GOAL ETHIOPIA

Sidama Child Survival Program

MID-TERM EVALUATION REPORT

Awassa Zuria and Boricha Woredas of the SNNP Region of Ethiopia

COOPERATIVE AGREEMENT # GHN-A-00-07-00010-00

START DATE – September 30, 2007 (FY2008)
END DATE – September 29, 2011 (FY2011)

SUBMISSION MTE REPORT: October 30, 2009

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ACRONYMS

ACT	Artemisinin-based Combination Therapy
ANC	Antenatal Care
BL	Baseline
CDD	Control of Diarrheal Disease
CG	Care Groups
CHP	Community Health Promoter (volunteer)
CHW	Community Health Worker (volunteer, another name for CHP)
CMAM	Community Management of Acute Malnutrition
CORE	Child Survival Collaborations and Resources group
CSHGP	Child Survival and Health Grant Program
CSTS+	Child Survival Technical Support
DIP	Detailed Implementation Plan
FE	Final Evaluation
FMOH	Federal Ministry of Health in Ethiopia
GFATM	Global Fund for AIDS, Tuberculosis and Malaria
HFA	Health Facility Assessment
HIV	Human Immuno-deficiency Virus
HMIS	Health Management Information System
HPF	Health Post Facilitator (GOAL field staff)
HQ	Headquarters
IMNCI	Integrated Management of Newborn and Childhood Illness
IPTp	Intermittent Preventive Treatment in pregnancy
IRS	Indoor Residual Spraying
ISA	Institutional Strengths Assessment
ITN	Insecticide Treated Net
KPC	Knowledge, Practices and Coverage
LLIN	Long-lasting Insecticidal Net
LOP	Life of the Project
LQAS	Lot Quality Assurance Sampling
MOH	Ministry of Health
MTE	Mid-Term Evaluation
NGO	Non-Governmental Organization
ORS	Oral Rehydration Salts / Solution
PNC	Postnatal Care
PRA	Participatory Rural Assessment
RDT	Rapid Diagnostic Test
RHB	Regional Health Bureau
SNNPR	Southern Nations, Nationalities and Peoples Region
TT	Tetanus Toxoid
TTBA	Trained Traditional Birth Attendant
USAID	United States Agency for International Development
vCHW	Volunteer Community Health Worker
WoHO	*Woreda* (District) Health Office
WRA	Woman of Reproductive Age

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Date: October 27, 2009
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A. Executive Summary

GOAL was awarded a CSHGP grant to implement a Child Survival Project in two districts of Sidama Zone in the Southern Nation, Nationalities and Peoples Region of Ethiopia from September 30, 2007 (FY08) to September 29, 2011 (FY11). The CSP is implemented in 30 *kebeles* (community groupings at the sub-district level) and benefits 31,198 children under age five and 37,100 women age 15 to 49. The program goal is to contribute to a sustainable reduction in maternal and child mortality and improved health outcomes for the local community; which will assist in progress toward achievement of the Millennium Development Goals for Ethiopia. (Results Framework in Table 1 below). **Technical interventions** include Nutrition (25%), Control of Diarrheal Diseases (25%), Malaria (25%) and Maternal and Newborn Care (25%). Cross-cutting interventions include: (a) Behavior change communication developed through the BEHAVE framework and with use of the Care Group approach at the community level; (b) Capacity building of local community, MOH structures and GOAL staff; (c) Integrated management of childhood illness in communities and Health Posts, and (d) Monitoring and evaluation of progress toward objectives in conjunction with key stakeholders.

Main accomplishments at midterm include:

- Effectiveness of Care Group model with behavior change measured by KPC survey showing increases in exclusive breastfeeding, appropriate IYCF practices, child and maternal immunization, access to iron folate (maternal) and Vitamin A (child).
- Operations research in place for assessing effectiveness of Care Groups, introduction of new zinc/ORS protocol for management of diarrhea, and social marketing of Water Guard with successful phase one (acceptance and awareness).
- Strengthened link between communities and Health Posts for promotion of maternal and newborn care, with use of HP labor & delivery services beginning to increase.
- Initiation of joint supportive supervision (Woreda Health Office and GOAL) using COPE tools and with community participation and representation.

Primary constraints include a lack of continuous and sufficient supply of essential medicines for child health at Health Posts leading to poor care seeking behavior by mothers; and low availability of usable ITNs in households at present.

Summary conclusions are that, as a New Partner, GOAL has taken advantage of technical assistance and available CSHGP tools to install good capacity in monitoring and evaluation and in developing a behavior change communication plan. Achievements in behavior change at the community level and improvements in health service skills at the Health Post level are measurable at MTE. A strong base has been established that should contribute to further achievements in years 3 and 4.

Key recommendations are to: (a) expand Care Groups and initiate exit strategies that will encourage self-leadership and future sustainability; (b) close technical follow-up with HEWs after training in Safe & Clean Delivery to install quality service availability; (c) strengthen focus on quality assurance with continued and expanded use of COPE tools; and (d) continue to maintain information and data contributing to operations research.

Table 1: Summary of Major Project Accomplishments

Result 1: Improved health outcomes for children using IMCI approach			
IR 1.1: Improved hygiene practices and management of diarrhea at the community level. IR 1.2: Improved nutritional status and nutrition practices at the community level. IR 1.3: Improved care seeking and appropriate malaria practices to reduce risk of transmission for children age 0 to 23 months. IR 1.4: Improved health seeking practices to address the causes of child morbidity and mortality from communicable diseases.			
INPUTS	**ACTIVITIES**	**OUTPUTS**	**OUTCOME**
Step 1 for social marketing of Water Guard: distribution to households through Care Groups (complementary funding) Low osmolarity ORS supplied to Health Posts (complementary funding) Zinc introduced and supplied to health posts 2 months prior to MTE (complementary funding) Family Health Card distributed through Health Posts and used in Care Group trainings Large scale ITN (not all LLIN) distribution by MOH prior to and during Year 1 LOP	CSP staff conduct Doer/Non-doer behavior change analysis on use of ORS by mothers; ITN Rapid Assessment Year 1 Workshop for WoHO partners on zinc/ORS, facilitated by PSI; TOT for Health Center nurses and HEWs on CDD; ESHE Project training of CSP staff and partners on Essential Nutrition Actions Supportive supervision and on-the-job training of HEWs by GOAL CSP field staff Monthly training of Care Groups (CG) and CHPs	More than 70,000 bottles of Water Guard distributed 45 HEWs and 6 nurses with refresher training CDD and new training in use of zinc/ORS protocol 866 mothers participating in Care Groups; 991 CHPs trained ~45,000 home visits by CGs; 47,000 CHPs	Increased HH use of Water Guard (2.6% BL to 66.7% MTE) Increased % of mothers reporting exclusive breastfeeding of children 0 to 5 months of age (27.2% BL to 78.4% MTE) Increased % of mothers using appropriate child feeding practices for ages 6 to 23 months (25.4% BL to 63.1% MTE) % of mothers with knowledge of at least two signs of childhood illness that indicate a need for referral more than doubled (40.4% BL to 94.7% MTE)
Result 2: Improved health outcomes for women which will address the leading causes of maternal mortality and morbidity.			
IR 2.1 Improved effective management of delivery at the community level. IR 2.2 Improved maternal health practices at the community level.			
INPUTS	**ACTIVITIES**	**OUTPUTS**	**OUTCOME**
Delivery tables provided to all Health Posts along with other key missing equipment; water system improved at 5 Health Posts (complementary funds); TTBA hygiene kits restocked during transition to institutional delivery	GOAL facilitated HEW attendance at 30 day Safe and Clean Delivery training with practicum 3 refresher trainings for TTBAs, emphasizing role for promotion of use of health services and referral	60 HEWs certified in Safe and Clean Delivery 107 TTBAs referring women to Health Posts	CSP monitoring shows increase from 0 to 44 deliveries in 30 Health Posts since training.

Result 3: Improved capacity of health facilities to provide quality essential basic services for women and children.			
IR 3.1 Increased immunization coverage in children 0 to 23 months. IR 3.2 Increased access and provision of quality care for women during pregnancy and for postnatal care in health facilities. IR 3.3 100% of GOAL supported HPs have improved capacity to respond to leading causes of child and maternal mortality and morbidity.			
INPUTS	**ACTIVITIES**	**OUTPUTS**	**OUTCOME**
Loan of vehicles and drivers to WoHO during immunization outreach activities Iron folate supplied to Health Posts (complementary funding)	On-the-job training and supportive supervision for HEWs Initiation of COPE assessment for participatory joint supervision Care Groups and CHPs trained on importance of complete immunization for children and women of childbearing age; birth preparedness and importance of ANC, PNC and newborn immunization	See above.	• Increased % children 12 to 23 m. with measles vaccine (72.8% BL to 81.6% MTE); • Increased % children 6 to 23 m. who received a dose of vit A in last 6 months (67.5% BL to 78.9% MTE) • Increased % of pregnant women receiving iron folate (11.4% BL to 22.8% MTE) and increase in the average number of tablet/days received (from 7.5 BL to 27 days MTE) • Increased % of women with at least 2 TT before birth of youngest child (49.1% BL to 60.5% MTE)
Result 4: Improved capacity of GOAL, MOH and communities to implement and replicate effective and sustainable community based Child Survival strategies			
INPUTS	**ACTIVITIES**	**OUTPUTS**	**OUTCOME**
External TA for KPC survey and BCC strategy development; internal training in PRA and focus group discussion	Training for CSP staff and partners in KPC survey Training for CSP staff and partners in BCC / BEHAVE framework with Doer/Non-doer barrier analysis Training for CSP staff and partners in qualitative methods	CSP staff and partners conducted KPC survey at BL and MTE with LQAS methodology. CSP staff and partners regularly conducting qualitative investigation using PRA, Doer/Non-doer behavior analysis and Focus Group Discussion	Strong CSP established with positive changes in mothers MCHN practices found at Mid-Term Evaluation.

B. Overview of the GOAL Sidama Child Survival Project

As a New Partner, GOAL was awarded a Child Survival Grant for four years in Ethiopia, starting September 30, 2007 (FY2008) and ending September 30, 2011 (FY2011). At the beginning of 2008, CSTS+ facilitated a workshop in Ethiopia to assist GOAL in preparing for development of the Detailed Implementation Plan (DIP). A Health Facility Assessment (HFA) was done in March 2008, using an adapted version of the CSTS HFA tool and the DIP was initially submitted in April 2008. A baseline KPC survey using LQAS methodology was conducted between August and November 2008 and these findings also were incorporated into the DIP, which was resubmitted in response to CSHGP questions and recommendations, with final approval in December 2008.

A repeat HFA was done in March 2009 and repeat KPC survey in August 2009. At the end of Fiscal Year 2 (September 2009), this Mid-Term Evaluation has been conducted.

