CHILD-*E*

Child Health Initiatives for Lasting Development – in Ethiopia

Farta Woreda, Amhara Region, Ethiopia
Child Survival and Health Grants Program
CSXVIII

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Report prepared by:
Renee Charleston, Consultant

CARE Etiopía Contact:
Dawn Wadlow
P.O. Box 4710
Addis Ababa, Ethiopia
Tel: 251-1-538040
Fax: 251-1-538035
Email: wadlowd@care.org

CARE USA Contact:
Joan M Jennings
151 Ellis Street NE
Atlanta, GA 30303
Tel: 404-979-9413
Fax: 404-589-2624
Email: jjennings@care.org

ACRONYMS

BCC	Behavior Change Communication
BFCI/ BFHI	Baby Friendly Community Initiative/ Hospital Initiative
CBRHA	Community Based Reproductive Health Agent
CDD	Control of Diarrheal Diseases
CHA	Community Health Agents (with 3 months training)
CHW	Community Health Workers (include CHA, VCHW, trained TBA, CBRHA, etc)
C-IMCI	Community IMCI
COPE	Client Oriented Provider Efficient (Engender Health tool for improving quality of health care services)
CORE	Collaborations and Resources Group
CSP	Child Survival Project
CSTS	Child Survival Technical Support
DIP	Detailed Implementation Plan
EOC	Ethiopian Orthodox Church
ESHE	Essential Services in Health in Ethiopia
FCSP	Farta Child Survival Project
FWHO	Farta Woreda Health Office
HEA	Health Extension Agent (with 1 year training)
HF	MOH Health Facility
HFA	Health Facility Assessment
HIS	Health Information Systems
HIV/AIDS	Human Immune Deficiency Virus/ Acquired Immune Deficiency Syndrome
HQ	Headquarters
HSC	Health Sector Coordinator
IEC	Information Education and Communication
IMCI	Integrated Management of Childhood Illnesses
JSI	John Snow Incorporated
KPC Survey	Knowledge, Practice, and Coverage Survey
M&E	Monitoring and Evaluation
MB	Megestawi-buden or Village, each PA is made up of an average of 22 MBs
MOA	Ministry of Agriculture
MOE	Ministry of Education
MOH	Ministry of Health
MTMSG	Mother-to-mother support groups
NGO	Non Governmental Organization
ORS	Oral Rehydration Salts
PA	Peasant or Farmers Association lowest level of rural administration, below woreda.
PCM	Pneumonia Case Management
PM	Program Manager
PRA	Participatory Rural Assessment
PVO	Private Voluntary Organization
TBAs	Traditional Birth Attendants
TOT	Training of Trainers
USAID	United States Agency for International Development
VCHW	Volunteer Community Health Worker (with 1 month training).
WRA	Women of Reproductive Age
Zone	Second level of administrative unit, under the Region and above the woreda

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A. Summary

The Farta Child Survival Project (FCSP) is a five-year project being implemented by CARE Ethiopia which targets under-five children and women of reproductive age residing in 40 peasant associations (PAs) of Farta Woreda, South Gondar Zone of the Amhara Region. The goal of the FCSP is to improve the health status of children under five and of women of reproductive age through four targeted interventions: Nutrition (35%), Pneumonia Case Management (25%), Control of Diarrheal Diseases (20%) and Immunization (20%) within the framework of Integrated Management of Childhood Illnesses (IMCI). The project will reach 35,997 children <5 and 46,165 women for a total of 82,162. The project is being implemented in coordination with the Ministry of Health (MOH), the Ministry of Education, Ethiopian Orthodox Church (EOC), Debra Tabor Health College and Farta Woreda administration.

The FCSP objectives include:

1. To promote the practice of healthy behaviors, including care seeking, by caregivers of children under five years and women, especially pregnant and lactating mothers.
2. To increase sustainable access to health education, quality care and essential medicines.
3. To ensure that quality health care is provided by health personnel, Community Health Workers (CHWs) and other service providers.
4. To strengthen local and community-based institutions and partners and build capacity to support child survival activities on a sustainable basis.

The program employs the strategies of skill development, community mobilization, behavior change communication (BCC), quality assurance and improved access to and availability of health services. The project began implementation in 10 PAs, where CARE currently has other projects and has worked previously. Lessons learned in the initial experience were used in expanding activities in the remaining 30 PAs. The expansion of activities to all 40 PAs has been slower than expected and very challenging given that staff does not have adequate transportation.

The reality of implementing a CSP in Ethiopia is extremely difficult. Ethiopia has some of the highest rates of malnutrition and lowest rates of access to quality health services in the world. Another stumbling block for CARE has been the lack of local qualified health personnel resulting in CARE's inability to permanently fill the vital position of Project Manager with a qualified person and a low level of capacity among project field staff in general. In addition, governmental policy has been slow to support planned project activities in some areas.

Despite difficulties, the FCSP has accomplished the following during the first half of the project:

- Baseline HFA, KPC Survey, and PRA were conducted by CARE and partners
- Potential Community Level Organizations/Volunteers were identified
- Community based groups for promotion of healthy behaviors were established
- Training for School Clubs, Support Groups, EOC Priests, CHWs, FCSP and MOH workers were conducted in:
    - Nutrition messages
    - Counseling skills; BCC skills
    - Maternal Health messages
    - Cold Chain Maintenance and Expanded Program for Immunization
    - Health Information Networking
    - IMCI

- Training of Trainers for Partners and CARE on BCC Strategy Development and a BCC strategy document has been developed and reviewed by partners.
- Educational materials developed and under production
- Participatory design of potential Revolving Drug Fund at health facility level.
- Strengthening of MOH information system, reporting formats provided for staff
- Conducting monthly review meeting with partners
- IMCI wall chart given for lower level HF workers
- Supportive supervision and follow-up of use of IMCI protocols for treatment of children

Due primarily to the above mentioned problems, the FCSP is approximately one year behind schedule and minor adjustments have been made to the DIP work plan. No modification of the DIP is recommended at this time. The project should focus efforts during the next two and a half years on the establishment of high quality clinical and community IMCI. The project has laid down a foundation in the 40 PAs of the woreda for community based health promotion but strong follow up, support and supervision are required to facilitate project activities during the remaining two years of the project.

A modified mid term evaluation (MTE) of the FCSP was carried out in two stages in 2005. An initial field visit to the project was made by Renee Charleston, external evaluator and author of this report, during February 2005. From that visit, a Trip Report was shared with project staff (and USAID CSHGP) and an Action Plan was developed by project staff in response to key recommendations. In late June 2005, the CARE USA Technical Advisor for Child Health -- Dr. Khrist Roy -- visited the project to assess on-going follow-up in response to the previous recommendations and to provide general backstop technical assistance, guidance and support. He also organized follow-up on a list of specific questions to be investigated that had been formulated by the external evaluator to complete any gaps in information for this MTE report. In addition to the project documentation reviewed prior to the first MTE visit in February 2005, review for this report also included CARE internal quarterly Project Implementation Reports.

This adaptation of the traditional methodology for conducting MTEs was discussed, and agreed upon, with USAID. An Action Plan based on the preliminary recommendations made during the first MTE visit was prepared by CARE Ethiopia staff and updated based on the present status following the second MTE visit. Key recommendations included:

- FCSP should discuss with MOH partners a referral system between communities and local health facilities.
- Follow up for supportive supervision to all planned training activities should emphasize the critical elements in the process of activities (such as Mother to Mother Support Groups), not just information on messages.
- Quality of care should be strengthened through a supportive supervision system, with simple checklists and feedback for CHWs and project staff; consider using the participatory COPE methodology for Quality Assurance assessment of healthcare.
- As the Ethiopian Orthodox Church participants are active and important partners, it is recommended that their role be expanded.

Action taken to-date on each of these recommendations can be found in Section E, Action Plan. Other action taken between field visit in January 2005 and August 2005, has been to develop a training plan as part of the Annual Plan for 2006 which specifies *who* will be trained, *how many* will be trained, *what* will they be trained in, and *who will provide* the training. As part of the second field visit by CARE HQ, a plan for additional skills development training for FCSP staff was developed, including COPE methodology, LQAS, qualitative analysis, Participatory Rural Appraisal and Focus Group Design. Emphasis continues on technical updates related to C-IMCI training and topics. Also, action on recommendation to translate into Amharic parts of the DIP and share with partners has been completed.

Additional suggestions are included in this report to contribute to continuous quality improvement:

- With the changes by partners in defining "community health" roles, responsibilities (and remuneration) FSP staff and partners should look at defining an organizational structure for health activities at the community level, which takes into account the available and active human resources, including CHWs, with better clarification of their roles and inter-relationships.
- The FCSP should continue to coordinate with FWHO and other governmental agencies to define the role of the project in training health committees, in lieu of waiting for a policy decision of the structure of the committees, the project should proceed with planning for training community leaders.
- A plan of action should be developed as to how the FCSP could realistically build the capacity of the partner organizations, given current resources and based on the prior assessment.
- Filling the PM position as soon as possible and providing him/her with adequate support is critical to the successful outcome of this project.
- A complete revision of the M&E Matrix from the DIP should be conducted to make sure that all indicators can be measured. Special attention needs to be made for developing tools for measuring the monitoring indicators.

B. Assessment of progress made in achievement of program objectives

1. Technical Approach

a. General Overview

The Farta Child Survival Project (FCSP) is a five-year project being implementing by CARE Ethiopia which targets under-five children and women of reproductive age residing in 40 peasant associations (PAs) of Farta Woreda, South Gondar Zone of the Amhara Region. The goal of the FCSP is to improve the health status of children under five and of women of reproductive age (WRA) through four targeted interventions: Nutrition (35%), Pneumonia Case Management (25%), Control of Diarrheal Diseases (20%) and Immunization (20%) within the framework of Integrated Management of Childhood Illnesses (IMCI). The FCSP objectives include:

1. To promote the practice of healthy behaviors, including seeking of appropriate medical care as needed, by caregivers of children under five years and WRA, especially pregnant and lactating mothers.
2. To increase sustainable access to health education, quality care and essential medicines (from government, private health sectors, private institutions and partner organizations).

3. To ensure that quality health care is provided in areas of diarrhea, pneumonia, malnutrition and immunization by government health personnel, Community Health Workers (CHWs) (including CHAs (Community Health Agents), CBRHAs (Community Based Reproductive Health Agents) and trained TBAs (Traditional Birth Attendants)) and other service providers.
4. To strengthen local and community-based institutions and partners and build capacity to support child survival activities on a sustainable basis.

The program employs the strategies of skill development, community mobilization, behavior change communication (BCC), quality assurance and improved access and availability to health services. The FCSP was developed in coordination with the regional and local Ministry of Health (MOH), and is consistent with the MOH National IMCI and nutrition policies. Other project partners include the Ministry of Education (MOE), Ethiopian Orthodox Church (EOC), Debra Tabor Health College (formerly Debra Tabor Nurses Training School) and Farta Woreda administration.

Population

The population figures used in the Detailed Implementation Plan (DIP) from the Ethiopia Statistical Abstract for 2000 (46,314 children under 5 and 71,909 WRA, total 118,223) varies considerably from the actual figures found through the project census (35,997 <5 and 46,165 WRA for a total of 82,162). The project will be able to reach all 40 PAs as planned but the actual population will be less than the original estimate. The project has expanded some activities to all 40 PAs, although some new initiatives are being piloted in only 10 PAs in a positive strategy to start small and scale up to the remaining PAs.

Political Structure

The political structure of the target area is somewhat confusing and can be summarized as:
Country Ethiopia
Region Amhara
Zone South Gondar
Woreda Farta
40 PAs (also called kebeles)
200 Sub-kebeles (average 5 per PA)
883 Megestawi-budens (MB) (15-50 households) (average 4-5 per Sub-kebele or 22 per PA),

A Knowledge, Practices and Coverage (KPC) Survey was carried out during 2003 and provided the following results. The KPC information is compared with the most recent Demographic Health Survey (DHS) results for the Amhara Region.

Rapid CATCH Indicator	KPC[1] (Woreda)	DHS (Regional)
1. Percentage of children age 0-23 months who are underweight (-2 SD from the median weight-for-age, according to the WHO/NCHS reference population)	59.2%	51.8%
2. Percentage of children age 0-23 months who were born at least 24 months after the previous surviving child	25.9%	--

[1] In the case of the underweight indicator, data from a complimentary CARE assessment was used.

3. Percentage of children age 0-23 months whose births were attended by skilled health personnel	4.3%	3.1%
4. Percentage of mothers of children age 0-23 months who received at least two tetanus toxoid injections before the birth of their youngest child	57.1%	16.0%
5. Percentage of infants age 0-5 months who were exclusively breastfed in the last 24 hours	72.8%	54.2% nationally
6. Percentage of infants age 6-9 months receiving breastmilk and complementary foods	38.1%	43.0% nationally
7. Percentage of children age 12-23 months who are fully vaccinated (against the five vaccine-preventable diseases) before their first birthday	29.8%	14.4% (not by first birthday), 12.0% nationally card or mother's report
8. Percentage of children age 12-23 months who received a measles vaccine	24.8%	27.1% card or mother's report
9. Percentage of children age 0-23 months who slept under an insecticide-treated bednet the previous night (in malaria-risk areas only)	0	--
10. Percentage of mothers who know at least two signs of childhood illness that indicate the need for treatment	28.7%	--
11. Percentage of sick children age 0-23 months who received increased fluids and continued feeding during an illness in the past two weeks	13.8%	33.9%
12. Percentage of mothers of children age 0-23 months who cite at least two known ways of reducing the risk of HIV infection	40.3%	38.8%
13. Percentage of mothers of children 0-23 months who wash their hands with soap/ash before food preparation, before feeding children, after defecation, and after attending to a child who has defecated	7.3%	--

Detailed comments on the KPC Survey are included in Section C-7. Information Management. The data from the preceding table should be viewed with caution, as a number of discrepancies exist with the definition of the indicators.

Key Program Activities Completed

- Baseline Health Facility Assessment (HFA). KPC Survey, and Participatory Rapid Assessment (PRA) were conducted by CARE and partners as part of the DIP development process
- Potential Community Level Organizations/Volunteers were identified
- Community familiarization was conducted with dissemination of survey findings regarding child health, project objectives and the expected support from the community
- Community based groups for promotion of healthy behaviors were established
    a. Mother to Mother Support Groups (MTMSG)
    b. School clubs
    c. Community Health Workers (CHW)
- Trainings were conducted in Nutrition, Counseling, Maternal Health, Cold Chain Maintenance, Health Information Networking, EPI, IMCI and BCC for School Clubs, MTMSG, Religious Leaders, CHWs, FCSP and MOH workers;
- Training of Trainers for Partners and CARE on BCC Strategy Development

- BCC strategy document developed and reviewed by partners
- Educational materials developed and under production
- Training Manual/Curriculum on Counseling developed
- Design of Revolving Drug Funds
- Strengthening of MOH Health Information System (HIS), reporting formats provided for all lower level Health Facility (HF) staff
- Conducting monthly review meeting with partners
- IMCI wall chart given for lower level HF workers
- Supportive supervision and follow-up of use of IMCI protocols for treatment of children

The FCSP has encountered a number of challenges that has adversely effected the implementation of the project. The principal problem has been the inability of CARE to permanently fill the vital position of Project Manager (PM) with a qualified person.

