upon the special expertise of its subcontractors, as described below.

- **IntraHealth** provides support in quality assurance, training, and performance improvement, facilitating the review, revision, and implementation of clinical standards, norms, and protocols.
- **Loma Linda University** supports clinical skills development through visiting professors and fellowship programs.
- **Training Resource Group** is responsible for the training of core MOH managers and leaders, enabling them to make organizational changes and lead the health reform agenda.
- **Health Strategies International** works within the health financing and public sector financial reform activities.
- **Massar** provides office management and logistical support to project offices and supports procurement and institutional development.
- **Alpha International** is responsible for conceptualizing, designing, analyzing, and presenting the results of assessments and market surveys, as well as providing information management expertise.

VI. SCOPE OF WORK

The evaluation team is expected to perform a midterm evaluation of the five-year Palestinian Health Sector Reform and Development Project (The Flagship Project).

The objectives of the evaluation are to:

- Assess and document the progress made under the Flagship Project in achieving results under component one.
- Assess and document the progress made through the Flagship Project in achieving results under component two.
- Assess and document the progress made under the Flagship Project in achieving results under component three.
- Assess progress made in health promotion and behavior change at the community level, including the contents of the BCC messages and their reach and relevance to project components and target audiences.
- Assess the effectiveness of capacity building (technical/administrative, training, management, and financial) interventions utilized by the Flagship team.
- Assess the effectiveness of the package of quality improvement interventions utilized by the Flagship team.
- Assess the quality of the management and clinical training materials and courses offered to various health managers and providers.
- Assess the sustainability of improvements achieved within the health system.
- Assess the effectiveness and efficiency of the Flagship Project's staff and organizational structure in achieving program objectives.
- Determine progress toward achieving monitoring and evaluation (M&E) goals.
- Recommend strategies for strengthening successful efforts and areas and approaches for change or improvement.

Illustrative key questions to be addressed by the team:

- What has been the project's progress to date in achieving planned results, based on the performance indicators? Has the project achieved its year 1 and year 2 targets?

- Are there any gaps in performance and achieving targets? What are the steps to be taken to address these gaps?
- Are the interventions in line with the original mandate of the project? Are there any gaps?
- To what extent is the Flagship Project achieving its primary objective of strengthening the institutional capacities and performance of the Palestinian health sector? How successful is the project in building institutional capacities of the MoH and the NGOs?
- How has the project strengthened the management/technical capacity of the MoH and NGO staff at various levels?
- How are the institutional development plans (IDPs) being implemented? What are the achievements so far?
- How are the interventions—at all levels—addressing the MoH's and NGOs' needs?
- How successful is the project in establishing formal linkages with the MoH, the NGOs, and other stakeholders? How effective is the working relationship between the project and the MoH and the NGOs?
- How are the project design and priorities linked to the Global Health Initiative (GHI) and addressing GHI priorities? Is there a need to make any changes in order to better align with GHI?
- How effective are the project implementation mechanisms and management systems including technical support, planning, monitoring, finance, etc.? Are there specific management policies or practices that contributed to either success or failure of intervention implementation?
- What are the management strengths and challenges of this project, with regard to project design, staffing, partnering, etc.? How should these challenges be addressed to enhance achievement of results?
- What are the strengths/limitations of USAID management of this project? How could USAID management be improved during the remainder of the project's life?
- How is the partnership between the prime contractor and the subcontractors working? What has worked well and what have been the challenges?
- How effective are the key technical elements and approaches?
- How successful is the project in bringing in and implementing evidence-based best practices and technical approaches?
- Is the mix of technical expertise within the project team (the prime contractor and subcontractors) relevant to achieve the intended results? Are there any gaps in technical skills? How can they be addressed?
- What are the strengths and challenges regarding short-term technical assistance the project draws upon?
- Does the project systematically follow and comply with USAID regulations as laid out in Mission Order 21?
- Does the project fully comply with USAID procurement regulations?
- How does the project ensure that the procurement of equipment and supplies are based on true needs? Are the beneficiaries (MoH and NGOs) satisfied with the procured goods?
- What are the issues, challenges, and lessons learned in monitoring, evaluation, and reporting?
- How does the project coordinate and collaborate with other USAID supported projects and with international donors? Are there any redundancies? What are the examples of complementarities?

VII. METHODOLOGY

Evaluation Organization

The evaluation team shall work under the supervision and guidance of the Contracting Officer's Technical Representative (COTR) for the Flagship Project. The COTR will organize all internal USAID meetings, including linking the team with all Health and Humanitarian Assistance (HHA) team members overseeing other HHA activities.

The evaluation team will use a variety of methods for collecting and analyzing qualitative and quantitative information and data. The methods to be used in completing this evaluation will include, but not be limited to, reviewing documentation, interviews, site visits, stakeholder meetings, etc. The following essential elements should be included in the methodology as well as any additional methods proposed by the team:

Document Review

Prior to arriving in country and conducting field work, the team will review various project documents and reports. A list of key documents is included in Annex 3. The USAID/West Bank Gaza team will provide the relevant documents for review as soon as possible.

Team Planning Meeting

A two-day planning meeting will be held during the evaluation team's first two days in-country. This time will be used to clarify team roles and responsibilities, deliverables, development of tools and approach to the evaluation, and refinement of agenda. In the team planning meeting, the team will:

- Share background, experience, and expectations for the assignment.
- Formulate a common understanding of the assignment, clarifying team members' roles and responsibilities.
- Agree on the objectives and desired outcomes of the assignment.
- Establish a team atmosphere, share individual working styles, and agree on procedures for resolving differences of opinion.
- Develop data collection methods, instruments, tools and guidelines, and methodology, and develop an assessment timeline and strategy for achieving deliverables.
- Develop a draft report outline for Mission review and approval.

In-depth Discussions with USAID/West Bank Gaza Staff and Flagship Project Staff

Key Informant Interviews

The team will conduct structured interviews with the project staff and key partners, including the MoH and NGOs, other donors, implementing partners, and other stakeholders. To ensure that comparable information is collected during interviews, the team will develop standard guides reflecting the questions posed by the evaluation scope of work.

Field Site Visits

The Flagship Project activities are focused in parts of all 12 governorates in the West Bank In East Jerusalem, technical assistance and procurement support is limited to selected NGO facilities which are within the referral network for the Palestinian Authority. Due to the current political situation in Gaza, Flagship activities are focused on eligible NGOs, with the goal of achieving geographic representation in the north, south, and midsections of the territory. The team will not travel to Gaza, but will conduct phone interviews with NGOs receiving support from the project in Gaza. The evaluation team shall arrange to visit selected sites in each of the

12 governorates in the West Bank. Decisions will be made in consultation with the COTR, MOH, and the Flagship Project Chief of Party (COP). Where possible, the evaluation team will be accompanied by a member of staff from either Flagship or USAID/WBG. Meetings should be held with MOH representatives, health center staff, NGO representatives, and community health volunteers and community members.

Debriefings

- Internal USAID/WBG meetings will include, at a minimum: Initial organizational/introductory meeting at which the evaluation team will present an outline and explanation of the design of the evaluation.
- Mid-evaluation review with the COTR and program office representative to outline progress and implementation problems.
- Evaluation debrief/summary of the data, findings, and draft recommendations with relevant USAID/WBG staff.

An oral briefing meeting will be held with USAID/WBG either as part of the team planning meeting or directly following it. The evaluation team shall propose and organize the evaluation process. The evaluation design and workplan shall be presented to the COTR and HHA team members for comments during the initial meeting with the Mission HHA team.

A second meeting will be held with USAID/WBG approximately halfway through the in-country work. This meeting will serve to outline progress and address any implementation problems.

A third debriefing meeting will take place approximately four days before the evaluation team leaves the country. This meeting will be approved by USAID/WBG and held with USAID/WBG and other key stakeholders after the site visit work is completed. The objective of the debrief will be to share the draft findings and recommendations, solicit comments and inputs, and clarify any remaining questions or issues before the team hands in the draft report and departs.

Arrangement of Meetings

The Flagship COTR will arrange for an initial introductory meeting with appropriate MOH staff at the outset of the process. Where necessary the COTR may participate in meetings with the MOH representatives and partners. A general list of relevant stakeholders and key partners will be provided to the evaluation team by the COTR prior to the team's arrival in the country, but the evaluation team will be responsible for expanding this list as appropriate and arranging the meetings and appointments so as to develop a comprehensive understanding of the program and services offered through the Flagship contract. A local administrative assistant will be hired to schedule the team's meetings and arrange logistical support prior to the team's arrival in the country. The evaluation team will also need to review recent activities of the MOH and donors in order to understand the Flagship program activities and develop an appropriate interview list.

VIII. TEAM COMPOSITION, SKILLS AND LEVEL OF EFFORT

The evaluation team will be composed of four international experts in the following areas: evaluation team leader, BCC/community health specialist, quality improvement/assurance specialist, and procurement specialist. In addition, the team will be accompanied by a local hospital management/clinical expert.

Roles of the Team Members

Team leader: The team leader (TL) will be responsible for overseeing the team and ultimately responsible for the submission of the final draft report to the Mission. S/he will provide team leadership, plan and coordinate meetings and site visits, and be responsible for payments of local logistical needs and local staff working with the team. S/he will lead the preparation and

presentation of the key evaluation findings and recommendations to the USAID/WBG team and other major partners and will consolidate reports from other evaluation team members and ensure that a draft report has been left with the Mission on departure.

The TL should have an advanced degree in public health or a related field with a minimum of five years of experience in management and evaluation of health programs at all levels of care, experience in leading teams of experts in health activities, and experience in international health specifically dealing with health systems strengthening and institutional development activities. Additionally, the TL should have worked extensively with USAID-supported programs.

BCC/community health specialist: The second team member should have an advanced degree in medical anthropology or a related discipline and at least five years of experience in the implementation of field behavior change communication and community mobilization strategies. A comprehensive knowledge of the application of BCC strategies to alter health behaviors is desirable.

Quality improvement/assurance specialist: This team member should have an advanced degree in health sciences or public health and at least five years of experience in program management, implementation, and monitoring and evaluation of internationally based quality improvement/assurance programs, particularly within health reform efforts. S/he should possess comprehensive technical knowledge of and experience in quality improvement/assurance approaches, especially in service provider training. Additional experience in hospital management is highly desirable.

Procurement/supply and grants management specialist: This team member should have an advanced degree in a relevant field and at least five years of working experience in procurement/supply management of health equipment and products, as well as grants management. S/he should have extensive technical knowledge in procurement, distribution, installation, preventive maintenance, and utilization of health equipment and products.

Local hospital management/clinical expert: This team member should be a senior local expert, preferably a medical doctor with both hospital management experience as well as clinical skills. S/he should have at least 10 years of working experience in the West Bank and Gaza and extensive knowledge of the local health structures and systems. Past experience in working with USAID-funded programs is a plus.

Local logistics assistant: This team member will arrange field visits, key informant interviews and meetings, local travel, hotels, and appointments with stakeholders as required.

IX. LEVEL OF EFFORT

Level of Effort

The budget shall be based on the following estimated level of effort (LOE):

Task	Team leader	Other international consultants (3) (days each)	Local management/ clinical consultant	Local logistics assistant
Background reading/preparation	3 days	3 days	3 days	3 days
International travel– RT	5 days	4 days	0 days	0 days

Task	Team leader	Other international consultants (3) (days each)	Local management/ clinical consultant	Local logistics assistant
Team planning meeting and initial briefing with USAID/West Bank Gaza	3 days	3 days	3 days	0 days
Field site visits/key informant interviews, meetings	14 days	14 days	14 days	10 days
Midterm and final debriefings	2 days	2 days	2 days	0 days
Discussion, data analysis, and report preparation in-country	5 days	5 days	5 days	0 days
Draft report revision and submission prior to team departure	1 day	1 day	1 day	0 days
USAID/West Bank Gaza reviews draft report (10 working days)				
Report revisions, based on Mission comments (out of country)	5 days	2 days	2 days	0 days
GH Tech edits and formats final report (3–4 weeks)				
Total est. LOE	38 days	34 days each	30 days	15 days

X. LOGISTICS

A six-day work week is authorized while the team is working in country.

The evaluation team will be responsible for offshore and in-country logistical support. This includes arranging and scheduling meetings, in-country travel (including vehicle rentals), hotel bookings, working/office space, computers, printing, and photocopying. A local administrative assistant/secretary will be hired to arrange field visits, local travel, hotels, and appointments with stakeholders (see section VII above).

GH Tech will be responsible for the following:

- Arranging travel in the U.S. and from the U.S. to overseas assignment location (country clearance, visa, plane tickets, hotel reservations, processing travel advance, and expenses). Consultants are responsible for arranging in-country travel while overseas and ground transportation in the U.S.
- Facilitating contact with USAID staff.

- Instruction and/or assistance with formatting charts, graphs, and tables, and PowerPoint slides.
- Arranging for editing/layout of final report.

XI. DELIVERABLES

The contractor deliverables shall include:

1. A written methodology plan (evaluation design/operational workplan) during the pre-evaluation meeting (due no later than fourth day in-country).
2. A draft report outline with possible issues for discussion during the mid-evaluation meeting (within two weeks of the start of the evaluation).
3. A Mission and partner debrief meeting that will be held before the team's departure and prior to the submission of the draft report.
4. A draft report, due prior to the team leader's departure, will incorporate comments and suggestions from the debriefings.
5. A final report (five hard copies and a CD ROM in Microsoft Word) will be submitted as follows:
    a. The mission will have 10 days following the submission of the draft report to respond and provide written comments and feedback.
    b. The revised, final unedited report will be provided to the mission 5 days after the comments are received.
    c. Once the mission signs off on the final unedited report, GH Tech will have the documents edited and formatted and will provide the final report to USAID/WBG for distribution (five hard copies and CD ROM). It will take approximately 30 days for GH Tech to edit/format and print the final document. This will be a public document.

The Final Report Format shall include:

- Executive summary, concisely summarizing critical elements of the main report.
- Table of contents.
- Introduction, describing the purpose and objectives of the evaluation.
- Background of the project, including goals and objectives and the Results Framework.
- Findings.
- Conclusions and lessons learned.
- Recommendations for improving the Flagship Project in the future.
- Other information relevant to the evaluation but not necessarily central to it may be included in annexes.

The report shall not exceed 30 pages, excluding the annexes.

XII. MISSION OR WASHINGTON CONTACT PERSON

The USAID/West Bank Gaza point person for the evaluation is Dr. Suzy Srouji, who is the Flagship Project COTR. There is one other activity manager on the program managing component three of the project, Sawsan Baghdadi-Tabari.

