HANAN SECOND ANNUAL REPORT

Reporting Period: January 1, 2006 to December 31, 2006

Submitted to: USAID West Bank/Gaza
Date: December 7, 2006

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Introduction

This is the second of two annual reports, which the Hanan Project is required to submit. The report will summarize what was accomplished in 2006 and, looking ahead to 2007, outline key challenges, as well as where the Project could be by December of next year.

Section I provides a timeline and quarterly narrative analysis of major activities that were completed and external events that influenced the Project during 2006. Major constraints and areas of significant delay are noted and explained.

Section II looks ahead to 2007, commenting on key challenges facing the Project and what is likely to be needed to support implementation and in order to achieve impact.

I. Major activities timeline and narrative analysis

A. First quarter

Up until the Palestinian Legislative Council elections on 25 January 2006, Project implementation was proceeding according to the program strategy and work plan established during 2005. The Ministry of Health was a primary counterpart to implementation and 17 of Hanan's then 23 partner clinics were Ministry of Health clinics.

In response to the outcome of the elections and Hamas' dominance of the Legislative Council, international donors, including the US Government, suspended all assistance to the Palestinian Authority. This decision, as well as the new policies and procedures that were issued in association with it, has had a profound effect on the Project.

Most immediately, during the first quarter, the Project was asked to temporarily suspend all major planned activities, including the launch of the West Bank community program, and the procurement of essential equipment for partner clinics. Pending Communication and Marketing program subcontracts were also put on hold. This meant postponing approximately $1 million of program budget expenditure.

The suspension continued throughout the first quarter and so it was not possible to maintain activity implementation as scheduled in the first annual work plan. The Project's future was uncertain and this understandably affected team morale and motivation. Nonetheless, during the first quarter, the team conducted 5 training courses on maternal and child health topics and infection prevention and control.

Through Mission Order 21, issued on 17 March 2006, USAID updated its procedures for 'ensuring that USAID-funded assistance does not inadvertently provide support to entities or individuals associated with terrorism'. This Order effectively limited the range of partners that the Project could work with,

because many local organizations were unwilling to accept the revised vetting procedures, applicability rules, and mandatory clause outlined in it.

On 31 March 2006 USAID verbally informed the Project to cease all contact with the Palestinian Authority, pending further written policy guidance.

B. Second quarter

Verbal guidance given at the end of the first quarter was followed on 26 April 2006 by Mission Notice Number 17, formalizing the policy of no contact with the Palestinian Authority officials and employees. With this policy, it became finally certain that the Project would not continue with the Ministry of Health as its primary counterpart or with the 17 Ministry of Health partner clinics. Further, the Project could not have any contact with or work with public sector officials and employees under any Ministry.

At this point the team began envisioning new implementation approaches and partnerships, limited to the non-government sector. By the end of April, USAID formally requested the Project to prepare a revised Project Description, setting out a modified activity program and work plan and including new humanitarian assistance and emergency components. The final revised Project Description, including an annual work plan, was submitted to USAID on 20 June 2006.

The revised Project Description retained the original program goal of reaching 60% of women of reproductive age and children under 5 years of age with an essential package of high quality maternal and child health and nutrition services. However, the criteria of reaching the most vulnerable had to be modified. As a direct or indirect result of the cessation of international donor assistance, a substantially increased proportion of the population was now vulnerable. In addition, it was no longer possible to ensure a comprehensive package of services, due to the central role played by the Ministry of Health in delivering certain key services, such as immunization and integrated management of childhood illnesses.

The initial geographic areas targeted for implementation remained as Gaza City and North Gaza, and Jenin and Hebron districts in the West Bank. Similarly, the components of clinical services strengthening, community mobilization, and communications and marketing were retained. However, it became clear that the holistic approach originally envisioned for the Project, whereby Hanan would work with both clinics and communities together in selected geographic sites, was going to be harder to achieve, due to the fact that there were no eligible non-government clinics in many of the community program sites. New activities on pre-hospital emergency medical services, neonatal resuscitation and advanced life support in obstetrics training were introduced, along with procurement of pre-hospital emergency and emergency delivery kits. A new $1 million emergency fund was also established to respond to *ad hoc* requests for urgently needed medical equipment and spare parts.