Although centralized training activities have proceeded as planned, coordination of transportation resources at the CARE regional level has been problematic and has limited FCSP staff follow up and support at the community level. Governmental policy has not supported project activities in some areas, such as inhibiting the definition of protocols for establishment of revolving drug funds, not authorizing the use of antibiotics by community volunteers, health facility support for community health committees, full implementation of IMCI, and the training of CHWs, particularly within a C-IMCI protocol. All of these problems have limited the effectiveness of the project and put implementation about one year behind schedule.

A modified mid term evaluation (MTE) of the FCSP was carried out in two stages in 2005. An initial field visit to the project was made by Renee Charleston, external evaluator and author of this report, during February 2005. From that visit, a Trip Report was shared with project staff (and USAID CSHGP) and an Action Plan was developed by project staff in response to key recommendations. In late June 2005, the CARE USA Technical Advisor for Child Health -- Dr. Khrist Roy -- visited the project to assess on-going follow-up in response to the previous recommendations and to provide general backstop technical assistance, guidance and support. He also organized follow-up on a list of specific questions to be investigated that had been formulated by the external evaluator to complete any gaps in information for this MTE report. In addition to the project documentation reviewed prior to the first MTE visit in February 2005, review for this report also included CARE internal quarterly Project Implementation Reports.

This adaptation of the traditional methodology for conducting MTEs was discussed, and agreed upon, with USAID. Specific information concerning the MTE methodology can be found in Annex C, a list of persons interviewed and contacted during the two MTE visits can be found in Annex D, and a list of CARE staff and partners who participated in a workshop facilitated by the external evaluator is included in Annex B. Through out this document additional suggestions for improving the project during the next two years are included and written in **bold.** Recommendations are summarized in Section D Conclusions and Recommendations An Action Plan based on the preliminary recommendations made during the first MTE visit was prepared by CARE Ethiopia staff and updated based on the present status following the second MTE visit. The Action Plan is included in the final section of this report.

b. Progress report by intervention area.

IMCI

The FCSP is implementing four interventions: Nutrition, Pneumonia Case Management (PCM), Control of Diarrheal Diseases (CDD) and Immunization (EPI) within the framework of IMCI. The project is implementing both clinical and community IMCI. Clinical IMCI has been being used for some time in Ethiopia, but needs to be strengthened. Community IMCI (C-IMCI) is being newly introduced in Ethiopia and does not have strong national, regional or zonal support. As all four interventions are within the IMCI framework, an overview of general activities related to IMCI will be covered first, followed by comments on individual interventions.

The project includes all three components of the IMCI approach including:

1. Improving case management skills of the health care staff
2. Improving the overall health system
3. Improving family and community health care practices.

The strategies to carry out this approach are:

1. Skill Development of MOH and partner staff, CHWs, community leaders, school clubs, MTMSGs and other community members to improve communities' access to information and health care services.
2. Community Mobilization to promote ownership through active involvement and support to religious leaders, CHWs and community leaders.
3. BCC approaches to promote healthy practices at the community, family and individual level.
4. Quality Assurance for MOH service delivery by use of COPE (Client Oriented Provider Efficient) methodologies, supportive supervision and technical training.
5. Improve access and availability of services and supplies by strengthening MOH logistical systems.

Each of these strategies will be discussed further in this report.

One of the major strategies of the project is skill development for health workers. Refresher training on clinical IMCI was given for HF personnel during November 2003. The training had a practical approach and used adapted IMCI materials compatible with the level of junior professionals. Four resource persons from the Zonal health office, Debra Tabor Hospital, and Health Center facilitated the training. Twenty lower level health workers attended the training. Subsequent supervision of the HFs made with the Farta Woreda Health Office (FWHO) and performance reviews and monitoring of health service activities show that HF staff has been using IMCI and referring sick children to the Debra Tabor Hospital (referral hospital) according to IMCI protocol.

Planned Future Activities

- Collaborate with MOH partners in establishing C-IMCI as a health care strategy, including training of CHWs, developing curriculum on case management, and more as defined as the process advances.
- Follow through on recent training in counseling and communication skills, with field supervision and feedback to FCSP, CHWs and community leaders.
- Encourage the use of emergency funds for health emergencies (Idirs)
- Strengthen supportive supervision

- Revise the reporting formats
- Strength the referral linkage from the community to the HFs
- Improve the availability of IMCI drugs (and other supplies) at all times
- Work with quality in the context of IMCI with the use of COPE
- Use information for decision making
- Develop educational materials for counseling and IMCI

IMCI Supplies

Review of available supplies in February 2005 found some problems with the logistics system, particularly cold chain and vaccine availability. **Problems exist with availability of essential IMCI drugs and supplies; an analysis of the logistics system should be conducted to identify bottlenecks and weaknesses, leading to concrete steps to improve the system.**

Inventory of Supplies February 2005

Item	Kanat	Buro Teraroch	Kimir Dingay	Hospital
ORS#	Yes	Yes	Yes	Yes
Iron/Folic Acid	Yes	No	Yes	No
Vitamin A	Yes	No	No	No
Deworm for pregnant women	No	No	No	if indicated
Refrigerator	No	No	Yes	Yes
All Vaccines	No	No	Yes	No
Child Cards	-	Yes	Yes	Yes
Referrals	No	No	No	Y no feedback
Malarials	Yes*	Yes*	Yes*	No**
Outreach Sites	3	6	2	-
Time to farthest site	1 ½ hrs	2 hrs	1 ½ hrs	-
Training Received	EPI	IMCI EPI	IMCI EPI	IMCI EPI

ORS packets are normally sold
* Drug of choice- chloroquine and Fansidar
** Doctor said not using Fansidar or chloroquine, but new drugs, which they don't have
Some outages reported for antibiotics(cotrimoxazole and amoxiciline)

One problem affecting the cold chain had been that the MOH increased the number of existing health facilities over the past few years. Between January and June 2005, the Ethiopian Orthodox Church and CARE supplied an additional 16 refrigerators to health facilities. Review of supplies by the CARE HQ Technical Advisor in late June 2005 found all 3 of 3 facilities visited to have cold chain equipment available and in working order, and 2 of the 3 facilities to have all vaccines, with one having all but BCG and polio.

One of the proposed activities in the DIP was the establishment of revolving drug funds at HFs and in communities. During the MTE visit, this point was discussed extensively with CARE and partners. The following work has begun on establishing HF revolving funds:

The FCSP conducted a study of national policies and experiences of two hospitals and one health center that have special pharmacies. The national guideline for special pharmacies has been adapted and draft guidelines for the Revolving Drug Funds was presented to all FCSP partners for finalization. A committee was established comprised of:

- Farta Woreda Administration.
- FWHO
- Farta Woreda Disaster Prevention and Preparedness Office
- South Gondar Zonal Health Office
- Debra Tabor Hospital
- FCSP

The committee is working on finalizing plans for establishing the HF drug funds. Remaining tasks include training on drug use and financial management for HF staff and release of the seed money. It is expected that several pilot revolving drug funds will soon begin functioning.

Future Activities

- Once plans and protocols are finalized, the project will begin with skill development for HF staff in charge of the implementation of the revolving funds.
- A complete systems analysis should be conducted to identify bottle necks in logistical supply. The FCSP has been in contact with the ESHE project (Essential Services in Health in Ethiopia) being implemented by John Snow Incorporated (JSI) with funds from USAID for assistance with this activity.
- The FCSP has conducted negotiations with the FWHO to encourage them to increase their budget for basic IMCI and life saving childhood drugs.
- There is a lack of political will and policy to support the introduction of community level drug funds. MOH policy dictates that community workers are not authorized to distribute drugs and because the FWHO is understaffed and unable to adequately supervise community pharmacies, it is recommended that community pharmacies be omitted from this project. **The FCSP should focus their efforts on the establishment of HF revolving drug funds, and not proceed with the implementation of community level drug funds.**

Nutrition (35%)

In addition to the activities related to IMCI which were previously mentioned, additional activities specific to the nutrition intervention are included. Activities within the nutrition intervention are being carried out as outlined in the DIP, with a few exceptions noted below.

The Household Livelihood and Problem Analysis in South Gondar conducted in March 2000 reported indicators for stunting, wasting and underweight for children under five in the South Gondar zone where the Farta Woreda is situated. Of the 764 children under five surveyed, prevalence of stunting was 49.6%, wasting 22.9% and underweight 59.2%. This underweight indicator (weight-for-age) is being used as baseline for the FCSP also.

PD Hearth/ Positive Deviance

The use of the PD Hearth was only very briefly mentioned in the DIP and was not a well-formed strategy. Due to the scope of malnutrition in the project area it is felt that activities that target a wider audience are preferable to the resource intensive PD Hearth methodology. A Positive

Deviance model is being used in the MTMSG by identifying women who exhibit positive behaviors in infant feeding to serve as role models for other mothers in the group. These positive deviant mothers serve as leaders of the MTMSG and help other mothers of malnourished children to use local foods and knowledge to improve the nutritional status of their children.

Home Gardens

An additional planned nutrition activity was the formation of home gardens to increase the household supply of and access to nutrient-rich foods. This activity provides a way of increasing household availability and diversity of food. The FCSP planned to work with the Ministry of Agriculture's development agents in mobilizing the PA leaders in support of this activity. Little concrete work has taken place on this front, although extension workers from other CARE projects have been trained in nutrition and are providing nutritional messages in conjunction with other agricultural activities in communities where there is synergy between projects.

Baby Friendly Hospital/Community Initiatives

In the DIP, it was planned to have the Debra Tabor Hospital certified as a Baby Friendly Hospital, and the Baby Friendly Community initiated as a pilot in 5 PAs. UNICEF normally spearheads this initiative, but this is not the case in Ethiopia, making it difficult to garner support for the initiatives with partners. During a visit to the Debra Tabor Hospital, it was observed that most of the 10 steps for Baby Friendly Hospital Initiative were being met. All newborns room-in with their mothers, no formula is available, if there is a problem i.e. death of the mother, they use cows milk mixed with sugar and water. All women are advised to breastfeed immediately, on demand, and exclusively and they are taught positioning. The Nurses' station has posted protocols for obstetrical problems, but not for breastfeeding. **FCSP staff should continue to work with Debra Tabor hospital staff on developing written policy for breastfeeding, linking mothers with MTMSG, and providing information on resolving common breastfeeding problems.**

Growth Monitoring

The promotion of growth monitoring at HFs and outreach sites has been a major focus of project and FWHO staff. Growth monitoring is being conducted for under three children at HFs and outreach sites. **Counseling for mothers and caregivers is given on nutritional practices, but this activity needs to be further strengthened.**

Introduction of Complementary Foods

Among partners and mothers confusion still exists as to when complementary foods should be introduced. It is also of concern that according to the KPC report "The appropriate age for introduction of complementary feeding, 4-6 months, was known by 79 (57.2%) of the mothers, while among the remaining (39.1%) reported ages beyond 6 months. The mean age for such supplementation, as perceived by mothers, was 7.3 months." **The FCSP should send a clear message that the appropriate age to introduce complementary feeding is six months of age.**

Establishment of Nutrition Demonstration "Rooms"

This activity, which was included in the DIP, has been replaced by the promotion of nutrition demonstrations within MTMSG or HF using extension agents from the Ministry of Agriculture and CARE's other projects. Having a "place" to have a demonstration is less important than

having easily accessible demonstrations and CARE's modification of this plan is considered positive towards achieving results.

Breastfeeding

Almost all women breastfeed, but it is a strong cultural practice to discard colostrum and initiate breastfeeding several days after birth. Anecdotal reports show that the priests from the Ethiopian Orthodox Church (EOC) have been especially influential in persuading families to not discard colostrum and to begin immediate breastfeeding; this was confirmed during field visit focus group discussion with a MTMSG by the CARE HQ Technical Advisor.

Pneumonia Case Management (PCM) (25%)

In addition to the activities related to IMCI which were previously mentioned, additional activities specific to PCM are included. Activities within the PCM intervention are being carried out as outlined in the DIP, with a few exceptions as outlined below.

Advocacy for allowing CHWs to distribute antibiotics for treatment of pneumonia

One of the DIP activities was to advocate for authorization from the MOH for CHWs to distribute antibiotics in cases of pneumonia. In two and a half years, no progress has been made on changing national policy through CARE's efforts so at this time it seems prudent to accept the policy and plan for the remainder of the project in line with MOH national policy. JSI through the ESHE project and other NGOs will be continuing with this advocacy, but from a broader geographical base. CARE should continue supporting these efforts. Advocacy work should continue at national and regional levels on availability of ORS at the community level and availability of Vitamin A outside of bi-annual national campaigns. This would be the responsibility of the Health Sector Coordinator (HSC) based in Addis Ababa.

Mother's Recognition of Danger Signs

The definition of danger signs of pneumonia is unclear within the FCSP. The following is an excerpt from the baseline KPC Survey report:

Cough, grunting, difficult breathing	Number	Percent
Yes	88	29% (CI=23.9-34.1)
No	215	71%

FCSP staff stated that the 3 principal symptoms/signs of pneumonia are:

1) Cough
2) Difficulty in breathing
3) Chest in-drawing

A detailed discussion of the KPC Survey is included in Section C-7 Information Management but the problem related to PCM is in clearly defining the danger signs of pneumonia to be included in the training plan for all health workers and measured by the KPC survey.

The CARE HQ Technical Advisor followed up on clarifying this technical issue with FCSP field staff during his field visit in June 2005; however, **the correct and clear definition of danger signs of pneumonia should continue to be emphasized within FCSP activities, educational materials and curricula.**

Control of Diarrheal Diseases (20%)
In addition to the activities related to IMCI which were previously mentioned, additional activities specific to CDD are included. Activities within the CDD intervention are being carried out as outlined in the DIP.