ANNEX 2. LIST OF PEOPLE INTERVIEWED AND SITES VISITED

USAID/WEST BANK GAZA

Ms. Mary Cobb, HHA Office Chief
Ms. Lisa Baldwin, COTR, Flagship Project
Dr. Suzy Srouji, HHA
Ms. Sawsan Baghdadi-Tabari, HHA

FLAGSHIP PROJECT STAFF

Dr. Taroub Harb Farmand	COP
Dr. Daminanos Odeh	D/COP
Ms. Rebecca Sherwood	D/COP Operations
Ms. Tamara Tamimi	Knowledge Management Unit Director
Dr. Jihad Mashal	Clinical Community–Based Health Director
Dr. Issa Bandak	Hospital Support Program Officer
Dr. Daoud Adeen	Primary Health Care Specialist
Mr. Yasir Harb	Director of Health Information System
Mr. Fadi Hidmi	Grants Manager
Ms. Narmeen Fayyaleh	Grants Management Program Officer
Ms. Nadera Shibly	Procurement Director
Mr. Raed Qubbaj	Pharmaceutical Procurement Manager
Ms. Susanne Shamali	Medical Waste Management Specialist
Mr. Hazem Khweis	Procurement Manager
Dr. Salem Jaraiseh	Health Program Officer
Ms. Amal Bandak	Hospital Specialist
Ms. Randa Bani Odeh	Community Mobilization Officer
Ms. Luna Aroury	Program Assistant, BCC

MOH RAMALLAH

Dr. Fathi Abu Mogli	Minister of Health
Dr. Anan Masri	Deputy Minister of Health
Dr. Ass'ad Ramlawi	Director General Primary Health Care
Dr. Naim Sabra	Director Secondary Health Care
Dr. Qasem Al Maani	Director General International Cooperation
Dr. Rania Shahin	General Director of Pharmacy

PALESTINE MEDICAL COMPLEX (PMC) RAMALLAH

Dr. Amjad Kiwan	PMC Acting CEO
Dr. Husni Atari	CMO

MOH CENTRAL STORES

Dr. Hasan Harb	Director
Dr. Shatha Shraim	Control Supervisor

MOH NABLUS

Dr. Husni Atari	CMO MOH Nablus
Dr. Khaled Qaderi	Director Primary Health Care Nablus
Mr. Zaher El Bahsh	Head Allied Health Professionals
Mrs. Aysha Aydi	Nursing Director – PHC Directorate
Mrs. Marwa Dumiati	Clinic Supervisor – PHC Directorate
Mrs. Nazmieh Abu Samra	Head of Human Resources
Mr. Samer Jaber	Head of Health Finance Unit
Mr. Barrak Jum'a	Head of Projects within Planning Department
Mrs. Lubna Sader	Head of Health Education Unit

BEIT FUREEK PHC

Mrs. Huda Hanani	CBO
Mr. Ashraf Mleitat	CBO
Mrs. Dalal Abu Soud	Nurse/MOH

WHO

Mr. Anthony Laurence	Country Head

AUGUSTA VICTORIA HOSPITAL

Dr. Tawfiq Nasser	CEO
Miss Juha	Chief Accountant

ST. JOHN EYE HOSPITAL

Mr. David Dahdal	Fund Raising manager

UNICEF

Mrs. Najwa Rizqallah	Nutriton Specialist
Dr. Kamel	Chief, Health and Nutrition Division

WORLD BANK

Mrs. Eileen Murray	Lead Operation officer

DEIR AL HATAB PHC

Mrs. Raeda Hussein	Nurse
Mrs. Zuhria Sawafta	Nurse

PHARMACEUTICAL PROCUREMENT

Mr. Hassan Harb

RAFIDIA HOSPITAL

Dr. Khaled Saleh	Director
Mr. Samer Awartani	Administrator
Dr. Hasan Fitiani	Head Pediatrics Department
Mr. Raod Assaf	Quality Control
Dr. Abdel Raouf	Director of Planning and Quality

NABLUS ASKAR CBO

Mr. Amjad Rfaieh	Director

SABASTIA PHC

Mrs. Rikaz Sawalha	Nurse
Mrs. Enaya Kayed	CBO

INSTITUTE OF COMMUNITY AND PUBLIC HEALTH, BIRZEIT UNIVERSITY

Dr. Rita Giacaman,	Research and Program Director
Dr. Rana Khatib,	Director

HUWARA PHC

Mr. Ahmad Odeh	Deputy Mayor
Kayrieh Odeh	CBO
Mrs. Basma Mansour	Nurse
Mrs. Manal Dameiri	Pharmacist

IBN SINA NURSING COLLEGE

Afaf Hamdan	Nursing Instructor
Nihad Bisharat	Nursing Director
Suha Hreish	Administration Director

QALQILIA HOSPITAL

Mrs. Myassar Mansour	Director
Dr. Mohamed Abu Lebda	Medical Director
Mrs. Lana Nezal	Quality Coordinator

NABLUS

Dr. Anan Al Masri	Deputy Minister of Health

JICA

Mr. Hidiaki Hwase	Project Formulation Advisor
Koki Jin	Project Administration Coordinator
Ms. Fadia Alkhatib	Deputy Chief Advisor – Technical Affairs

AUSTRIAN COOPERATION

Mrs. Ruba Aburoqqti	Senior Health officer

PR. BASMA REHAB CENTER

Ms. Betty Majaj	Director
Mrs. Maha Yasmeeneh	Deputy Director

AL MAKASSED HOSPITAL

Dr. Rustom Namari	Director
Dr. Yehya Rifai	Public Relations Director
Ms. Fadia Alkhatib	Deputy Chief Advisor–Technical Affairs

ALIA HOSPITAL

Dr. Said Sarahneh	Director
Dr. Sharif Halaika	Medical Director
Dr. Nidal Qmeizi	Head X-Ray Department

EWAS/ANERA

Mr. Mohammed Rajab	Office Manager– South
Ms. Hanadi Darwish	Engineer Coordinator

BETHLEHEM PHC

Dr. Mohammed Rizq	Director PHC Bethlehem
Dr. Ghada Qawa'	Head of Preventive Medicine

HOLY FAMILY HOSPITAL

Dr. Jacques Keutgen	CEO
Mrs. Elizabeth Anastas	Project Manager

UNRWA

Dr. Umayyah Khammash	Chief Medical Officer

ITALIAN COOPERATION

Dr. Angelo Stefanini	Health Program Coordinator
Dr. Marco Barone	Health Program Officer
Ms. Sawsan Aranki-Batato	Health Policy Development Officer

UNPFA

Mr. Ali Sha'ar	National Programme Officer, Reproductive Health

JERICHO HOSPITAL

Dr. Naser Anani	Director

JERICHO PHC

Dr. Mohamed Kar'en	District Health Office Administrator
Dr. Ali	Director of Primary Health Care
Rania	Health Education
Mrs. Raeqa Haddad	Nursing Director
Siham	Chief Nurse

PALESTINIAN MEDICAL COUNCIL

Dr. Munzer Al Sharif	Director

ANNEX 3. LIST OF DOCUMENTS REVIEWED

PALESTINIAN HEALTH SECTOR REFORM AND DEVELOPMENT PROJECT (FLAGSHIP PROJECT) DOCUMENTS

Annual Implementation Plan – Year 3: October 1, 2010–September 30, 2011.

Annual Implementation Plans – Years 1 and 2. [Date?]

Annual Report (draft): Investing in the Future of the Palestinian Health Sector,

Year 2, October 1, 2009–September 30, 2010.

Annual Report, Year 1, October 1, 2008–September 30, 2010.

BCC materials and training documents.

Chemonics Contract dated October 2008 and 7 contract amendments.

Equipment and pharmaceutical procurement documents.

"The Integrated Multi-Sectoral Approach for PHC Intervention."

Medical waste management documents, including Medical Waste STTA Report and individual hospital assessments.

Ministry of Health Institutional Development Plan, Palestinian Health Sector Reform and Development Project: The Flagship Project, March 2009.

Ministry of Health Health System Assessment Report, Palestinian Health Sector Reform and Development Project: The Flagship Project, December 2008.

NGO documents, including grant manuals, grant documents, self-assessments, and institutional development plans.

"Package of Essential Primary Care Services."

"Package of Standards of Care" (ANC, postnatal Care, family planning, infection control, nursing care services, health center management, diabetes mellitus, hypertension and bronchial asthma).

Performance Monitoring Plan, March 19, 2010.

"Primary Health Care Strategy," Palestinian Health Sector Reform and Development Project.

"Primary Health Care Facility Assessment."

STTA reports from years 1 and 2.

Training modules for the Financial Capacity Strengthening and Leadership Development Programs.

Quarterly Progress Reports: Years 1 and 2.

OTHER KEY DOCUMENTS

Alva, Soumya, Edkhard Kleinau, Amanda Pomeroy, and Kathy Rowan. "Measuring the Impace of Health Systems Strengthening: A Review of the Literature." (Washington, DC: USAID, November 2009).

Mason, Jennifer, and John Rogosch. "Health Program Review." USAID, April 20–30, 2010.

Request for Proposal. USAID/West Bank Gaza, May 20, 2008.

Palestinian National Authority, Ministry of Health. *National Strategic Health Plan, Medium Term Development Plan*, 2008–2010.

Palestinian National Authority, Ministry of Health. *Palestinian National Health Strategy 201–2013: Setting the Strategic Direction towards Getting Results*.

Palestinian National Authority, Ministry of Health. "2010 Annual National Health Workplan," February 2010.

World Bank. *Reforming Prudently Under Pressure, Health Financing Reform and the Rationalization of Public Sector Health Expenditures.* West Bank and Gaza Health Policy Report, December 2008.

World Health Organization. "Everybody's Business: Strengthening Health Systems to Improve Health Outcomes." 2007.

THE LANCET SERIES

Batniji, Rajaie, Yoke Rabaia, Viet Nguyen-Gillham, Rita Giacaman, Eyad Sarraj, Raija-Leena Punamaki, Hana Saab, and Will Boyce. "Health in the Occupied Palestinian Territory 4: Health as Human Security in the Occupied Palestinian Territory." Published online March 5, 2009.

Giacaman, Rita, Rana Khatib, Luay Shabaneh, Asad Ramlawi, Belgacem Sabri, Guido Sabatinelli, Marwan Khawaja, and Tony Laurance. "Health in the Occupied Palestinian Territory 1: Health Status and Health Services in the Occupied Palestinian Territory." March 7, 2009.

Husseini, Abdullatif, Niveen M. E. Abu-Rmeileh, Nahed Mikki, Tarik M. Ramahi, Heidar Abu Ghosh, Nadim Barghuthi, Mohamad Khalili, Espen Bjertness, Gerd Holmboe-Ottesen, and Jak Jervell. "Health in the Occupied Palestinian Territory 3: Cardiovascular Diseases, Diabetes Mellitus, and Cancer in the Occupied Palestinian Territory." Published online March 5, 2009.

Mataria, Awad, Rana Khatib, Cam Donaldson, Thomas Bossert, David J. Hunter, Fahed Alsayed, and Jean-Paul Moatti. "Health in the Occupied Palestinian Territory 5: The Health-care System: An assessment and Reform Agenda." Published online March 5, 2009.

Rahim, Hanan F. Abdul, Laura Wick, Samia Halileh, Sahar Hassan-Bitar, Hafedh Chekir, Graham Watt, and Marwan Khawaja. "Health in the Occupied Palestinian Territory 2: Maternal and Child Health in the Occupied Palestinian Territory." Published online March 5, 2009.

ANNEX 4. FLAGSHIP MIDTERM EVALUATION ANALYTIC FRAMEWORK AND METHODOLOGY

BASIC REFERENCE DOCUMENTS

- Chemonics contract scope of work, with list of deliverables.
- Project performance monitoring plan with indicators.

FRAMEWORK FOR ASSESSING PROGRESS (AFTER TWO YEARS OF IMPLEMENTATION)

Goal: To strengthen the institutional capacities and performance of the Palestinian Authority Ministry of Health, selected nongovernmental organizations, and eligible educational and professional institutions to support a functional, democratic Palestinian health sector capable of meeting the priority public health needs of its people.

Impact Level PMP Indicators:

- Distribution of specialized primary and secondary health care services per capita (equity).
- Percentage of community-clinic boards reporting increased access to planning and policy-making for health care services provided in their community (access).
- Percentage of improvement in efficiency in management and delivery of MOH health care services at facilities equipped with the project-provided Health Information System (efficiency).
- Percentage of satisfaction of clients/providers with the quality of services provided at their health facility (quality).
- Percentage of improvement in performance of MOH/NGO staff who have completed project-assisted leadership development program (sustainability).

Project Component 1 – Health Sector Management and Reform

Objective 1.1—Improve good governance and management practices in the Palestinian health sector

Activities

Task 1.1.1—Strengthen the capacity of the Ministry of Health to implement reforms needed for improved quality, sustainability, and equity in the Palestinian health sector.

Task 1.1.2—Strengthen the capacity of nongovernmental organizations to manage quality health care services.

Contract Deliverables (from contract statement of work)

Task 1.1.1

- Situation analysis and needs assessment regarding MOH governance and management systems.
- Five-year institutional development work plan for the Palestinian Ministry of Health governance and management systems.
- Health Administration and Management Program for the public sector (including policies, procedures, standards, job aids, training, and oversight).

- Upgrade the HIS capacities of the Palestinian Authority MOH.
- Put systems in place and provide technical assistance to operationalize the PMC in the area of administration and management of health facilities and services.
- Support the MOH to implement and scale up an intergrated multisectoral approach to improve management and administration practices at MOH.
- Expanded opportunities for fellowships, foreign study programs, and/or development of local certificate training programs in health management and administration.
- Other deliverables as specified in the MOH institutional development workplan.

Task 1.1.2

- Situation analysis and needs assessment regarding health administration and management for each beneficiary NGO.
- Five-year institutional development workplan for each beneficiary NGO.
- Expanded opportunities for intensive on-the-job training and mentoring for NGO counterparts in health management and administration.
- Other deliverables as specified in the NGO institutional development workplans.

PMP Indicators (from PMP)

- Percentage of drafted laws, policies, regulations, or guidelines related to improved access to and use of health services adopted with U.S. Government support through the Flagship Project.
- Number of institutions that have used U.S. Government-assisted (through the Flagship Project) MIS information to inform administration/management decisions (F Indicator).
- Number of individual patient records stored in the U.S. Government-supported MIS (through the Flagship Project).
- Percentage of planned institutional development plan activities implemented.
- Number of improvements to laws, policies, regulations, or guidelines related to improved access to and use of health services drafted with U.S. Government support, through the Flagship Project (F Indicator).
- Number of MOH institutions receiving capacity strengthening support.
- Number of eligible NGOs receiving capacity strengthening support.
- Number of grants awarded to selected NGOs.

Project Component 2—Clinical and Community-Based Health

Objective 2.1 – Improve the quality of essential clinical services for Palestinians

Activities

Task 2.1.1—Strengthen the capacity of Palestinian health institutions to deliver a quality package of essential primary care services.

Task 2.1.2—Strengthen quality improvement systems within Palestinian health institutions to deliver better secondary health care services.

Task 2.1.3—Strengthen the capacity of Palestinian health institutions to provide quality emergency care services.

Task 2.1.4—Strengthen the capacity of Palestinian health institutions to provide quality rehabilitative care services.

Contract Deliverables (from contract statement of work)

Task 2.1.1

- Situation analysis and needs assessment regarding clinical services in the MOH primary health care system.
- Five-year institutional development workplan for improved quality of clinical services in the Palestinian MOH primary health care system.
- Package of "Essential Primary Care Services" for each level of MOH clinics.
- Integrated quality improvement program for delivery of the essential package of primary health care services.
- Medical waste management assessments for the MOH and each beneficiary NGO.
- Medical waste management technical assistance and mitigation plans for the MOH and each beneficiary NGO.
- Annual medical waste management monitoring report for each beneficiary NGO.
- Continuing education program for primary health care providers.
- Expanded opportunities for intensive on-the-job training and mentoring for MOH and/or NGO counterparts in technical areas related to quality service delivery at primary health care clinics.
- The Flagship Project shall support the MOH to implement and scale up an integrated multisectoral approach to improve management and administration practices at MOH.
- Other deliverables as specified in the MOH institutional development workplan for primary health care.
- Situation analysis and needs assessment regarding primary health care services for each beneficiary NGO.
- Five-year institutional development workplan for each beneficiary NGO.
- Other deliverables as specified in the NGO institutional development workplans.

Task 2.1.2

- Situation analysis and needs assessment regarding clinical services in the MOH hospital system.
- Five-year institutional development workplan for improved quality of clinical services in the Palestinian Ministry of Health hospital system.
- Integrated quality improvement program for delivery of hospital services.
- Expanded opportunities for scholarships, residencies, fellowships, visiting professors, or certificate programs to support improved quality of MOH and NGO hospital services by training Palestinian doctors and nurses in various areas, including advanced clinical specialties related to maternal/child health care and in chronic disease prevention and treatment (i.e., midwifery, general pediatrics and subspecialties, laparoscopic surgery).
- Other deliverables as specified in the MOH institutional development workplan for hospitals.
- Situation analysis and needs assessment regarding hospital care for each beneficiary NGO.
- Five-year institutional development workplan for each beneficiary NGO.
- Put systems in place and provide technical assistance to operationalize the PMC in the area of quality health care service delivery.

- The Flagship Project shall support the MOH to implement and scale up an integrated multisectoral approach to improve management and administration practices at the MOH.
- Medical waste management assessments for the MOH and each beneficiary NGO.
- Medical waste management technical assistance and mitigation plans for the MOH and each beneficiary NGO.
- Annual medical waste management monitoring report for each beneficiary organization.
- Other deliverables as specified in each NGO's institutional development workplan.

Task 2.1.3

- Situation analysis and needs assessment regarding MOH emergency departments and emergency preparedness.
- Five-year institutional development workplan for improved quality of emergency department services in the Palestinian MOH hospital system.
- Expanded opportunities for fellowship training and/or visiting professor program to support improved quality of MOH emergency services.
- Put systems in place and provide technical assistance to operationalize the Palestinian Medical Complex in the area of health care service delivery.
- The Flagship Project shall support the MOH to implement and scale up an integrated multisectoral approach to improve management and administration practices at the MOH.
- Other deliverables as specified in the MOH institutional development workplan for emergency services.

Task 2.1.4

- Situation analysis and needs assessment regarding provision of rehabilitation services in the West Bank and East Jerusalem.
- Expanded opportunities for visiting professor and/or fellowship programs in rehab medicine and nursing.
- Five-year strategy and workplan for improved quality of rehabilitation services for Palestinians.

Objective 2.2—Support delivery of a quality package of community-based health promotion and disease/injury prevention services

Activities

Task 2.2.1—Strengthen the capacity of Palestinian health institutions to provide effective outreach services in partnership with local communities for improved health and safety outcomes.