Whilst preparing the Project Description, the team began identifying new clinic partners from the non-government sector, in accordance with the USAID no contact policy. During May and June, 74 clinic visits were conducted and 53 potential partners were identified and their information submitted to USAID for vetting. Palestinian Medical Relief Society, the previously selected West Bank community program partner was able to resume work under its subcontract and 27 community mobilization officers, community mobilizers and community health workers were recruited and began their orientation training.

C. Third quarter

On 14 July 2006 USAID authorized the Project to resume implementation in accordance with the new Project Description, pending a formal modification of its Cooperative Agreement. On 5 August 2006, the Project also received the clinic vetting results. 28 of the 53 clinics submitted for vetting were approved, and these became Hanan's new clinic partners. With them, the team immediately began agreeing plans of support for improving maternal and child health service quality. Thus, during the third quarter, Hanan returned to full implementation of all clinical, community, and communications and marketing activities.

The Project also began to use the new emergency fund facility. At USAID's request, 9 non-government hospitals' urgent needs for maternal and child health related medical equipment and spare parts were assessed and prioritized. The assessment was carried out in the West Bank and Gaza jointly with Care International's Emergency Medical Assistance Project III, which has responsibility for emergency procurement of pharmaceuticals and disposables. After receiving approval from USAID for the items to be procured, in August Hanan issued a tender request for the medical equipment and spare parts.

The 2006 household baseline survey, measuring 14 maternal and child health outcome indicators, was outsourced to the Community College for Applied Science and Technology, Gaza. All of the preparations were completed in order to ensure that data collection and analysis could be completed by the end of the fourth quarter. With support from Hanan, an operations research study on mothers' complementary feeding practices was initiated by Al Quds University, Center for Development of Primary Health Care.

Increased program expenditure reflected the resumption of Project implementation. During the quarter approximately $825,000 in subcontracts was either re-activated or their approval went forward. Three new subcontracts, at an estimated value of almost $800,000, were provisionally selected through open tender processes.

D. Fourth quarter

After having activities suspended for over 5 months and then having to redesign and restart the Project over an additional 2 months, and despite increased restrictions imposed by USAID policies and procedures, by the end

of the fourth quarter the Project can report some solid results. This is a real credit to the team and their resilience and dedication.

Since July, when Project implementation resumed, until the end of December 396 clinic employees will have participated in training activities (formal and on-the-job) in the West Bank and Gaza. A range of topics related to maternal and child health and nutrition, infection prevention and control and clinic management and supervision were covered. This represents 75% of the cumulative total of 527 people trained since the beginning of the Project, indicating how quickly momentum has been built up. Additionally, the team will have conducted 127 supervision support visits to clinic partners, using checklist aides that the team and clinic staff members can jointly use to gauge compliance with maternal and child health and infection prevention and control protocols. A major procurement, valued at approximately $1.4 million, of essential equipment that will be needed by Hanan's current and future clinic partners was put to tender during this quarter.

Through the West Bank community program, 1869 maternal and child health knowledge promotion activities (including health education sessions and courses and home visits) were carried out, benefiting a total of 16,868 women of reproductive age and children under 5 years old. Additionally, 1,511 community activities highlighting maternal and child health messages were conducted, benefiting a total of 22,751 participants, of which 15,629 were women of reproductive age. 119 staff members of non-government and community based organizations received training in community mobilization. 27 Community Coalitions were formed and developed action plans for supporting women's and children's health.

In August, the Palestinian Coalition for Human Resource Development (PCHRD) was selected as Hanan's Gaza community program partner. By the end of October, PCHRD had recruited a team of 29 community mobilizers and community health workers, who began working in 37 neighborhoods in North Gaza and Gaza City.