Recommended home fluids
The HFA at baseline found that only 30% of health facilities had ORS available. The KPC Survey found; "Among the children with diarrhea, 25 (22.5%) were given fluids other than breast milk in the same amount or more than usual and 15 (13.8%) of children with diarrhea were given the same amount or more foods during diarrhea." Due to problems with the availability of ORS and the current practice of decreasing fluids, it is recommended that locally available liquids are identified which can be promoted in addition to ORS. The KPC questionnaire did not identify other liquids commonly given to children with diarrhea but simply stated "Cereal-based ORT" and "Any fluids at home". **FCSP should investigate what fluids, both cereal based and other liquids, are traditionally used for children with diarrhea, and, in coordination with the MOH, define which are "recommended home fluids". Community and HF based education should actively promote the use of other fluids in addition to ORS during diarrhea.**

Immunization (20%)
In addition to the activities related to IMCI which were previously mentioned, additional activities specific to EPI are included. Activities within the EPI intervention are being carried out as outlined in the DIP and in accordance with MOH policy.

The project's support for EPI activities has been one of the most important achievements to date. The FCSP organized FWHO and HF planning for EPI, with a strong emphasis on outreach programs. A point person responsible for coordinating EPI activities has been assigned at each HF. There were gaps in responding to the community demand for services. Efforts have been made to improve the outreach clinics scheduled in the communities. New outreach sites have been established and supportive supervision has helped to motivate HF staff. Further work is required to institutionalize the supervision visits and methodology within the FWHO.

The other area of support was to equip HFs which lacked refrigerators. According to the HFA conducted at baseline functioning refrigerators and cold boxes were found in only half of the health facilities. The procurement of refrigerators was very slow but recently 16 refrigerators were installed in HFs. The project has been supporting the FWHO in coordinating transportation for maintaining refrigerators.

CARE's trained Volunteer Community Health Workers (VCHW) have been supporting the HFs during outreach clinics, particularly in community mobilization, counseling, growth monitoring and immunizations. Mothers are reportedly increasing their care seeking at HFs and increasingly vaccinating their children. The EOC priests have also been instrumental in influencing and persuading parents to vaccinate their children.

EPI Coverage

According to the HFA, outreach vaccination services were provided in 90% of the health facilities, most health workers (85.7%) had the correct knowledge of the EPI schedule and 45% and 85% of facilities had an immunization tally sheet and immunization register respectively, DPT, BCG and measles were available in 30% of facilities, whereas OPV was available in only 15%. The KPC found that 19% of children 12-23 months received the BCG, DPT3, OPV3 and measles vaccine. Coverage of children 12-23 months receiving DPT3 was 29.7%. The following table is from the KPC Survey report:

Table 9.1. Immunization status of children (card-confirmed)

	Frequency	***Percent***
Possession of Vaccination Card, age 0-23, (n=300)	58	19.3
EPI Coverage I, age 12-23 (n=121) (Percent of children aged 12-23 months who received BCG, DPT3, OPV3, and measles vaccines)	23	19%

This is compared with the Rapid CATCH indicator reported by the project in the annual report:

Percentage of children age 12-23 months who are fully vaccinated (against the five vaccine-preventable diseases) before their first birthday	29.8%

This may be a typographical error given the similarity with the result of children with DPT3. This figure should be verified by the FCSP. It is unclear exactly how this Rapid CATCH indicator was calculated, but it appears that it does not take into consideration the age of the child when all vaccines were received.

A follow-up EPI survey conducted in 2004 found 39.7% coverage for OPV3, 38.7% coverage for DPT3, 58.6% coverage for BCG and 49.3% coverage for measles for children 12 to 23 months of age. The availability of vaccination cards was 39%. Results indicate that immunization coverage of 2 or more tetanus toxoid for women was 51.3%. Only 34.4% of women possessed a vaccination card.

Training

A number of training activities have been carried out in support of EPI activities:

- Three MOH facilitators jointly conducted a modular training on EPI for ten days in February 2004. There were a total of 25 trainees, 19 from Farta Woreda, 2 from Debra Tabor health center, 1 from Debra Tabor Hospital, 1 from South Gondar Health Office and 2 from FCSP.
- The project organized cold chain maintenance training for those involved in the EPI modular training. This training was given in September 2004. Two resource persons assigned by the Regional Health Bureau facilitated the training.
- A CORE Group workshop was attended by CARE and FWHO staff to develop a one-year action plan for EPI. The major planned activities were community mobilization programs to create awareness on the importance of immunization and when and how to get the service.

- A second EPI and cold chain maintenance training was held in October 2004 for 22 health workers who had not been previously trained.

c. New tools or approaches

The FCSP is using several interesting new approaches in the implementation of the project: the involvement of the Ethiopian Orthodox Church (EOC) and the use of traditional funeral associations to cover the cost of emergency medical treatment and transportation.

Ethiopian Orthodox Church

CARE's strategy to work with the EOC by training and supporting religious leaders to then provide information and influence health behaviors of its members is an innovative approach to reaching the target population. The EOC is a very influential institution within the Farta Woreda, approximately 95% of Ethiopians in the project area are members of the EOC. The church has 166 churches and approximately 5,000 priests in Farta Woreda. Given this strong presence, the church is being effectively used as an additional forum for the reinforcement of health education messages. The EOC is very interested and committed to applying their previous experience in HIV/AIDS education to act as change agents for Child Survival.

Each family is assigned a priest who maintains a close relationship for spiritual guidance. These priests have the potential for being powerful agents of change due to their level of authority and special relationship with individual families. Priests deliver IMCI messages during church activities, particularly Sunday services, and make home visits.

In a focus group discussion as part of the MTE, project staff recorded the following:

> *Question: "Are health messages talked on each and every Sunday meeting?*
>
> *Answer: "Most priests bring the topic maybe twice a month,*
> *Mulualem said: "The priests favorite topic is HIV/AIDS ."*
> *Yetemegen said: "They talk mostly on immunization."*
> *Yeshareg said: "They talk often on cleanliness and exclusive breastfeeding. They spend a lot of time on these topics, maybe up to an hour on the topics. They refer and quote the Bible, point to individual verses frequently during their teachings, as and when applicable."*

It can be difficult when a major partner is a religious organization to maintain inclusiveness of other religions. CARE staff has attempted to strike a balance by training some Muslim leaders, they should be applauded for this effort and encouraged to include followers of all religions in project activities.

Idir/funeral funds

One of the constraints for many families in seeking health care is financial. Frequently emergency care is delayed while adequate funds are sought for transportation. The FCSP is using a new strategy for linking with community idirs as a source of support for emergency transportation and medical care costs. An idir is a traditional community fund to cover burial expenses and to aid the bereaved family. Discussions at the PA level have been initiated to

explore the possibility of using the current idir/funeral funds for emergency health situations. Memorandums of Understanding have been signed with three idirs so far.

2. Cross-cutting approaches

a. Community Mobilization

Community mobilization activities include:

- Use of CHWs for the implementation of health activities
- Formation of mother-to-mother support groups (MTMSG)
- Training of School Clubs for the dissemination of health messages
- Mobilization of EOC priests to deliver health messages
- Strengthening of community leaders and formation of community committees
- Delivery of health messages to community members via HFs and outreach clinics and CHWs

Use of CHWs for the implementation of health activities

The original plan in the DIP was to train dormant volunteers or volunteers with prior health projects (Community Based Reproductive Health Agents-CBRHA) and Traditional Birth Attendants (TBAs) and to train new CHWs. Shortly after the project began, the government changed the official definition of CHW to a paid position and all training for CHWs was officially suspended. As a stop gap measure, the FCSP negotiated with the Regional Health Bureau to train 40 "VCHWs" a new designation of volunteer which received a month's training at the Debra Tabor Health College. The project and key partners organized a training using an adopted training curriculum with the approval of the Regional Health Bureau. The training was conducted in July/August 2004. There are 40 trained VCHWs (Male=32, Female=8), one for each PA.

CHWs also include Community Health Agents (CHA), which was a previous designation of community worker who principally works with EPI activities. The project has not yet been able to integrate CBRHAs and TBAs into the project.

In addition to the VCHWs and CHAs previously mentioned, the following categories of persons also make up the cadre of community level workers:

Person	Planned Health Activities
EOC Priests	Sunday services, Home visits, Support to MTMSG
MTMSG leaders	Facilitate SG at least monthly, make home visits
VCHW	Collects monthly reports from priest, MTMSG, CHA, Support to MTMSG, liaison to HF
CHAs	Mobilize communities, EPI activities
PA Leader	Supervises work of CHWs, mobilizes MB leaders and communities

Each PA presents a distinct situation due to differing structures, relationship with governmental agencies such as PA committees and HFs, and available human resources. **With the changes by partners in defining "community health" roles, responsibilities (and remuneration) FCSP staff and partners should look at defining an organizational structure for health activities at the community**

level, which takes into account the available and active human resources, including CHWs, with better clarification of their roles and inter-relationships.

The main activities for strengthening the CHWs have been training, supply of some educational materials, monthly meetings with HF staff, and supervision. In addition, VCHWs have been provided with umbrellas for rain and sun protection on which child health messages are printed.

It is difficult to measure the effectiveness of the CHWs as no routine monitoring system exists. They have been integrated within the health system and local government and anecdotal reports show them playing a significant role in organizing communities and delivering health messages. The main weakness of the use of CHWs is the lack of assessment of the quality of the activities. **A supportive supervision system, with checklists which include feedback, and a monitoring system for measuring effectiveness should be implemented at all levels.**

Formation of mother-to-mother support groups (MTMSG)

The FCSP formation of MTMSG uses the concept of positive deviance to identify model mothers, who work with other mothers within the support group framework as a forum for discussion on child health issues, especially breastfeeding. The MTMSG are formed by local women with a leader trained to disseminate messages and lead the group. A different topic is presented each month. The ideal steps, according to FCSP staff, for managing the support group are:

1. Ask questions to find out what people are doing now
2. Share experiences within group, including the positive Deviant Mothers
3. Leader gives a summary of the topic, including the benefits of practicing the behavior
4. Discussion is conducted on the reasons for not changing, involving other influential people, etc.
5. Action plan is developed if needed on where to get more information (Priest, HF, VCHW), and a commitment is made to practice the new behavior. The practical application of the behavior is included if possible

The overall steps used in forming the MTMSG generally are based on the following:

- In the initial ten PAs, three Positive Deviant mothers from each PA were selected and trained directly by FCSP. These mothers were responsible for training other MTMSG leaders within the PAs and monthly discussions are being conducted jointly by them.
- Another 90 women were trained directly by FCSP in the remaining 30 PAs. These women are training the remaining facilitators in their respective PAs in coordination with HF staff and priests and they will also continue to facilitate group discussions at village level.
- VCHWs, health workers, PA leaders and priests facilitated the establishment of the MTMSGs.
- Upon formation, the CHWs or members identified mothers in the group who have model behaviors related to child health and/or leadership capacity and present them as lead mothers of the mother-to-mother support groups.
- MTMSGs have been discussing child health issues and providing support to mothers among themselves, without direct project input.

FCSP staff estimate there are 2,200 organized MTMSGs in the project area. The project reports that it is providing strengthening and support to the MTMSGs through regular supportive supervision. Given the number of MTMSGs, regular visits by FCSP staff would be infrequent, if not impossible. The FCSP recently implemented a plan for prioritizing supervision visits by the five CARE Community Mobilizers, visiting at least one active MTMSG and around 9-10 weak groups per month. The visits will help to revitalize weak groups and share lessons learned on what makes an active MTMSG.

At the Health Facility level, MTMSGs leaders (along with priests, VCHWs and other health workers) are involved in monthly review meetings, which gives an opportunity for the exchange of ideas, and to identify problems and find solutions. Some MTMSG leaders are submitting monthly activity reports via the VCHWs to the HFs. This activity needs to be strengthened. An effort at networking of MTMSG leaders with other community based health workers has begun but also requires additional support.

Due to the number of MTMSGs it is critical to clarify the responsibilities of all key actors, both for replication and continuation of activities and for future training, supervision, etc. -- in other words, for future sustainability of MTMSG activities.

There have been positive reports of the impact of the MTMSGs within the area. During a visit as part of the MTE, a HF worker showed a chart of all the MTMSG facilitators in his area. He considers them an important strategy for improving child health. He stated that he attends the MTMSG meetings twice a month. He knew that there were 51 MTMSG facilitators in the PA and all of them meet on the 29th of each month for discussions with the group. A profile for MTMSGs has been developed and is being distributed through the VCHWs. Some HFs are using the MTMSGs for the integration of other activities like family planning. There are some reports that HF staff and other CHWs refer women who need help to the support groups.

It should be noted that the full PD/Hearth methodology originally planned for implementation through MTMSG (and which has not been initiated) should be omitted due to project constraints and the limited time remaining for project implementation.

Additional support needed for the MTMSG in the future should include:

- **Better definition of the cascade approach to training , with mechanisms in place to ensure the quality of replication of training and plans for future sustainability.**
- **A lot of work has gone into strengthening the link with the HF, particularly through monthly meetings. Efforts need to focus on improving the effectiveness of the monthly meetings with HFs.**

Training of School Clubs for the dissemination of health messages

School clubs are designed to involve school aged children in the dissemination of health messages in the home and neighborhood, and in public forums such as special school days and at community gatherings. Messages are disseminated through poems, songs and theater developed by the students and facilitated by the teachers. Each school sends two children (7-15 years old) and one to two teachers to receive training facilitated by Debra Tabor Health College and the Woreda Office of Education. The steps followed in the training include:

- Introduction to the concepts and responsibilities of the club, students and teachers
- Presentation of the basic health messages to be transmitted
- Practical Session for the development of poem, song, etc. for a specific message
- Action Plan for each school on how they will transmit the messages in the future

School clubs in the initial 10 PAs have been trained and the schools in the other 30 PAs have been organized for training. Trained school clubs in the initial 10 PAs have been disseminating child health messages through poems and dramas for the community on various occasions. The project staff supports the schools in updating their works and monitoring that relevant messages are disseminated according to project interventions. The project plans to continue training school clubs in the 30 PAs and providing support to the existing school clubs in the initial 10 PAs. The school clubs receive materials from the project such as stationery, leaflets.

Additional support which should be considered for the school clubs includes that listed below; however, this support should be coordinated by the several CARE health and food security projects in the geographic area, rather than by FCSP alone:

- **Promotion of school gardens for schools with water and garden space through the support of Woreda Office of Agriculture Agents**
- **Monthly meeting to review performance, discuss problems, and evaluate the effectiveness of the activity**
- **Monthly report to VCHW**
- **Supervision system with checklist needs to be developed**
- **Schools should be encouraged to send one boy and one girl to represent the school club.**

Mobilization of EOC priests to deliver health messages

The Ethiopian Orthodox Church is a very influential institution within the Farta Woreda. There are approximately 5,100 priests in Farta Woreda. Given this strong presence, the church is an effective mechanism for the reinforcement of health education messages. The EOC is very interested and committed to applying their previous experience in HIV/AIDS education to act as change agents for Child Survival.