Task 2.2.2—Strengthen the capacity of Palestinian health institutions to effectively use communication strategies to promote healthier and safer behaviors.

Contract Deliverables (from contract statement of work)

Task 2.2.1

- Situation analysis and needs assessment regarding MOH and NGO community health services.
- Five-year institutional development workplan for improved community health services.
- National standards, expanded opportunities for training, and certification program for community health workers.

- The Flagship Project shall support the MOH to implement and scale up an integrated multisectoral approach to improve management and administration practices at MOH.
- Other deliverables as specified in the institutional development workplan for community health services.

Task 2.2.2

- Situation analysis and needs assessment regarding MOH health communication programs, materials, and systems.
- Five-year strategy and institutional development workplan for improved health communication services through the MOH.
- Fifteen behavior change communication modules targeting key health knowledge and behaviors for the Palestinian population.
- Expanded opportunities for Health Communication Training Program for health care providers and patient educators.
- Feasibility study for creating a youth health outreach program.
- Other deliverables as specified in the institutional development workplan for health communication services.

PMP Indicators for Component 2 (from PMP)

- Number of clients benefiting from health services at targeted health care facilities following project inputs
- Number of participants in community health promotion activities
- Percentage of target audience in project-assisted communities reached by BCC messages
- Percentage of health care facilities assisted to provide improved quality of services
- Number of protocols and job aids developed and/or updated
- Number of communities assisted to implement community-based activities
- Number of BCC modules developed

Project Component 3—Procurement Support for Health and Humanitarian Assistance

Objective 3.1 – Procure essential commodities to help achieve USAID development objectives in health and humanitarian assistance

Activities

Task 3.1.1—Provide essential health commodity inputs to support successful implementation of institutional development workplans under the Palestinian Health Sector Reform and Development Flagship Project.

Task 3.1.2—Provide limited, complementary health commodities to support achievement of USAID objectives for other health projects under the Palestinian Health Sector Reform and Development Program.

Task 3.1.3—Procure emergency medical commodities and general humanitarian assistance materials as directed by USAID.

Contract Deliverables (from contract statement of work)

Task 3.1.1

Semiannual procurement plan for the MOH and each beneficiary NGO to provide expanded support

- Timely delivery of quality products as specified in the semiannual procurement plans

Task 3.1.2

- Targeted procurement plan for selected beneficiaries
- Delivery of quality products as specified in the targeted procurement plans

Task 3.1.3

- Emergency procurement plans as directed by USAID
- Delivery of quality products as specified in the emergency procurement plans

PMP Indicators (from PMP)

- Number of people benefiting from services introduced or enhanced as a result of U.S. Government-procured medical equipment, through the Flagship Project
- Number of facilities benefiting from U.S.-funded medical equipment
- Value (in USD) of procured commodities delivered – disaggregated as follows:
  - Total amount USD of medical disposables/ supplies provided
  - Total amount USD of pharmaceuticals provided
  - Total amount USD of medical equipment delivered
  - Total amount USD of MIS hardware, software, and support provided
  - Total amount USD of humanitarian assistance/emergency supplies provided

Cross-cutting PMP Indicators

- Percentage of trainees applying skills/knowledge acquired during U.S.-funded training, through the Flagship Project
- Number of health professionals trained in technical and management areas, disaggregated as follows:
  - Number of medical and paramedical practitioners trained in evidence-based clinical guidelines
  - Number of health professionals from the MOH trained
  - Number of health professionals from NGO trained
  - Number of community members trained
  - Number of people trained in essential maternal health services
  - Number of people trained in essential child survival interventions
  - Number of people trained in chronic diseases
  - Number of people trained in injury prevention
  - Number of people trained in women's health
  - Number of households trained to improve practices for safe water use and hygiene
  - Number of people trained in other technical areas
  - Number of people trained in administration/management topics

EVALUATION METHODOLOGY

- Document and data review
- Structured questions of selected stakeholders
- Observations during site visits
- Analysis of progress and likelihood of achieving project objectives
- Strategic assessment of program directions

ANNEX 5. LIST OF FURTHER ANALYTIC WORK NEEDED

MAJOR ANALYTIC WORK

The evaluation team believes that undertaking the following analyses and data collection efforts will help the Flagship Project make a stronger contribution to the Palestinian MOH's health systems strengthening and reform activities by generating a better evidence base for decision-making.

1. **Palestinian Medical Complex:** Long-term budgetary, human resources, and health systems implications of transforming the PMC into a tertiary care facility, including policy options and alternatives.
2. **Health Information System:** Long-term budgetary and human resource training requirements for expanding the Flagship-supported pilot HIS to all MOH facilities. Link this analysis to the findings and recommendations of the WHO assessment of HIS as appropriate, especially in areas such as strengthening the use of HIS and other data sources for strengthening analysis and decision-making.
3. **Human Capacity and Professional Development:** Using the topics areas in the MOH Needs Assessment (Section D 2: Possible Options for Strengthening Human Resources) as a starting point, analyze the areas for Flagship intervention that are likely to have reasonable outcomes within the next three years. (Note that three of the four options outlined in the MOH Needs Assessment for improving human resources do not involve training.) Work with USAID's PACE Project, if appropriate, to better understand the challenges and opportunities within the Palestinian civil service system in order to develop, with the MOH, the priority objectives and activities for the Flagship Project in this area.
4. **Behavior Change Communication:** Knowledge, attitudes, and practices (KAP) baseline survey of adults regarding noncommunicable diseases (NCDs). The questionnaire for women should also address relevant questions regarding birth spacing, contraception, and screening for breast cancer. The results of this study should indicate key drivers in behavior surrounding risk factors and health-seeking behavior, and should drive the development of all future BCC materials and activities. These, combined with the findings of the youth survey, should also be used to set baseline and end-of-project indicators that measure impact.

RAPID ASSESSMENTS OF LESSONS LEARNED/TOOLS DEVELOPED FROM PREVIOUS WORK

In some cases, rapid assessments of the lessons learned from previous USAID (or other donor) investments will help improve the approach and ensure sustainability of current interventions. Look at UNRWA and NGO programs, as well as MOH experience to help guide Flagship strategies. These topics should include:

1. **HIS:** Challenges associated with establishing health information systems in earlier USAID projects or the projects of other donors, if information is available.
2. **QA/QI:** The tools developed and people trained, as well as challenges faced by previous efforts in this area, can help avoid reinventing the wheel and taking advantage of people already trained where possible. Collaboration with other donors working on the QA/QI issues (e.g., the training funded by the WHO for hospital quality control coordinators in Egypt) is important.

3. **Emergency medicine:** The emergency room protocols developed by EMAP or other USAID-supported activities need to be examined, and aspects felt to be useful should be discussed and incorporated into the current Loma Linda protocols, if appropriate.

ANNEX 6. DETAILED FINDINGS AND RECOMMENDATIONS BY WORK AREA

PRIMARY HEALTH CARE

Contract Scope of Work

The task as described in the contract is to "strengthen the capacity of Palestinian health institutions to deliver a quality package of essential primary care services" (Objective 2.1, Task 2.1.1). Improving the quality of MOH PHC services is also listed among the IDP priorities.

Progress toward Achieving Results

The Palestinian National Strategic Health Plan (2008–2010) states that PHC and public health facilities provide services through multiple activities and programs including preventive medicine, noncommunicable diseases programs, community health, mother and child health, environmental health, and others. A "Package of Essential Primary Care Services" classifies all PHC facilities into four levels according to the type of services they provide.

The distribution of MOH PHC centers by level of services provided is as follows:

Area	Level 1	Level 2	Level 3	Level 4	Total
West Bank	73	187	89	8	357
Gaza Strip	0	29	19	7	55
Total Number	73	216	108	15	412
%	18%	52%	26%	4%	100%

**MOH Strategic Health Plan*, 2011–2013

Improving the quality of health services at the PHC level is fundamental to strengthening the health system as a whole. The Flagship Project was tasked to work with the MOH to strengthen, improve, and sustain the quality of essential PHC clinical services. To date, the Flagship Project equipped 83 clinics based on needs assessments received from the MOH and verified by field visits conducted by the project staff in collaboration with district MOH teams. However, the full model of clinic with community interventions has only been implemented in 21 facilities in Nablus. The project is currently expanding the implementation of the model to 15 more facilities in Qalquilia, Bethlehem, and Hebron.

The Flagship Project selected the Nablus district to launch its PHC level program, which was an excellent choice since Nablus was isolated by and suffered during the second Intifada. The MOH (central and district levels) and the Flagship Project selected the intervention clinics/communities using criteria based on the level of the clinics, vulnerability or potentiality of the community, urban or rural, and availability of CBOs (community-based organizations), especially if they had experience with a health project. The Flagship Project and MOH staff conducted site visits to the clinics and together with the facility staff; they conducted the needs assessment and collected baseline data for the clinics. Based on the needs assessment, the clinic, community, and district team developed their action plans and the Flagship Project facilitated a process allowing the team to present their action plan to the Primary Health Care General Director. This not

only empowered the field level teams but also emphasized the sense of ownership and commitment to the plan.

Based on the Package of Essential Primary Care Services and building on curricula developed under previous USAID projects, the Flagship Project updated/developed the standards of care (including ANC, postnatal care, family planning, infection control, the UNICEF-supported IMCI, nursing care services, health center management, and noncommunicable diseases such as diabetes mellitus, hypertension, and bronchial asthma). A committee including stakeholders working in the PHC level (private, NGO, UNRWA, MOH) was actively involved in reviewing, updating, and adapting the standards. The finalized standards are awaiting the minister's approval before being translated into Arabic, printed, and distributed to the PHC facilities. The equipping of clinics also generally followed the list of required equipment for the four levels of clinics.

A high quality training of facility staff was conducted by Jezour Company, which is affiliated with Colombia University, on the standards of practice topics. The Flagship Project is confident about the sustainability of the training after the end of the project. There are many qualified trainers at the MOH who received Training of Trainers (TOT) with other donors. On-the-job training (OJT) followed the formal training to reinforce and further build the staff capacity on quality service provision. The assisted supervision training the district team received equips them with the skills needed to provide constructive assistance to the facility staff. This clearly positively affects the quality of services provided at the clinic and hence increases the client flow. The nurses at the clinics visited praised the regularity of the supervisory visits after Flagship intervention. According to the Flagship experience, the OJT is the most important intervention that improves the quality of care. The Flagship Project collects monthly reports for the supervisory visits conducted of the 21 facilities where the project is implementing its activities.

Nutrition was identified as a serious problem that should be addressed at the PHC and community level. The project responded to the MOH's concern about this issue by developing standards of care for the most prevalent nutrition-related chronic diseases. During the second year of the project, the Flagship developed four nutrition-related guidelines: dietary management of diabetes, dietary management of cardiovascular diseases, obesity and overweight in adults, and dietary guidelines for Palestinians. The dietary and national guidelines were produced through the National Nutrition Working Group, which includes representatives from the MOH, WHO, UNFPA, UNICEF, Action Against Hunger, World Food Association, Flagship Project, and the MOH representatives from the NCD and health education departments. Since the MOH nutrition department is new, the Flagship developed job aids for the nutritionists at all levels of the Ministry, as well as nutrition-related components of other job descriptions of MOH personnel. The Flagship built the capacity of central level nutritionists (19–21 newly appointed nutritionists graduated from Birzeit University). At the hospital level the project introduced the position of a consultant responsible for diabetes and food services in Rafidia hospital.

Findings

In general the evaluation team found that the work of the project at the PHC level was proceeding well and achieving tangible results. The project used an already well-established PHC clinic system achieving good results for MCH services as a platform to help introduce prevention and primary level management of chronic diseases. Supportive supervision is reported to be increasing the frequency and usefulness of the visits from district managers. The evaluation team witnessed an encouraging level of enthusiasm among clinic staff about the community mobilization activities and how they are positively affecting the work of the PHC clinics. The collaborative effort described above for developing the nutrition work in the project is a positive example of the Flagship PHC team's systematic approach to addressing a public health challenge.

The team identified only a few areas for improvement as follows:

- ECG machines have been provided to a number of PHC facilities, contrary to the national guidelines that only Level 4 clinics are supposed to be equipped with these machines according to the "Package of Essential Services." This is ill-advised since the physicians at the PHC facilities are not trained on using the ECGs. The equipment provision should conform to the MOH's own guidelines.
- Training on how to operate the equipment was only provided to staff when the sonogram machines were given to the PHC facilities; however, the staff did not receive technical training. Despite the Flagship assumption that the doctors receiving the machines have gynecological experience and are able to use the equipment appropriately, the lack of training and the large load of patients when the doctors visit the clinics several days a week eventually resulted in an underuse of the equipment in some facilities.
- There is a great need to develop a supervision checklist at the national level to be used during the supervisory visits. The Flagship Project should take on this initiative. A draft checklist, produced by Mrs. Marwa from the Nablus PHC Directorate, can be used as an initial guide. The checklist should include a scoring system to compare and monitor the improvement in each facility.

Recommendations

- Because there is a shortage of MOH physicians to provide coverage to all PHC facilities, the Flagship should advise the MOH to take advantage of the availability of NGO clinics in some places to provide a lower level facility with more preventive services that does not require a doctor to be present more than a few days a week.
- Add a scoring system to the supervisory checklist to help the MOH compare and monitor improvements among facilities.
- The Flagship should help the MOH institutionalize on-the-job training, as this is the most effective way to improve the skills of clinic staff. Mentoring and demonstrating good counseling skills is an example of how MCH services, such as nutrition and birth spacing, can be improved.
- USAID should lift the prohibition on the Flagship providing assistance in family planning, especially since counseling on the timing and spacing of pregnancies to improve maternal and newborn health is already MOH policy.
- This component of the Flagship should be expanded throughout West Bank and Gaza as it shows potential for having continued positive impact over the next three years. Graduation criteria can be used to complete work in some facilities and moving on to another geographic area.

COMMUNITY MOBILIZATION

Contract Scope of Work

The Flagship Project supports "delivery of a quality package of community-based health promotion and disease/injury prevention through the provision of effective outreach services in partnership with local communities" (Objective 2.2, Task 2.2.1). Contract deliverables include (1) a situation analysis and needs assessment; (2) national standards, expanded training, and a certification program for community health workers; and (3) support to the MOH to implement and scale up an integrated, multisectoral approach.

Progress toward Achieving Results

The Flagship Project's "Champion Community" initiative is a community mobilization program whose aim is to improve knowledge and awareness about key disease areas, encourage uptake of related services, and empower citizens and communities to work together with their clinic to find local solutions to identified health needs. The initiative brings together leaders of the community and civil society to identify health problems and to work with local health care providers and the MOH directorates to plan for future community health needs.

In year 2, the Flagship provided one-year subcontracts (for $16,800 each) to support the establishment of 21 community-clinic committees in Nablus. Committees are chaired by existing, women-led CBOs and consist of a maximum of 12 local community leaders, including the CBO staff, clinic nurse, school officials, non-MOH health workers, and other key figures. The champion community initiative is focused on preventative health outreach activities that promote healthy living to reduce noncommunicable diseases such as hypertension, diabetes, and heart disease; education on injury prevention and the dangers of smoking; as well as woman and child health issues. It also builds community capacity to self-identify priorities, needs, resources, and solutions, in such a way as to promote representative participation, good governance, accountability, and change.

After a needs assessment of priority health problems was conducted, a community action plan was developed to identify possible solutions for the problems identified in the needs assessment report. MOH and Flagship staff conducted training for committee members, CBO staff, and the community health volunteers (CHVs) on provision of health education activities, home visits, and outreach and mobile services in their communities. Alongside the daily outreach activities of the CHVs, the committees are required to conduct five medical days, seven community campaigns, and two first-aid courses during the course of the contract. Bimonthly meetings of the committee and monthly activity reports are submitted to the MOH and project. Communities are encouraged to mobilize their own resources to further contribute to improved health and wellness.

Flagship will reward its "champion communities"—those with the best outcomes and impact—with follow-on one-year contracts. The Nablus health directorate has also committed to maintaining and scaling up activities in the district once Flagship contracts have ended. Four additional communities from the Jenin, Jericho, and Tulkarem districts are currently piloting this approach as a result of participating in the Flagship Project's TOT in-community mobilization. In year 3, the project will scale up the approach by engaging communities in two additional districts—Hebron and Qalquilia.

Flagship staff also worked with Ibn Sina Nursing College to integrate a community mobilization module into the permanent four-year nursing curriculum. This is significant in that it further bolsters the sustainability of this approach in later years after the project is finished.