B1. Goal, Objectives and Results

Program Goal: To contribute to a sustainable reduction in maternal and child mortality and improved health outcomes for the local community; which will assist in progress toward achievement of the Millennium Development Goals for Ethiopia.

Strategic Program Objective: Develop a sustainable primary health care system in partnership with the local community of Boricha and Awassa *Woredas* (districts), which will improve the health outcomes of the most vulnerable and increase the capacity of relevant stakeholders to assume responsibility for the health needs of their community.

Result 1: Improved health outcomes for children using IMCI approach which will address the leading causes of child mortality and morbidity in target communities.

- **Intermediate Result 1.1**: Improved hygiene practices and management of diarrhea at the community level.
- **Intermediate Results 1.2**: Improved nutritional status and nutrition practices at the community level.
- **Intermediate Result 1.3**: Improved care seeking and appropriate malaria practices to reduce the risk of malaria transmission for children aged 0 to 23 months at the community level.
- **Intermediate Result 1.4**: Improved health seeking practices to address the causes of child morbidity and mortality from communicable diseases at the community level.

Result 2: Improved health outcomes for women which will address the leading causes of maternal mortality and morbidity in target communities.

- **Intermediate Result 2.1**: Improved effective management of delivery at the community level.
- **Intermediate Result 2.2**: Improved maternal health practices at the community level.

Result 3: Improved capacity of health facilities to provide quality essential basic services for women and children.

- **Intermediate Result 3.1**: Increased immunization coverage in children 0-23 months in health facilities.
- **Intermediate Result 3.2**: Increased access and provision of quality care for women during pregnancy and for postnatal care in health facilities.
- **Intermediate Result 3.3**: 100% of GOAL supported health facilities have improved capacity to monitor and respond to the leading causes of child and maternal mortality and morbidity.

Result 4: Improved capacity of GOAL, MOH and communities to implement and replicate effective and sustainable community based Child Survival strategies.

- **Intermediate Result 4.1**: Child Survival strategies being effectively implemented by GOAL and partner organizations.

B2. Project Location: Sidama Zone in the Southern Nation, Nationalities and Peoples Region (SNNPR) of Ethiopia. The program is implemented in 30 selected *kebeles* (sub-districts) across the two *woredas* (districts) of Awassa Zuria and Boricha. Sidama Zone is located within the southwestern portion of the Rift Valley and is one of the more densely populated areas in the country, with an average family size of six people.

B3. Estimated Target Population: Figures in Table 2 come from a national census in 2004 and were agreed upon by MOH representatives participating in the DIP process.

Table 2: Target Population

Woreda	Total population	0-11 months	12-23 months	24-59 months	Total 0-59 months	Women 15-49 years
Awassa Zuria	74,033	2,961	2,961	7,773	13,695	16,287
Boricha	94,603	3,784	3,784	9,933	17,501	20,813
TOTAL	168,636	6,745	6,745	17,707	31,198	37,100

B4. Technical Interventions:

- **Nutrition (25%)**: Promotion of Essential Nutrition Actions; support for MOH outreach and distribution of Vitamin A.
- **Control of Diarrheal Diseases (25%)**: Promotion of ENA, early care seeking, appropriate case management in home and at health post, Point of Use water treatment, introduction of zinc/ORS treatment protocol at health post/center.
- **Malaria (25%)**: Prevention through appropriate use of ITN/LLIN, early care seeking, appropriate case management at health post.
- **Maternal and Newborn Care (25%)**: Recognition of danger signs, birth preparedness, promotion of use of ANC, delivery and PNC at health post; training of Health Extension Workers in Safe and Clean Delivery; training of TTBAs in promotion and referral to existing services and hygienic delivery if no other option during transitional period for the region; provision of key equipment and supplies for delivery at Health Post.

B5. Cross-cutting Interventions:

- **Capacity building** of local community, MOH structures and GOAL staff.
- **Integrated management of childhood illness** in the community and in health facilities (Health Posts).
- **Monitoring and evaluation** of progress toward objectives in conjunction with the local community and other key stakeholders.
- **Behavior change communication** using a health promotion strategy developed using the BEHAVE framework.

B6. Project Design: A major objective of the Ethiopian Federal MOH Health Sector Development Program / Health Extension Program is to achieve universal primary health care coverage. To this end, a training program for **Health Extension Workers** was created and two HEWs have been placed in almost every *kebele* throughout much of the country. In the GOAL Sidama Child Survival target area of 30 *kebeles*, each has two HEWs placed in renovated or newly built Health Posts.

To strengthen the capacity of HEWs, GOAL staff provide on-the-job training for HEWs to review diagnosis and treatment protocols for the common childhood illnesses of diarrhea and malaria. In addition, they assist HEWs to improve documentation skills using MOH registers and to improve the organization of materials and supplies in the Health Post. An on-the-job training strategy was selected because assessment and community discussion shows HEWs to already spend more time than desired out of the Health Post for Zone Health Office meetings, to obtain supplies, and for other reasons. GOAL has coordinated a two critical training events for HEWs: (1) with Woreda Health Office staff, an orientation to the new zinc/ORS protocol for management of diarrhea; and (2) a 30 day training from accredited MOH trainers at selected Health Centers in Safe and Clean Delivery during childbirth.

HEWs coordinate with **volunteer Community Health Workers** (vCHWs[1]), known as Community Health Promoters (CHPs) in the target area. CHPs assist HEWs in improving the hygiene and sanitation of the community, promote use of available services and early care seeking, and assist in coordinating special immunization outreach days (SIDS). CHPs also have received some orientation on the key health messages for women and young children. The GOAL program provides refresher training to CHPs through monthly meetings in the community. HEWs are invited to attend and/or facilitate.

As more than 60% of CHPs are male, GOAL has established **Care Groups[2]** with mothers with children under age two, as an additional strategy to promote behavior change for maternal and newborn care, for recommended infant and young child

[1] "Community Health Workers: Ethiopia", Sandra Kong and Marcia Brown for USAID Knowledge Services Center, July 23, 2008.
[2] "The Care Group Difference: A Guide to Mobilizing Community-Based Volunteer Health Educators", by World Relief, produced by the Child Survival Collaborations and Research (CORE) Group, 2004,

feeding practices, and for basic prevention and management of common childhood illnesses. Care Groups are oriented through monthly meetings in the community and, as is expected of CHPs, do home visits. However each member targets home visits to roughly 15 households where there are pregnant women or children under age two.

Care Groups and CHPs have participated in Step One (building awareness and acceptance) of a social marketing plan for Water Guard, a point of use water treatment.

GOAL CSP has initiated a process for joint supervision, assessment and action planning in Quarters 3 and 4 of Year 2. GOAL CSP staff, with previous experience in the use of COPE health facility self-assessment tools, coordinated with Engender Health to become oriented to an additional tool developed for community participation in assessment of health services. GOAL CSP staff then provided training and orientation to WoHO staff in the use of a limited number of the health facility self-assessment tools and a few of the C-COPE tools. This was followed by a participatory exercise with WoHO Health Extension Supervisors and community representatives at two Health Posts in Awassa Zuria, with discussion of results. A formal Action Plan will be developed in Quarter 1 Year 3 and the process will be replicated for other Health Posts in both *woredas*. Communities have already taken some action to improve Health Post facilities where the exercise was conducted. A Quality Task Force has been organized with WoHO for review and follow-up of these activities and to identify action needed at management level.

B7. Partnerships: Key partners include the ***Woreda* Health Office** staff in each of the two target districts, along with coordination with the Regional Health Bureau. **Population Services International** (PSI) has provided technical assistance for the social marketing of Water Guard and has facilitated a workshop for project staff and partners on the new zinc/ORS protocol. Water Guard and zinc have been obtained through PSI assistance to-date, while low osmolarity ORS has been obtained from **DKT**, who also collaborates with PSI. GOAL exchanges information from operations research on the introduction of the new zinc/ORS protocol for diarrhea management with **Save the Children US**, who also has a Child Survival Project in a nearby area and in which the zinc/ORS protocol is promoted. With the recent USAID award to the Johns Hopkins University Center for Communications Program for a Global Health Communication Project, it is expected that collaboration on the zinc/ORS protocol will also be a part of the project focus. GOAL will share all operations research information and collaborate in any way that is useful as this initiative develops.

The GOAL program greatly benefits from **complementary funding**, primarily from Irish Aid, that is used to improve access to safe water at Health Posts and to supply Health Posts with zinc and ORS, for management of the new protocol, and with iron folate for antenatal care. With Irish Aid funding GOAL has provided some key equipment and supplies to Health Posts, primarily in support of labor and delivery at these institutions.

The **Essential Services in Health in Ethiopia Project** (ESHE, USAID funded) provided GOAL with a large supply of the Family Health Card as a key BCC material for

promotion of key health and nutrition messages. They also facilitated training for GOAL CSP staff in the Essential Nutrition Actions. This project has now been absorbed into the Integrated Family Health Project.

B8. USAID Mission Collaboration: GOAL has maintained regular contact with the USAID mission in Ethiopia, providing updated information on project status and key upcoming events. Debriefing of key findings and recommendations from the Mid-Term Evaluation was done with the USAID Health Officer who has recently taken the position of liaison with USAID-funded Child Survival Projects in Ethiopia. The CSP DIP was designed to contribute to the USAID mission strategy 2004-2008 in Ethiopia for the health sector and to provide support that would increase social resilience and the capacity of government and community structures to withstand shocks.

In Annex 4, a Mid-Term Evaluation review of the DIP Work Plan is found. Information on how this incorporates the MTE Action Plan is included. There have been no significant changes in the program design, strategies, indicators, intervention mix, activities or location. The GOAL CSP has had to withdraw from 2 of the project target of 30 kebeles (in Boricha Woreda) for the past quarter due to conflict among a small sub-group of people that seek to be administratively linked to an adjacent border area. It is expected that staff will be able to return to collaborating with communities in this area soon. The GOAL CSP Development Manager position was turned over to a new staff member; handover occurred during the MTE and the new Development Manager participated in review of key findings and development of the Action Plan.

C. Data Quality: Strengths and Limitations

GOAL, as a New Partner, has (successfully) invested considerable effort into strengthening their existing capacity for monitoring and evaluation through the use of tools and techniques developed for or promoted by the USAID Child Survival Health and Grants Program. The overall quality of data from evaluation activities is strong and the mix of quantitative and qualitative techniques is excellent.

CSTS+ project provided assistance in developing their baseline survey plan, using Lot Quality Assurance Sampling methodology and the KPC survey questionnaire and tabulation of indicators available at www.childsurvival.com. This KPC survey has been repeated at mid-term. GOAL also adapted the Health Facility Assessment tool developed by CSTS and has conducted HFA at baseline and mid-term. The information from mid-term KPC and HFA has been of great value in assessing the program's achievements to-date and determining areas to be strengthened in Years 3 & 4.