A capacity building workshop was held in September 2003 in the initial 10 PAs for church leaders. Monitoring and supervision of activities at the community level for these PAs led the project to include training on nutrition and maternal health for the priests in the same PAs. The second workshop on nutrition and maternal health was held for 43 religious leaders in April 2004 facilitated by two nurses from Debra Tabor Health College. An additional 131 priests from 30 PAs have been trained on basic skills of maternal and child health, counseling, messages reinforcement and dissemination. The training was facilitated by Debra Tabor Health College in November/December 2004.

Since receiving training the priests have contributed to child health behavioral message dissemination, especially at churches during the Sunday ceremony. Some are using other various occasions, such as funerals and community gatherings, for message dissemination. They are also expected to expand the dissemination of messages through house-to-house counseling for pregnant women and under five children's mothers. The priests have reportedly been effective in persuading mothers to improve health practices, particularly in vaccination and promotion of breastfeeding.

According to the DIP the EOC priests would provide interpretation of community data boards and use the data to reinforce and promote health messages. "The Ethiopian Orthodox Church has agreed to play the facilitator's role for the community Health Information System (HIS) in addition to its role as community change agents in promoting behavior change related to child health." This has not been implemented, but would be an excellent role for the EOC priests to assume in the future. The project recently developed a plan for using data boards at five churches as a pilot project. This has not yet been implemented but is a positive step forward in establishing a community HIS.

Additional support needed for the EOC priests in the future should include:

- **A clarification is needed as to the supervisory relationships at the community level and the role of the priests.**
- **Priests are encouraged to make home visits but no system exists for ensuring the quality of this activity. A system for monitoring the quality and effectiveness of home visits should be established**
- **The priests' role in the community HIS should be strengthened and expanded based on the pilot in five churches to be implemented in the near future.**

Strengthening of community leaders and formation of community committees

When community level institutions were initially explored by the FCSP, it was planned for health committees to be used as an important element to promote maternal and child health activities. These committees were expected to play an important role in data collection and analysis for use in decision-making at the community level. Little progress has been made during the first half of the project to form health committees.

The government is currently restructuring the community health committees into a more structured system that is composed of three different level, PA level (10-15 members), sub PA level (5-7 members), MB level (3-5 members). The project is working with the FWHO to define how the health committees will be integrated to the existing health service delivery system. Duties and responsibilities have recently been developed and distributed to PA leaders to orient the health committee members. The project will be using the government restructured health committees.

This activity has included training for community leaders in health and BCC topics but this aspect requires additional strengthening. **The FCSP should continue to coordinate with FWHO and other governmental agencies to define the role of the project in training health committees, in lieu of waiting for a policy decision of the structure of the committees, the project should proceed with planning for training community leaders.**

Delivery of health messages to community members via HFs and outreach clinics and CHWs:

The project began by introducing community members and leaders in the target area to a general description of the project, CARE's general mission and vision, baseline survey findings, and the expected role of the community.

The project has intervened at two levels; strengthening HF staff capacity, to improve the quantity and quality of educational/counseling contacts at static and outreach clinics, and by training and supporting a cadre of community workers to reach community members. Health education has

been targeted to different community segments (mothers and fathers) about basic health information and topics related to project interventions at churches, meeting places, community gatherings, health facilities, during MTMSG meetings, and a homes by CHWs and HF staff.

b. Communication for Behavior Change

The project utilizes a variety of methods for reaching people with health messages:

- MTMSG
- Health education talks in static and outreach MOH clinics
- Home visits by MTMSG, priests and HF staff
- Counseling
- School clubs
- Radio drama/listening tapes
- Sunday sermons and other church activities

The effectiveness of the methods used has not been measured and some have only been implemented in the initial 10 PAs. All messages are technically up-to-date with the exception previously mentioned of the introduction of complementary foods along with continued breastfeeding at 6 months. All messages are in line with MOH policy.

Numerous actors are involved in the BCC activities; EOC priests, MTMSG leaders, CHWs, School Club leaders and teachers, and HF staff. Their role was previously discussed in the section on Community Mobilization.

The FCSP is struggling with implementation tasks and ensuring the quality of the activities has not been a priority. During the next phase of implementation, the project plans to focus more on quality issues. The use of priests for BCC messages is a particularly innovative approach and has good potential for encouraging a change in practices. The main weaknesses of the BCC strategy are a heavy reliance on "transmitting" messages and the lack of a system for assessing the quality and effectiveness of BCC activities. The principal BCC activities are detailed below.

BCC Strategy

A Training of Trainers was held by previously trained CARE Ethiopia staff for the CARE FCSP staff and Partner Staff on BCC Strategy Development in February 2004. The training covered the Essential Nutrition Actions for children, pregnant and lactating women, and to enable participants to be involved in the BCC strategy development process. The training objective was to begin developing a BCC strategy, and for the development of behavioral change messages for project interventions that are to be disseminated to the communities.

A written BCC strategy has been developed for the project by a consultant group which was reviewed by CARE and partner staff at the end of 2004. The BCC strategy focuses on key community IMCI family practices in relation to the prevention and treatment of common childhood illnesses (as defined by national IMCI policy) and includes these activities:

- Counseling through home visits and MTMSG
- Transmission of key community IMCI family practice messages
- Radio drama recordings

The strategy is being utilized and BCC materials production has been started. The profile for the MTMSG leaders was extracted from the BCC strategy document and distributed to VCHWs to be used for the support of MTMSGs.

Radio Drama

One method of message dissemination to the community is through cassette listening groups with targeted child health messages. The radio dramas are pre-recorded cassettes made by local artists with previous health experience who have converted IMCI messages to songs and plays. According to the DIP, CHWs (inclusive of CHAs, CBRHAs and trained TBAs) would be responsible for convening the groups and ensuring that messages were discussed within community groups. This has not happened; it was recommended during the MTE visit to provide one radio per health facility and have health facility staff convene the discussion groups. The tapes could be made available for loan on a rotating basis to CHWs (VCHW, Priests, MTMSG)

Listening materials have been procured for 10 pilot PAs and are available in some HFs. **Future steps for implementing the radio dramas/listening cassettes should be:**

- **Develop a question guide to stimulate discussion, to be used by the facilitators**
- **Develop a plan for distribution of the cassettes and training in all 40 PAs**
- **Purchased the tape recorder/radios, batteries and cassettes.**
- **Develop a mechanism for evaluating the effectiveness of the cassettes**

Educational Materials

A limited number and amount of pilot leaflets and a flipchart have been field tested and produced by the project. While this was not a specific activity outlined in the DIP, some type of printed materials will help support message transmission.

Home Visits

HF staff, priests, MTMSG, and VCHWs are encouraged and supported to provide home visits, especially to pregnant women and newborns. This is one of the points to be emphasized during monthly review meetings and supportive supervision visits. This activity has been slow getting started and needs to be strengthened during the second half of the project.

Counseling

Some training has been conducted for improving counseling skills for HF workers, but this activity also needs to be a continued focus at both HF and community levels. Some health and nutrition counseling materials have been developed for different audiences: religious leaders, school clubs, and CHWs.

c. Capacity Building Approach

i. Strengthening the PVO Organization

Participation in the USAID Child Survival program has greatly benefited CARE as an organization. Specific examples include the institutionalization of monitoring and evaluation techniques, including information systems and survey methods, standards for project design and grant writing, and the development of a highly qualified technical Health Unit at HQ. CARE Headquarters (HQ) capacity in Child Survival programming has increased during the life of this

project through multiple opportunities provided through CORE and/or CSTS sponsored learning opportunities. CORE annual meetings and CARE's participation in CORE Working Groups, along with the mini-university DIP presentation approach, have provided opportunities to share with and learn from other implementing PVOs. The previous HQ technical staff providing backstop support to this project had attended workshops on such topics as Adult Learning Methodologies, BEHAVES framework for Behavior Change Communication, the Child Survival Sustainability Assessment framework, and Networking and Leadership. This information was shared with field office staff through the CARE Annual Child Survival Workshop and through information sharing during TA visits to the field. This strategy will continue to be implemented by the new CARE HQ Child Health staff.

CARE Ethiopia's regional office in Debra Tabor has three projects in addition to the FCSP; Water and Sanitation, Institutional Capacity Building and Food Security. These projects supplement the FCSP nutrition intervention through their support for household livelihood security, diversification of food crops through irrigation and soil conservation, and institutional capacity building of local partners.

The coordination is good among projects and specific joint activities have been identified, including training Extension Agents from other projects to disseminate health messages and support for home/school gardens and nutritional demonstrations. A great deal of synergy exists between projects working in the same area with agricultural diversification, water projects, latrine construction, hygiene education and fruit tree projects. FCSP is the only project which works in all 40 PAs, the other projects work in either 5 or 10 PAs.

ii. Strengthening Local Partner Organizations

One of the project objectives focuses on capacity building and sustainability and has the following indicators

Objective	Indicators	Comments from MTE
To strengthen local and community-based institutions and partners and build capacity to support child survival activities on a sustainable cases	**Monitoring**	
	Number of CHWs trained in PHC	40 VCHWs have been trained
	Number of mother-to-mother support groups in place and active	2,700 groups have been established
	EOC BCC and C-HIS strategy in place	BCC strategy has been developed
	Number of health facility revolving drug funds and community pharmacies in place	No HF drug funds are currently operating, no community pharmacies will be established
	Evaluation	
	60% of communities in PAs have established revolving drug funds (community pharmacies) and mechanisms for cost recovery for essential drugs including ORS	No community pharmacies will be established. A recommendation from the MTE was to not complete this activity.
	80% of CHWs are involved in health education and community mobilization efforts	This was not quantified, but the majority of the 40 VCHWs are active
	50% of EOC leaders actively support child survival intervention	If by "leaders" the project means priests, 131 of 5,000 priests have been trained
	Advocacy strategy for use of antibiotics by CHAs developed	A recommendation from the MTE was to not complete this activity.

	Nursing College and EOC staff provide ongoing training	131 trained priests are providing education. The college has an ongoing training function.
	90% of health facilities within the district provide IMCI services and receive referral cases from CHWs	Staff in all HFs have been trained in IMCI, use of IMCI was not quantified. Referral system from communities is just beginning

The primary partners for implementation are the Ethiopian Orthodox Church (EOC), Farta Woreda Health Office (FWHO), and Debra Tabor Health College.

Institutional Assessment

An institutional assessment was held in June 2003 with seven partner organizations:

Farta Woreda Health Office
Farta Woreda Education Office
South Gondar Health Bureau
Debra Tabor Health College
Debra Tabor Hospital
Farta Woreda Administrative office
South Gondar Zonal EOC
Kanat PA
Gerbie MB

The main finding of the assessment were:

- 67% of partner organizations proposed IMCI training as their number one need
- 44% of the organizations proposed training in management skills as another important need

The assessment's main conclusion was that the majority of partner organizations (75%) are working with very limited un (?qualified)qualified personnel.

Among the recommendations from the assessment were:

- The Woreda Health Office is the major partner hence capacity-building should focus more on this organization.
- The activities of the project should be implemented according to the timetable stated in the project document because most partners, particularly the PAs have been frustrated with the delays.
- Attention should be given to health institutions that are expected to be a model for HFs, such as Debra Tabor Hospital. For example in the availability of materials for an ORT corner and growth monitoring.

Unfortunately, no actions have been taken based on the assessment. **A plan of action should be developed as to how the FCSP could realistically build the capacity of the partner organizations, given current resources and based on the prior assessment.**

Visits were made to major partners during the MTE visit. Other partners include the Zonal health office, Debra Tabor hospital and health center, Ministry of Education, District Disaster Prevention and Preparedness Commission (DPPC) and Woreda administration. Representatives

from all partners make up the FCSP core team. All of these partners have signed a Memorandum of Understanding.

MTE finds that partners have been involved in some capacity building activities during the first half of the project:

- The DIP was developed in coordination with partners
- Partners received an orientation to project goals, objectives, strategies and activities
- Partners received a Training of Trainers session on BCC and reviewed the BCC Strategy
- The relevant experts of partner organizations participated in the HFA, KPC and PRA surveys
- All partners agreed on the importance of the training held in IMCI and feel part of the implementation process.
- Counseling training for IMCI and nutrition was held for most partners.

During a visit with partners at the Health Offices at both the Woreda and Zone level in February 2005, partners were not completely satisfied with project progress. This negativism results in great part from the absence of a Project Manager and the lack of acceptance by health partners of the parameters and limitations of the FCSP and funds. During meetings with partners in June 2005, an improvement in satisfaction and a better understanding of the project was found, although there continues to be room for improvement. However, the health partners are generally supportive of all training activities the project has conducted and have been amenable to open discussion of various strategies, such as referral systems, revolving drug funds, etc.

The Ethiopian Orthodox Church is very supportive of the project and saw the shared mission of saving children's lives as completely in line with church teachings. The priests are very dedicated and show creativity in presenting messages within a biblical context. However, their role at the project management level has been less well defined and they have not demonstrated much interest in this. CARE HQ Technical Advisor and FCSP field staff have held discussions with EOC leaders and have proposed developing a more formalized arrangement, which is under consideration at present.

Debra Tabor Health College provides an excellent opportunity for mutual benefit. They have provided training to a variety of project targeted audiences (VCHWs, school clubs and priests). An excellent opportunity for capacity building of the college would be to involve them in COPE quality assurance assessment implementation. Their students are assigned to health posts for field practicum and could be helpful in conducting client interviews, etc. as part of COPE.

During the first MTE field visit in February 2005, all major partners participated in a 1-day workshop as part of the MTE process to increase involvement in project implementation by reviewing major strategies, discussing adjustments to the DIP, and focusing on next steps for supervision, referral system and improving the quality of project activities. (See Annex 2 for a list of participants)

Future Steps

The main challenges facing the project are:

- The MOH at all levels (FWHO, Zonal Health Office, Hospital, and HFs) are extremely understaffed, severely curtailing the impact and sustainability of project activities
- Limited expertise/time/personnel on the part of FCSP staff to meet the multiple and broad capacity building needs of partners.

Needed steps include:

- Use the work already completed in assessing the capacity of partners to develop a plan for capacity building for the principal partners.
- **The FCSP should continually look for alternative sources for capacity building of partners outside of FCSP staff, including recognized national consultants and/or other projects focused on MOH capacity-building.**

iii. Health Facilities/Health Worker Strengthening

The project has had an impact on both the demand for services and the supply of quality services. The implementation of the referral system, community support groups, and coordination with EOC priests have increased demand for services by motivating use of health facilities, as well as dispelling fears of use of services. HF staff is currently conducting education sessions at the clinics (mainly lectures) with a different topic each day and during Outreach clinics and community gatherings. Staff is expected to make home visits for pregnant women and children under 5, especially newborns. Staff also is responsible for counseling with IMCI and monthly reporting.

The MOH at all levels (FWHO, Zonal Health Office, Hospital, and HFs) are extremely understaffed, severely curtailing the impact and sustainability of project activities. The zonal hospital in Debra Tabor is the only hospital for the two million people in the zone -- with one health center, six health stations and thirteen health posts within Farta Woreda.