Findings

The Champion Community Initiative has realized countless successes already in its first year of implementation, and the project should be commended for achieving both improved community linkages with MOH and measurable health impact (increased awareness and use of services) in this short time. There are too many successes to list them all here, but examples collected from a handful of PHC clinics visited include:

Increased Knowledge and Awareness

- CBOs reported a vast increase in health education activities; whereas before, health education activities occurred only two or three times in a year, there are now as many as 17 activities conducted each week, reaching as many as 150 individuals in a day.

- Community health volunteers conduct educational sessions in the clinics on days when large groups are gathered and waiting to see the doctor, and health education days and mobile clinics encourage individuals identified as possibly at-risk to follow up at the clinic.
- Mothers of young children at one clinic indicated that they received better health information from the nurse and from the volunteers in the last year, and this encouraged them to return more regularly for ANC and PNC, immunizations, and other services.
- In one community, the first educational session on mammogram screening for breast cancer attracted only 14 women. By the second session there were 40, and by the third, 60 women came. Now, the volunteers are being stopped in the road to ask when the next one will be held.

Increased Service Utilization (Clinic and Mobile Services)

- CBOs are tracking service utilization within the clinics, as well as in mobile outreach services. Significant increases in attendance can be seen in everything from screening for noncommunicable diseases to MCH services.
- Blood screening for newborns, screening for diabetes, pap smears, breast screening, osteoporosis checks, and blood pressure screening were all listed unprompted by clients in the PHCs as important improvements in the clinics and/or changes in their behavior as a result of the community initiative.
- Alongside increases in attendance, CHVs conducted home visits to dropouts to determine why they did not return for treatment as scheduled and to encourage them to do so.
- In one community, 98% of women of target age had had a mammogram screening during the course of the year because of community activities to improve awareness about and access to this service.
- Community first-aid training has proven to be of significant value: one young girl cut her face badly on a barbed wire fence, and her teacher provided first aid to clean the wound and stop the bleeding before she reached the clinic for stitches. Another child who was choking and had turned blue received successful first aid in her community. In another instance, a woman bitten by a snake was administered first aid. The doctors at the hospital indicated that she would not have survived had she not received this treatment.
- Linkages with NGO grantee mobile programs resulted in identifying over 70 children in need of eye care (through St. Johns Eye Hospital) and hundreds of women screened for breast cancer (through Augusta Victoria Hospital).

Improved Advocacy and Coordination with MOH

- Advocacy with the district MOH directorate for improvements at local facilities showed results; some clinics were able to move to a preferred location, while others succeeded in upgrading the existing facility (including painting, improved water, and cleanliness and hygiene).
- A number of committees complained about the limited time with skilled health staff, and particularly the availability of doctors or nurses with specialty training. As a result, doctors are rotated more frequently through these clinics, and other staff—such as administrative assistants—have been hired by the MOH to assist nurses with administration and record-keeping.
- Communities reported feeling more "in touch" with the MOH and more empowered to communicate directly with them about needs in their area.

Increased Ability to Mobilize Local Resources

- One CBO hired a fulltime cleaner for the clinic—who will stay on after the contract with Flagship is finished—in response to the community needs assessment (and alongside the MOH's commitment to provide administrative assistants).
- In some communities, where contaminated water was identified in the needs assessment, environmental groups were contacted to treat their water at the source.
- Many communities raised funds locally to contribute to their efforts (one community reported over $3,000 contributed during the year), volunteer time (one community reported over 200 active volunteers in its network), and in-kind contributions (towels and other provisions) as a result of community mobilization activities.
- Communities reported having more "credibility" as a result of this initiative, indicating that support in the community for their work was growing and willingness to contribute (financially or otherwise) increased each time they had demonstrable results.
- A number of the committees were comprised of individuals from a variety of sectors outside of health. These included the Ministry of Education, municipal sports department, and in one case, the deputy mayor.
- CBOs reported that their organizational, managerial, and report writing skills had all improved as a result of this activity, and felt this would further enable them to maintain activities as well as fundraise in the future.
- One committee had already begun compiling income generation ideas to maintain its community activities in 2011.

Although the majority of the feedback was overwhelmingly positive, a few constraints or complaints did emerge. Some committees felt it would be a challenge to maintain activities at the current level of effort once contracts were closed and volunteers' stipends were no longer available. It was unclear if the Flagship had provided adequate training and preparation for fundraising and sustaining of activities once the contracts ended.

The laudable increases in service utilization, which are a major success of this program, also present an increased burden on the MOH's already strained services. Increased awareness of patient rights to services at the primary health care level, such as diagnostic screenings, present a new challenge to the MOH. To this extent, it is important to manage community expectations of what their local clinics can do and to challenge them to adopt healthier lifestyles and promotion of disease prevention to address this gap.

The biggest challenge to the Flagship will be ensuring the sustainability of this approach in coming years and, more significantly, in three years when the project comes to an end. While enthusiasm for this activity at the local, clinic, and district levels is extremely high at present, it is too early to know if this approach will get the traction it needs to be sustained over the long term.

Recommendations

- **Scale up community committees throughout West Bank and Gaza.** This achievement should be rolled out across the country in the coming three years, alongside MOH and Flagship support to primary health clinics.
- **Complete and distribute the "champion community" manual, with best practices included.** A "how-to" guide to implementation of the champion community program is drafted and should be completed, as well as a short training guide for the start of this in various districts and communities. This will help the MOH, other districts and communities, and other interested stakeholders to implement this approach.

- **Measure the sustainability of this approach.** The project plans to return to Nablus (and other districts after they "graduate") to monitor the sustainability of this approach in years 3, 4, and 5. Sustained mobilization takes place when communities remain active and empowered after the program ends. Ideally, having measurable indicators—continuation of BCC activities, changes in knowledge and awareness, community donations/funds raised, increases in client flow, linkages with MOH directorate at the district level and/or with NGO programs, etc.—would help to measure the sustainability of this initiative, to compare and contrast successes and weaknesses across communities, and to identify areas where communities are most likely to be successful and those where more project emphasis might be needed. The project has begun to identify how this would be done (see consultant reports from Shaun O'Neil), and these should be followed up on and finalized in consultation with the MOH.
- **Document successes and "best practices" and the conditions under which communities sustain community mobilization activities.** Documentation of successes, achievements, weaknesses, and constraints in the Palestinian context will help guide future work in community mobilization.
- **Work with other nursing colleges to include community mobilization modules in Palestinian nursing curriculums.** Inclusion of the community mobilization module developed jointly with Ibn Sina Nursing College into other nursing college curricula will help sustain these important activities in future.

BEHAVIOR CHANGE COMMUNICATION

Contract Scope of Work

The Flagship Project was asked to "strengthen the capacities of Palestinian health institutions to effectively use communications strategies to promote healthier and safer behaviors" (Objective 2.2, Task 2.2.2). Contract deliverables include (1) a situational analysis and needs assessment of MOH health communications programs, materials, and systems; (2) 15 behavior change communication modules targeting key health knowledge and behaviors; (3) expanded opportunities for health communications training for health care providers and educators; and (4) a feasibility study for creating a youth health outreach program.

Progress toward Achieving Results

The Flagship's behavioral change communications activities began with a situational analysis and needs assessment to help identify key technical areas for intervention. In coordination with the Health Education and Promotion Department (HEPD) of the MOH, donors, and other stakeholders, 15 health areas were identified as "gaps" in current health education and outreach activities, and thus became priority intervention areas for the Flagship Project. These 15 health areas were collapsed into six key intervention areas in year 2, which include: (1) noncommunicable diseases, (2) women's health, (3) healthy lifestyles, (4) injury and accident prevention, (5) community first aid, and (6) child health.

To date, the Flagship Project developed or reprinted 12 BCC materials (booklets, leaflets, and coloring books) covering 11 health areas, including diabetes, cancer, hypertension, healthy living, nutrition, smoking cessation, complications in pregnancy, and injury prevention. Printed materials are sent from the HEPD of the MOH to the district MOH directorates, who distribute these to clinics and community health workers and send reports back to the central HEPD office about the dissemination of materials. The project is currently in the process of developing a further two brochures, alongside a series of radio spots and TV cartoons intended for dissemination year 3. An ambitious number of print, TV, and radio spots are planned in years 4 and 5.

With funds provided by the Flagship, three NGO grantees also produced printed BCC materials. These include information on healthy pregnancy and healthy lifestyles for women (from the Shepherd Field Hospital), eye care (from the St. John Eye Hospital), and early detection of breast cancer (from the Augusta Victoria Hospital). The project does not appear to recognize the materials produced by grantees as comprising a part of their own objective to produce 15 BCC "modules."

The project conducted three trainings in the first two years of implementation (an overview of BCC and techniques for MOH staff and other health workers, a joint MOH-MOE training on healthy lifestyles and obesity for health educators, and a training for media to improve understanding and correct dissemination of key disease information). Other BCC activities being implemented under the project include summer camps for kids, community health days, and—importantly—community-level activities with CBOs and community councils.

The project plans to evaluate BCC activities through a recall survey to be implemented by Intra annually (starting in early 2011), and a limited number of questions in their quality of care consumer surveys addressing health education and counseling received from doctors.

The project is currently developing a BCC manual to strengthen capacity and the sustainability of BCC approaches and activities developed under the program and in coordination with the MOH.

Findings

While the BCC component of the Flagship Project has been very active in producing materials, it does so in the absence of any evidence-based decision-making required to provide strategic direction to the development, implementation, monitoring, and evaluation of its activities.

Needs Assessment: Early in the project, the Flagship worked successfully with the MOH, donors, and other stakeholders to undertake a situational analysis and needs assessment to guide future interventions in BCC. The identification of gaps in materials, coupled with epidemiological data—e.g., the need for more education and outreach on NCD prevention—was strategically driven, evidence based, and well coordinated between key players.

Materials Development: While the project had a strong start in defining the gaps in BCC, the development of BCC materials to date has not been informed by any kind of evidence-based decision-making process. While the technical content of BCC materials was checked by the corresponding MOH departments and materials were field tested to be sure the messages were clear, the project has no way of knowing whether the information included addresses key drivers in behavior or will lead to any changes in knowledge or practice as a result. That said, the evaluation team did note that people in the clinics were reading the brochures available and taking them home with them, so it appears that these are being used and do contain useful information.

It is unfortunate that the deliverables outlined in the contract do not require the project to measure achievements beyond outputs achieved at the activity level and, furthermore, that they are tasked with the rather onerous and seemingly arbitrary goal of producing 15 BCC "modules." Project staff expressed frustration, echoed in one STTA report early in the project, that this is an ambitious number of disease areas to cover. In addition, no definition of a "module" is ever provided, making it hard to know if one brochure, or a broad scale multimedia campaign supported by intensive community outreach activities, is required to reach the contract's objectives. The evaluation team got the impression that the project has been racing to produce BCC materials to meet its criteria in 15 disease areas, rather than strategically designing BCC activities to help them achieve the ultimate goal of a shift in knowledge, attitudes, or behaviors that might ultimately lead to reductions in morbidity and mortality.

Evidence-based Decision-making: It is troubling that the project has no baseline data derived from a knowledge, attitudes, and practices survey (KAP) of their target audience, and has no end of project indicators against which it can measure the successes of these interventions. Without this, it will be impossible to say whether the considerable time and resources invested in BCC activities have had any real impact.

A notable exception to this is the deliverable report entitled "Health Lifestyles of Palestinian Youth," a baseline survey undertaken in year 1 of the project about youth and healthy lifestyles, including exercise, smoking, and eating patterns. While the executive summary states that the survey was conducted to "provide reliable baseline data to measure knowledge, practices and attitudes of youth in health-related issues, and to serve as a formative basis for designing behavior-change communications messages directed at Palestinian youth" (page 5), it does not appear that the findings in this survey were used to set baseline and end-of-project indicators for interventions which target youth. Nor were findings used to segment target groups amongst youth (girls versus boys, smokers versus non-smokers, etc.) to guide the development of messages, interventions, and BCC materials produced, or to monitor progress toward achieving goals. While the contract states only that this report is a deliverable in and of itself, the evaluation team feels this is a missed opportunity to realize an informed BCC campaign targeting youth with key messages about health.

BCC Manual: The project is in the process of developing a BCC manual, and a cursory review of the draft version indicates that this is a very comprehensive guide to development of evidence-based communications programs, which, when finalized and used, should help the project and the MOH to use quantitative indicators to drive development, monitoring, and evaluation of all future BCC activities.

Donor Coordination: There are a number of other donors working on BCC in the disease areas identified by the project, with whom the project is not currently collaborating. The UNFPA is working in women's health; UNICEF in child health, IMCI, and nutrition; and the Austrians in noncommunicable diseases. Close collaboration and coordination of activities would ensure that the project is not duplicating efforts and is likely to lead to greater impact as a result of shared resources. For example, at the time of writing, the Austrians were airing a multimedia campaign about prevention of noncommunicable diseases. The Flagship is currently in the process of developing radio and TV spots and plans to develop billboards, posters, and theater sketches addressing similar topics. Coordinating these efforts and the implementation of one unified campaign on noncommunicable diseases could potentially increase its reach and impact, as well as bolster MOH capacity for future initiatives. Similarly, combining efforts to undertake quantitative and qualitative analyses is encouraged.

Recommendations

- **Use Evidence-based Decision-making (EBDM) to guide all future BCC activities.** Before any further materials are developed or distributed, the project needs to step back and conduct a population-based survey of knowledge, attitudes, and practices of Palestinian men and women in key focal areas. Baseline (or really, midterm) and end of project indicators should be set using the research findings of this new survey and the youth survey already conducted. Findings should also be used to segment target markets, identify key drivers of healthy behavior, and develop an appropriate message mix alongside the channels to be used to deliver this information.
- **Limit the number of key interventions to two or three disease areas.** Contract deliverables for BCC should be amended to steer focus away from production of materials or modules and toward measurable impact of project activities on healthy behaviors amongst the Palestinian population. Noncommunicable diseases, women's health, and

nutrition all appear to be areas with sufficient epidemiological data and lacking BCC initiatives to warrant focus within the project. Once baseline research is conducted, the project can determine what mix of interventions (mass media, community-based outreach, in-school programs, etc.) should be developed and implemented. Materials already produced in other disease areas and deemed valuable could still be reproduced to cover gaps in other non-focal areas as needed.

- **Hire a permanent and qualified BCC expert to manage these activities.** The project staff currently lacks the expertise required to undertake EBDM and effective implementation of BCC activities. While short-term consultants have provided some valuable insight to the program, there was insufficient follow up on recommendations made in these reports. At least one additional staff member is required if the project is to be successful in its BCC programming.
- **Capacity building at the MOH is essential for long-term success of BCC activities.** The MOH should be closely involved in the development of the BCC manual, baseline research, and development and implementation of messages and campaigns that follow. Behavior change takes a long time and requires sustained, consistent efforts to see results. The Flagship should assist and measure the MOH's ability to manage and coordinate BCC activities, both within the project and beyond.
- **Collaboration with other donors and stakeholders is urgently required.** Other donors working in the Flagship's focal health areas and identified by the team include UNICEF, UNFPA, and the Austrians. There are likely more, and the Flagship—alongside the MOH—would benefit from closer collaboration of efforts. In addition, there are a considerable number of studies (e.g., the Family Health Survey, the MICS survey from UNICEF, and various youth studies from the Institute of Community and Public Health) which would further aid in the development of evidence-based communications campaigns.
- **Close coordination of activities between components within the Flagship will improve impact.** The Flagship's efforts in BCC need to be better coordinated between its own production of materials, those produced by NGO grantees, its community-based initiatives, and improvements in quality of care provision at the primary health care level (including health education of service providers). The project's current approach is fragmented, which reduces the likelihood of impact.

SECONDARY HEALTH CARE—PALESTINE MEDICAL COMPLEX (PMC)

Contract Scope of Work

The tasks in the contract in the area of hospital services are fairly general and are aimed at strengthening the capacity of Palestinian health institutions to deliver improved quality of secondary and emergency health care (Objective 2.1 and Tasks 2.1.2 and 2.1.3). There is also a contract deliverable on improving management of the PMC.

Progress toward Achieving Results

Legal documents establishing the PMC are still awaiting ratification by the Palestine Legislative Council. However, once the PMC formally opened and the leadership positions were filled on an acting basis, the Flagship began providing technical assistance and support to improve the management efficiency of the complex, as well as improvements in nursing services and medical update seminars for medical personnel. A full-time expatriate hospital administrator was assigned to work with the PMC to provide management and operations advice.

The project staff accompanies PMC senior management staff on weekly administrative rounds in order to identify and address the problems. They have offered lectures pertaining to the care of

high-risk newborns and children and implement a weekly journal club in pediatric medicine at the PMC to help staff learn the latest techniques and best practices. In the PMC Children's Wing in particular, interdisciplinary meetings are routinely scheduled and focus on quality improvement as well as pediatric rules and regulations for both physicians and nurses. In addition, the job descriptions were developed as part of HIS implementation, which has helped to clarify roles and responsibilities.