GOAL built upon existing skills in use of focus group discussion and Participatory Rural Assessment techniques for qualitative investigation by contracting a consultant with experience in Child Survival methods and tools, to train staff and partners in use of the BEHAVE framework to develop a behavior change communication plan. GOAL staff

have repeatedly and appropriately used the Doer/Non-doer method of barrier analysis to inform program strategy.

GOAL CSP staff have assisted in strengthening the quality of information obtained through the FMOH Health Management Information System at the district and Health Post level. GOAL CSP staff gathered the variety of forms being used at Health Posts and worked with the Woreda Health Office (WoHO) to up-date and standardize formats, in line with the HMIS. GOAL CSP staff have provided on-the-job training and supportive supervision to HEWs in correctly filling out HMIS forms and maintaining complete and up-to-date registers of services provided.

WoHO has established processes for regular review of HMIS data, along with annual review in coordination with the Regional Health Bureau. GOAL CSP and WoHO staff have not instituted a process of reviewing HMIS data together as a part of action planning. Recently, a process of joint supervision and self-assessment of service provision through use of COPE tools has been initiated. It is expected, and recommended, that this lead to review of HMIS data as action plans are developed. The FMOH appears to be under-going some restructuring at present and it is anticipated by the project that there may be upcoming changes in the HMIS also.

GOAL CSP staff gather implementation information for their internal monitoring system and operations research. Information is gathered on: Care Group participation; CHP participation in monthly meetings, and information on gender breakdown; pre and post-test group results for Care Group and CHP training; tracking of the distribution of Water Guard; and needs assessments of Health Posts. This information is reviewed monthly by field staff and supervisors, and quarterly by all program staff. It has been used thus far to identify geographic and/or technical areas where activities need strengthening and to determine what equipment and supplies to provide to which Health Posts.

D. Assessment of Progress Toward Results Achievement

At Mid-Term Evaluation, the GOAL Sidama CSP has exceeded final targets established for four indicators (exclusive breastfeeding, IYCF, knowledge of signs of illness that indicate the need for treatment, and point of use water treatment). Positive change was found for an additional twenty-four indicators (related to hygiene and safe water, antenatal care, child access to immunization and Vitamin A, and child spacing, among others) and the project is on track to achieve final targets for these indicators. Positive change was seen for child weight-for-age status, which can be considered a higher level indicator reflecting cumulative positive change in many behaviors. Eleven indicators, (related to feeding during illness, access to essential medicines by mothers of sick children under age two, use of postnatal care services and use of LLINs) did not show positive change at mid-term and will be the focus of additional efforts, along with other planned activities in Years 3 & 4. Two indicators (HP supply of zinc and joint collaboration in HMIS) were not yet evaluated as activities were introduced shortly before Mid-Term Evaluation.

Table 3: Monitoring and Evaluation Matrix – Progress at Mid-Term

Objectives	Indicators	Data Source	BL Value	MTE Value	Final Target	Explanation of Progress
Result 1: Improved health outcomes for children using IMCI approach for the leading causes of child mortality and morbidity.	% of children age 0-23 m with an illness in the past 2 weeks.	KPC	73.7%	74.6%	65%	Although POU water treatment greatly increased, hand washing did not improve, resulting in continued levels of child diarrhea
IR 1.1: Improved hygiene practices and management of diarrhea at the community level.	% of mothers of children 0-23 m who live in a HH with soap or ash at the place for hand washing	KPC	29.8%	31.6%	45%	This will be a focus for strengthened activities in Years 3 and 4.
	% of children age 0-23 m with diarrhea in the last two weeks who receive ORS &/or recommended home fluids	KPC	43.0%	38.6%	65%	ORS supplies were found to be low at HFA and MTE observation, perhaps due to use during a measles outbreak in March-April 2008. This message and review of supplies will be a focus of the CSP in Year 3.
	% of children age 0-23 m with diarrhea in the last two weeks who received zinc treatment with ORS.	KPC	0%	n/a	15%	Zinc has just been introduced to the Health Posts in the target area. HEW knowledge of treatment protocol was strong at MTE.
	% of children age 0-23 m with diarrhea in the last two weeks who were offered more fluids during the illness	KPC	12.3%	11.4%	35%	ENA for feeding during illness receive additional emphasis in BC activities in Years 3 and 4.
IR 1.2: Improved nutritional status and nutrition practices at the community level.	% of infants age 0-5 m who were exclusively breastfed in the last 24 hours	KPC	27.2%	78.4%	42% New target 80%	CSP has had great success with this message. MTE results exceed final target. Final target will be adjusted to 80%.

Objectives	Indicators	Data Source	BL Value	MTE Value	Final Target	Explanation of Progress
	% of children age 6-23 m fed according to appropriate child feeding practices	KPC	25.4%	63.1%	34% New target 65%	CSP has had great success with this message. MTE results exceed final target. Final target will be adjusted to 65%.
	% of children age 0-23 m who are underweight (≤-2 SD weight for age, according to WHO/NCHS reference population)	KPC anthro-pometric measure	28.1% (BL report 43.9%)	25.7%	37% New target 24%	In spite of chronic poor harvests during the LOP, improvements in IYCF practices are protecting child nutritional status. BL was reviewed at MTE using EPI-NUT and outliers cleaned. Final target will be adjusted to 24%, a 15 percentage points reduction from baseline, the same amount of reduction proposed in DIP.
IR 1.3: Improved care seeking and appropriate malaria practices to reduce the risk of malaria transmission for children age 0-23 m	% of children age 0-23 m who slept under an LLIN the previous night	KPC	22.8%	8.8%	55%	MTE suggests care of ITNs has been poor and previous high levels of coverage no longer exist. CSP will conduct Doer/Non-doer barrier analysis to look at care and use of ITNs in Year 3.
	% of children age 0-23 m with febrile episode that ended during last 2 wks who were treated with an effective anti-malarial within 24 h onset of fever	KPC	7.9%	4.4%	45%	HFA and MTE found a lack of ACT at Health Posts. Joint supervision activities will focus on this topic.
IR 1.4: Improved health seeking practices to address the causes of child morbidity and mortality.	% of mothers of children age 0-23 m who know at least two signs of childhood illness that indicate the need for referral (treatment)	KPC	40.4%	94.7%	65% New target 95%	MTE results have exceeded final target. Final target will be adjusted to 95%.

Objectives	Indicators	Data Source	BL Value	MTE Value	Final Target	Explanation of Progress
	% of mothers of children age 0-23 m who took their children with ARI/fast breathing to an appropriate health care provider for advice/treatment	KPC	54.4%	57.0%	65%	Pneumonia requires referral to a Health Center as Health Posts are not provided with antibiotics. The improvement seen in this indicator has required efforts at all steps, from recognition of illness by mothers to family support for transport to access to services and essential medicines.
	% of mothers of children age 0-23 m which treat their water in the home prior to drinking (excluding straining to remove solid matter)	KPC	5.3%	69.3%	22%	Step 1 of the social marketing of Water Guard has been very successful. As Step 2 involves moving from free distribution to purchase from local distributors, the final target will not be adjusted.
Result 2: Improved health outcomes for women which will address the leading causes of maternal mortality and morbidity in target communities.	At least one Care Group functioning each GOAL supported *kebele*	Monitoring system	0%	100%	100%	Care Groups are not only present in all communities but also show excellent knowledge of key messages at MTE.
IR 2.1: Improved effective management of delivery at the community level.	Number of HEW and TTBAs with knowledge of safe and clean delivery skills for effective management of deliveries in the community	Monitoring system	0%	90%	100%	HEWs and TTBAs are coordinating to identify pregnant women and encourage use of MNC services, including delivery.
	% of mothers of children age 0-23 m whose last birth was attended by a skilled health professional	KPC	4.1%	2.6%	15%	Since HEWs received training in Q3 and Q4 of Y2, a steady increase in the number of deliveries at Health Posts has been monitored and confirmed by MTE.

Objectives	Indicators	Data Source	BL Value	MTE Value	Final Target	Explanation of Progress
IR 2.2: Improved maternal health practices at the community level.	% of children age 0-23 m who were breastfed within a few minutes of birth	KPC	65.8%	67.5%	85%	Improvement in this indicator requires changing a traditional practice that persists. CGs and TTBAs have become BC agents to promote change.
	% of mothers of children age 0-23 m who received or bought iron tablets for 90 days or more during last pregnancy	KPC	0% (90 d) 11% (7.5 d)	0% (90 d) 23% (27 d)	8% (90 d)	Obtaining iron has doubled and the amount provided has more than tripled. The target of 90 days is challenging.
	% of mothers of children age 0-23 m who know at least two methods of modern contraception and how to access this.	KPC	83.3%	93.0%	95%	"Ever use of modern methods" also increased from 44.7% to 68.4%.
	% of children age 0-23 m born at least 33 months after previous surviving child	KPC	65.3% (24 m)	69.6% (33 m)	74%	Change in indicator to comply with new KPC standards implies amount of change since baseline is greater than shown.
Result 3: Improved capacity of health facilities to provide quality essential basic services for women and children.	% of Health Posts with improved functional performance (assessed on access, inputs, processes and outputs)	HFA	46.5% (Y1 result, reported after DIP)	59.5%	65%	Greatest improvement shown regarding "access" for Health Posts in both districts.
IR 3.1: Increased immunization coverage in children 0-23 m in health facilities.	% of children age 12-23 m who received a measles vaccine	KPC	72.8%	81.6%	83%	Data does not capture concerns about cold chain due to measles outbreak in 2009.
	% of children age 12-23 m who received DPT3 before reaching 12 m.	KPC	65.8%	69.3%	78%	DPT1 increased from 84.2% to 88.6%.

Objectives	Indicators	Data Source	BL Value	MTE Value	Final Target	Explanation of Progress
	% of children age 6-23 m who received a dose of Vitamin A in the last 6 m.	KPC	67.5%	78.9%	80%	HFA found almost all HPs to have Vitamin A in stock.
IR 3.2: Increased access and provision of quality care for women during pregnancy and for postnatal care in health facilities.	% of mothers of children age 0-23 m who during their previous pregnancy attended ANC at least 4 times (*change since DIP from 2 visits*).	KPC	11.5%	16.5%	20%	Indicator changed from 2 visits to 4 visits since DIP, with 2 visits at BL 34.2%.
	% of mothers of children age 0-23 m who received at least two Tetanus Toxoid injections before birth of youngest child	KPC	49.1%	60.5%	68%	CG and TTBA promotion of TT has been effective in increasing mother's use of this available ANC service.
	% of mothers of children age 0-23 m who received a Vitamin A dose within 8 weeks of delivery of their youngest child	KPC	19.3%	14.9%	35%	HFA shows availability is not the limiting factor; more promotion through CGs and TTBAs will be done in Years 3 and 4.
	% of children age 0-23 m who received a post-partum visit from an appropriate trained health workers within two days after birth	KPC	1.8%	1.8%	12%	MTE found mothers do not perceive the benefits of PNC; refresher emphasis on benefits will be done with CGs and TTBAs.
	% of mothers of children age 0-23 m who received a post-partum visit from an appropriate trained heath worker within two days after the birth of the youngest child	KPC	3.5%	3.5%	10%	See above.