Progress made before the Project suspension by the Communications and Marketing team was set back to the beginning when the subcontractor that had been identified to implement most of the activities under this component was not able to sign the new mandatory clause. Between July and September, the team restarted work under the subcontract with the remaining partner Sama Productions, and identified and contracted with three new program partners to cover the other planned activities. Between October and December, the health education materials, theatre performances, radio plays and magazines, and original songs CD were designed or written, pre-tested and prepared for production. It is anticipated that this component will be fully launched by the end of January, 2007.

Under the $1 million emergency fund, $895,896 has been committed for the procurement of emergency medical kits for health and non-health providers, and of urgently needed medical equipment and spare parts for 9 non-government hospitals in the West Bank and Gaza. So far, $374,476 of this

total has been purchased and is at the delivery stage. Contracts are now being prepared for the remaining balance of $521,420.

This quarter the team also initiated a second assessment of urgently needed medical equipment and spare parts for 4 additional hospitals in the West Bank. Pending USAID approval, it is anticipated that $250,000 will be spent on this hospital procurement. Thus, between July and December, the Project will have obligated the entire emergency fund, plus an additional $150,000, to be reallocated from other budget line items upon USAID approval.

To move forward with program expansion, 67 potential new clinic partners in the West Bank and Gaza were identified and their information submitted to USAID for vetting. These clinics work in new geographic areas of Middle and Southern Gaza, and Bethlehem, Ramallah, Jerusalem, Toulkarem and Salfeet in the West Bank. Typically it takes two months for clinics to be vetted, and so it is anticipated that a new cohort of additional clinic partners will be receiving support from Hanan by February, 2007. At the same time, 27 new communities to be reached through the West Bank community program have been identified.

Implementation has, however, suffered some new set backs. At USAID's request, work with 14 (50%) of the 28 partner clinics and 1 of the 13 hospitals for the emergency procurement were indefinitely suspended. The clinics and hospital had previously been vetted, but were later disapproved. This has further limited an already limited pool of viable clinic partners for the Project. Further, the current cohort of 14 partner clinics serves a total population of 333,037 women of reproductive age and children under 5, comprised of 162,382 beneficiaries in Gaza and 170,655 beneficiaries in the West Bank. This can be compared to the total population of 519,417 women of reproductive age and children under 5 served by the previous cohort of 28 partner clinics. Thus, the potential to reach 186,380 beneficiaries was lost through the suspension of the 14 clinics.

Additionally, our community program partners do not wish to comply with a new request by USAID to gather information about Community Coalition members, for the purposes of obtaining from a waiver of the no contact policy for those members who are Palestinian Authority employees. (Originally, the legal counsel had ruled that it was permitted for these members to serve in an individual capacity on the Coalitions.) Our partners do not want to assume the responsibility of determining who is to be included or excluded from community bodies or the risk to their reputation and possibly their safety. As a potential solution to this impasse, USAID is now seeking a blanket no contact waiver for the Community Coalitions. The future of Hanan's community program will rest on whether or not this waiver is granted.

II. Looking ahead to 2007

A. Key challenges

The major challenges facing the Project obviously relate to the policy and procedural requirements outlined above. The no contact policy's prohibition on working with the public sector creates a barrier to reaching a large segment of the Project's target beneficiary population of vulnerable women and children. Non-government clinics reach a relatively small client population that can afford to pay the fees that they charge for service delivery. This population tends to be better off economically and thus less vulnerable. The public sector, which provides services free of charge, reaches a much larger client population, including those who are most vulnerable.

Especially during the current humanitarian and economic crisis, more women and children can only seek services in the public sector or from UNRWA if eligible. This is at a time when, due to the cessation of international donor assistance, the public sector lacks basic resources to function, much less ensure service quality.

Additionally, non-government clinics are often located in geographic areas where the population is less isolated and vulnerable. In more remote areas with vulnerable populations that lack access to services, public sector clinics are often the only available provider.

Hanan was built on a sound basis of evidence and experience of what works to achieve impact in improving the health and well being of mothers and children. For example, in the original design, community mobilization and clinic services strengthening activities were carefully crafted to ensure a simultaneous increase in the availability of high quality services and in the demand for those services in Hanan intervention sites. In the current policy and legal context, intervention site selection takes place in large part according to where eligible partners can be found and the need to avoid organizations that we are not allowed to work with and the government sector. This has led to the selection of different intervention sites for community mobilization and clinic services strengthening activities, thus reducing the opportunity for impact. In some intervention sites, service quality will be improved but no demand for those services will be created. In other sites, demand will be created, but high quality services may not be available.