The project staff also worked with the PMC chief nursing officer and director of nursing to develop a nursing system that addresses staffing deficiencies and encourages nurses to engage in patient care through an interdisciplinary approach.

Findings

The MOH conceived the PMC as a tertiary center and intends to develop it as such for the West Bank, but serious issues such as whether the West Bank needs a tertiary hospital were never considered or sufficiently analyzed. One official interviewed by the evaluation team stated that PMC becoming a tertiary facility would constitute the public sector competing with the NGO and private sectors and that buying the services is a much cheaper and more efficient option. The evaluation team noted that there is no clear vision for the PMC. One highly credible interviewee remarked, "The PMC is a potential white elephant." Others interviewed felt that the MOH would have serious difficulties transforming the PMC into a tertiary care center given staffing problems and resource constraints, and should examine alternatives.

Consultants were brought in by the project to "justify the establishment of the PMC," given the "need to organize and provide tertiary care services that will inspire the Palestinian health system to provide high quality services in a complementary fashion."[8] Various consultants' reports were not aimed at looking critically at the feasibility or desirability of the investment but focused on what it would take to make such a complex function as a viable, autonomous public sector referral facility. Instead, the project should have conducted a rigorous analysis of the budgetary and health systems implications of the investment and the availability of alternatives to expansion of MOH responsibility for tertiary services, presented policy options and alternatives, and sought advice and participation by USAID, other development partners, and stakeholders in the process of dialoguing with the minister on an important and far-reaching policy issue. All this was especially crucial given the importance of the hospitals in East Jerusalem, which would inevitably be affected in one way or another by the PMC.

Clearly, there are serious questions of policy and the role of the MOH involved in further developments at the PMC. The most important contribution from the Flagship Project could have been to undertake this analysis of the issues involved. Presenting such a study to senior leaders as a way to engage in important reform dialogue is an opportunity lost, and it may now be too late.

Recommendations

- If there is a suitable opportunity, the project should conduct an analysis of the budgetary and health systems implications of the investment in PMC as a tertiary center and the availability of alternatives to expansion of MOH responsibility for tertiary services, present policy options and alternatives, and seek the advice and participation by USAID, other development partners, and stakeholders in the process of dialoguing with the minister on this important and far-reaching policy issue.

[8] "Development of a Start-Up Plan for the Palestinian Medical Complex", Flagship Project, February 12, 2010, page 7.

- Redefine what the project will contribute, if anything, and make it parallel with what the Flagship will do with other secondary hospitals.
- As the only MOH hospital in the Ramallah District, the Flagship Project could:
  - Strengthen the administration and financial management of the PMC.
  - Strengthen the quality assurance systems.
  - Strengthen the capacity of the PMC to provide quality emergency care services.
  - Serve as a training hospital for the ongoing Emergency Residency Program.

SECONDARY HEALTH CARE—MOH HOSPITALS

Contract Scope of Work

The tasks outlined include strengthening quality improvement systems within Palestinian health institutions to deliver better secondary health care services and increasing the capacity of Palestinian health institutions to provide quality emergency care services (Objective 2.1 and Tasks 2.1.2 and 2.1.3).

Progress toward Achieving Results

In addition to the work with the PMC, the project provided technical assistance and other inputs to the MOH for other secondary hospital sites. The project assessed Rafidia Hospital in Nablus and Alia Hospital in Hebron and drafted action plans to improve the quality of health services at both facilities, with recommendations on improving emergency and pediatric services, as well as medical staff organization. Emergency protocols were developed and are in the process of being translated into Arabic and distributed.

Other project activities included a number of technical and administrative elements. Project staff worked with USAID's EWAS program to provide the necessary infrastructure changes in the pediatric/neonatal and emergency departments. They also provided bedside coaching and mentoring within the new neonatal intensive care unit at Rafidia and Alia hospitals.

Recommendations were developed for the MOH related to staffing, distribution, supplies management, and configuration of the layout and placement of equipment and furnishings. Project staff helped build up the capacity for decentralization at Qalquilya Hospital, which is the MOH's pilot site for decentralization of hospitals.

Project documents state that it introduced the concept of interdisciplinary teams consisting of physicians, nurses, and ancillary service staff working together to improve the quality of patient care. The project supported the MOH to host scientific nursing days in an effort to enhance nurses' knowledge. A total of 180 nurses from 11 MOH hospitals attended.

The project also reported that it is working with NGO secondary level hospitals to strengthen their ability to deliver better secondary health care services within their specialties.

Findings

During the period when the Flagship Project had suspended work at the PMC, the MOH decided to move the pediatric department from the old Al Watani Hospital in Nablus to the new location at Rafidia Hospital, and the project agreed to provide technical assistance in pediatric medicine and offered recommendations to transform Rafidia Hospital into a child-friendly facility. Working in the area of pediatrics is not mentioned in the original contract or in the amended scope of work. The team found that the project was also assisting the neonatal department at Alia Hospital in Hebron. While this work may be useful in the long run, it illustrates the reactive nature of the project's work in the hospital sector and illustrates how it

is not anchored in a clear vision about the role it plans to play in supporting secondary health care.

One of the dangers of working with hospitals if the parameters of the assistance are not carefully defined is that secondary health care can consume large resources as costs are high and the needs are often great. To have sustainable impact, the Flagship needs to take a more strategic approach to focus clearly on specific objectives related to improving secondary care and then target resources and technical assistance to achieving those objectives and measuring the results. For example, the Flagship contract gives the project a mandate to improve the capacity to deliver high quality secondary care. If the project focused on establishing a quality improvement system and worked on demonstrating the concrete outcomes that result from improved quality in selected departments, the value of such a system (and the motivation of hospital personnel to implement the changes) could become institutionalized and used more broadly by hospital leadership within various hospital departments. As staff move, the system and oversight of it remains, and new staff arrivals are trained to carry out the same procedures. Simply developing standards of care for various departments may not be sufficient to ensure that clinicians use those standards or understand how the standards result in better outcomes, for example, reduction of nosocomial infections, reduced case fatality rates, shortened hospital stays, and so on.

Not surprisingly, the group of specialists and managers in the project working on hospital activities are not functioning as a cohesive team with a clear sense of direction and purpose. Some staff do not know about each other's work or do not coordinate effectively.

Recommendations

- USAID and the Flagship Project need to develop a clearer plan for its support to the secondary hospital sector, including what hospitals to focus on in the course of the project as well as what elements of hospital operations are mostly likely to contribute to improved quality of secondary care, so that the USAID project can demonstrate a positive impact during the next three years.
- The plan developed should carefully delimit and justify the USAID support and set forth specific outcomes that are feasible within the remaining period of the project given investments already made. This will prevent the Flagship from responding too readily to MOH requests without thorough analysis.
- Define more narrowly the work of the project in secondary care to only the following, but continue to expand geographically:
  - Emergency medicine residency program.
  - Establishing the HIS in pilot facilities and associated training on costing, computer software, and use of information for improving hospital management.
- Using any available clinical protocols or related materials, develop a QA system (working with hospital QA committees) in a limited number of departments to demonstrate how such a system works (e.g., infection control, emergency, OB/GYN, or pediatrics/neonatal intensive care departments). Measure improved compliance to standards to show concrete outcomes for quality improvement. Compare and publicize results among hospitals to engender competition.

QUALITY IMPROVEMENT

Contract Scope of Work

Two tasks are listed for strengthening the capacity of Palestinian health institutions to deliver quality primary and secondary services (Objective 2.1 and Tasks 2.1.1 and 2.1.2). The deliverables also include a directive on developing an "integrated quality improvement program for delivery of an essential package of primary care services" and the same for hospital services.

Progress toward Achieving Results

The Flagship Project succeeded in activating the quality department at the MOH central level. Through different workshops the project introduced the concept of quality and the importance of supportive supervision to enhance the skills and build more understanding of QA. The project also finalized important documents like the "Standards of Care for PHC Services." The MOH appointed a quality control coordinator at each hospital and gave them an overall orientation about the concept of quality.

The PHC clinics are equipped with all inputs that lead to improving the quality of services; the standards and guidelines of practice are available (finalized by the Flagship and awaiting the minister's approval to be distributed), the facility is equipped according to the standards, the staff received specialized training, the clinic is strongly linked with the community by the CBO involved in shaping the provision of care to the needs of the community, the staff receive regular constructive and supportive supervision and on-the-job training from the district team, and they receive feedback from their supervisors to ensure the improvement of quality of services provided. This creates a quality culture at the facility level, which can now be built upon to develop a quality improvement system.

Findings

Many previous quality improvement activities have not been sustained beyond the period of the donor projects that funded them, which underlines the importance of building a system across the levels of health care rather than focusing only on specific tools or committees. For example, a National Quality Committee was developed under a previous USAID project but did not remain active after the end of the project. UNFPA trained 300 people on quality improvement and these champions were able to reduce the rate of sepsis in Rafidia hospital from 10% to 0% (according to the National Health Programme Officer at UNFPA). However, the trained people have moved on to new positions, and no system remains in place. The experience in West Bank and Gaza should be a lesson on the importance of developing a sustainable QA environment and systems rather than on simply training people or developing QA tools.

The Flagship lost the key staff member assigned to work on quality, which may have caused some setbacks. So far, little has been accomplished to agree on the details of a national system for QA other than identifying it as a priority. A systematic plan to building that system in a stepwise fashion is not in place. At the clinic level, the important inputs are now in place for equipment, supplies, and drugs; and the PHC Standards of Care is awaiting final approval. A promising effort is underway to monitor community feedback on quality of services, including involvement by the CBO in monitoring increases in utilization of selected PHC services, as well as monitoring client perceptions of quality improvements. Despite these promising activities, a QA/QI system has yet to be fully conceptualized or implemented at the clinic, district, or hospital levels. The Flagship appointed staff for QA/QI development, but the project still lack a clear vision about how to move forward on this issue, although steps are being taken to enhance technical staff in this area.

Recommendations

- The MOH, with Flagship support, must develop a national QI/QA system that accurately reflects outcomes and monitors progress over time. The PHC indicators suggested by Dr. Mary Segall, a short-term consultant for the project, are useful to begin discussions that should involve UNRWA and NGOs.
- UNRWA has an excellent supervision system; that system should be explored to enhance and expand the MOH's supervision system. Understand and use resources developed to date. Seek out experience in UNRWA and NGOs to conceptualize a system with input from those who have been working on this in the past. Develop a plan with MOH and relevant partners on a step-by-step process that institutionalizes a QA system at the central, district, and service delivery levels.
- Include a system to measure and monitor quality outcomes, beyond just client surveys. Provide MOH with international best practices in this area to urge moving forward. Ensure tools and systems are part of the MOH system and part of the internal system, not Flagship protocols.
- To demonstrate how a QI system affects outcomes, a baseline must be established and the improvements monitored over time. "Self-assessment tools" can also be a powerful way to inculcate the "culture of quality" at the service delivery level.
- Work at both primary and secondary levels building on tools already developed in earlier USAID projects and other programs in the private and public sector.
- In hospitals, the project should focus on a limited number of departments to start the QA system. The unified Protocol for Obstetrics and Gynecology developed with UNFPA assistance is an excellent start and could also be used by NGO hospitals. Involvement by academic institutions would also broaden support and buy-in for clinical standards of practice. Focus on establishing systems within the hospital for monitoring the quality improvement practices and assist them in measuring progress and using that information themselves to expand QI throughout all departments.

MEDICAL WASTE MANAGEMENT

Contract Scope of Work

The Flagship Project's mandate for medical waste management interventions was originally linked in the scope of work to the procurement component, and thus is quite narrow. That mandate was broadened and moved to component 2 after the MOH needs assessment and IDP identified medical waste management as a systemic problem and a key priority.

The deliverables in the scope of work are waste management assessments for the MOH and beneficiary NGOs, followed by mitigation plans and technical assistance, as well as monitoring reports. These deliverables do not reflect the magnitude of the medical waste management challenge presented in the IDP module. The issue is not picked up in the PMP.

Progress toward Achieving Results

Based on conversations with the Flagship procurement team and spot checks at medical facilities, the Flagship Project has generally taken care to include the necessary supplies for medical waste management when procuring medical equipment, where relevant. In fact, where relevant, medical waste management supplies for one year were made an integral part of the supplier's contract.

A Flagship Project short-term consultant, a Loma Linda Associate Professor with expertise in medical waste management, developed an assessment tool. She also identified key factors that

are essential to the development of a sustainable and functional medical waste management system (August 2009). The Flagship Project has used this assessment tool to review medical waste management practices at individual secondary MOH and NGO hospitals.

A total of 17 "assessments" have been completed according to Flagship Project staff, 7 by the Loma Linda consultant and 10 others by Flagship staff (sometimes together with a MOH representative). The first seven only have been approved by USAID to date; they cover three MOH hospitals (Alia Hospital in Hebron, Ramallah Hospital in Ramallah, and Rafidia Hospital in Nablus) and four NGO hospitals (the Makassed and Augusta Victoria hospitals in Jerusalem, and the Bethlehem Arab Society for Rehabilitation and the Holy Family Hospital in Bethlehem).

The Flagship Project originally also conducted medical waste assessments at the primary health care level, but this was discontinued at the request of the MOH, who reasonably suggested to first focus on hospitals.

The Flagship Project organized two medical waste management related training sessions or workshops at the Augusta Victoria hospital. The first training was organized for hospital and HCF staff involved in infection control; the second training was for biomedical engineers. The latter inspired a MOH mechanical engineer to introduce an Augusta Victoria medical waste management practice in the plans for a unit in the Palestinian Medical Complex.

A local consultant is currently developing a medical waste management mitigation strategy and system. The Flagship Project expects the report to be ready in December 2010; after review, the project plans to present the strategy and system to the MOH.

Findings

The IDP and revised scope of work raised high expectations about the role of the Flagship in addressing the "chronic problem" of medical waste management in the West Bank and Gaza. Together they implied that the Flagship Project would go far beyond procurement of medical waste management supplies and engage at two other levels: it would start working on medical waste management within health care facilities as part of infection control and quality assurance, and—even more importantly—it would engage at the national level and help develop a clear and well-developed medical waste management system and strategy (including agreement on the roles of various authorities; enactment of specific legislation, regulation, and standards; improved coordination; and training of staff). Two years into the project, very little progress has been made, and the prospect of tangible results by the end of the project, at the hospital and especially at the national level, is rather dim.

At the Hospital Level

The hospital "assessments" do not go in depth; they reflect a cookie-cutter approach, a checking off of boxes on a list and, in the latter batch of assessments, a bland repetition of the same recommendations in every report. There is no indication of any in-depth analysis having been done; the assessment reports thus cannot form a sufficient basis for targeted mitigation strategies and implementation plans in the given facilities. At any rate, the Flagship has not yet begun the process of follow up to the assessments. In its view, there is no point to developing mitigation and monitoring plans within health facilities as long as there is no national system in place and no officially adopted bylaws (signature is awaited)—a point of view that may not necessarily be shared by all.

Interlocutors in all hospitals visited were dismissive of what the Flagship Project had done in terms of medical waste management to date. In their view, nothing had been achieved.

Based on the field visit to Rafidia hospital in Nablus, a Flagship emergency care specialist is working on improving medical waste management practices in the hospital's emergency

department. This work seems to be taking place in the framework of strengthening emergency care only, without coordination with the Flagship's medical waste management team.

At the National Level

The IDP module's implementation plan paints with broad strokes the steps that need to be undertaken to establish a functional medical waste management system; its timetable has already proven to be unrealistic. A thematic working group exists, but it is reportedly not very active.

The Flagship Project has not moved forward on the national level agenda. It is essentially waiting for a report it has commissioned, which—it expects or hopes—will include an acceptable proposal for an operational medical waste management system and strategy. This may very well not be the case: the local consultant developing the proposal has experience in solid waste management and wastewater, but no experience in medical waste management. According to a Flagship staff member, it was too expensive to tap again into the technical expertise of the Loma Linda consultant who was brought out to do the initial assessment and identify key factors for moving forward. It is not clear at this point to what extent the work of the local consultant will tap into, replicate, or divert from the medical waste management master plan the World Bank published in March 2006.

Based on comments provided, the Flagship's medical waste management team has no other implementation plans in the near future than presenting the consultant's report and proposal to the MOH early next year, hoping that the MOH will endorse it and become its champion. Given the reported impatience of the MOH with medical waste assessments of hospitals that only lead to reports, and the MOH unwillingness "to engage in developing a medical waste management system until treatment technologies are procured" (Y2Q2, p 9), the road toward the MOH championing any strategy may be bumpy. The Flagship is not undertaking any groundbreaking discussions with the Ministry of Environment and/or the Ministry of Interior Affairs, overseeing local municipalities, in the meantime.