Objectives	Indicators	Data Source	BL Value	MTE Value	Final Target	Explanation of Progress
IR 3.3: 100% of GOAL supported health facilities have improved capacity to monitor and respond to the leading causes of maternal mortality and morbidity	% of health staff who have been trained in IMCI	Monitoring system	0%	0%	100%	Training of HEWs in IMNCI is scheduled for Y3.
	% of Health Posts with iron in stock (for the prevention/ treatment of anemia in pregnancy)	HFA	0%	75%	75%	GOAL supplies iron folate through use of complementary funding. CSP will focus on maintaining and/or improving HP supply and emphasize benefits of iron folate through CGs and TTBAs.
	% of Health posts with zinc and ORS in stock for the treatment of diarrhea	HFA	0%	n/a	75%	Not measured at MTE HFA in Y2 Q3 as zinc was introduced Y2 Q4.
Result 4: Improved capacity of GOAL, MOH and communities to implement and replicate effective and sustainable community based Child Survival strategies.	Child Survival interventions are sustainable – 80% of Care Groups continue to function after the program duration ends.	External evaluation	0%	n/a	80%	Exit strategies for Years 3 and 4 call for gradual handover of Care Groups to member leaders and strengthened links with *kebele* administration.
IR 4.1: Child Survival strategies being effectively implemented by GOAL and partner organizations.	Percentage of GOAL and community partners trained in behavior change methodology and GOAL behavior change strategy in place	Monitoring system External evaluation	0%	100%	100%	Training in use of BEHAVE framework; repeat use of Doer/ Non-doer barrier analysis

Objectives	Indicators	Data Source	BL Value	MTE Value	Final Target	Explanation of Progress
	Care Group initiative evaluated and if successful replicated in at least one other GOAL site in GOAL Ethiopia program	ORG Capacity Assessment & External evaluation	0%	50%	100%	MTE KPC results show effectiveness as BC agents, particularly in relation to promotion of IYCF.
	CHPs, HEWs and TTBAs retain 80% of the knowledge and skills that they learn throughout the project.	Monitoring system	0%	80%	80%	Pre and post group tests show good retention of key messages by Care Group members.
	Attendance at Care Group and CHP training sessions remains above 80% throughout the project	Monitoring system	0%	63%	80%	CHPs had previously received stipends for attendance at training activities; GOAL policy of not offering stipends is thought to have reduced attendance by some group members.
	Strengthen MOH mechanisms for supplying Health Posts with essential meds (ORS, zinc, iron folate) & for collection HMIS data.	HFA	0%	50%	100%	MOH supply and provision for ORS and iron folate has been strengthened; zinc has been initiated.
	Joint planning and collaboration: HMIS data collection in HPs and the community results in HMIS data collection mechanisms in function	Monitoring system External evaluation	0%	100%	100%	Joint planning and collaboration in place; activities for HMIS have been initiated at mid-term.

E. Discussion of Progress Toward Achieving Results

The program's cross-cutting approaches noted in the DIP include:

- **Capacity building** of local community, MOH structures and GOAL staff.
- **Behavior change communication** using a health promotion strategy developed using the BEHAVE framework.
- **Integrated management of childhood illness** in the community and in health facilities (Health Posts).
- **Monitoring and evaluation** of progress toward objectives in conjunction with the local community and other key stakeholders.

Mid-Term Evaluation shows that approaches for building organizational capacity, building capacity at the community level, and strengthening selected skill sets of Health Extension Workers at the Health Post level have been particularly effective to date. The GOAL Sidama Child Survival Project's behavior change communication strategy is an integral part of all capacity-building activities.

The Integrated Management of Child Illness (now updated as the Integrated Management of Newborn and Childhood Illness in Ethiopia) has not yet been rolled-out by FMOH to the Health Post and community level in the project target area, but is planned for Year 3. To-date the project has focused on building or refresher the capacity of Health Extension Workers in specific skills sets (see E1c below).

As a New CSHGP Partner, GOAL has dedicated significant efforts and demonstrated commitment to building capacity for monitoring and evaluation. More information on this progress is provided in section C Data Quality and Annex 3 Project Management. In this section, more information on Operations Research to-date is provided, along with information on the project's strategy for joint supportive supervision and action planning.

In addition to the cross-cutting approaches noted above, GOAL as an NGO in Ethiopia has a strategic vision to better bridge the gap between humanitarian relief efforts and development programming, especially in areas with frequent need for short-term emergency response. The GOAL Child Survival Project and the GOAL Rapid Response Team in Sidama Zone have fostered links which have been mutually strengthening and beneficial for communities. This coordination has not diluted the level of effort either team dedicates to its individual program objectives and activities.

E1. Capacity Building

E1a. Organizational Capacity: As mentioned in section C Data Quality, GOAL has drawn upon technical assistance, tools and resources developed for USAID CSHGP partners to build upon GOAL's previously existing capacity for monitoring and evaluation and for program design. The use of KPC indicators and survey questionnaire guides has contributed to a strong Monitoring and Evaluation Matrix that can assess the impact of program activities at the household level. GOAL has also

adapted the CSTS Health Facility Assessment tool to evaluate program effects on the quality and availability of maternal and child health services.

To develop the program's behavior change strategy, GOAL obtained technical assistance from a consultant experienced in use of the BEHAVE framework. The consultant provided training to GOAL CSP staff and partners, other GOAL health program staff, and invited NGO partner guests. The workshop included a practical experience in use of Doer/Non-doer barrier analysis.

Locally, GOAL has also drawn upon existing technical resources in Ethiopia: training on the Essential Nutrition Actions was provided by the (former) ESHE Project; assistance in designing strategy and training for staff and partners on social marketing of Water Guard and introduction of zinc/ORS protocol was provided by PSI; and local consultants with previous experience in the Home Based Life Saving Skills methodology drew upon their experience to develop a curricula and training that focused only on the minimum activities for maternal and newborn care (MAMAN framework) and then provided training for Health Extension Workers and TTBAs.

During MTE, the GOAL HQ Child Survival Technical Advisor and the MTE consultant reviewed the CSTS Project Institutional Strengths Assessment Methodology tool for assessing and building the capacity of a PVO Health Unit. After MTE fieldwork, the HQ CS Technical Advisor and GOAL Ethiopia Desk Officer then went through a self-assessment. Their final recommendations for further capacity building are: (1) further technical support on behavior change communication and sustainability in health programs; (2) wider sharing of lessons learned and innovative approaches across programs; and (3) more regular training for Health Unit staff (See Annex 12).

E1b. Community Capacity: GOAL has focused behavior change efforts through the training of three types of community members with influence on community health and nutrition behaviors – mothers with children under age two, Community Health Promoters (also sometimes referred to as volunteer Community Health Workers) and Trained Traditional Birth Attendants.

E1b1. Care Groups: The GOAL Sidama CSP has successfully established 1 or more Care Groups in each of the 30 kebeles targeted in the project area. Drawing upon general rule-of-thumb recommendations from multiple sources regarding group activities using adult learning methodology, a group size of about 25 was promoted. As enthusiasm has grown and/or in kebeles with large coverage areas, additional Care Groups have been formed. CSP monitoring data shows Care Groups to range in size from 15 to 30, with an average membership of 25, and with 66% (average 20) having attended all sessions. At present approximately 630 mothers with children under age two are active in the Care Groups. Members are not referred to as "volunteers" or "leaders" as many expectations regarding compensation and volunteerism are still an obstacle in the target area; however, members demonstrate a willingness to "share" their new knowledge through home visits to 10-15 other households where there are mothers with children under age two.

To-date, Care Group members have received training in the topics of: safe water and improved sanitation, the Essential Nutrition Actions for infants 0 to 5 months of age, the Essential Nutrition Actions for children 6 to 23 months of age, recognition of signs of common childhood illness requiring referral and treatment, prevention of malaria, control of diarrheal disease and key recommendations for maternal health care. Focus group discussion with Care Group mothers during MTE found all mothers to be very confident and to demonstrate good and correct knowledge regarding all key maternal and child health and nutrition messages. When asked during FGD what behaviours are easiest to convince other mothers to change, it was noted that exclusive breast feeding practises was not difficult to change (this is reflected in the KPC results). Giving birth at health units is considered the most challenging recommended practise to change.

The effectiveness of the Care Group approach as implemented by GOAL CSP can be seen in the positive results of behaviour change demonstrated by comparison of KPC survey results from baseline to mid-term. Very positive change was found in two indicators of recommended infant and young child feeding practices and in mothers recognition of signs of child sickness requiring referral and treatment:

- % of children age 0 to 5 months exclusively breastfed: 27.2% BL, 78.4% MTE
- % of children age 6 to 23 months fed according to appropriate child feeding practices: 25.4% BL, 63.1% MTE

GOAL CSP staff received training in the Essential Nutrition Actions from ESHE Project staff (which built upon previous efforts by the LINKAGES Project) and have replicated this training at community level. Currently there are a number of external threats to child nutritional status in SNNPR, including chronic sub-optimal harvests. In spite of this, a small but significant reduction in the percentage of children with malnutrition (weight for age Z score below -2 standard deviations) was measured at midterm KPC (28.1% BL, 25.7% MTE). Improvements in infant and young child feeding (IYCF) practices are most likely protecting child nutritional status in the current situation.

IYCF feeding practices during illness did not show improvement per KPC results and this topic will be re-emphasized in Year 3. Although KPC results for the indicator of the "% of mothers of children age 0 to 23 months who know at least two signs of childhood illness that indicate the need for referral" showed great improvement (40.4% BL, 94.7% MTE), improvement was not found for specific care seeking indicators for malaria nor use of ORS. It is likely that the lack of essential medicines seen during Health Facility Assessment in Years 1 and Years 2 (see below) is affecting care seeking decisions.

E1b2. Community Health Promoters (CHP): CHPs (or, using the term recently suggested to standardize terminology, volunteer Community Health Workers) are a volunteer position called for by the FMOH Health Sector Development Program Health Extension Program strategy. They are selected by the community and communities tend to the selection of males to participate (although in the GOAL CSP target area,

40% of CHPs are now women, with GOAL encouraging gender equity when communities are called upon to replace CHPs that no longer participate).