As a solution to staffing shortages, the MOH recently established a new level of worker; Health Extension Agents (HEA). Approximately 20 HEA recently graduated after completing one year of training and have been assigned to Farta Woreda. They were assigned to 10 of the health posts (2 per post). They are from the same PA as where they will be working so they should be more sustainable than staff which is transferred into the area. More HEAs are scheduled to graduate next year. As this position did not exist when the DIP was written, no specific plans were included for strengthening or coordinating with them. **The FCSP is working closely with the FWHO to determine how the HEAs can be best utilized to strengthen CS activities. This should continue to be a priority focus for the FCSP.**

The main strengthening activities for Health Facilities and Health Workers include the following:

- Training
- Quality Improvement
- Supervision
- Establishing Links with the Communities
- Materials/Equipment
- Strengthening of Meetings

Training

Most of the HF staff has received training in IMCI and EPI. Some HF staff still need IMCI training and all need refresher training in IMCI with an emphasis on counseling. Additional information on training is included in the next section.

Quality Improvement

According to the DIP, the project planned to use the Client-Oriented, Provider-Efficient (COPE) method using tools developed by Engender Health (including Self Assessment, Client Interview, Client Flow Analysis and Action Plan) to assess quality of services and to organize quality circles at the zonal level. The Zonal quality team would then be responsible for designing, implementing, and monitoring quality of care in the HFs. CARE Ethiopia has past experience using the COPE methodology and a number of CARE staff have been trained in its use. These activities have not yet been incorporated into the FCSP. A Technical Support Plan for Improving Quality of Care and Facilitative Supervision was developed during the MTE visit which had the stated purpose of implementing the COPE methodology in the FCSP as a strategy for quality improvement and supervision of Child Health activities (IMCI) in 29 HFs. Training is planned in either October or November of this year in the COPE methodology.

The quality of health services is the focus of the project, but all activities needs to be monitored for quality; education by priests and VCHWs, functioning of the MTMSGs, effectiveness of the school clubs, etc. Other methods of improving quality need to be explored:

- Formation of Quality Teams (Part of COPE)
- Supervision checklist
- Pre- Post-tests
- Supportive supervision

Supportive Supervision

According to the HFA only 15% of health facilities received a supervision visit in the past year. A supervision checklist was recently developed for supervision of IMCI activities. Other checklists will be developed in the future. The system for supervision needs to be strengthened to ensure that joint visits are being carried out with FWHO on a quarterly basis, and monthly visits are being made by CARE. The focus of the supervision should be on IMCI implementation, including technical skills and the quality of counseling. Additional supervision tools/activities should include accompanied visits, observations and review of reports.

Establishing Links with the Communities

An important activity has been the strengthening of the linkage between HFs and communities by improving MOH staff skills, providing opportunities for coordination through monthly meeting of MOH and CHWs, coordination with MTMSGs and the first steps in developing a referral system. CARE and FWHO first worked on strengthening the referral system between the HFs and the referral hospital and recently produced a tool for referrals between the communities and HFs. A seminal effort to develop local health committees has the potential to involve civil society in health activities in the future.

Materials/Equipment

The following have been distributed:

- Radio drama cassettes and radios (in 10 pilot PAs)
- IMCI Algorithms
- Scales for growth monitoring
- Reporting forms and registers
- 16 Refrigerators were purchased and distributed to HFs
- Water purification filters at 18 sites

Activities which are still pending are the establishment of HF drug funds and flip charts for educational sessions.

Strengthening of Meetings

A quarterly planning meeting has been established with FCSP, FWHO, and the HFs, which is facilitated by Woreda Administration. Monthly performance review meetings are now being held at most HFs for CHWs. The FCSP should develop a guide for organizing HF monthly meetings with CHWs including activities in:

- Performance review (review of reports and use of information for decision making)
- Problem solving
- Distribution of materials/supplies
- Technical update based on review of needs

iv. Training

The project employs a cascade training approach for MTMSG leaders. This approach needs to be carefully monitored to ensure quality in the replication of information. Clarity is also required in defining what additional training the project will carry out for the remainder of the funding cycle. **A training plan specifying *who* will be trained, *how many* will be trained, *what* will they be trained in, *who will provide* the training should be developed for the remaining two year of the project.**

Supportive supervision/monitoring methods should be developed to measure the amount of information being retained and skill development by participants in all trainings.

Training conducted during the first half of the project is shown in the following table:

Topic of Training	Category	Quarter & Year	Training Participants			Trainers
			Male	Female	Total	
Clinical IMCI	Mid and high level health professionals	1st 03	*	*	20 (CARE = 1)	Gonda Univers
Clinical IMCI using adapted materials	Lower level health workers.	1st 03	12	8	20 (CARE = 1)	Traine Partne
BCC messages for MCH	Religious leaders	1st 03	41	0	40	Initial 10 PAs
BCC messages	Existing CHWs	1st 03	16	0	16	Initial 10 PAs
BCC and interventions	School leaders and students	2nd 05	68	167	235	Debra Ta Health Co
BCC messages for MCH.	School club leaders and directors 10 schools in initial 10 PAs	1st 03	19	3	22	Project F for 10 P
BCC on Essential Nutrition Actions	Partners.	2nd 04	16	0	16 (CARE = 6)	CARE A
Counseling and communication on Nutrition and BCC	Partners and project staff	2nd 05	18	1	19	LINKAC
Counseling and MCH	Positive Deviant Mothers	2nd 04	0	30	30	Partne
Nutrition and counseling.	School club leaders and directors 12 schools in initial 10 PAs	2nd 04	23	5	28	Debra Ta Health Co
Nutrition and counseling.	Religious leaders	3rd 04	43	0	43	Debra Ta Health Co
Basic MCH	VCHWs	4th 04	32	8	40	Debra Ta Health Co
Nutrition and counseling.	Religious leaders	1st 04	131	0	131	Debra Ta Health Co
Nutrition and counseling.	Religious leaders		147	0	147	Debra Ta Health Co
Counseling and MCH	MTMSG leaders on Positive Deviance approach to child health	2nd 05	0	90	90	Debra Ta Health Co
Nutrition and counseling.	Religious leaders	2nd 05	149	0	149	Debra Ta Health Co
Nutrition and counseling.	Religious leaders	3rd 05	142	0	142	Debra Ta Health Co
Micronutrients/BCC materials production		2nd 05	50	8	58 (CARE =9)	FCSP

EPI modular training	HF health workers	2nd 04	11	14	25 (CARE = 2)	Region Hea
Cold chain maintenance	HF health workers	4th 04	8	11	19	Region He Bureau
Refresher EPI training/ cold chain maintenance.	HF health workers	1st 04			22	Region He Bureau
HIS	VCHWs	4th 04	32	8	40	FCSP

d. Sustainability Strategy

Sustainability can be viewed based on four principles- permanent behavior change, supportive structures, links with permanent institutions, and financial support. Due to the staffing problems within both CARE and the MOH, institutional sustainability will be very difficult for this project. Other levels of sustainability will be much more feasible. The structures being created at the community level, mainly the MTMSGs, have the potential to be sustainable, especially if they receive support from the EOC priests and HF staff. The priests are a stable asset in the area if the health focus can be maintained and expanded in the future. The monthly meetings with HF staff and CHWs are a low cost way to provide support and strengthening linkages between the communities and the HF.

Some positive steps being taken to ensure sustainability of project activities are:

- Monthly meetings with MOH and CHWs for in-direct supervision and continuous training
- Referral system improves communication and creates demand
- CHWs and community leaders support community level behavior change
- Improved quality of health services enhance both supply and demand

Future activities which will enhance sustainability include:

- The involvement of community leaders (for example with the M&E process) encourages the sustainability of the project activities.
- Development of a Community HIS to collect and use information at all levels
- Efforts are being made to integrate project activities with other organizations in the Woreda which have a link with FCSP activities for example working with the Department of Agriculture extension agents, participation in a workshop to integrate organizations working on child survival and to launch the development of the C-IMCI manual, and involvement in various CORE group sponsored activities for coordination and planning. Discussions are at the beginning stage with GTZ, the Woreda Community Mobilization office, and others to enhance integration
- Revolving drug funds have an important role in financial sustainability when they are established in health facilities. The activities related to community pharmacies have been omitted to allow a more focused approach to the health facility funds which have stronger political and supervisory support.

C. Program Management

1. Planning

Beginning in October 2002, the FCSP began to conduct set up activities and assessments to prepare a base for successful implementation. CARE hired staff and held partner meetings for agreement on roles and responsibilities. CARE and its partners conducted zonal and Woreda level orientation meetings regarding project goals, objectives and overall strategies. CARE and partners also conducted orientation meetings for all 40 PAs.

Three baseline assessments were also completed. These assessments were the KPC Survey, Health Facility Assessment (HFA) and a Participatory Rapid Appraisal (PRA). A dissemination and planning workshop was held from March 31-April 2, 2003 in Bahar Dar (Amhara regional headquarters) as a part of the DIP preparation.

The DIP process was very inclusive of partners and other stakeholders. However, the DIP has never been translated to Amharic, limiting use of the document by CARE and partner staff. **It is suggested that the FCSP translate selected sections of the DIP for partners, to increase their understanding of project objectives, indicators, and activities.**

The workplan developed as part of the DIP process was well thought out, but with the difficulties the FCSP has encountered, the work plan is approximately one year behind schedule, particularly in implementation in all of the 40 PAs. Many activities have been piloted in the initial 10 PAs and are more advanced in including all elements as planned for each intervention. The challenge for the project is to fully roll out all activities within each intervention to the other 30 PAs.

A system of quarterly meetings with all partners has been implemented, as well as an annual planning meeting. Both of these steps have help to strengthen the linkage between partners and increase their involvement in project activities.

A two day annual planning workshop was organized with HFs and FWHO representatives in August 2004. During this workshop, strategies were defined and plans developed particularly in relation to strengthening the Expanded Immunization Program, establishing the Mother to Mother Support Groups, involving EOC leaders as health message disseminators, prioritizing house-to-house counseling for pregnant women and mothers of children under five, and other community mobilization strategies.

As many of the planning workshop participants were Junior Heath professionals, they were briefed on the following points to strengthen the activities:

- Establishing referral linkages from health facilities to referral facilities
- Facilitating regular and outreach health education programs
- Strengthening the growth monitoring and promotion activities
- IMCI refresher orientation.
- Health information system
- Reporting formats and how to utilize them.

The activities were planned for each HF and PA independently to monitor progress of the activities and ensure coverage and equity. The FWHO took full responsibility for monitoring and

follow up of the planned activities with facilitation and supervision support of the project and partners.

2. Staff Training

At the beginning of the project, staff participated in an orientation of strategic approaches and technical areas. A cross visit to CARE Kenya was organized for the Project Manager (PM) and MOH counterparts to learn more on the implementation of IMCI and C-IMCI. A project officer attended a Training of Trainers workshop on community-based surveillance for vaccine preventable diseases, which was organized by CORE group in Ethiopia and the WHO. The BCC officer attended a training by LINKAGES on technical areas of BCC and on how to design a BCC strategy for promotion of improved infant and child feeding practices.

FCSP staff attended a workshop to integrate strategies among organizations working on child survival in Ethiopia and to launch the development of the C-IMCI manual with the Ethiopia MOH. FCSP and MOH staff participated in a two day CORE Group workshop in August 2004 on "Partners Planning Forum" to allow partners to plan activities to strengthen EPI activities. One FCSP staff attended the four day CORE Group training on Lot Quality Assurance Sampling (LQAS) in August 2004. Other CARE Ethiopia staff have also received technical training in IMCI, EPI, Essential Nutrition Actions and BCC, and have shared some of this expertise in all-staff country office meetings.

Unfortunately many of the people who were trained are no longer with the project. Five new staff members have been hired within the last year, and have received some training. **Many of the staff have limited skills for implementing a CSP -- the project needs to identify more opportunities to improve their skills.**

Some skill training of the present staff is planned for through Annual Plan activities to implement an LQAS, the COPE methodology, some Participatory Rural Appraisal methods training and other. However, this will continually be an issue for follow-up by CARE HQ backstop.

The CARE Annual CSP workshop in July 2005 provided an opportunity for training and was attended by the present FCSP Project Officer and the Acting Project Manager. Technical topics covered were: 1) The differences between "good" IEC and advanced BCC; 2) Control of Diarrheal Disease and new protocols for zinc; 3) Malaria and recommended Intermittent Preventive Treatment during Pregnancy;

3. Supervision of Program Staff

CARE endorses the concept of "supportive supervision", in which staff are active partners in assessing project progress. Staff are adequately supervised and have opportunities for exchanging ideas and experiences within a supportive environment. Regular meetings are held to give staff the opportunity to share experiences and for problem solving. In the absence of a PM, the M&E officer has been acting as PM. He provides good support to the staff and the small number of staff enhances supervision and opportunities for sharing.

4. Human Resources and Staff Management

In general, the recruitment and hiring of project staff followed CARE's personnel manual. Staff received orientation on CARE Ethiopia's program, policies and procedures. Performance of staff is monitored and evaluated using CARE's performance evaluation system. Each staff member has a job description and develops an annual individual operating plan.