It is noteworthy that other donors are no longer active in this field. JICA no longer funds UNDP work in this regard because of budget cuts, and the World Bank is also no longer active, according to Flagship staff.

Recommendations

- **The project should withdraw its engagement from the national-level activities in medical waste management, based on the above findings and in context of the overall recommendation, in favor of program consolidation.** It is unrealistic of the project to believe that a proposal written by a non-expert in medical waste management will be able to turn around the situation in a few months, mobilize stakeholders, and enable the foundation of a sustainable system by the end of the project. The prospects for future success are also dim, given the lack of in-house, in-depth expertise at the project and the enormity of the task at hand.
- **The Flagship Project should strengthen medical waste management activities at the hospital level, and continue to make further improvements to the work at the primary health care levels.** Given the importance of medical waste management in the context of infection control, a focus at the facility level is justified. It is recommended the project does so by making medical waste management an integral part of its QA work in general, and an integral part of the emergency care support package in particular. The project's medical waste management staff should be firmly anchored in, and perhaps supervised by, the project's primary health care and hospital teams.
- **Explore other donor interest.** It may befit USAID and the project to consult and explore which other donor organization(s) may be willing to (again) support the MOH and

other ministries in developing an operational and sustainable medical waste management in the foreseeable future. The assessments, the forthcoming report, and any other information collected should then be passed on.

NGO GRANTS AND CAPACITY DEVELOPMENT

Contract Scope of Work

The Flagship Project recognizes that the NGO community plays a significant role in the delivery of health care services, which is why the project aims to strengthen not only the MOH but also selected NGOs. The scope of work singles out NGOs who provide referral services in East Jerusalem, delivery quality rehabilitative care, or provide professional training and development for health professionals. Both NGO networks and smaller stand-alone NGOs can be eligible to receive assistance (SOW, p. 12). The beneficiaries are to be selected according to their institutional capacities, sustainability, compliance with USAID/WBG anti-terrorism requirements and successful completion of the vetting process (SOW, p. 11, FN 7).

The list of deliverables includes references to institutional development plans for beneficiaries and on-the-job training; the PMP focuses on capturing the number of NGOs receiving capacity strengthening support (LOP target: 30) and the number of grants issued (LOP target: 53).

The reported LOP budget is $1.8 million.

Progress toward Achieving Results

To date, the Flagship Project is supporting 12 NGOs through 13 grants, of approximately $90,000 each. In total, the Flagship Project has committed $1,115,986, or 74% of the total grant budget foreseen. An overview of the NGO beneficiaries and the status of grant implementation as of November 2010 are presented below.

In accordance with the overall mandate of the contract, the project has also supported several NGOs (some of them grantees, others not) in institutional and management capacity development, through a fixed-price contract with a company called IDaRA. In this context, the project identified change agents (often, but not necessarily, the NGO director) and guided the NGOs through self-assessments, which then formed the basis for institutional development plans. Training sessions were organized in function of identified needs. Based on information provided by the project, 56 NGO staff received training in self-assessment and institutional development planning (8 staff in West Bank and 48 staff in Gaza), and a further 15 West Bank NGO staff received training in financial management. In addition, 32 representatives of 15 West Bank NGOs were taught how to be effective "change agents" in the course of year 1 (Annual Report I, p.14); more benefitted from this training in year 2 (numbers to be confirmed in Annual Report II). The IDaRA contract has now closed.

The Flagship is further supporting NGOs by organizing, among other things, orientation workshops on grant development and on compliance with USAID rules and regulations for (candidate) grantees.

Sector	Location/ District	Purpose of Grant	Institutional Capacity Development	Amount Disbursed/ Grant Budget
Rehabilitation Services				
Princess Basma Center for Disabled Children	Jerusalem	Community outreach into the West Bank		$50,372/ $88,843
Bethlehem Arab Society for Rehabilitation (BASR)	Bethlehem	Service provision in situ	IDaRA: Change agent + Self-assessment + IDP	$52,478/ $89,340
Nablus Association for Social and Community Development/Askar Camp	Nablus	Service provision in situ & community outreach	IDaRA: Change agent + Self-assessment + IDP	$33,589/ $88,990
Four Homes of Mercy	E. Jerusalem	Service provision in situ & community outreach	IDaRA: Change agent + Self-assessment + IDP	$20,104/ $89,970
Children's Relief Bethlehem (Caritas Baby Hospital)	Bethlehem	Service provision in situ		$3,324/ $75,614
Palestinian Happy Child Center	Ramallah	Service provision in situ		$0/$90,000
Palestine Save the Children Foundation	Gaza	Community outreach	IDaRA: Change agent + Self-assessment + IDP	$0/$89,440
Referral Services				
Al Makassed Hospital	E. Jerusalem	1) Specialized health care training, bringing in a pulmonologist to train residents in pulmonary critical care	IDaRA: Change agent + Self-assessment + IDP	$0/$89,920
		2) Specialized health care training, in orthopedic services for 2 orthopedic surgeons abroad	IDaRA: Change agent + Self-assessment + IDP	$0/$77,400

Sector	Location/ District	Purpose of Grant	Institutional Capacity Development	Amount Disbursed/ Grant Budget
St. John's Eye Hospital	E. Jerusalem	Community outreach in the West Bank & specialist health care training for 2 orthoptic assistants	IDaRA: Change agent + Self-assessment + IDP	$64,821/ $90,000
Holy Family Hospital	Bethlehem	Specialized health care training, implementing the first neonatal residency program for 3 students	IDaRA: Change agent + Self-assessment + IDP	$17,824/ $85,720
Augusta Victoria Hospital	E. Jerusalem	Community outreach re breast cancer prevention and care in the West Bank		$39,240/ $90,000
Other/Primary Health Care Services				
Sheppard's Field Hospital/Beit Sahour	Bethlehem	Training of 8 midwives and BCC material development re mother and child health		$17,690/ $70,749

Findings

Distribution of Grant Benefits*:* Based on information provided by the Flagship Project and field visits to six of the nine NGOs whose grant programs started at least six months ago, the Flagship has stayed close to the parameters provided in the statement of work. The grant support is roughly divided between NGOs involved in rehabilitative care and NGO hospitals providing referral services. The majority of rehabilitative care grants serve to strengthen service provision and community outreach; the main focus of the grants to referral hospitals is on training the hospital's own or MOH staff in a particular subspecialty. While the rehabilitation grants present themselves as a relatively coherent body of work in a sector where the MOH relies on NGOs, the place of some of the specialized training grants in the overall scheme of the project is less obvious. This is partially due to the fact that the project has not yet consolidated and/or communicated its "grand strategy" for support to the hospital sector (e.g., How does the training of two orthopedic surgeons at Makassed hospital serve the project's goals beyond the broad statement of strengthening the hospital sector?).

It is noteworthy that many of the NGO beneficiaries are repeat beneficiaries from USAID's grant support program, dating back to USAID's Pilot Health Program and Emergency Medical Assistance Programs. This continuum of financial and programmatic support to selected NGOs can be viewed as positive; it also raises the question, however, of what else may be out there. Some interlocutors in the rehabilitative care sector, for example, expressed disappointment that the Flagship Project had not ventured further in using the grant mechanism to support the overall rehabilitative care structure and strategy currently being pursued in the West Bank.

(Note: Flagship staff reported it had coordinated closely with other organizations active in the sector, in order to embed its support into the wider structure and strategy.) The repeat selection of NGOs, it can be assumed, is to a large extent the result of the requirements in the statement of work regarding (1) demonstrated institutional capability, (2) willingness to sign the anti-terrorism clause, and (3) ability to pass vetting. These conditions, as well as the pressure to show results in a timely manner, almost automatically steer an implementing partner to the tried and proven NGOs. The search for and engagement of new partners, at different levels of the care spectrum, requires a determined and continuous effort to tread new ground.

As illustrated in the table above, only a small proportion of the grant funds committed have in fact been disbursed (26%). Five of the grants are relatively recent (i.e., the grants to Caritas Baby Hospital, Makassed Hospital, Palestinian Happy Child, and Palestine Save the Children), but the rest were launched almost a year or half a year ago. Based on information provided by the Flagship, lack of good record-keeping and reporting are at the root of the delays in reimbursement. The low disbursement rate does not pose a problem per se, given that the Flagship Project has three more years to go. However, it does point to a need for further training and support in USAID grant fund management. According to the Flagship grant manager, the problem has been addressed and the funds are now starting to flow better for most of the "older" grantees. The Flagship team is also attuned now to the importance of coaching the new arrivals in this regard from the get-go.

Beneficiary Satisfaction: The Flagship Project's NGO support program is a success story in the eyes of all NGO beneficiaries interviewed. The grantees visited (i.e., Askar Camp, St. John's Eye, Augusta Victoria, Princess Basma, Holy Family, and Makassed) were uniformly positive about the grant program and the Flagship's management of it overall. Many interlocutors took pains to express their appreciation for the responsiveness and helpfulness of the Flagship Project staff, especially the grants manager. The only deviation from this rule took place at Makassed Hospital, where the directors seemed confused about one of the hospital's two grants and unaware that it had been amended. The directors, however, expressed overall satisfaction with the other grant (the hospital's grant manager was not present during the discussion).

The grantees interviewed were also unanimously positive about the support and training received through the "institutional development" arm of the project's support to the NGO sector. The adopted approach—i.e., identifying change agents in an organization and leading the organization through self-assessment, that then form the basis for the institutional development plan—has proven to be an effective model for the NGO sector.

The project refers to the combination of grant and institutional development support as its "dual track" approach. It is very unfortunate, from a program management perspective, that not all grantees have been able to benefit from the institutional development support offered by the Flagship's contractor, IDaRA. The fixed-price contract closed before several of the grant proposals were approved, and the contract was not rebid. Among those who did benefit from the IDaRA intervention, it was striking to what extent even the more established NGOs, such as Al Makassed, made strong statements about the usefulness of this support.

Effectiveness of Outreach: Based on the field visits to different grantees, which represented mostly rehabilitative care and community outreach work, the Flagship's grant program is an effective mechanism to reach patients in local communities. Askar, Princess Basma, Augusta Victoria, and St, John's Eye hospitals all expressed satisfaction with the results obtained and the number of patients reached. The numbers provided in the quarterly reports regarding people and patients reached appear to back this up.

To its credit, the Flagship successfully enlarged the outreach potential of the grants program by bringing grant-supported outreach activities to the attention of the community-based

organizations with which the Flagship is involved under a different component. In particular, several representatives of community-based organizations during field visits expressed their appreciation for the fact that the Flagship Project had put them in touch with the outreach activities of St. John's Eye Hospital (visual screening) and Augusta Victoria Hospital (breast cancer screening). It is difficult to determine within the time allotted whether the Flagship could have done even more in this regard, but it is clear that the linkage, where established, was a win-win situation in terms of increased outcomes—both for the Flagship's grants program and its work with CBOs. It is a model that warrants replication in other areas of the project.

Sustainability of Efforts: All grantees interviewed had ready answers to the question about what would happen after the grant ends, and they took pains to emphasize their commitment to sustain the activities set in motion by the grants. The Princess Basma representative, for example, explained that the outreach activities of the grant had now been incorporated in the NGO's new strategic five-year plan. Furthermore, the Askar representative's response was emblematic of how grant and management support can in fact have a real strengthening impact on a relatively small NGO in the long run. The director of the Askar camp proudly explained how he had started several small financial ventures to ensure continued income for the camp after the grant ends. The camp had gone through a rough financial patch after the EMAP grants ended and before the Flagship grant started. The director considered this experience a good lesson learned. He credited the IDaRA training, as well as experiences gained under the USAID grants, for helping him now on his way toward financial security for the camp. In sum, while there are no guarantees, sustainability was a factor in both the grant application and the grant review process, and it continues to be on the mind of the grantees. Arguably, this is all one can really expect in the context of a small grants program.

Support to NGOs in Gaza: To date, the Flagship Project funds only one grant to an NGO in Gaza. The war in Gaza in the winter of 2008–2009 created political conditions that made progress in grant support problematic. The Flagship also reports that it took to heart USAID's message as the project understood it, namely, to hold off on grant support to Gaza until further notice. According to the Flagship, this message was only reversed approximately six months ago. There exist, however, so many complications to grant support in Gaza, and the pool of eligible NGOs within the given parameters is so small, that it is a real challenge to get a grant system going. Grant support to Gaza cannot realistically represent more than a small drop in an ocean of need.

Grant Selection Process and Management: To the extent it could be determined, the technical process by which the Flagship Project has been identifying, selecting, vetting, and managing grants seems to be reasonably systematic, rigorous, and in compliance with the USAID-approved grants manual. The token NGO grantee file cursorily reviewed was well organized and extensive.

Recommendations

Recommendations for improving performance and effectiveness of the NGO support program are presented below for consideration, as long as the following is kept in mind. There is only 25% of the grant budget left to distribute, and the grants are by definition limited in terms of scope, funding, and time horizon. Even if the outreach mechanisms employed are quite effective, sector-wide impact is virtually impossible given the pinpoint nature of grants and, in the case of the West Bank and Gaza, given the exclusion of several important NGO networks from the program for various reasons. This does not mean that grant support should be stopped or its role underestimated. The Princess Basma grant is a good example of how grants can enable organizational changes that ultimately contribute to systemic changes. One interlocutor further argued that the time and budget-limited grants are, in fact, a good development tool because they keep grantees on their toes.

Based on the above, it is recommended that the Flagship Project:

- Continue, or even expand, the grants program for rehabilitative care and outreach services. To the extent possible, embed the grants to rehabilitative care NGOs into the overall structure and strategy under development in the West Bank.
  - Justification: As stated, rehabilitative care grants easily fit within the overall picture of Flagship support to health care provision in West Bank Gaza, given that NGOs are the main providers in this area and the MOH relies on their services. By the same token, the provision of outreach services presents a nice fit with the grant mechanism, given that a small investment, if focused, can go a long way in reaching people in isolated communities or rural areas.
  - Note: Outreach services in rehabilitative care are well established in West Bank Gaza, but in need of financial support; supporting outreach services by referral hospitals from East Jerusalem (e.g., cancer screenings) is an excellent way to bring high-level specialist care directly to the people.
- Base any decision regarding future training grants to referral hospitals on a clearly defined strategy for the hospital sector and/or a clearly defined package of hospital services that represent a priority for Flagship support.
  - Justification: In order to maximize to the extent possible the impact of the training grants, it is important that these grants correspond to priority areas for the MOH and the Flagship Project.
  - Note: If this Flagship strategy is not yet defined or in need of fine-tuning, hold off on training grants for the hospital's own or MOH staff until further notice.

In order to further maximize the effectiveness and impact of the grant program to the extent possible, it is also recommended that the Flagship Project:

- Ensure that all grantees benefit from the "dual track approach" and receive both grant support and in-depth institutional development capacity support.
- Consider the renewal or continuation of successful grants under the project, in order to build on experiences gained and/or outcomes achieved.
- Continue to systematically link CBOs with grant activities, in order to maximize the number of people reached.

Finally, it is recommended that USAID and the Flagship Project:

- Redefine the deliverables in the scope of work and the indicators in the PMP, in order to better capture the essence and achievements of the NGO support program.
- Reset unrealistic targets in the PMP. For example, given the limited pool of eligible NGOs and the limited budget, it is simply impossible to reach the target of 53 NGO grantees. A target of 15–20 grants is more realistic, and even then, it may require additional funds.

HUMAN CAPACITY AND PROFESSIONAL DEVELOPMENT

Contract Scope of Work

The project's task is defined as strengthening the capacity of the MOH to implement reforms needed for improving quality, sustainability, and equity in the Palestinian health sector. Deliverables include supporting the development of the IDP, as well as training programs in management and finance.

Progress toward Achieving Results

The MOH needs assessment supported by the Flagship was completed in December 2008, shortly after the signing of the contract in October 2008. The IDP, completed and approved by March 2009, defined the 18 priority areas (modules) and tasks that reflected the MOH's priorities for the project, and is viewed by the Flagship as their guiding document for working with the MOH. Pertinent to the work under component 1 are module 2 (develop a health information system), module 3 (support implementation of the new Health Insurance Program), module 4 (design and implement a continuous education program for health professionals), and module 15 (training and fellowship program in health administration and management for the public sector).