The FMOH has not provided for specific training of CHPs but rather calls upon HEWs to orient them. As the initial Health Extension Program strategy has always had a strong focus on improved community sanitation, CHPs are often most active in promoting latrine construction, safe water storage and hand washing facilities. To draw upon and strengthen their skills, the GOAL CSP has provided monthly training sessions for CHPs which have encompassed all key behavior change messages for primary maternal and child health care. This has greatly strengthened CHP capacities to promote recommended infant and young child feeding practices. It has also assisted the GOAL CSP in reaching fathers to support women's use of available maternal health services. Many female CHPs are also members of Care Groups and were interviewed in MTE focus group discussion with Care Groups. Male CHPs participated in MTE focus groups with community leaders, and their technical knowledge and enthusiastic support for CSP strategies was apparent.

Intermittent presumptive treatment of malaria is not part of the protocol for maternal health care in Sidama Zone. GOAL CSP promotes use of LLINs by pregnant women and this message was frequently mentioned as a key message during focus group discussions with CHPs, Care Groups and TTBAs during MTE.

E1b3. Trained Traditional Birth Attendants (TTBA): More than five years previous to the initiation of the GOAL CSP, the role of previously trained Traditional Birth Attendants in the health catchment area had been changed. Training for TTBAs was suspended and they were no longer recommended to attend childbirth but rather were encouraged to refer women to existing maternal health services. However, it is recognized that increasing access to/use of institutional delivery services involves a transitional period.

The GOAL CSP has provided training to TTBAs in support of this transitional period and centered around the MAMAN framework of "Minimum Activities for Mothers And Newborns" in the community. With TTBAs and Care Groups, the CSP promotes birth preparedness and the importance of accessing antenatal care to receive tetanus toxoid (TT) and iron folate (which is supplied to the Health Posts by GOAL from complementary funds). Nutrition training for TTBAs has included promotion of adequate maternal nutrition during pregnancy and promotion of immediate exclusive breastfeeding at delivery. Positive results were found at MTE KPC survey for several key maternal health care indicators, including access to TT and iron folate (see below, section E1c. Health Facility Capacity Building).

The GOAL CSP has also included specific activities in support of the creation of demand for institutional delivery at Health Posts (see below). During the transition period, training for TTBAs has also included training on safe and clean delivery with appropriate cord care and thermal care for the newborn. TTBAs have also received

refresher training for recognition of danger signs during pregnancy and the perinatal to neonatal period, with appropriate referral.

In focus groups with TTBAs during MTE, they stated they emphasise to mothers that antenatal care services are free and enable a mother to know both her condition, the number of months of pregnancy and estimated delivery date, "and the baby's position in the womb". They stated that, except for socially-related reasons why women sometimes wish to hide pregnancy, women are eager to receive the tetanus toxoid vaccine during pregnancy. The key messages TTBAs mentioned promoting also included good nutrition during pregnancy ("eat at least 1 or 2 extra meals") and recommendations that women reduce workloads and/or "take time to rest" during pregnancy. TTBAs also mentioned recommending and following up with mothers to ensure newborns receive vaccinations. Many TTBAs also function as CHPs and/or are members of Care Groups. Through this they also promote and influence other key recommended child nutrition and health practises. TTBAs were asked to share recent success stories. Two mentioned identifying danger signs of anaemia during pregnancy (dizziness in one case, swelling of extremities in the other) and referring the women to the Health Post to obtain iron folate supplements, with elimination of these symptoms.

In the MTE focus groups, TTBAs stressed that they encourage women to deliver at Health Posts because the Health Extension Workers have "tools and resources" that the TTBAs do not have and that they perceive as providing protection for women's health. When asked for an example, TTBAs responded: "the apparatus to measure a women's blood pressure" and alluded to methods to prevent the spread of communicable disease (a reference to HIV). TTBAs admitted that they were previously reluctant to refer women for delivery before the HEWs received a recent special training on Safe and Clean Delivery (see below) but that now they, mothers and the HEWs themselves are more confident about their skills. Two TTBAs told of accompanying women to the Health Post for labour and delivery and being welcomed by the HEW to participate in the process and provide support and comfort to the woman. TTBAs noted that the HEWs are willing to come to the woman's home and assist delivery and that this had occurred in at least one case in each community in the month previous.

Several mentioned that they are often only summoned to a woman's home when she is already in the middle of delivery and thereby have to assist the birth. They emphasized the steps they took to prevent infection, with promotion of the early initiation of breastfeeding even before the placenta is delivered (contrary to traditional practice). All TTBAs stressed that they no longer encourage mothers to give herbal teas to infants and expressed pride that their advice has resulted in a change in this previously common practise. KPC results at MTE showed a slight positive trend in the percentage of children age 0-23 months who were breastfed within a few minutes of birth (65.8% BL to 67.5% MTE) and a dramatic increase in exclusive breastfeeding, as noted above.

Through links with other GOAL non-CSP health programming, TTBAs have also viewed a video to enable fistula recognition and are able to make referrals for surgical repair at Yirgalem Fistula Hospital (linked with a main hospital in Addis Ababa), with costs

covered by private donations to these hospitals. TTBAs have also received training on and promote the benefits and availability of modern family planning methods

E1c. Health Facility Capacity: The GOAL Sidama CSP seeks to build the capacity of Health Extension Workers that are the only staff at Health Posts located in the target area *kebeles* and involve community members in collaborating with HEWs to maximize health benefits for women and children.

Although precise information is not available, CSP staff perceive that there are limitations in the availability of health services due to Health Posts not being open as often as they should be. MTE focus groups with community leaders somewhat support this concern although community leaders were obviously reluctant to be perceived as criticizing health services in any way. It is also difficult to determine when HEWs should be present. They are frequently called away for training and other activities, and must leave the Health Post and go to the Health Centers to obtain supplies. There are no clear guidelines as to what hours Health Posts should offer services but rather it is expected that the two HEWs which staff Health Posts will organize their time (which is expected to be spent 30% offering services and 70% doing outreach and promotion house to house within the kebeles) so that services are reasonably available. Another difficulty is that at first it was thought that HEWs would be selected from within the community and therefore be accessible at all times; however, most HEWs come from nearby (larger) communities (where perhaps better access to education was available to them) and Health Posts do not have adequate facilities to support extended stays.

In response to this concern, the GOAL CSP changed its original capacity-building strategy for Health Posts (which called for organized training events that would require HEWs to be absent from communities) to an on-the-job capacity building strategy and made adjustments to the CSP organizational chart. As noted above, the majority of GOAL CSP field staff have technical training in health as nurses. A subset of 1 Supervisor and 2 Health Post Facilitators (1 per woreda) were selected to dedicate 100% of their time to working only with the Woreda Health Offices and the Health Posts.

To strengthen **child health services**, on-the-job capacity building has focused on review of diagnosis and treatment protocols for common childhood illness (diarrhea, pneumonia and malaria) and use of the WoHO Health Management Information System tools, including completion of registers of service provision. After CSP and WoHO staff received training and orientation by PSI on zinc/ORS treatment protocols, this orientation was also provided to HEWs at Health Posts in a structured fashion drawing upon the PSI workshop.

Health Extension Workers are invited to participate in GOAL CSP monthly Care Group and/or CHP training activities in the community and in this way they maintain links with community volunteers, share their knowledge and coordinate upcoming outreach activities, and also refresh or deepen their knowledge to some degree.

The FMOH has been rolling out the **Integrated Management of Newborn and Childhood Illness** approach to all levels. GOAL CSP will coordinate with the SNNP Regional Health Bureau and WoHO to support participation by HEWs in IMNCI training in Year 3. GOAL CSP will promote training organization and logistics that do not remove all HEWs from Health Posts for extended periods, but rather is accomplished in small batches similar to the organized training of HEWs in Safe and Clean Delivery (see below.)

KPC results at MTE did not show any improvement in care seeking and access to health services for common childhood illness. Use of ORS (and/or other home fluids) when a child has diarrhea remained low (~40%). As zinc was only recently introduced (June 2009), this was not captured on KPC survey. MTE visits to Health Posts and interviews with HEWs found good knowledge of the correct treatment dosages for children under age two. In one case, however, it appeared that HEWs were giving ORS or zinc for diarrhea, most likely in an attempt to extend short supplies of essential medicines. HFA in Year 2 found only 1 of 16 Health Posts surveyed to have all essential child medicines; only 50% had ORS in stock and only 37.5% had in-date Coartem®. It is speculated by CSP staff that the regular supply of low osmolarity ORS provided by the project through use of complementary funds from Irish Aid may have been used up more quickly than usual due to a measles outbreak in March-April 2009.

The lack of ACT, which was also observed during MTE Health Post visits, most likely contributed to the poor results seen by KPC survey for children accessing correct treatment for fever in a malarial zone (7.9% BL, 4.4% MTE). Only the Zonal Health Bureau had an explanation for the lack of ACT and which was attributed to a large supply going out-of-date the year previous, reducing overall supplies. Interviews with HEWs and with WoHO staff found a lack of clarity regarding protocol and follow-up when Rapid Diagnostic Tests are negative. Although non-resistant *p*.vivax is present in Sidama zone, no chloroquine was present in Health Posts.

The GOAL CSP has not specifically focused on pneumonia as it is not part of their technical level of effort which is directed at the Health Post level. HEWs are not provided antibiotics nor permitted to treat pneumonia. KPC at mid-term found only a slight increase in the percentage of mothers of children 0-23 months with signs of pneumonia seeking care (54.4% BL, 57.0% MTE); however, the percentage taken to a professional able to prescribe antibiotics (doctor or nurse) increased from 29.9% BL to 44.1% MTE.

The GOAL Sidama Child Survival Project proposal and DIP did not include any level of effort for child immunization activities as Woreda Health Office partners dedicate significant efforts to this intervention and the Regional Health Bureau receives support for this intervention from multiple donors. However, in support of partner activities at the community level, the GOAL CSP regularly provides logistics support for any WoHO Special Immunization Day outreach activities, loaning vehicles and drivers. KPC results for MTE show a consistent increase in the percentage of children age 12 to 23 months

with DPT1, DPT3 and measles vaccines (along with vitamin A dose in the six months prior to survey) since baseline survey.

To strengthen **maternal health services,** HEWs were involved in refresher training provided by GOAL CSP for TTBAs to review key antenatal, delivery and postnatal care. This refresher training has been conducted three times total in Years 1 and 2. The benefit of use of maternal health services is also promoted through the Care Groups. GOAL also uses complementary funding from Irish Aid to provide iron folate to Health Posts in support of antenatal care.