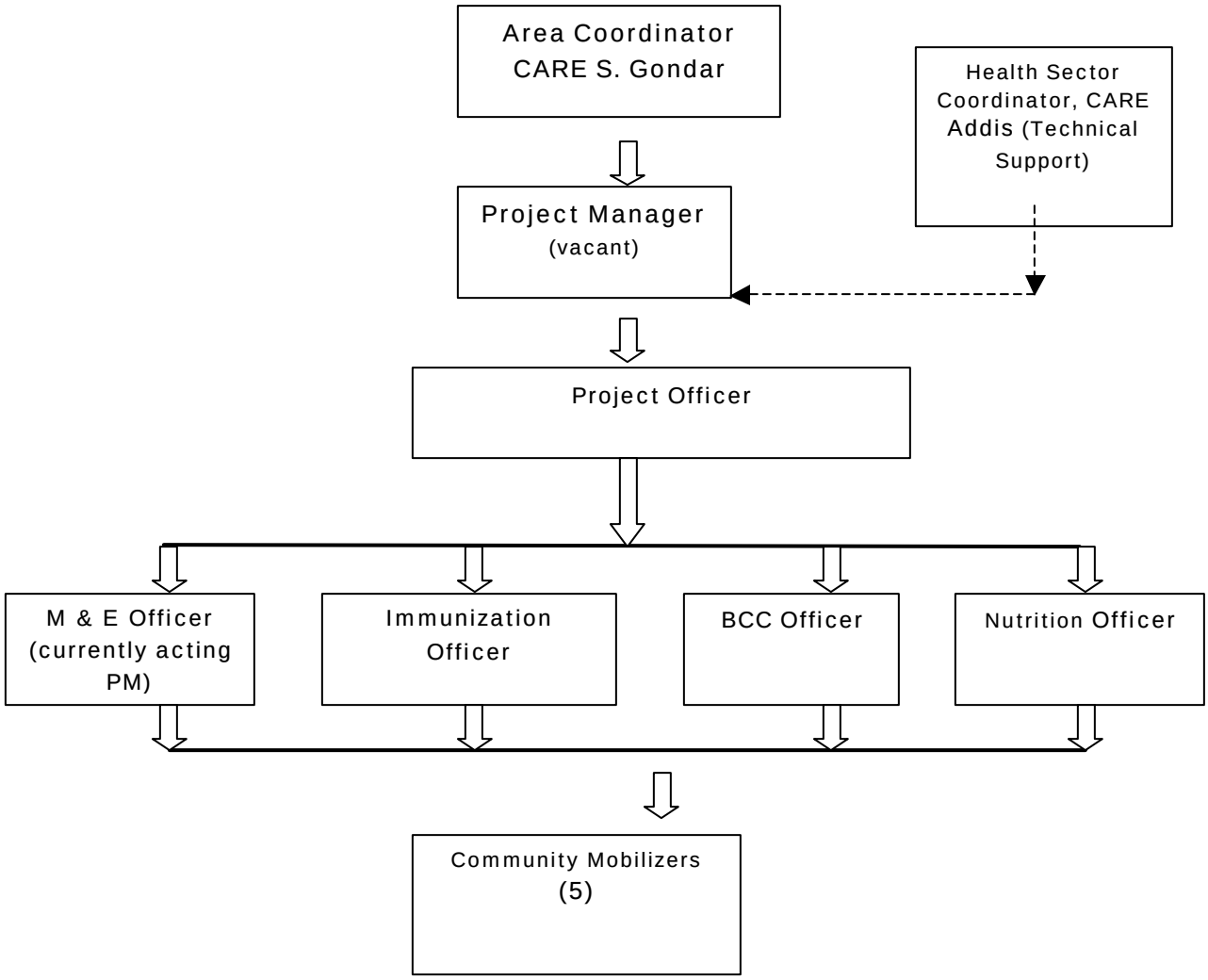
The Debra Tabor regional field office is led by an Area Coordinator responsible for the overall coordination of the field office and the projects operating under its auspices. The newly hired CARE Ethiopia Health Sector Coordinator (HSC) located in Addis Ababa provides technical assistance to the project. There has been a Project Manager (PM) for the FCSP for less than 12 of the 35 months since the project started (although a PM was present for much of the first year of getting the project established). This situation represents the most critical issue of the FCSP and the problem most often cited by partners. It has been especially difficult to find a PM with the normally required MPH, English-speaking skills and willingness to be located at the project site, far from Addis Ababa.

The CARE Ethiopia HSC has provided backstop support directly to the project; this position, however, was also empty for a period of several months in 2005. At present, a new HSC has been hired and has been providing support to the project; his Annual Work Plan calls for him to provide 25% of his time at a minimum to the project. A new Project Officer position was created and filled by someone with slightly lesser qualifications than that defined for the PM position; however, senior management has found it difficult to place this new Project Officer position as the "Acting PM" due to general lack of familiarity with the project overall as compared to other staff. Although the recent active recruitment has continued for almost one year at present, the PM position continues to be vacant. **Filling the PM position as soon as possible and providing him/her with adequate support is critical to the successful outcome of this project.**

There have been other changes in staffing that have also been disruptive to the project. The original staffing structure was for a Project Manager and five "Technical Officers": 2 Partnership Supervisors, 1 M&E Officer, 1 BCC Officer and 1 Training Officer. Of the original five, only 2 are still with the project. Moreover, organizational chart has been modified to make changes to position titles and job definitions more than once over the life of the project. This has been done partly in attempts to better define each individual's responsibilities, partly as a means of releasing personnel that did not demonstrate the qualities and skills desired by CARE and allowing for new recruitment, and also as part of CARE Ethiopia's long-range strategy of standardizing Human Resource protocols among the many CARE Ethiopia projects in action.

The current organizational chart is included on the following page.

CARE Child Survival Project in *Farta Woreda*
Organizational Chart (May 2005)



Some of the redefinition of technical position titles is not supportive of furthering IMCI strategies in collaboration with MOH partners -- for example, now there is an "EPI Officer" and a "Nutrition Officer". It is not recommended that titles be changed now as there has been too much change over the life of the project, but there should be a review of responsibilities as a team, with emphasis on the over-arching IMCI approach.

The project also created a new position of Community Mobilizer at the end of 2004 and hired 4 new staff and moved one of the former Partnership Officers to this position. This is a positive move in that their job definition is focused towards community visits, supervision and support which was found at midterm to be another key deficiency in this project.

The position of Project Officer was newly created in 2005 as a temporary means of dealing with some of the decision-making and lines-of-authority issues that are problematic without a Project Manager, even though one of the Technical Officers that has been with the project from the start (the M&E Officer) had been functioning as de facto Acting Project Manager. The thought was that a Project Officer could both provide greater technical expertise and would be at an organizational position appropriate for fulfilling Acting Project Manager responsibilities. The position was filled by someone with a BSc degree in public health and has been providing good technical skill input to the project.

Despite the many human resource problems which the project has suffered, the current FCSP team is very dedicated and hard working. There is a great deal of frustration on their part, as they have not received adequate support and training for effective implementation of this project.

5. Financial Management

In the absence of a PM, the Area Coordinator and field office Administrator fill a greater role in assisting with the financial management of the project. The Administrator is responsible for recording and processing payments and expenses of each project and compiles financial reports. Cost-sharing among projects is applied to specific cost elements - rent, utility, support staff, etc.

The Finance Department in Addis Ababa provides good support to the FCSP in financial management and reporting, annual orientations on budget preparation, and budget reviews on a quarterly basis. The international CARE accounting system, SCALA is used for financial and budgetary control.

The total budget for the five-year project is $1,758,080 with $1,300,000 from USAID and $458,080 from CARE (for a match of 26% of the total budget). The project has spent approximately 45% of the total budget as of July 2005.

6. Logistics

The two main logistical problems have been the slow process for obtaining equipment such as refrigerators and motorcycles. Refrigerators were recently obtained after more than a year, but procurement of motorcycles has still not been completed. The limited transportation opportunities for the FCSP staff severely effects the project's ability to make measurable progress. This will be the biggest logistical challenge during the remainder of the project.

7. Information Management

The main activities completed so far in information management are:

- Baseline KPC, HFA, and PRA Surveys
- Census /Survey on EPI Coverage in all 40 PAs
- Improvement of MOH HIS
- Community HIS strategy
- Focus on Use of Information

<u>Baseline KPC, HFA, and PRA Surveys</u>

A standard 30 cluster KPC was carried out in January 2003, utilizing a clear methodology and good supervision. Several modules from the KPC 2000+ were used with slight modifications and information was collected for 11 of the 13 Rapid CATCH indicators. Two indicators were not collected and are detailed below:

- The Rapid Catch indicator on insecticide treated bed nets was not used since the area was not considered malaria endemic. The current baseline survey findings did, however, show some pocket areas with high prevalence of malaria. There is increasing evidence of a higher incidence of malaria in the area than was previously thought.
- Anthropometric measurements were not included in the KPC survey due to the presence of a previous nutritional survey carried out by CARE in the same operational area. The Nutritional indicator (weight-for-age) reported was from the previous survey.

The KPC Survey to be conducted as part of the final evaluation should include both of the Rapid CATCH indicators which were omitted in the baseline survey.

The KPC survey will be repeated as part of the final evaluation, but due to problems with project implementation, it was felt that staff time should be used for other priority activities, and so the scheduled MTE KPC was not conducted. Due to the problems the project has suffered with implementation, it is doubtful that a KPC Survey at midterm would show a measurable change.

Even though the KPC survey was in general of good quality some improvements should be made:

- Compare the baseline KPC with project indicators, the following indicators were not included in the baseline survey:
    - Women with children < 2 years who during their recent pregnancy received more than 100 IFA tablets increased to 40%.
    - % of women with children <2 years who received deworming during second or third trimester of pregnancy to 50% of target population
    - Increase % of children aged 0-23 months whose weight is taken, plotted on the growth monitoring chart and their mothers counseled from zero to 40%.

The following project indicators were collected in the KPC survey, but not included in the KPC Survey Report:

- Increase the proportion of households disposing children's stool properly from 6% to 25%.
- Increase the % of children 12-23 months who consume vegetables, fruits and foods rich in Vitamin A in previous 7 days from survey from 18.9% to 45%

- **An indicator table should be included in the KPC Survey report which clearly indicates what the numerator and the denominator is for calculating the indicator.** Without this information it is impossible to tell is the indicator has been correctly calculated.
- Some of the Rapid CATCH indicators may have been incorrectly calculated in the baseline KPC Survey:
    - Danger signs refers to IMCI danger signs, not the recognition of danger signs for diarrhea
    - Complete immunization should be calculated as those children receiving all vaccinations by their first birthday, it is unclear if this was done
- Locally available foods should be defined before beginning the KPC based on formative research and general knowledge of the core team. The names of these foods should be included in the questionnaire and all interviewers should be trained based on the locally available foods. For example in the project area sorghum is not commonly eaten, but teff is. The question: *Any food made from grains [e.g. millet, sorghum, maize, rice, wheat, porridge, or other local grains]?* should be changed to reflect locally available foods.

A complete revision of the M&E Matrix from the DIP should be conducted to make sure that all indicators can be measured. Special attention needs to be made for developing tools for measuring the monitoring indicators.

A Health Facility Assessment (HFA) was carried out in March 2003 to assess the capacity of all HFs with regard to case management and preventive services for children under five years of age and to obtain concrete and up-to-date information on the status of the facility-based child health services in Farta Woreda. Instruments used for the HFA were comprised of five different survey forms. These forms contain several modules and were modified and adapted from the originals developed by WHO. Additional questions were added to explore the links between facilities and communities.

A Participatory Rural Appraisal (PRA) was also conducted in March 2003 with the objective of generating qualitative information on existing household and community behaviors, beliefs and practices on child health for the development of the DIP. This qualitative needs assessment was carried out in two rural villages and one rural town. In addition to focus groups, the IMCI-tailored PRA tool modified and adapted from the WHO standard PRA tool was used for the assessment. Techniques included transect walk, social/resource mapping, disease severity ranking, health management or curative matrices, gender analysis and livelihood profiles.

<u>Completed Census /Survey on EPI Coverage in all 40 PAs</u>
In an effort to improve the low coverage of EPI, FWHO proposed a survey be conducted to find out what actual coverage has been reached and to develop a data base for tracing information for further interventions and decision making. The project supported the survey technically and financially. As a joint effort between the FWHO and FCSP staff, the registration of the target groups of the Woreda for EPI was conducted.

It was believed that the census/registration of EPI target groups with their EPI status would have the following advantages:

- Baseline information of the EPI status of the target groups
- Identification of the target groups of the EPI service at village level
- Follow up of defaulters as early as possible
- Service planning, monitoring and evaluation
- Measuring change in health behaviors

The survey was conducted in the 40 PAs of Farta Woreda in October 2003. The total number of households surveyed was 47,836. The survey process included the work of 400 data collectors/enumerators, 21supervisors from all HFs, six team leaders from FWHO and all FCSP staff. Two data encoders and two data entry clerks were contracted. Data editing/filtering and analysis was conducted by the FCSP. The survey results for each PA were disseminated to the respective HFs through the FWHO.

The survey was conducted to obtain information at village and PA levels for the following:

- Polio, BCG, DPT and measles status for children under two years
- TT status of women of childbearing age (15-49 years)
- Motherhood status of women
- EPI card possession for mothers and children

- Primary and secondary water sources for households
- Usage of latrine by households.

The value obtained from this survey in term of investment in project funds and staff time is questionable. Little has been done with the results of the survey and the results were not returned to HFs in a timely manner which made follow-up of defaulters unfeasible. The sample size was unnecessarily large for this type of survey.

Improvement of MOH HIS

The FCSP provided technical assistance and material support to the FWHO to conduct a Health Information Management Gap Analysis and contributed to the establishment of a Health Information Management Team and the preparation of an information management framework. Reporting formats and training on their use was also provided to HF staff. These activities have reportedly improved the flow of information as well as the use of information. The link between communities and HFs has been strengthened by providing report forms and training to CHWs so that they can report their activities.

Community HIS strategy

The FCSP has developed a community level HIS strategy. The original plan was to have reporting done monthly by MTMSGs and priests on their activities. These reports were to be collected by the VCHW and passed on to the HF and FCSP. This has not proved to be feasible and is currently under revision.

VCHWs were trained in basic skills on information collection, analysis, and utilization during a two-day training. The same training was also organized for HF staff during a planning workshop. Trained VCHWs have started reporting to the HFs and serve as a bridge between the community and HFs.

The original plan in the DIP was to have community data boards (similar to CARE's strategy in Kenya) to be organized by the EOC. This has not yet been completed. Beginning in December 2005, the project hopes to pilot test data boards in five EOC churches. The FCSP team is analyzing whether the project should pre-determine the information to be included on the data boards or allow each community/church to collect information according to their interest. The project will continue working with the EOC and the communities to finalize plans for the data boards.

A M&E technical assistance consultancy in developing a community HIS was planned for the first year of the project but was not carried out. **The FCSP should revisit the original plan of receiving technical assistance in developing a HIS for the community.** The project points out that the use of information at community level needs attention and should be a major focus on the introduction of data boards.

Use of Information

To strengthen the linkage and integration between CARE and partners, to review community activities, and to encourage the use of information, the FCSP has promoted a series of quarterly review meetings and an annual planning workshop for FCSP and partners, FWHO, VCHWs, HF staff and PA leaders. The annual and quarterly performance of the FCSP and the FWHO are

reviewed. An analysis of planned versus accomplished activities is conducted for each quarter and this information is used in revising the next quarterly plan. Lessons learned were use to identify weak areas for improvement and strong areas for replication. The FCSP staff has found that the regular monitoring of activities is a positive way to ensure effective and efficient implementation. The objectives of these meetings was summarized by the FCSP staff as:

- To track the planned activities at each HF, community and household level in the project target area- are we going well and on schedule?
- To increase\improve the relationship and integration among CHWs, HF staff, and PAs administrators in terms of joint planning, implementing, reviewing, monitoring of health programs.
- To improve achievements in quality, quantity and results
- To improve community based maternal and child health promotion and disease prevention at grass roots level.
- To revise and update plans for the next year or quarter – encouraging homogeneous plans between CARE and partners
- To strengthen and promote the use of data for decision making and improve the HIS for communities and the HFs
- To more effectively orient the BCC strategy and determine the way forward
- To identify major problems and barriers, to promote learning from the past and make adjustments and corrections for improvement in the next implementation period.