To support modules 4 and 15 during the second year when training actual began, the project developed a Financial Capacity Strengthening Program (FCSP) and reported that 82 MOH participants completed the training. Under the professional development programs, the project reported that more than 100 participants were trained under a Leadership Development Program (LDP). All participants (three cohorts) took the leadership training in the past two quarters of 2010. A second course in managing performance (17 participants) was just completed in September 2010. A group of trainers were trained and identified as "change agents" to ensure program sustainability. The Flagship also reported that professional development occurred through expatriate professionals providing MOH health workers with on-the-job training and lectures.

Findings

The MOH needs assessment appeared to be a useful exercise to assess the six key components of health systems strengthening, an internationally recognized set of definitions of health systems and a solid methodology representing global best practice. While the IDP contains an annex that relates the IDP to the six components of the needs assessment, the list of 18 modules is a combination of MOH political imperatives and training needs without the background analysis to support them. The IDP lost the opportunity of becoming a document that illustrated clearly the areas where the Flagship is not positioned to support the MOH so that alternative sources of support could be pursued. The institutional capacity and professional development objective became somewhat synonymous with module 15, a training program in health administration and management.

Administration, management, and leadership training included work at the hospital level on costing and pricing of hospital services for the new HIS, training support for a new decentralization pilot in Qalquilia hospital, and the FCSP and the LDP training. Laudable efforts were made to identify "change agents" at various levels in the MOH in hopes of institutionalizing new skills and behaviors. During field visits, the team learned that many of those who underwent the TOT program have been reassigned or moved on to other jobs, so continuous development of trainers is also important.

In general, the evaluation team, after discussions with various MOH officials at the number of sites visited, concluded that while everyone appreciated the training in general, the likelihood that it will have much lasting impact will depend largely on using the new skills they acquired. That varies by training activity. The costing and pricing training will probably be useful, assuming that the new HIS is introduced on schedule and the people receiving the training are then deployed to use their work by entering the data into the new HIS. The financial management training appears to have been greatly modified based on the realization that it was too sophisticated for the kinds of financial functions that occur at the district, hospital, and clinic levels. Much of that training has occurred only in the past few months. The training may be useful to those staff who are in a "decentralization" pilot such as Qalquilia hospital, but the

others are unlikely to retain the skills since little financial planning or management occurs other than at the national level at the moment, and even there is constrained by the budgetary system employed by the Ministry of Finance.

Likewise, the leadership training appears to be excellent, but in an environment where people may not even have job descriptions, performance management, for example, becomes difficult to operationalize. No one interviewed for the evaluation was able to clearly explain how their work would likely benefit from the training and at least one facility manager said that while it was appreciated, it was not immediately applicable. Furthermore, some reported that since the Flagship Project cannot pay incentives to MOH staff, their motivation to participate in new initiatives is difficult to sustain.

Recommendations

- A human resources needs analysis and capacity development plan as described in the National Health Sector Strategy is needed and could be an important contribution of the project. USAID and the Flagship should collaborate with other donors who may support the MOH in this effort. The project has valuable experience from the field that could benefit the development of such a plan.
- Continue to work with the MOH on the costing and decentralization work with an emphasis on analyzing experience and raising issues that need resolution at the national level (both with the Ministry of Finance and the MOH). Work with partners like the USAID-funded PACE program to identify the kinds of training programs that are likely to build skills most immediately needed.
- Be completely transparent and open with USAID about the challenges and policy barriers as they may be able to help pressure for changes.
- Focus on training that is relevant to actual changes occurring (e.g., costing and pricing of hospital services for the HIS), but postpone training in areas where the skills are not immediately applicable in the work setting. Learn from what works and what doesn't and share with USAID and the MOH the reasons for it.
- Put emphasis on TOT and establishing ownership/leadership of human resource development activities in the central MOH or at the directorate level as appropriate. Work to institutionalize training capacity.

EMERGENCY MEDICINE TRAINING AND PREPAREDNESS

Contract Scope of Work

The contract task states that the project will strengthen the capacity of Palestinian health institutions to provide quality emergency care services and contains a deliverable related to expanding fellowships and training to improve the quality of services (Objective 2.1, Task 2.1.3).

Progress toward Achieving Results

The Flagship Project worked on transforming emergency rooms into interactive and responsive emergency departments in Hebron's Alia Hospital, Nablus's Rafidia Hospital, and the Ramallah PMC. Triage areas were established in all three hospitals and training conducted in emergency triage as well as in basic and advanced life support. The project also initiated an Emergency Residency Program in the three hospitals in partnership with the MOH, the Faculty of Medicine of Al Najah University in Nablus, and the Palestinian Medical Council. Emergency protocols were developed and are being translated into Arabic before distribution. The project has also been working on emergency preparedness at the national and hospital levels. A new patient uptake form was adopted to ensure the delivery of quality care and consistency throughout

MOH hospitals as well as to facilitate HIS implementation. The process also included the procurement of some needed equipment for those emergency rooms.

Findings

Under USAID's EMAP and CARE programs, emergency protocols were developed and instituted by Johns Hopkins University. Unfortunately, it appears that the Flagship Project did not use the materials or experience from USAID's previous project in the development of its own program. As a result, some emergency staff feel that the new procedures need revision to include some of the better elements from the earlier project. Work in the area of emergency medicine training is ongoing, and short-term consultants are providing useful on-site coaching and mentoring of physicians' work in emergency rooms. The evaluation team did not find a schedule to implement the emergency preparedness plan at other existing secondary hospitals. The fellowship training and visiting professor programs mentioned in the contract have not been initiated.

The Secretary General of the Palestinian Medical Council told the evaluation team that in reality they began the Emergency Residency Program in collaboration with the University of Lille France and the University Al Najah in Nablus before the Flagship Project was involved.

They worked on a three-year diploma course supervised by the University of Lille. The program included one year of training in Lille and an external examiner from that university. They developed a curriculum and agreed that a fourth year of residency (as per the regulations of the Palestine Medical Council) will be conducted in the country after the diploma course before the final board exam. The University of Lille was to have a supervisor in the country that would rotate every two weeks. The training centers that were chosen for this residency program were Alia Hospital Hebron in the south, Ramallah Emergency Hospital in the center, and Rafidia Hospital in the North.

When the Flagship Project became involved, they arranged for a visit of a Loma Linda University consultant who brought with him the curriculum of the emergency residency program at Loma and wanted to apply it. This angered Lille University, which pulled out from the program.

The program began recently in October 2010 and is under the control of the Emergency Medicine Committee of the Palestinian Medical Council, which is made up of specialist doctors from the various relevant medical and surgical fields in collaboration with Al Najah University. The program is recognized by the Arab Board, which also has a supervisory role. The direct supervision and follow up of the resident doctors are done by the consultant doctors in the various hospitals, and a logbook, provided by the Palestinian Medical Council, is continuously updated and signed by the supervisors. The candidates are chosen after sitting for a qualifying exam and then they must sit for the first part of the board exam during the second or third year. At the end of the fourth year, they sit for the second part of the board exam at which two examiners from the Arab Board assist.

The STTA pediatric emergency specialist who met the evaluation team during the site visit at Alia Hospital thinks that the resident doctors have good emergency room skills, especially with trauma, but they do not receive adequate supervision and mentoring from more skilled emergency medicine specialists. The Emergency Residency Program could potentially have substantial long-term impact and is worthy of support.

The team noted that there is no clear schedule to implement the emergency preparedness plan at the secondary hospitals in the Palestinian area.

There is no long-term plan for fellowship training and/or visiting professor programs for the duration of the project.

Recommendations

- The Flagship Project must coordinate all medical specialization training activity with the Palestinian Medical Council. Short-term training visits in the residency program are useful but they need to fit into the existing program.
- Schedules for assisting with emergency preparedness plans at other existing hospitals in the Palestinian area should be planned and approved.
- A decision is needed on whether to proceed with the plan for fellowship training and visiting professor programs for the emergency preparedness plan, as the time left on the project may pose constraints and the added value is not clear to the evaluation team.

TRAINING, CONTINUING EDUCATION, AND LICENSING

Contract Scope of Work

The mandate in this area is not clear from the contract, but it does seem to include continuing health care education for professionals and expanded opportunities for specialized medical education. The topic of licensing is included in the IDP. Project documents state that the Flagship is working with the MOH to strengthen its role as the regulator body by addressing key issues in governance, licensing, and accreditation.

Progress toward Achieving Results

The Flagship supported the MOH in its endeavor to regulate the licensing and re-licensing of health care professionals according to internationally accepted standards. These standards require health care professionals to engage in continuing health care education (CHCE), which keeps them current on continuously evolving best practices for clinical and administrative work in health care. The MOH created a framework that links CHCE with the re-licensing process.

The project claims to have worked with the MOH in developing a licensing/re-licensing framework for 13 professional fields; specific bylaws were drafted for community health workers, dentistry, and pharmacy.

Working with the MOH, the Flagship reported that it helped prioritize needs for *fellowships*. Through a series of focus group meetings, 10 priority areas for fellowships were reported as identified and shared with the Minister of Health to guide the nomination of potential MOH and non-MOH participants. The priorities identified were neurosurgery, pediatric neurosurgery, pediatric cardiac surgery, urology, nephrology, cardiac surgery, endoscopy, radiology and interventional radiology, hematology, and management sciences.

Project documents state that it initiated a fellowship program that provides opportunities for Palestinian health care professionals to learn new skills by enrolling in programs through what is called the Visiting Professionals Program (VPP). Health care professionals are receiving training, mentoring, and coaching in specialty fields that are currently unavailable in the West Bank and Gaza. So far, the project sponsored only the participation of two orthopedic surgeons from Makassed Hospital in long-term training courses at academic institutions in Germany and Australia through a grant to Makassed, as well as a position in the hospital to self-manage the program in the future.

The Flagship provided support to the MOH to conduct a workshop to develop a consensus on a policy and regulatory framework for accreditation of continuing health care education programs and re-licensing of health professionals. The workshop hosted 35 health professionals and key stakeholders representing relevant departments within the MOH; medical, dental, and nursing schools of local universities; medical and allied health associations; private hospitals; and NGOs

providing continuing medical education (CME) programs. To provide training to residents, the project fielded its first physician, pulmonologist Ragheb Assaly, to Makassed Hospital. Dr. Assaly provided mentoring and training to residents on issues related to pulmonary critical care and emphasized the need for certified respiratory therapists in MOH hospitals.

The Flagship Project supported the MOH's efforts to develop guidelines for the registration of medical devices and consumables. Three technical personnel from the Ministry, accompanied by a project staff member, participated in a three-day session at the Jordan Food and Drug Administration during the third quarter. Through cooperation with the Palestinian Medical Relief Society, the project said that it worked to develop nationalized standards for training and accreditation of community health care workers.

Findings

The Flagship Project did not analyze previous related training work by previous USAID sponsored projects, other donors, UNRWA, or NGOs. The training programs lack adequate vision about the specific outcomes they are trying to achieve and how these can be institutionalized. The result appears to be ad hoc activities without clear plans for follow up or assessment of the value of the professional training activities.

The Palestinian Medical Council is developing the system for continuing health care education (CHCE) programs and re-licensing of health professionals in cooperation with the different professional bodies, medical schools, and the MOH. The system needs at least another year before it can be applied. The project has only contributed with one workshop on developing CHCE methodology.

Recommendations

- Review the Flagship Project's whole training program and design the scope of work and the follow up methodology after analyzing previous training work done by USAID-funded projects, UNRWA, and the various donors.
- The project should reexamine the overseas fellowship program in view of the time left in the project.
- The Flagship Project should work closely with the Palestinian Medical Council on all training activities for doctors, CHCE programs, and re-licensing of health professionals, with emphasis on targeted needs linked to the CME and re-licensing program (e.g., capacity building of the council members).

HEALTH INFORMATION SYSTEM

Contract Scope of Work

The HIS work falls under Task 1.1.1 in the Chemonics contract, which lists a deliverable that reads, "Upgrade the HIS capacities of the Palestinian Authority MOH." The HIS development is high (second) on the list of modules in the IDP.

Progress toward Achieving Results

The HIS is a very important priority for the Minister of Health and other senior managers who recognize the value of access to such comprehensive data about the health care system. Reportedly, consultations were held with stakeholders and presentations made to describe the proposed system. After a tendering procedure, the local affiliate in Ramallah of a Turkish company (Dimensions) was selected to modify and translate software developed in Turkey. More than 250 existing data sets are being modified to fit into the HIS. The main data center, data recovery center, and hardware are either installed or are being procured for the main data

center, four hospitals, and three clinics selected by the MOH as pilot sites to be completed by the Flagship Project. According to the draft *Year Two Annual Report*, the system will be established in Ramallah Hospital (PMC), Hebron's Alia Hospital, Rafidia Hospital in Nablus, and the Darwish Nazal Hospital in Qalquilia. Nine clinics are listed without an indication of geographic location.

Findings

The political support for the HIS is very strong and many MOH managers interviewed by the evaluation team were strongly supportive of having such an HIS. While most of the donors expressed support for the idea of strengthening the HIS as a high priority, many of them felt that the Flagship effort had been driven by excitement over the sophisticated software systems and not enough by practical issues of feasibility, ability of the MOH to expand it beyond the facilities to be targeted by the Flagship, and concerns about where the human resource and training requirements had been properly anticipated.

The evaluation team found very little written information about the HIS, with only the most general and often repetitive information about total numbers of anticipated beneficiaries in the quarterly and annual reports. Reports from various sources about where the system will be installed with funding from the Flagship varied from what was described in the annual report. There seems to be a fair amount of ambiguity and confusion about which facilities will be included as pilots, as that information is not well documented. The Flagship Project did not do an extensive strategic study before starting this effort nor did it study documents related to previous work to develop HISs in the Palestinian Territory. No comprehensive study was undertaken to analyze alternatives, determine long-term costs to the MOH, or evaluate other such factors. The evaluation team was also concerned about whether the training and mentoring needs for accurate data entry and use by facilities has been accurately assessed. The HIS system as envisioned is extremely ambitious and highly sophisticated if it works as envisioned. Clearly, it will be an enormous challenge to install throughout all MOH facilities. The Flagship has taken on what is essentially a pilot effort although some of the largest up-front costs of installing the IT infrastructure and modifying the software will be completed. The responsibility for expanding this within the Palestinian MOH system, and paying for the rest of the computer equipment as well as annual Internet fees, will rest with the MOH and its partners.

Recommendations

- Improving the HIS is an important priority and it is one that the Flagship has taken on. A contract to adapt the software, buy the hardware, and install the system has already been signed and work is well underway; therefore, it is too late to cancel and rethink the strategy. The contract with Dimensions should continue to completion.
- Bring all partners into the picture and engage proactively with the WHO strategic assessment. Assist with moving recommendations forward as they relate to the work of the Flagship to help ensure that the HIS is used and becomes a viable planning and monitoring tool.
- Assist in developing a phased plan that does not require the system is live at all sites immediately or introduces various components in different phases.
- Conduct the analyses necessary to give the MOH concrete information on the capital investment, recurrent costs, and training efforts needed to expand the system to all public facilities after the Flagship Project ends. The MOH can use this information to seek buy-in from other donors and partners for future expansion.

- An ongoing assessment of the MOH staff computer literacy followed by a detailed training plan to include basic computer skills and the HIS's different modules (each employee trained according to his needs in both) is necessary.

MEDICAL PRODUCTS, VACCINES, AND TECHNOLOGIES

Contract Scope of Work

The Flagship Project's marching orders with regard to procurement are captured in component three of the contract's scope of work, which specifies three tasks: (1) procurement in support of the Flagship Project's objective to improve the quality of clinical services in the MOH and NGO sector, (2) procurement in support of other USAID projects, if warranted, and (3) emergency procurements. The deliverables for each task include a procurement plan for the beneficiaries (MOH or NGOs) and the actual delivery of quality products.

The focus of the PMP with regard to this component is on capturing the total value of equipment and pharmaceuticals procured (LOP target = $22 million). The PMP also tracks the number of facilities that benefit from the Flagship's equipment procurement (LOP target = 80 facilities) and the number of beneficiary patients (LOP target = 200,000).

Progress toward Achieving Results

Based on information provided by the Flagship Project and captured in the summary table below, the Flagship has contracted 75% of its procurement budget to date. All procurements so far have been directed toward health facilities in the West Bank.