KPC results at Mid-Term found a significant increase in the percentage of women with at least two tetanus toxoid vaccinations (49.1% BL, 60.5% MTE) though the percentage of women with 4 or more antenatal care visits during the last pregnancy only showed a slight positive trend (11.4% BL, 14.9% MTE). Health Facility Assessment found most Health Posts to have iron folate in stock and KPC results showed an increase in the percentage of pregnant women obtaining iron folate (11% BL, 23% MTE) and an increase in the average number of daily doses obtained (7.5 days BL, 27 days MTE). As noted above, IPTp is not standard protocol for antenatal care in Sidama Zone.

Postnatal care for mothers or newborns remained low but showed a slight positive trend (PNC check of newborn *any* time, 6.2% BL, 14.1% MTE) but did not improve within the recommended window of 2 days after birth (Rapid Catch indicator). Similar results were seen for postnatal check-up for mothers, with some increase in a check up at *any* time (3.5% BL, 7.0% MTE) but no improvement within the recommended two week period after birth. There was even a slight decrease in the percentage of mothers obtaining vitamin A post-partum (19.3% BL, 14.0% MTE).

To promote delivery at Health Posts, with the use of complementary funding from Irish Aid, GOAL has provided delivery tables to all Health Posts and other specific key equipment unavailable at specific Health Posts per needs assessment (for example, a few sphygmomanometers or sterilizers; all other needed instruments have been provided by UNICEF, per HEW and WoHO interviews and MTE observation). Complementary funding has also been used to improve access to water at 5 Health Posts in Awassa Zuria woreda, with additional support for access to water at Health Posts planned for Boricha woreda in Year 3. In interviews with WoHO staff for Awassa Zuria woreda, some Health Posts are expected to be linked to a piped water system that is being extended into the district while there may also be other funding support available to improve HP access to water.

In Year 2, in coordination with the SNNP Regional Health Bureau and the WoHO for Awassa Zuria and Boricha, GOAL agreed to provide funding and logistic support for HEWs to attend the 30 day WHO-sanctioned training on Safe and Clean Delivery at selected Health Centers. Mid-Term Evaluation included observation of practical training of four HEWs during assisted delivery. Infection control measures were seen to be in place. Interview of one HEW post-delivery demonstrated new confidence in attending childbirth, strong appropriate technical knowledge with a focus on infection

prevention, promotion of early initiation of breastfeeding with assistance for correct positioning and attachment, and knowledge of basic techniques for support of a woman during emergency referral transport.

Besides the practical training, trainers were using synthetic obstetric / gynecologic models for instruction, along with flipcharts they themselves prepared. In interviews with two of the trainers, their only concerns were related to language and communication. The extensive manual used for training is only available in English at present, although GOAL health staff believe that the FMOH is in the process of translating this manual into Amharic. Though HEWs understand Amharic, they might not speak it well enough for trainers to be able to gauge their comprehension of some training topics, although practical demonstration assists in this aspect.

The Safe and Clean Delivery trainings were attended by batches of 10 HEWs for 30 days each since April and was on-going at MTE (100% of 60 HEWs for 30 Health Posts will have been trained by the end of Fiscal Year 2). The MTE KPC survey was done before many of the HEWs had completed training and did not yet capture expected effects. CSP monitoring data reports 44 deliveries to have been attended at 25 Health Posts since the training. MTE interviews with 6 HEWs found an average of 3 deliveries in 1 to 2 months since training. It should be noted that the greatest proportion of mothers usually give birth without any assistance. KPC at baseline and mid-term found 13% to 26% to give birth alone while another 50-60% call upon a relative or friend to assist. The initial progress seen in these first months post-training is encouraging.

A separate GOAL health program provides supplies of injectable family planning methods (depo-provera) to Health Posts. This activity also complements the USAID-funded Integrated Family Health Project activities that promote family planning. During MTE observation of Health Posts, it was noted that all HEWs had the table-top flipcharts on family planning developed with USAID funding. These were reproduced and distributed to all Health Posts in the target area through use of GOAL counterpart funds. HEWs demonstrated comfort and familiarity in their use for client counseling. KPC results for “ever contraceptive use” showed an increase from a baseline of 44.7% to MTE 68.4%, with most having ever used injectables (65%). With child spacing providing benefits for the health of mothers and young children, KPC results also showed a slight increase in the percentage of children age 0 to 23 months who were born at least 33 months after the previous surviving child.

E2. Behavior Change Strategy

During a workshop for DIP preparation facilitated by CSTS+, GOAL CSP staff became familiar with the BEHAVE framework. As the DIP was prepared, CSP staff and partners identified the priority groups and key behaviors to be targeted, along with identifying the key factors to be addressed and critical activities. The BEHAVE framework continued to be the basis for designing project training activities to promote behavior change and was further developed throughout Year 1. GOAL has identified persons of influence, including peers (mothers with children under age two) and elderly women in roles as TTBAs or relatives, along with community political and religious leaders.

Early in Year 2, GOAL contracted a consultant experienced in use of the BEHAVE framework in the Designing for Behavior Change (DBC) curriculum developed in 2008 by the CORE Group Social and Behavioral Change Working Group. The DBC calls for use of Doer/Non-doer Barrier Analysis to identify determinants that further influence behavior change. The DBC workshop was facilitated for all GOAL CSP staff, other GOAL health staff and partners and included a practicum using Doer/ Non-doer Barrier Analysis. GOAL CSP staff have continued to use this new skill for qualitative investigation as they define and refine activities throughout the LOP.

Mid-Term Evaluation found the GOAL CSP to be effectively training community volunteers in the key messages for child and maternal health care, with behavior change evident at mid-term (see above for more details).

Besides training in use of the BEHAVE framework, CSP staff were also trained in the Essential Nutrition Actions by staff from the USAID-funded (former) Essential Services for Health in Ethiopia Project (now absorbed into the Integrated Family Health Project). Several GOAL staff, including the GOAL Ethiopia Health Advisor and the CSP Health Coordinator had also had previous training in ENA through the LINKAGES Project and they have continually reinforced the quality of IYCF messages throughout the LOP. This installed capacity for GOAL Ethiopia has contributed to the fact that, in the CSP Monitoring and Evaluation Matrix, IYCF indicators have shown the greatest positive change at mid-term.

The ESHE Project also provided the GOAL CSP with a large supply of the Family Health Card, which functions as a Maternal and Child Health Card and as an IEC/BCC tool that includes key messages for MCH in written (Amharic) and pictorial fashion. The Family Health Card is used in Care Groups in which both literate and illiterate women participate. The GOAL CSP also drew upon pictorial materials developed by Population Services International to produce and distribute widely throughout the target area calendars which have pictures that depict the appropriate use of LLINs and prioritization for pregnant women and children under age two. Key messages for the prevention of malaria are also displayed on the calendar. The GOAL CSP plans to develop and distribute another calendar in each of Years 3 and 4. Likely message focus will be on diarrhea prevention through improved point of use water safety and zinc/ORS management as the new protocol rolls out in the area, although this remains to be coordinated with project partners.

In discussion of MTE findings, GOAL Health Coordinator and CSP staff will look into the feasibility of coordinating the development of a Quick Reference version of the existing FMOH approved and WHO supported manual for Safe and Clean Delivery. The FMOH is preparing a translation to Amharic of the entire manual but a Quick Reference would be handy and could help to fully install these new skills acquired by HEWs.

E3. Monitoring and Evaluation: In section C Data Quality and in Annex 3 more information is provided on the excellent job that GOAL has done as a New CSHGP

Partner to build capacity in qualitative assessment and quantitative monitoring and evaluation. Activities have included participatory rural assessment, Doer/Non-doer Barrier Analysis, KPC survey at baseline and mid-term using LQAS methodology, HFA survey in Years 1 and 2 using CSTS tool and rapid assessment of ITN/LLINs in Year 1.

E3a. M&E and Operations Research: In the DIP, GOAL proposed Operations Research on two topics: (a) the effectiveness of the Care Group approach; and (b) the introduction of zinc/ORS protocol. GOAL CSP is maintaining a database of information in support of this Operations Research and has been using the above-mentioned skills in qualitative and quantitative assessment, monitoring and evaluation to document these activities. At Mid-Term Evaluation, the Care Group approach has already demonstrated some effectiveness in changing mothers' practices for infant and young child feeding (see Table 3 and section E). Zinc has only recently been introduced into the target area Health Posts; however, MTE interview with HEWs showed good knowledge of the protocol for treatment. GOAL will continue to document all activities related to these Operations Research topics and link with project evaluation results.

Although there was some discussion of collaborating in social marketing of zinc/ORS at the community level, this does not seem realistic at this point. GOAL will focus on documenting the introduction of the zinc/ORS protocol, its use, acceptance and effectiveness. What has evolved into a viable social marketing activity is the use of Water Guard point-of-use treatment for safe water. As with zinc, GOAL has closely partnered with PSI in the first phase of a plan for social marketing of Water Guard – building awareness and acceptance through Care Group distribution of free samples with household orientation to use. PSI has facilitated training on phase two for social marketing – the identification and selection of appropriate and accessible vendors – and this will be the next priority activity early in Year 3. MTE focus group discussion with community participants found broad agreement that social marketing of Water Guard was feasible; close monitoring and documentation of the next steps will be critical.

It should be noted that besides finding high use of Water Guard at MTE in KPC survey (5.3% BL, 69.3%), results also showed an associated improvement in safe water storage in appropriate containers (56.1% BL, 65.8% MTE).

E3b. Monitoring Health Service Quality: As noted above, GOAL CSP staff and WoHO partners have conducted a Health Facility Assessment in each of Years 1 and Year 2 and this will be repeated at final evaluation.

GOAL CSP field staff provide on-going supportive supervision and on-the-job training for Health Extension Workers in their respective Health Posts. Health Facility Assessment showed a large proportion of HEWs to have received a supervisory visit by the Woreda Health Office Extension Supervisors within the three months previous to the HFA in both Year 1 and Year 2. However, GOAL has had difficulty coordinating joint (GOAL-WoHO) supportive supervision visits to Health Posts as WoHO staff have many competing activities.

In order to achieve several objectives (including joint supportive supervision, continuous improvement of quality, and community involvement), the GOAL CSP initiated the use of the **Client Oriented, Provider Efficient** (COPE®) methodology. Some GOAL CSP staff had previous experience in use of COPE tools and they provided orientation to WoHO staff on the methodology and different tools available. Then GOAL staff and partners selected two tools from the options available for self-assessment by health facility providers for use with Health Extension Workers, and two tools from the Community COPE manual (draft), which is the newest COPE manual developed and which promotes community participation in the assessment of health services.