8. Technical and Administrative Support

Technical Assistance Visits by CARE HQ

Sanjay Sinho	Planning for project start-up	August 2002
Namita Kukreja	Preparation of the DIP	2002
Judi Canahuati	Field visit and TA	August 2003
Sanjay Sinho	Project assessment	May 2004
Consultant	Review of project (MTE)	February 2005
Khrist Roy	Follow-up to MTE	July 2005

CARE HQ provided technical assistance during project start-up and development of the Detailed Implementation Plan. The original Project Manager also visited CARE's Child Survival project in Kenya to learn from practical application of implementation plans. And different project staff attended CARE's Annual Child Survival Workshop. However, there has been so much turnover in staffing that the team needs additional technical orientation at present. Staff are scheduled to participate in Training of Trainers for C-IMCI and this will be to their benefit. Also, some of the technical assistance planned below will strengthen their capacity. CARE HQ backstop will need to focus on technical capacity. CARE HQ regularly sends updated technical materials to all field offices with Child Survival Projects or other maternal-child health programs. Whether this material reaches project staff in the field varies. It will be important for the CARE Ethiopia Health Sector Coordinator to ensure that CSP staff in the field are receiving the materials. Technical assistance from CARE Ethiopia was also weak due to changes in staff and conflicting priorities. The newly hired HSC lacks experience specifically in CSP implementation and will also require additional support. **CARE should provide additional skills development training to the FCSP staff in basic CS concepts such as supportive supervision, qualitative investigation, and information management, based on a needs assessment to determine**

what the priority training needs are according to those activities which must be completed during the next two years.

Technical Assistance Needs

Topic	Suggested Source
COPE implementation	Planned in Oct/Nov 2005 by Engender Health, CARE Ethiopia
Qualitative Methodologies: Key Informant Interviews, Focus Group Discussions	CARE Ethiopia- This is expected to be done before December 2005
Systems Analysis for improving logistics	UNICEF, JSI-DELIVER
C-IMCI	Currently being conducted by central MOH and WHO staff, Regional Health Bureau, and pilot C-IMCI woredas in Amhara region
LQAS	CORE-Ethiopia in mid September

D. Conclusions and Recommendations

The reality of implementing a CSP in Ethiopia is extremely difficult. Ethiopia has some of the highest rates of malnutrition and lowest rates of access to quality health services in the world. There are myriad reasons for this situation, but a very important element, which is the main stumbling block for CARE, is the lack of local qualified health personnel. CARE's ability to attract and retain qualified staff has been very weak and the result is obvious in the FCSP. The FCSP staff, during the evaluation visit, was extremely willing to work and learn and participate as agents for improving the health status of the area. They however lack the basic skills to effectively do that and they have not had sufficient leadership and support to develop the skills they need.

The program employs the strategies of skill development, community mobilization, behavior change communication, quality assurance and improved access to and availability of health services. All of these strategies are built on principles of partnership with relevant counterpart institutions functioning in the target area. These include government, civil society, community-based institutions and community level volunteers. The project began implementation with a good strategy of beginning activities in 10 PAs, where CARE currently has other projects and has worked previously. Lessons learned in the initial experience were used in formulating a more concrete plan for expanding activities in the remaining 30 PAs. The expansion of activities to all 40 PAs has been slower than expected and very challenging given that staff does not have adequate transportation.

Despite difficulties, the FCSP has been able to accomplish the following activities during the first half of the funding cycle:

- Baseline HFA, KPC Survey, and PRA were conducted by CARE and partners
- Potential Community Level Organizations/Volunteers were identified
- Community orientation

- Community based groups for promotion of healthy behaviors were established (MTMSG, School clubs, CHWs)
- Trainings were conducted in Nutrition, Counseling, Maternal Health, Cold Chain Maintenance, Health Information Networking, EPI, IMCI and BCC for School Clubs, MTMSG, Religious Leaders, CHWs, FCSP and MOH workers;
- Training of Trainers for Partners and CARE on BCC Strategy Development
- BCC strategy document developed and reviewed by partners
- Educational materials developed and under production
- Training Manual/Curriculum on Counseling developed
- Design of Revolving Drug Fund for one HF central location
- Strengthening of MOH HIS, reporting formats provided for all lower level HF staff
- Conducting monthly review meeting with partners
- IMCI wall chart given for lower level HF workers
- Supportive supervision and follow-up of use of IMCI protocols for treatment of children
- Epi modular training for all the health staff
- Counseling training to all interested partners on nutrition and IMCI
- C-IMCI training is in progress for all partners

The FCSP has encountered a number of challenges that has adversely effected the implementation of the project. The principal problem has been the inability of CARE to permanently fill the vital position of Project Manager with a qualified person. Other exacerbating problems include:

- FCSP staff has not received adequate technical support and training to provide them with the skills to effectively carry out the project
- The FCSP field staff has not been provided with the planed-for motorcycles, which limits their mobility.
- Governmental policy has not supported project activities in some areas:
    - Restructuring of community health workers with the suspension of training for CHWs
    - Restructuring of community health committees with a lack of definition of responsibilities and inability to move forward on forming committees
    - Policy not allowing CHWs to distribute ORS, Vitamin A, antibiotics or other medicines leading to the elimination of activities for community pharmacies
    - A series of bureaucratic barriers to implement drug funds in health facilities
    - Lack of agreement on training curriculum for IMCI for community workers and junior level HF staff

Due primarily to the above mentioned problems, the FCSP is approximately one year behind schedule and minor adjustments have been made to the DIP work plan (detailed in Annex A).

The project should focus efforts during the next two and a half years on the establishment of high quality clinical and community IMCI. The project has laid down a foundation in the 40 PAs of the woreda for community based health promotion but strong follow up, support and supervision are required to facilitate project activities during the remaining two years of the project.

Preliminary Recommendations discussed with FCSP staff in February 2005 and upon which the Action Plan is based:

Training/Education

- Review all educational materials (Guides and Profile) for clarity of Amharic, appropriate vocabulary according to the reading level of the intended audience, and understanding of all pictures. All materials should be field tested.
- Study the possibility of making the flipchart with the picture on one side and on the other side include: the main message, benefits of the behavior and questions to stimulate discussion.
- From Sanjay Sinho's May 2004 trip report *"I strongly recommend providing capacity building for all priests directly through project staff and not through a training of trainer cascade approach to ensure quality and consistency "*. All priests (2 per church) and MTMSG leaders (1 per megistawi buden) should be directly trained by FCSP, not through cascade training.
- Education should focus more on recognition of danger signs with the establishment of a referral system from communities to Health Facilities.
- For training community workers, more emphasis is needed on the process of activities, not just information on messages. For example; how should a facilitator organize a MTMSG? How can positive deviant mothers be utilized as role models? What are the steps to doing a home visit? How can you evaluate the effectiveness of activities?
- Use the Health Facility as a depot for educational materials such as flipcharts and cassettes. These could be borrowed by CHWs on a rotating basis for use in their communities.
- Evaluation methods should be developed to measure the amount of information being retained and skill development by participants in all trainings.
- Provide technical assistance to implement the COPE methodology for improving quality of care in Health Facilities..

Community Mobilization

- Develop a plan for working with CBRHAs and TBAs in order to include them as part of the CHW team at Mengistawi-buden level.
- An organizational structure should be developed with each PA, based on available human resources. Job descriptions should be developed for all positions, clearly defining their responsibilities and supervisory relationships.
- A supportive supervision system, with checklists which include feedback, should be implemented at all levels, in accordance with MOH established systems.
- Schools should be encouraged to send one boy and one girl to represent the school club.

Information sharing and use

- Review the HIS; the emphasis should be on strengthening the MOH system, not creating an unsustainable parallel system. Focus on having information at the community level using data boards, and on the use of information for decision making at all levels.
- Translate selected sections of the DIP for partners, to increase their understanding of project objectives, indicators, and activities.
- Prepare a one page leaflet summarizing the project for information sharing purposes.
- A complete revision of the M&E Matrix from the DIP should be conducted to make sure that all indicators can be measured. Special attention needs to be made for developing tools for measuring the monitoring indicators.

Logistics

- Serious problems exist with availability of essential IMCI drugs and supplies; an analysis of the logistics system should be conducted to identify bottlenecks and weaknesses, leading to concrete steps to improve the system.
- The total number of refrigerators needs to be re-evaluated in order to have a functioning cold chain in all HFs.

Staffing

- From Sanjay Sinho's May 2004 trip report *"This project is the only CS project in history of CARE with no women staff on board. Project needs to make concerted attempt to recruit women for suggested additional positions of partnership supervisors or BCC officer."* This recommendation has not been taken even though 5 new staff have been hired since his trip report.
- Two new positions were created at the Project Officer level-one for nutrition and Diarrhea, the other EPI and ARI. This division does not support the IMCI concept; perhaps a more logical division would be clinical/community IMCI. It is not recommended that any staff changes be made until the Health Sector Coordinator and Project Manager are on board at least 3 months.

Logistics

- Procurement of motorbikes and refrigerators as per project proposal has not yet been done, many HF have no cold chain i.e. no vaccinations. The lack of both of these essential items severely effects the projects ability to make measurable progress.

Additional Suggestions:

- The FCSP should continue to coordinate with FWHO and other governmental agencies to define the role of the project in training health committees, in lieu of waiting for a policy decision of the structure of the committees, the project should proceed with planning for training community leaders.
- A plan of action should be developed as to how the FCSP could realistically build the capacity of the partner organizations, given current resources and based on the prior assessment.
- A training plan specifying *who* will be trained, *how many* will be trained, *what* will they be trained in, *who will provide* the training should be developed for the remaining two year of the project.
- CARE should provide additional skills development training to the FCSP staff in basic CS concepts such as supportive supervision, qualitative investigation, and information management, based on a needs assessment to determine what the priority training needs are according to those activities which must be completed during the next two years.
- The FCSP should focus their efforts on the establishment of HF revolving drug funds, and not proceed with the implementation of community level drug funds.
- FCSP staff should continue to work with Debra Tabor hospital staff on developing written policy for breastfeeding, linking mothers with MTMSG, and providing information on resolving common breastfeeding problems.
- The FCSP should send a clear message that the appropriate age to introduce complementary feeding is six months of age.

- A clear definition of danger signs of pneumonia should be made, and then included in all educational materials and curricula.
- FCSP should investigate what fluids, both cereal based and other liquids, are traditionally used for children with diarrhea, and, in coordination with the MOH, define which are "recommended home fluids". Community and HF based education should actively promote the use of other fluids in addition to ORS during diarrhea.
- Additional support needed for the MTMSG in the future should include:
    - Better definition of the cascade approach to training, with mechanisms in place to ensure the quality of replication of training and plans for future sustainability.
    - A lot of work has gone into strengthening the link with the HF, particularly through monthly meetings. Efforts need to focus on improving the effectiveness of the monthly meetings with HFs.
- Additional support which should be considered for the school clubs includes that listed below; however, this support should be coordinated by the several CARE health and food security projects in the geographic area, rather than by FCSP alone:
    - Promotion of school gardens for schools with water and garden space through the support of Woreda Office of Agriculture Agents
    - Monthly meeting to review performance, discuss problems, and evaluate the effectiveness of the activity
    - Monthly report to VCHW
    - Supervision system with checklist needs to be developed
    - Schools should be encouraged to send one boy and one girl to represent the school club.
- Additional support needed for the EOC priests in the future should include:
    - A clarification is needed as to the supervisory relationships at the community level and the role of the priests.
    - Priests are encouraged to make home visits but no system exists for ensuring the quality of this activity. A system for monitoring the quality and effectiveness of home visits should be established
    - The priests' role in the community HIS should be strengthened and expanded based on the pilot in five churches to be implemented in the near future.
- Future steps for implementing the radio dramas/listening cassettes should be:
    - Develop a question guide to stimulate discussion, to be used by the facilitators
    - Develop a plan for distribution of the cassettes and training in all 40 PAs
    - Purchased the tape recorder/radios, batteries and cassettes.
    - Develop a mechanism for evaluating the effectiveness of the cassettes
- The KPC Survey to be conducted as part of the final evaluation should include both of the Rapid CATCH indicators which were omitted in the baseline survey.
- An indicator table should be included in the KPC Survey report which clearly indicates what the numerator and the denominator is for calculating the indicator.
- The FCSP should revisit the original plan of receiving technical assistance in developing a HIS for the community.

E. Results Highlights

There was no results highlight developed at this time.

F. Action Plan

The following Action Plan was developed by CARE and partner staff based on preliminary recommendations following the February 2005 consultant's visit.