Procurement Categories	Value per Category	Medical Equipment Beneficiaries	Total Value
MOH Support			
Pharmaceuticals—Secondary HCF	$1,249,467	n/a	
Medical Equipment – Primary HCF	$913,052	83 MOH PHCFs	
Medical Equipment—Secondary HCF	$5,486,639*	10 MOH Hospitals	$7,649,158
NGO Support			
Medical Equipment—Secondary/Tertiary HCF	$4,829,664	5 NGO Hospitals	$4,829,664
HIS			
HIS Hardware and Systems	$4,219,058	n/a	$4,219,058
			Total = $16,697,880

**This includes a $974,100 CT-scan for the PMC, which has been procured but not delivered.*

The large majority of the procurements have taken place in function of task one (improving the quality of care of clinical services in the framework of the Flagship Project), not surprisingly. There was only limited procurement in support of another USAID project (i.e., The Holy Family Hospital Project; $172,900 in medical equipment). USAID has not yet made use of the emergency procurement mechanism. When the Gaza war broke out in the winter of 2008–2009, the Flagship Project mobilized, but the process was halted at the request of USAID when

it became clear that other donors were covering the medicine needs to the point of overwhelming the MOH in Gaza. As to the procurement of other items such as blankets, the Flagship Project undertook the RFP and bid analysis, the results of which were then passed on to another USAID project, which had a waiver in place for local procurement.

The remaining $5.5 million will cover, among other things, (1) procurement of equipment for selected NGOs in Gaza, valued at approximately $2 million; (2) further equipment for the NGO grant component; and (3) emergency pharmaceutical procurement reserves.

Findings

Given the wealth of findings, they are organized below in three separate categories:

1. Medical Equipment Procurement
2. Pharmaceutical Procurement
3. MOH Capacity Building in Procurement and Beyond

Procurement of Medical Equipment

Distribution of Procurement Benefits: The majority of equipment purchases have been directed at the secondary health care level, with support relatively balanced between NGO and MOH facilities. Five NGO hospitals have benefited from $4.8 million worth of equipment and 10 MOH hospitals from $5.4 million. Procurement of equipment for the Palestinian Medical Complex has been limited, especially if one takes into consideration that the CT-scan is currently being held back.

The equipment procured for the primary health care facilities, based on the documents provided and field visits, has ranged from ultrasounds to spectro-photometers to autoclaves and trolleys; 83 primary clinics have benefited.

All procurements to date have been to the benefit of the West Bank, though a $2 million procurement for Gaza is now pending. According to the USAID Mission, the USAID Program Office directs all program activities for Gaza. It has been difficult to get approval from the Israeli Ministry of Defense for several of the planned medical equipment deliveries.

Picture Moments: The Flagship reported early on in the evaluation that the majority of the procured equipment had been installed, and the field visits did indeed offer a wealth of picture moments of shiny new equipment with the USAID logo attached, in hospital wards and primary health care facilities across the West Bank. Especially impressive—if unusual, given the customary USAID focus on primary health care rather than secondary or tertiary health care—were: (1) the neonatal ward in Rafidia hospital, where the Flagship delivered 20 neonatal incubators and 10 bedside monitors; (2) the 16-slice CT-scan in an "ambient room" offering lighting and music to calm and relax patients (something the supplier had thrown in for free) at the MOH Alia hospital in Hebron; and (3) the preparation for the new state-of-the art linear accelerator to be installed at the NGO August Victoria Hospital in East Jerusalem, a $5 million endeavor all by itself.

Client Satisfaction: Hospitals and primary health care facilities expressed great appreciation in general for the procurement support provided, not surprisingly. Directors and other staff in all hospitals visited were also very complimentary about the project's comprehensive approach to procurement, including the preventive maintenance provisions and the clinical trainings. The only exception to this rule was the hospital director of the MOH hospital in Jericho. While the facility is in the midst of extensive renovation and it makes sense to postpone delivery of equipment that needs to be anchored, for example, it is unclear why the hospital in Jericho has not received more significant procurement support from the Flagship Project until now—i.e., in

terms of equipment that can already be put to full use, such as an ECG or basic operating tables for the emergency room.

Needs-based Procurement—to the Extent Possible: Based on information provided by the Flagship and conversations with several stakeholders and recipients, the Flagship put in place a solid system to ensure that the equipment it procured was based on real needs. Upon receipt of the MOH wish list, the Flagship team established a procurement committee (including representatives of the MOH primary health, hospitals, and biomedical engineering departments, among others) to review the list, check inventories, and visit each site in a coordinated way. The Flagship further verified with other donors to avoid duplication in procurement support. Finally, the Flagship made an effort to include clinical care considerations in its needs assessment, though this was implemented better at the primary health care level than at the hospital care level. For the primary health care facilities, the assessment was done against a checklist based on the so-called Package of Essential Primary Care Services. The same practice could not be applied at the hospital level because there was no similar "hospital master plan" available.

Checking equipment needs against a model list is a sound practice, even though, as it turns out, it does not represent a guarantee against "questionable procurement": the model itself may be flawed or abandoned, and the existence of the model cannot compensate for the lack of a strategic master plan for project support to health care facilities in function of location, catchment area, etc. The medical expert on the evaluation team, for example, has raised questions about the delivery of ultrasound machines to level 2 primary health care facilities (as allowed by the Package of Essential Primary Care Services). An even more striking example is the procurement of seven ECGs for "level 2 or 3" PHC clinics in the Nablus district, even though the Package of Essential Primary Care Services dictates ECGs only for "level 4" primary care facilities. The Flagship PHC team presented a technical justification, with which not all experts may agree. The delivery of ECGs to level 2 or 3 primary health care facilities became even more problematic when it became clear during a site visit that the MOH hospital in Jericho, the only hospital for the whole region, is in dire need of an ECG. There were no other red flags in the context of procurement for primary health care facilities.

Promotion of Effective Maintenance and Use: The Flagship Project is to be commended for the comprehensive, and to a certain extent innovative, approach it adopted to ensure effective maintenance and use of the equipment procured:

1. The project used the site visits to not only confirm the need for the equipment but also to inspect the adequacy of the site, review the technical requirements for installing the equipment, and identify the need for accompanying supplies, including accessories, spare parts, consumables, and medical waste management supplies where relevant. Facilities were generally provided with consumables for one year and made aware of "the obligation of future costs."
2. The project duly included a condition in its contracts, where relevant, that suppliers both ready the site[9] and provide service provision during the warranty period (in principle, two years).
3. Furthermore, the Flagship procurement team imposed on the suppliers that they provide a biomedical engineer for preventive maintenance during the warranty period and train the biomedical engineers in situ (for the hospitals) or the engineers of the MOH (responsible for equipment maintenance in PHC) on how to do preventive maintenance. In certain instances,

[9] A representative of the EWAS Project discussed a number of instances where problems arose from the lack of engineering staff on the Flagship (by USAID program design, the engineering capacity is concentrated in the EWAS project). These types of problems should be addressed through closer cooperation between the technical staff of both programs.

this training was provided at a technical training center of the manufacturer abroad. Preventive maintenance—a novel concept to USAID procurement practices to the evaluation team's knowledge—goes far beyond service provision; it refers to scheduled activities to prevent breakdowns and deterioration of equipment, thus extending the life of procured equipment.

4. As a final step in the process of ensuring effective use and maintenance of the procured equipment, the Flagship procurement team, in coordination with the Flagship's PHC and hospital teams, has also started organizing clinical trainings for health care facility staff where there is clear indication that the health staff does not really master the use of the equipment. In this context, the Flagship has begun introducing clinical training for ultrasound, defibrillators, and ECGs; it also plans to introduce clinical training in the use of the anaesthesia machines procured.
5. As an aside, the evaluation team took note of mention in the *Y2Q2 Quarterly Report* that the Flagship is working with vendors and the MOH to have the older, replaced equipment refurbished and transported to remote areas, which would otherwise not have the equipment on-site. It could not be determined to what extent this has really already happened, but it represents in essence another interesting way to optimize resources.

In technical terms, the Flagship Project deserves nothing but praise for the comprehensive approach it has adopted to ensure that the equipment procured is used and maintained effectively.

Compliance with Rules and Regulations: Based on a cursory review of documents, and to the extent it could be determined, the Flagship is following USAID rules and regulations; its procurement guidebook is clear and user-friendly; the token procurement file reviewed was well organized, and the activities well documented.

Procurement of Pharmaceuticals

Distribution of Benefits: The one-time procurement of a year-long supply of selected medicines for use in secondary hospitals took place at the request of the MOH; the appeal was launched in February/March 2009 and the first deliveries arrived in October 2009. The items requested were medicines the MOH could no longer procure itself, following the entry into force of the regulation that the MOH only procure medicines registered with the Palestinian MOH. International organizations still can import medicines that are not registered (though registration then becomes part of the bid requirements). According to staff at the MOH drugstores, Flagship staff visited the central warehouse to verify that the requested supplies were really out of stock before proceeding with the procurement. The director and pharmacist of the MOH drugstores declared themselves happy with the support; in their opinion, the procurement process had gone smoothly and correctly. There are still a few supplies left of a number of medicines.

Compliance: The Flagship Project has set systems in place to ensure compliance with USAID rules and regulations, as well as to set clear boundaries, providing a comfort zone for the project to work in. In particular, the Flagship Project has a list of some 200 essential medicines (culled from the Palestinian essential medicines list), which had been preapproved for procurement by USAID. Thus, when the MOH request came in, the project simply matched the request with the preapproved list and ultimately procured 18 items. All the procured medicines were FDA-approved and post-shipment quality control was done at the Birzeit University Lab.

Emergency Considerations: The Flagship does not anticipate undertaking other pharmaceutical procurements, except for emergencies. Interestingly, the Flagship does not seem to be set up for immediate action in case of such emergencies. Its procurement guide does not go beyond stating that medicines should be procured from the United States, and it does not

detail how to seek a waiver to allow for local procurement. The fact that the Flagship does not have such a waiver in place means a delay of easily two weeks before the project would be in a position to respond to urgent medicine requests in case of an emergency situation. This is mostly relevant in case of an emergency in the West Bank. It is not clear how much emergency procurement support USAID could really provide to Gaza, given the impossibility to provide to the MOH and the many restrictions on supporting NGOs.

MOH Capacity Building in Procurement and Beyond

Capacity Building in Procurement: The extensive medical equipment procurement process that took place in the context of the Flagship Project was arguably a good learning experience for the MOH in how to conduct procurement in a transparent and coordinated way. It included, among other things, (1) establishing a technical procurement committee with representatives of different MOH departments (e.g., procurement agency, primary and secondary health care department, biomedical engineering department), (2) verifying actual needs and coming to agreement on a consolidated list, (3) developing the standard bidding documents and fair and unambiguous technical specifications, and (4) undertaking open competition. This process has not (yet) been institutionalized in the MOH, but certain things have reportedly already been incorporated in MOH practices. For example, the concept of preventive maintenance has now been integrated among other MOH requirements for procurement of medical equipment. The same is true for verification of claims.

Following the anticipated passage of the new General Supplies Law, it is recommended that the Flagship support the MOH Procurement Department in the writing, passing, and implementation of relevant procurement rules and regulations, based on the lessons learned from the procurement exercise. This was at any rate part of the original mandate under the MOH IDP module on pharmaceutical procurement.

Capacity Building in Preventive Maintenance: The Flagship is seeking to institutionalize the concept of preventive maintenance by supporting the establishment of a national center that would bring together relevant, but currently disparate, departments of the MOH, as well as include a new unit, tentatively called the "Biomedical Calibration and Certification Center." There is currently no MOH expertise in the area of calibration, which is an intrinsic part of equipment maintenance. The establishment of the national center would promote the proper maintenance and quick repair of equipment, as well as enable the strengthening of local expertise in the field of medical instrumentation.

MOH Pharmaceutical Policy and Management Capacity Building: Both Flagship and MOH staff claim credit for broadening the MOH IDP pharmaceutical procurement module to a new module with the mandate to "support the Pharmacy General Directorate and Procurement Unit in their regulatory role and enhance their management and technical capacities." This new module is now in place. At first sight, the list of priorities seems quite disparate, but a closer look indicates a heavy emphasis on improving registration processes, not only for medicines, but also for medical devices, as well as vaccines and biological and blood products. In this context, the head of the MOH Pharmaceutical Policy Department was very appreciative of the Flagship Project support that allowed three MOH staff members to receive training in registration of medical devices and consumables at the Jordanian FDA recently (June 2010). The MOH staff trained are now expected to spearhead the development of a registration process for medical devices in the West Bank and Gaza. A similar training exercise is planned for MOH staff at the Jordanian FDA with regard to pricing. In the opinion of the head of the MOH Pharmaceutical Policy Department, the best contribution the Flagship can make in the pharmaceutical policy area is to continue to enable these types of technical trainings and the provision of consultants with in-depth technical expertise.

Recommendations

At the end of year 2, the Flagship Project has procured and installed an impressive array of medical equipment in hospitals and primary health care facilities across the West Bank and East Jerusalem.

There is some concern that the Flagship has simply given away its leverage with the MOH and the health care facilities by the early delivery of the equipment on their wish list. This argument could just as well be turned on its head: by delivering the equipment early, the project has robbed the MOH and the health care facilities of an excuse to deliver good quality care. From this perspective, the project now has three years to focus heavily on improving service delivery across the primary, secondary, and tertiary health care levels—based on up-to-date and evidence-based clinical care protocols and using state-of-the-art equipment. Furthermore, the project now also has three years to continue training and monitoring the clinical staff in the correct use of the equipment procured, and training and monitoring the technical staff in preventive and corrective maintenance of the same.

Based on the above, the following recommendations are offered for consideration:

Regarding the Strategic Aspects of Equipment Procurement by the Project

- Begin by (re)defining and articulating the strategic vision for health sector strengthening across the different levels of care, which is to underpin the project's procurements; take stock of the past procurements and make any necessary corrections where possible; ground any pending or future procurements in the agreed-upon strategic vision.
- Promote the effective use of the medical equipment procured as part and parcel of improving the quality of care, alongside the use of evidence-based clinical protocols. This can be done through clinical trainings and supportive supervision.

Regarding the Technical Aspects of Equipment Procurement by the Project

- Building on the intense exercise of the past year, stand ready when the General Supplies Law passes, help the MOH institutionalize the sound, transparent, and needs-based procurement process followed in the context of the Flagship Project.
- Support the consolidation of the disparate units for equipment maintenance within the MOH and build a national center and local expertise in medical instrumentation; help roll out and strengthen a system for equipment maintenance across the public sector.
- Monitor and ensure the implementation of the preventive and corrective maintenance procurement provisions by the suppliers, and later on by the biomedical engineers serving the beneficiary MOH and NGO health care facilities.

Regarding Support to the MOH Pharmaceutical Policy Department.

- Provide support to the MOH Pharmaceutical Policy Department in distinct and well-defined priority areas of common interest for the MOH and the Flagship Project. Do not spill over into areas already supported by other donors, especially the French Cooperation (which is building a new warehouse in Nablus) and the WHO (which is supporting pharmaceutical policy and EDL related work). The areas currently identified in the new IDP module may do.
- Provide in-depth technical training and expertise in these priority areas, if requested by the MOH Pharmaceutical Policy Department.
- Discuss with USAID the need for a waiver for local procurement in case of an emergency.

Regarding Program Monitoring and Evaluation

- Redefine the deliverables in the statement of work and the indicators in the PMP to adequately capture what the program is accomplishing in the area of pharmaceutical

procurement, policy, and management. For example, the deliverable regarding semi-procurement plans for the MOH and NGOs does not really makes sense, and there is no deliverable to capture the care the Flagship Project has taken to ensure effective use and maintenance of the equipment procured.

HEALTH FINANCING

Contract Scope of Work

The contract does not appear to have any specific tasks or deliverables related directly to health financing or health insurance specifically but it does include deliverables stated as "Other deliverables as specified in the MOH institutional development work plan." The IDP does list, "Support implementation of the new Health Insurance Program" as module 3 and therefore of high priority to the MOH.

Progress toward Achieving Results

While health financing is an important part of health systems strengthening, the Flagship should be clear with the MOH that its mandate from USAID does not cover any specific work in this area. The Flagship Project produced a useful summary analysis (no date or author) of the current situation with health insurance reform in the materials provided to the team. Potentially useful consultant reports and recommendations have been generated, but it is not clear whether the Flagship has actually shared any of this material with the MOH or other partners. Flagship staff seem to recognize that it must await further consensus among all stakeholders about the new health insurance law before any work can be useful, despite the statements in the IDP.

Findings

The Flagship as currently staffed has little to offer in the area of national health insurance. There is no real capacity in the project apart from bringing in short-term consultants. The project should definitely not be pressured by the MOH into engaging in this in the absence of donor and other stakeholder consensus on a clear path forward. Dabbling in this area could be dangerous and result in extremely negative outcomes. The Flagship might play a supportive role (such as the costing work) in the future that would facilitate health insurance reform, but should not take the lead.

Recommendation

The Flagship Project should not begin any work on financing reforms or health insurance other than the efforts already underway on costing and pricing. Other organizations are better equipped to support this effort with the MOH. USAID should discuss this with the MOH and other donors to try and help garner support and participation of others in this technical area.

For more information, please visit;
http://resources.ghtechproject.net

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