Many potential local partners, including some of the leading and most well established organizations in their fields, have decided that they cannot work with the Project, either because they cannot accept recently introduced vetting procedures, applicability rules and mandatory clause revisions or as a more general expression of objection to US government policy. This has also reduced the potential to program and spend funds through subcontracts to partner organizations. Many of the remaining partners are less well established. They have difficulty absorbing large amounts of funding and they require more intensive support.

Situations where assistance to partner organizations or clinics previously cleared is subsequently suspended have been damaging for the Project and most difficult for our field-based teams, who must abruptly break off relationships that were carefully fostered on a basis of trust and mutual

respect. 14 of the 28 clinics previously cleared by USAID were subsequently suspended. Strengthening vetting systems, from the stage of filling out forms to the final clearance, in order to minimize uncertainty about the decisions made, would help to alleviate this problem.

B. Supporting implementation

USAID has been unfailingly supportive in guiding the Project through the suspension period and in advising on how best to apply relevant policies and procedures. Nonetheless, up to 7 months was lost during Project suspension, redesign and restart, and in the end the team was faced with implementing a substantially different Project than the one originally intended. For example, the Project had to select, from a drastically limited pool, a completely new cohort of clinic partners, which needs a different kind of support than the previous cohort. The evidence base that the Project had built during the first year was carefully calibrated to intervention sites and partners. Much of it could no longer serve as an accurate baseline when the Project was redesigned, and there was no longer enough time left to gather anew such a comprehensive evidence base. In many ways Hanan has had to start over again, midway through the life of the Project. An extension to the Project would be needed to make up for this set back.

As described above, the framework of new policies and procedures that the Project must operate under slows the pace of implementation, limits the number and quality of partners to work with, and dislocates the Project from its beneficiaries. This in turn hampers program expenditure and reduces the potential for impact. If the Project is to continue operating as a large scale public health program under this framework, expectations regarding the pace of implementation, expenditure rates and results must be scaled back accordingly. It might also be advisable to rewrite again the Project Description, with a more modest design and scaled back activity program and work plan.

Alternatively, if the Project could be granted more scope and flexibility to operate, for example through no contact waivers and a notwithstanding authority, this could help considerably. A no contact waiver for the Community Coalitions would literally save the community program, which is now reaching over 6,000 beneficiaries each month and is set to scale up further. A notwithstanding authority could greatly expand the pool of clinic partners from which we could select and it could allow the Project to operate where its beneficiaries are seeking services.

C. Achieving impact

Achieving national level outcomes in improving maternal and child health and nutrition, as was originally envisioned for the Project, is not going to be possible under the current operating framework. We cannot now access the intervention sites and partners needed to achieve the coverage and scale, which are required for national impact. To achieve this, the Project would

need to obtain broad exemptions from current policies and procedures, and immunity from their legal implications, and we would now need more time.

By December 2007, the Project can continue to achieve a series of maternal and child health intervention successes, as measured by performance against maternal and child health process and output indicators, and through capacity building of smaller partners that are willing to work with us and want to grow.

Conclusion

Hanan is at a turning point, facing the options of either scaling back Project design and anticipated results to match the current operating framework, or seeking more scope and flexibility to operate. Both options are currently under discussion with USAID.

Under the current operating framework, it is recommended to scale back the current program design and activity program and work plan, setting sights on achieving discrete successes in supporting Palestinian mothers' and children's health and building the capacity of Palestinian non-government organizations working in the health sector.

If granted more scope and flexibility to operate, and given more time, the Project could still achieve national level impact in improving the health of mothers and children in West Bank and Gaza. This is clearly the preferred option for benefiting the Palestinian people and for demonstrating the effectiveness and efficiency of American assistance to West Bank and Gaza.

Anne Scott
7 December 2006