Training and orientation was followed by a participatory exercise with WoHO Health Extension Supervisors, HEWs and community representatives in use of the tools at two Health Posts in Awassa Zuria, with immediate discussion of results and tentative Action Planning. A formal Action Plan will be developed in Quarter 1 Year 3 and the process will be replicated for other Health Posts in both *woredas*. Communities have already taken some action to improve Health Post facilities where the exercise was conducted (providing voluntary guard services at night in one Health Post, digging a hole for burning of HP waste at another site). A Quality Task Force has been organized with WoHO for review and follow-up of these activities and to identify action needed at management level.

E4. Contextual Factors

As noted above, Sidama Zone has been experiencing chronic sub-optimal harvests during the life of this Child Survival Project. In spite of this, a small but significant reduction in the percentage of children with malnutrition was measured at mid-term and is likely attributable to improvements in infant and young child feeding practices demonstrated at mid-term.

GOAL Ethiopia seeks to find ways to **bridge the gap** that occurs between NGO relief efforts and NGO development programming. A previous GOAL emergency nutrition response program within some kebeles in the target area has been handed over to installed Out-patient Therapeutic Program (OTP) in Health Posts. These services have been improved through GOAL support for roll-out of the new national strategy based on the Community Management of Acute Malnutrition (CMAM) approach. GOAL CSP has also contributed to improvements in the capacity of community members for rapid assessment and response. With technical assistance from the GOAL Rapid Rural Response team, GOAL CSP staff included into training plans for community participants an orientation on the use of Mid Upper Arm Circumference (MUAC) measurement for pre-screening of acutely malnourished children and provided community participants with MUAC tapes. In this way they can identify and refer children for additional screening by Health Extension Workers to determine if there is a need to enroll the child in OTP services. In focus group discussion with all CSP community participants (CGs, CHPs, TTBAs and community leaders) they all noted this new skill as being an important contribution to community capacity to manage and improve child health. Observation of HEW MUAC technique during MTE Health Post observation visits showed good skills and correct screening procedures. This increased capacity for rapid

response may also have contributed to protecting child nutritional status as seen by weight-for-age at MTE.

Another area of concern for the local context is the discouraging status for **malaria prevention and treatment** found at Mid-Term Evaluation. GOAL changed original budgeting plans for the CSP when it was found at project start-up that, through the Global Fund for AIDS, Tuberculosis and Malaria, there was on-going large-scale distribution of insecticide treated bed nets in the SNNP Region. KPC baseline survey found 53.5% of households with children under age two to have ITNs (or LLINs), yet this percentage has decreased to 18.4% at MTE.

In focus group discussions with CHPs and community leaders during MTE, they expressed a perception that the nets did not last "very long", although they could not specify a length of time. Local health partners state that they expected the nets to last three years. Although some nets were distributed as long as three years prior to the MTE KPC, others were distributed in 2007 and 2008. GOAL CSP staff conducted an ITN/LLIN utilization survey using LQAS methodology in Year 1 and found 52.2% of nets to have holes in them. It was noted during MTE observation of Home Visits that all surfaces in homes are rough and can easily snag a net. At present, health partners know of no plans for any upcoming large-scale replacement distribution of LLINs.

GOAL CSP does not have the financial resources to purchase and distribute LLINs at this point; in addition, GOAL Ethiopia is committed to encouraging self-sustainability. GOAL CSP and other health staff will promote the importance of LLINs and the benefits to families that come from purchasing and appropriately using bed nets. GOAL CSP field staff and WoHO partners will also use the skills they have acquired to do a Doer/Non-doer barrier analysis in Y3 to determine, in those homes where previously distributed nets are still in use, how these families maintained the nets. This information will be incorporated into behavior change messages. One of the key messages of the GOAL CSP behavior change strategy for malaria at present is to prioritize the use of ITN/LLINs for pregnant women and/or children under age two. The KPC results at MTE did show that, among the low percentage of households using ITN/LLINs, at least half of those did use the nets for children age 0 to 23 months.

The Care Group approach has been well accepted by communities. With a high degree of **illiteracy among women**, the Care Groups have provided an opportunity for all women to participate in training that will lead to improved maternal and child health practices. Care Groups pair literate women with those that can't read to review training flipcharts and/or the Family Health Card, and Care Groups use participatory and active adult learning techniques (such as role play) that do not require literacy skills.
In spite of some communities expressing resistance to voluntary activities, the GOAL CSP has not encountered any difficulty in promoting home visits to be done by Care Group members. In the target areas, there is considered to be a very high degree of self-identification as being part of the Sidama tribal group and this leads to a **sense of unity** that appears to enable home visits. In focus group discussion during MTE, Care

Group mothers uniformly expressed that they are always and enthusiastically welcomed.

GOAL Ethiopia also includes a focus on reducing **Harmful Traditional Practices**, particularly those that affect women or children. In the GOAL CSP this has been primarily focused on eliminating the traditional practice of giving herbal teas to newborns and infants. It is also thought that the practice of uvulectomy and/or removal of children's "milk" teeth may occur, but these practices have not been specifically addressed as yet. Within GOAL Ethiopia's new strategic vision, there are activities for mainstreaming a focus on gender equity throughout all programming. All staff, including CSP staff, have had recent training on gender equity and this has included discussion of HTP that affect women. These practices are directly addressed in other GOAL health programs, such as the youth-focused Community Conversations about HIV/AIDS program that overlaps with CSP in the target area.

E5. Role of Key Partners

Table 4: Role of Key Partners

Partners	Role in Project	Result of Collaboration / Suggestions for Improvement
Woreda Health Offices (2)	• Approval and support for GOAL CSP activities, particularly with HEWs. • Participate in training activities and provide follow-up on service provision after training, such as the newly introduced zinc/ORS protocol for CDD. • Conduct joint supportive supervision of HEWs periodically with GOAL CSP. • Ensure that Health Posts have essential supplies and medicines for maternal and child health. • Appropriate distribution to Health Posts within the target area of any equipment donated and/or essential medicines supplied by GOAL to WoHO.	• CSP activities for building the capacity of HEWs have proceeded as planned. • Introduction of zinc/ORS protocol has proceeded as planned. • Increased frequency of joint supportive supervision through use of the COPE assessment tools is suggested. • Suggested to follow with development of Action Plans with a limited number of discrete actions that are possible to achieve.
Population Services International in Ethiopia	• Assist GOAL to identify appropriate suppliers of Water Guard, zinc and ORS. • Provide technical assistance in the development and implementation of GOAL plans for social marketing of Water Guard.	GOAL CSP staff cite PSI technical assistance as having been of excellent quality and instrumental in what has been achieved to-date.
Save the Children US	Collaborate in sharing plans and results regarding the introduction of the	SC US CSP staff have readily collaborated with GOAL,

Partners	Role in Project	Result of Collaboration / Suggestions for Improvement
	zinc/ORS protocol for CDD in SC-US CSP target area.	sharing available information and experiences.

E6. Overall Design Factors Influencing Progress

The GOAL CSP design for implementation has predominantly followed that noted in the DIP and has had a positive influence on the progress of the project to-date, as noted by GOAL CSP and other health staff. The structure and organization of activities which is required of CSHGP grantees is influencing GOAL health activities in other programs. The change in strategy for building the capacity of Health Extension Workers (changing from original plans for centralized training workshops to continuous on-the-job training through field visits to Health Posts by designated GOAL CSP staff) has assisted the project to be predominantly up-to-date with the DIP Work Plan.

At present, zinc and low osmolarity ORS are separately obtained from different sources (PSI and DKT respectively). If Diarrhea Treatment Kits are developed in Ethiopia, the GOAL CSP will need to be ready to adjust procurement strategies quickly and possibly repeat part of the training on zinc/ORS protocols already completed, to specifically orient HEWs on the use of the Diarrhea Treatment Kits.

F. Potential for Sustained Outcomes and Contribution to Scale & Global Learning

F1. Progress Toward Sustained Outcomes

At the community level, the fact that measurable behavior change in several key maternal and child health practices has been achieved by mid-term supports the idea that the key practices recommended through the GOAL CSP will have become the community norm by the end of four years, and thus be self-sustaining. Use of the Care Group approach essentially creates 20 to 25 behavior change agents in each *kebele*. They now are resources for orienting new mothers even after the project ends. To ensure this capacity and perceived role, in Year 3 the GOAL CSP will initiate the process of "handing over" leadership of the Care Groups to interested and willing members so that in Year 4 effective exit strategies are easily established.

The first phase of operations research for social marketing of Water Guard point-of-use water treatment has been very successful. This has involved creating awareness and acceptance of the product and creating demand for the next step. The next phase will involve establishing local vendors and continued demand for purchase of the product at a minimal cost. If the next phase of social marketing is successful, it is likely that improvements in access to safe water will be sustained.

At the health system level, activities which are strengthening the capacities of Health Extension Workers will be sustained among those HEWs that remain active. Contributions from complementary funds to safe and clean delivery equipment will sustain in the short-term an improved quality of maternal health service delivery.

WoHO partners have participated in Health Facility Assessment activities each year and joint supportive supervision and action planning, through use of COPE® methodology and selected tools, has been initiated. As both these activities continue to strengthen concrete and doable action planning in Years 3 and 4, this will contribute both to sustained improvements in health system management and in community involvement and influence on decision-making.

The GOAL CSP exit strategies and phase out plans are centered on leaving local capacities strengthened and with skills and tools that permit for self-sustaining progress even after the project ends. GOAL HQ staff and CSP management continue to build their understanding of the Sustainability Framework through review and follow-up of on-going working group and CSHGP partner activities; however, a formal sustainability design with use of the framework was not attempted at the DIP phase based on the overall level of new partner and staff activities.

F2. Contribution to Replication or Scale Up

The Operations Research that the GOAL CSP is conducting on the introduction of the zinc/ORS protocol for the management of diarrhea in health service facilities in the target area is designed to assist in developing the local evidence base on the benefits of this protocol. The Save the Children US Child Survival Project in a nearby target area is similarly involved in this operations research. It is expected that results from both projects will contribute to the body of experience in Ethiopia and will assist in an evidence-based decision by the FMOH to scale-up the protocol throughout the country. With a recent USAID award to the John Hopkins University Center for Communications Program for a Global Health Communications Project that will address child health, among other key primary health care priorities, this initiative may receive additional impetus before the end of the life of this CS project.

Internally, GOAL Ethiopia plans to replicate use of the Care Group approach in other health programs in other geographic regions of the country.

If, in Year 3, GOAL is able to coordinate with partners and key actors to develop a Quick Reference for Health Extension Workers for Safe and Clean Delivery, in Amharic, this will provide an important contribution to safe motherhood at the national level.

F3. Attention to Equity

GOAL has long focused its mission on assisting the poor. The geographic selection of poor rural areas with high unmet needs for this CSP is in line with GOAL's focus on equitable access for the poor to quality health services.

The level of effort dedicated to strengthening mothers' participation and leadership skills in the Care Groups is a key strategy for the GOAL CSP to seek improvements in gender equity in community participation in health. In all GOAL health programming, activities are designed so that a lack of education is no barrier to participation. Similarly, the

Care Groups include both literate and illiterate mothers and strategies to ensure their equal participation and sense of empowerment.

Last but not least, GOAL seeks to involve all ages in health programming. Complementary programming in HIV/AIDS in the target area focuses on youth. The CSP motivates women of reproductive age to participate, but also has carefully included elderly TTBAs (along with other age TTBAs) in both activities specifically focused towards TTBAs and in Care Group activities. In this manner, age is not a factor for exclusion while conversely, the project benefits from participation by another group of "persons of influence" in household decision-making on health care.

F4. Role of Community Health Workers

Developing or expanding the role of the volunteer Community Health Worker that is called for by the FMOH Expanded Health Program has not been the main focus of this GOAL CSP. Rather, increasing women's involvement in health issues and capacity for contributing to community improvement (as noted above in F3. Attention to Equity) has been the predominant focus. However, the GOAL CSP has coordinated with Community Health Promoters (the name given to vCHWs in Sidama Zone) and provided them with the same monthly trainings which the Care Group mothers have received. This has greatly broadened CHPs knowledge of the key maternal and child health messages as they have not officially received any other type of structured training. It is hoped that with the usual turnover in community participation, that more women from Care Groups will be selected as CHPs and will bring the strength of both the Care Group experience and their capacity as peers to benefit community primary health care actions.

F5. Contribution to Global Learning

One way in which USAID CSHGP partners collaborate in sharing experiences and contributing to global learning is through participation in the CORE Group conferences, listserves and working groups. NGOs that have been using the Care Group approach have initiated a process of sharing information on the effectiveness of the approach, particularly by using the Lives Saved Calculator and KPC results from projects. As MTE has already shown positive KPC results for some indicators, it is expected that at the end of this project, GOAL will be able to contribute to global learning on the effectiveness of the Care Group approach.

G. Conclusions and Recommendations

Program efforts in Years 1 and 2 have established a strong base and demonstrated sizeable positive changes for infant and child feeding indicators and positive trends in the majority of other indicators in the GOAL CSP Monitoring and Evaluation Matrix.

The program has invested considerable efforts into building organizational capacity and has implemented appropriate monitoring and evaluation activities, drawing upon USAID CSHGP resources, such as KPC survey, LQAS methodology and Health Facility Assessment tools. The program regularly uses qualitative methods to inform the design of strategies and implementation of activities.

Good quality external technical assistance was coordinated for training CSP staff and partners in the topics of: Developing a Behavior Change Strategy, the Essential Nutrition Actions, social marketing of Water Guard, Safe and Clean Delivery at the community and household level within the MAMAN framework, and FMOH/WHO accredited training in Safe and Clean Delivery for Health Extension Workers.

The project has particularly benefited from good use of complementary funding that has contributed towards achieving maternal health and child survival objective. Funding, primarily from Irish Aid, has been used to address access to safe water and sanitation at 5 of the 30 Health Posts in the coverage area in Years 1 and 2 (17%) and plans for Years 3 and 4 include support for additional Health Post coverage. Complementary funding is also being used to procure iron folate for ante-natal care and zinc/ORS for introduction of this protocol by targeted Health Posts.

GOAL's strategic approach has included a focus on bridging the gap between emergency response and development programmes in a local context where nutrition insecurity is chronic. Coordination between the GOAL Rapid Rural Response Team and the Child Survival Team has been efficient and effective in enabling communities to take a more active role in prevention and early warning-type actions.

In addition, the following conclusions and recommendations are highlighted:

Operations Research: Operations research processes are in place, with good coordination with partners for technical assistance and good documentation. As structured, this will assist in demonstrating the effectiveness of key strategies and contribute to the body of knowledge for evidence-based decision-making at the national level, and contribute to global learning. GOAL staff have conducted qualitative and quantitative assessment activities to document knowledge, attitudes and practises in relation to several key program strategies, including social marketing of Water Guard, introduction of zinc/ORS protocols, and training of Health Extension Workers on Safe and Clean Delivery.
MTE shows community awareness and demand for Water Guard to be high.

Recommendation is for GOAL to continue and maintain the existing level of quality in the processes for and documentation of operations research, and ensure plans (and

budget) for wide dissemination of results in the final quarter of the life of the project when preparing detailed work plans for Year 4. It is also recommended that CSP management invite key decision-makers from the SNNP Regional Health Bureau to visit field activities in the second half of Year 3 and first half of Year 4. This is so that decision-makers will be familiar with the strategies and are spokespersons for these strategies during the dissemination of findings.

Care Group Approach: Evaluation at mid-term shows the Care Group approach to be effective, with household survey providing evidence that participating mothers are able to promote behaviour change among peers. Mid-term KPC survey found final targets already reached and/or exceeded for four indicators (exclusive breastfeeding, IYCF, knowledge of signs of illness that indicate the need for treatment, and point of use water treatment) and positive change was found for an additional twenty-four indicators Mid-term evaluation has highlighted a few key messages for additional refresher effort in Year 3, including feeding during illness, care seeking and home management of common childhood illnesses, benefits of post-partum care and appropriate hand-washing.

Recommendation is for the project to use plans for expansion and replication of Care Groups within kebeles to also initiate hand-over for self-sufficiency. Through program efforts in Years 1 and 2, participating Care Group mothers have reached an excellent level of knowledge of the key maternal and child health and nutrition messages promoted by the program. They also display confidence in their knowledge. They are ready to assume the role of Care Group facilitators while GOAL field staff can focus on coaching them in this process. This will allow for replication of groups within communities, expansion to reach new mothers and other non-participating mothers in the community with children under age two, and initiate self-sustaining processes that will permit for effective exit strategies in Year 4.

Promotion of institutional delivery for childbirth: The GOAL Sidama Child Survival Project has focused efforts on several strategies to improve both demand for and access to quality delivery services at the Health Posts. Efforts have focused on building community awareness through Care Group activities, involving Traditional Trained Birth Attendants, and facilitating technical training in Safe and Clean Delivery for Health Extension Workers. At mid-term, there is initial evidence that these efforts are beginning to have an impact.

Recommendation is for GOAL to facilitate follow up to HEW training on Safe & Clean Delivery by those WoHO trainers who facilitated the training. GOAL Child Survival program staff provide regular on-the-job training and follow up at the Health Post level, to strengthen HEW skills for IMNCI and safe motherhood. This should continue as planned, with CSP staff review of the Safe & Clean Delivery training manual to ensure support and suggestions are aligned with the training received. In addition, it would be useful to coordinate some type of follow-up refresher (with practical experience at the Awassa Zuria or Boricha Health Centers) or review and problem-solving activity during

Year 3, with follow up facilitated by the RHB Master Trainers or the accredited WoHO trainers who provided the original Safe & Clean Delivery training for HEWS.

The Safe and Clean Delivery Manual (FMOH document) is in English and is expected to be translated into Amharic through a presently on-going FMOH activity. It is suggested that the GOAL Health Coordinator based in Addis Ababa coordinate with key partners and stakeholders and that GOAL CSP propose to develop a Quick Reference Guide on Safe and Clean Delivery in Amharic for distribution to HEWs.

There are plans for IMNCI training of HEWs to take place in year 3. If facilitation of this training is coordinated between GOAL and MOH partners, a similar type of follow-up by technical trainers should be coordinated within the quarter after training.

Collaboration with Woreda Health Office partners: A collaborative relationship exists between GOAL and Woreda Health Office partners, with periodic coordination with SNNP Regional Health Bureau (RHB) and/or Sidama Zonal Health Office as indicated. This collaboration and coordination has enabled efficient implementation of this Child Survival Project in Years 1 and 2. However, gaps between service demand which has been created by the project and access to service and essential medicines are identified at mid-term evaluation.

Joint WoHo and GOAL supportive supervision and action planning has been initiated in the 4th Quarter of Year 2, establishing a Quality Taskforce at Woreda Health Office for review of results and action planning as needed at management level. Activities at the Health Post level have centered on use of COPE® tools for self-assessment by HEWs, with community participation in the assessment through use of Community COPE tools.

It is recommended that activities for joint supportive supervision and action planning with review by a WoHO Quality Taskforce should proceed as planned, with continuous expansion to all Health Posts. It is recommended that GOAL not undertake these activities without direct partner participation. It is recommended that, along with the Quality Taskforce, CSP management staff structure a regular quarterly meeting with Woreda Health Office management to review the Quality Taskforce activities. Minutes of both the Quality Taskforce and management meetings should be documented.

These activities for joint supportive supervision and action planning should also link to and/or draw upon results from the Health Facility Assessments which have been conducted in Year 1 and Year 2. In addition in Year 3, GOAL CSP should coordinate a rapid assessment of those households that are still using previously distributed LLINs and, using Doer/Non-doer barrier analysis, identify how these households have successfully maintained the functional integrity of the LLINs. This information should be widely shared with partners and used to inform any future FMOH plans for LLIN distribution. It is not recommended that GOAL seek any additional funding for LLINs until FMOH future plans (and GFATM support) are clarified and detailed.

H. Action Plan

Mid-term evaluation findings and recommendations were amply discussed by GOAL executive management, GOAL CSP staff and project partners during the MTE process. Notes on key recommendations are also included in the MTE review of the status of the DIP Work Plan found in Annex 4. Activities in response to MTE findings and recommendations have been incorporated into an updated Work Plan schedule for Year 3 and Year 4 which can be found in Annex 13.

Specific activities additional to the DIP Work Plan include:

- Identifying human resources and developing a detailed strategy for expansion of Care Groups in a way that also builds capacity for self-sufficiency and sustainability.

- Coordinating with WoHO trainers of Safe and Clean Delivery and developing a plan for follow-on technical assistance for review and immediate refresher support at the Health Post level for recently trained Health Extension Workers.

- Coordinating with key actors for maternal health care in Ethiopia to propose development of a Quick Reference for Safe and Clean Delivery in Amharic to support recently trained HEWs and to contribute to national efforts towards safe motherhood.

- Continuation of joint supportive supervision and action planning activities as planned. Additional quarterly meetings between GOAL CSP management and WoHO management to review the findings and results of the Quality Taskforce, with documentation of the minutes of these meetings.

- Continuation of operations research as planned; continuation of monitoring and evaluation activities as planned (note: EPI-INFO software, with EPI-NUT, will be updated before final evaluation); feedback to communities on MTE results as planned, with additional meetings each year with community leaders and key actors, to maintain and strengthen community ownership of project activities.

- A rapid assessment of the use and maintenance of LLINs in Year 3.