Recommendation	Current Status	CS Project Plans	Responsible	Target Date
Key Strategies				
1) FCSP should discuss with MOH partners a referral system between communities and local health facilities. This strategy has proved highly successful for strengthening the linkage between communities and health services and achieving immediate direct benefit for women and children in many CARE and other PVO CS Projects.	Two types of referral formats have been developed in consultation with District MOH (one to refer sick child from community to health facility, and one from health facility to higher level referral health facility). And are in use in the project area	Orientation on referral systems and utilization of the referral formats at both facilities and community levels. Facilitating access of the formats at community and health facility levels. Strengthening the referral systems especially from community to health facilities using community networks (health workers, CHAs, priests, MTMSGs and school club representatives).	CS Project Officer with Nutrition Officer, Immunization Officer and Community Mobilizers.	May 05
2) Follow up supportive supervision to the planned training activities with LINKAGES should emphasize the process of Mother to Mother Support Group activities, not just information on messages.	After LINKAGES training, simple guidelines for MTMSGs, home visits, school clubs are being developed (How to organize MTMSGs, positive deviance approach child health; check list outlining steps in doing home visits).	a) Orientation of staff on use of the guidelines. b) Conduct follow up and supportive supervision. c) Develop tools to evaluate activities and conduct evaluation.	a) CS Project Officer with Nutrition Officer, Immunization Officer and Project Officer. b) CS Community Mobilizers and M&E Officer. c) CS M&E Officer and Project Officer	a) April – May 05 b) April – June 05 c) April – June 05
3) Quality of care	Supportive	Training for	External	June-

Recommendation	Current Status	CS Project Plans	Responsible	Target Date
should be strengthened through a supportive supervision system, with simple checklists and feedback for CHWs and project staff. Consider using the participatory COPE methodology for participatory Quality Assurance Assessments; the CARE QOC Officer should provide assistance in developing this activity.	supervision for health facilities was conducted in collaboration with Wereda MOH with use of a simple checklist developed jointly. Checklists have been developed and are in use	partners and project staff on use of COPE methodology for child health. Establish COPE action committees in each of the health facilities that conduct quarterly facilitative; evaluation and documentation of lessons learned.	consultant from EngenderHealth, CARE/E HSC, CS PM, CARE HIV/AIDS project QOC Officer	August 05
4) As the Ethiopian Orthodox Church participants are active and important partners, it is recommended that an expanded number of priests receiving training from the Project.	Religious leaders from two faiths had received training in first phase of project (Total 147 from Ethiopian Orthodox Church, 2 Muslims). The EOC has been approached for greater participation in the following and has agreed to the same as Pilots: CHIS initiative at the church level Nutrition Monitoring at the church level Selected EOC trainers are trained in TOT	Second round of training for expanded number of religious leaders. Continue planned second training for MTMSGs facilitators (1 per Mengistawi Budin)	CS Project Officer, BCC Officer, Community Mobilizers.	May – June 05

Recommendation	Current Status	CS Project Plans	Responsible	Target Date
	for further trainings Possible role in Idirs for overseeing proper use of seed money And community based nutritional screening			
Information sharing and use				
5) Review HIS activities with emphasis on strengthening MOH system without creating parallel system; focus on community use of information; focus on use of information for decision-making at all levels.	Discussions were held with the Woreda MOH on how to strengthen the existing HIS.	Orientation activities for staff to strengthen use of HIS at health facility level. Review C-HIS, strengthen the feedback route for use of information at community level.	M&E Officer	May – July 05
Logistics				

Recommendation	Current Status	CS Project Plans	Responsible	Target Date
6) Some availability problems exist for essential IMCI drugs/supplies; an analysis of the logistics system should be conducted to search for concrete steps to improve the situation. Due to an increase in the number of lower level health facilities, an increase in the number of refrigerators provided by the project should be considered to contribute to improvements in cold chain maintenance with immunization status.	Inventory of cold chain materials such as refrigerators has been conducted.	a) Further conduct a comprehensive inventory of basic cold chain equipment in MoH warehouses and health facilities; assess need for additional procurement cold chain equipment. b) Establish RDF to alleviate the problems of IMCI drugs shortage. c) Assess status and improve the logistic systems in the Woreda health delivery system and perhaps in the regional health bureau and the zonal health office	a) CS Immunization Officer b) CS PMr and CARE/E HSC c) Consultant from JSI DELIVER (TA specialist in Nairobi contacted) with CARE/E HSC and CS PM	May – July 05

Annex A.
Baseline information from the DIP

The Child Survival project will work in partnership with the Ministry of Health (MOH) to train staff, improve services, and promote behavior change. Perhaps even more exciting is CARE's strategy to work with the MOH and a Core Health Unit within the Ethiopian Orthodox Church to train and support religious leaders to provide information and profoundly influence the health behaviors of its members. As a result of a number of meetings and planning sessions. This allows CARE to work as a technical support partner, while the responsibility for implementing the activities remains with the partner institution.

The estimated population in Farta is 304,701. The project's target beneficiaries total 118,223 - 46,314 children under five and 71,909 women of reproductive age. The goal of the CS program is to improve the health status of children under five and of women of reproductive age through four targeted interventions: Nutrition (35%), Acute Respiratory Infection (25%), Control of Diarrheal Diseases (20%) and Immunization (20%) within the framework of community IMCI. The CS Program objectives include:

5. To promote the practice of healthy behaviors, including seeking of appropriate medical care as needed, by caregivers of children under five years and women of reproductive age, especially pregnant and lactating mothers.
6. To increase sustainable access to health education, quality care and essential medicines (from government, private health sectors, private institutions and partner organizations).
7. To ensure that quality health care is provided in areas of diarrhea, pneumonia, malnutrition and immunization by government health personnel, CHAs, CHWs (including CBRHAs and trained TBAs) and other service providers.
8. To strengthen local and community-based institutions and partners and build capacity to support child survival activities on a sustainable basis.

The **Nutrition intervention (35%)** will address the serious nutritional status including micronutrient deficiencies of more than half of the children under five and women of reproductive age. The Nutrition emphasis for children under five will include: promotion of early initiation and exclusive breastfeeding up to six months, adequate and timely supplementary feeding, and Vitamin A supplementation. Other multi-sectoral programs such as community and home gardens for micronutrient production, income generation, and education on intra-family distribution of food, will complement the nutrition intervention.

The **Acute Respiratory Infection (ARI) intervention (25%)** will address the low level of treatment of children under five with pneumonia (27.3%). MOH facility staff will be trained in pneumonia case management (PCM) as part of IMCI training. Logistics and supply chains for antibiotics will be strengthened and quality assurance training and supervision provided to all health facility staff. CARE will work with the MOH to pilot the training of some 40 CHAs for community-based PCM. All partners will promote prompt recognition of symptoms of pneumonia and care seeking behavior by caretakers and communities with symptoms.

The **Control of Diarrheal Diseases (CDD) intervention (20%)** will address the high prevalence of diarrhea and the low treatment levels. According to KPC survey results, 36.6% of children under five had diarrhea in the two weeks preceding the survey. Treatment with ORS, recommended home fluids or increased fluids are reported at only 18.9% in Farta compared to 33.9% in Amhara DHS data. To address diarrheal diseases, this component will also include IMCI training of all MOH staff. CHWs and other influential community members will be also trained to promote behavior change, home based care and to eliminate harmful traditional practices.

The additional **Immunization intervention (20%)** will address the low coverage of EPI in the program area. The KPC survey found 24.8% measles coverage compared to 33% in Amhara region (MOH 2001). Similarly, DPT3 coverage was 29.7% in the KPC and 36% for the region. The purpose of the immunization intervention is to reduce the incidence of vaccine-preventable diseases in children by means of high coverage of the core EPI vaccines administered at the appropriate age. In addition, improving the health facility services, outreach capacity, cold chain system and also promoting community mobilization and awareness creation of mothers and other caretakers to increase coverage.

The program will function under the C-IMCI framework and employ the strategies of skill development, community mobilization, behavior change communication, quality assurance and improved access and availability. This program was developed with regional and local MOH, and is consistent with the MOH National IMCI and nutrition policies. The following partners were also directly involved in the development of this plan: Ministry of Education, Ethiopian Orthodox Church, Nurses Training School and District administration.

No substantial changes have been made since approval of the DIP. There have been some minor adjustments in order to make the project more clearly focused on the implementation of Clinical and Community IMCI.

Adjustments to the DIP

Original Activity	Adjustment	Rationale
Community pharmacies	Focus only on Revolving Drug Funds at HF level	Community workers are not authorized to distribute drugs and the Woreda Health Office is understaffed and unable to adequately supervise the pharmacies.
Baby Friendly Hospital /Community Initiatives	Project to focus on supporting breastfeeding at community level and continue training and supporting HF (including hospital) staff in breastfeeding	This initiative is normally spearheaded by UNICEF, but this is not the case in Ethiopia, making it difficult to garner support. According to the KPC only 4% of women deliver at health facilities
Advocacy for allowing CHWs to distribute antibiotics for treatment of pneumonia	Advocacy work would continue at national and regional levels on availability of ORS at the community level and availability of Vitamin A outside of bi-annual national campaigns. Responsibility of Health Sector Coordinator	No progress has been made on changing national policy through CARE's efforts; CSP should accept the policy and plan for the remainder of the project in line with MOH antibiotic policy. Other organizations will continue this effort.
PD Hearth	A Positive Deviance model is being used in the MTMSG by identifying "doer" mothers who can act as role models within the support group.	This was only very briefly mentioned in the DIP and was not a well-formed strategy. Due to scope of malnutrition in target area other nutritional activities which reach a wider audience will be pursued using Linkages Essential Nutrition Actions
KPC Survey at midterm	Utilize the KPC at baseline and final for project evaluation	Due to the problems the project has suffered with implementation, it is doubtful that a KPC at midterm would show any measurable change. A census of over 47,000 women collected information on practices in 2003.
Establishment of a Nutrition Demonstration "Rooms"	Incorporate nutrition demonstrations within MTMSG or HF using extension agents from the Dept of Agriculture and CARE	Having a "place" to have a demonstration is less important than having easily accessible demonstrations

Annex B.
Evaluation Team Members and their titles

Workshop Participants for MTE review of DIP review for Farta Child Survival Project
February 2005

Name	Position	Organization
Jemil Sulayman	Expert	Farta Woreda Community Participation and Organization Office
Tsega Gelawneh	Head	South Gondar Zone Health Desk
Sisay Ayalew	Expert	Farta Woreda Administration
Zewdu Baye	Head	Debra Tabor Health College
Merigeta Hailemariam		Zone EOC
Befirdu Wochefo	Director	Theodros Preparatory School
Tefera Birara	Head	Farta Woreda Health Office
Priest Eshete Alemu	Head	Farta Woreda EOC
Nina Negash	Acting PM, M&E Officer, FCSP	CARE-Ethiopia
Mulualem Gete	Immunization Officer, FCSP	CARE-Ethiopia
Zelalem Mehari	Nutrition Officer, FCSP	CARE-Ethiopia
Getachew Asradew	Partnership Officer, Community Mobilizer, FCSP	CARE-Ethiopia
Berhanie Aregie	Community Mobilizer, FCSP	CARE-Ethiopia
Tibebu Getachew	Community Mobilizer, FCSP	CARE-Ethiopia
Melaku Tedesse	Community Mobilizer, FCSP	CARE-Ethiopia
Nibiyu Esayas	Community Mobilizer, FCSP	CARE-Ethiopia
Renee Charleston	Team Leader	Consultant

Annex C.
Evaluation Assessment methodology

Due to the unusually number and severity of challenges faced by CARE in the implementation of this project, a modified methodology was used for conducting the MTE. This modification was made in consultation with CARE Ethiopia, CARE USA, and USAID Washington Office. To make better use of project resources and staff time, the MTE was conducted utilizing the following sources of information:

1. A field visit to Ethiopia made by Renee Charleston, Consultant from February 1 to 18, 2005 to Addis Ababa, Bahar Dar and Debra Tabor
2. Project documents:
    a. Consultant's Trip Report from field visit and assessment
    b. Project report on progress after the assessment and Action Plan
    c. DIP
    d. KPC Survey Report
    e. Project Annual Reports
    f. Replies from project staff to specific queries
3. A field visit from CARE HQ Technical Advisor, Khrist Roy June-July 2005 to investigate specific requests for any critical additional information needed by consultant.

The CARE HQ Child Health Cluster arranged for a consultant to visit the project to work with field staff and partners, assess overall project progress and develop concrete suggestions for maintaining the momentum of project implementation activities. A field visit was made from February 1 to 18 by Renee Charleston, MPH. Renee is an experienced Child Survival consultant who is also quite familiar with CARE at both headquarters and the field. She met with Senior Management Staff in Addis Ababa, and with project partners and staff in Bihar Dar (MOH Regional Headquarters) and Debra Tabor (MOH zonal headquarters and the project location).

<u>The specific objectives for the consultancy in February were to:</u>
1. Assess where the project is in relation to the DIP and give recommendations on whether or not adjustments are necessary.
2. Provide CARE Child Survival field staff with guidance on current activities.
3. Consult with Partners to ensure they feel involved in the project and hear their suggestions.
4. Identify local resources that could provide periodic technical assistance support to CARE CS project staff, to continue project implementation plans as developed in the Detailed Implementation Plan.

One of the activities of the field visit was a workshop for all CARE FCSP staff and partners to review the DIP, agree on minor adjustments to the DIP (Annex A), and make plans for future activities, particularly focusing on supervision, quality improvement and BCC. See Annex B for a list of participants in the workshop.

A detailed Trip Report was a product of the consultancy. In regards to suggestions made by the consultant from the field visit in February, an Action Plan was developed and the project has moved forward on several aspects, for example, increasing technical assistance from the LINKAGES Project in Ethiopia.

Since the consultant's visit, CARE Ethiopia has continued to seek to fill the Project Manager position, but hired a Project Officer as a temporary solution to ensure that management issues would not be a limitation for project activities. CARE Ethiopia has also contracted a new Health Sector Coordinator, who is providing significant support to the CS Project.
Considering the depth of the assessment in February, and the overall best use of project resources, a request was made to the donor to accept the field visit and Trip Report in lieu of a Midterm Evaluation. This request was approved with the stipulation that the Trip Report be rewritten to follow CSHGP Midterm Evaluation Guidelines.

A follow-up visit was made by CARE HQ Technical Advisor, Khrist Roy, for three weeks in late June to early July, 2005 to provide continued technical assistance. His visit also provided an opportunity to investigate specific requests for any critical additional information needed by consultant for MTE Final Repot. Detailed results of those visits follow.

MTE visits by consultant in February 2005:

Feb 9 Kanat PA
Participants: Front-line HF worker, CHA, VCHW, 7 MTMSG, PA leader, 5 Priests
Comments: One of the original 10 PAs. Well organized team with monthly meetings. PA leader very involved. Some MTMSGs are reporting activities. Problem with referrals because process to get exemption letter (to show level of poverty for free services) is very slow. Problems-felt too much repetition of topics, no one is at the WHO on weekends to pick up vaccines, no refrigerator

Feb 10 Buro Teraroch PA
Participants: Rural nurse, VCHW, Priest, PA leader. Comments: New PA, not much participation because they were advised of the meeting late. Having monthly meetings with as many as 85 people. Very experienced and active VCHW. MTMSGs are functioning and priest is giving messages during Sunday service and supporting the MTMSGs. Nurse is very well organized and with years of experience.

Feb 11 Kimir Dingay PA
Participants: HF staff (Health Assistant and front-line), VCHW, PA leader, 2 MTMSG, Priest.
Comments: New PA. Just beginning to organized MTMSG, have monthly meeting, mainly mobilizing community, some home visits and priest conducting Sunday service. Coordinating with Women's Association. Requested educational materials. Need to recruit and train another VCHW.

Feb 9 School Clubs
Participants: 41 total; average 2 teachers and 2 students each from 9 different rural schools.
Comments: Only 9 were females. Students range in age from 10-17. Group discussion included but information conveyed by lecture with no educational materials.

Feb 11 Debretabor Hospital:

Therapeutic Feeding Center: Comments: 14 beds for malnourished children, average stay 1 month with a parent
Use therapeutic formula mix supplied by UNICEF; Provide some education to parents- improving this could be a minor role for CSP

Maternity ward: Comments: All newborns room-in with mothers. No formula available, if problem i.e. death of mother, use cows milk mixed with sugar and water. All women are advised to breastfeed immediately, on demand, and exclusively, they are taught positioning. Nurses' station has posted protocols for obstetrical problems, but not breastfeeding. CSP staff to work with hospital staff on developing written policy, linking mothers with MTMSG, and providing information on resolving common breastfeeding problems. Confusion still exists on when complementary foods should be introduced.

Additional community visits in July 2005 by CARE HQ Technical Advisor Khrist Roy as part of the MTE process:

July 3: MTMSG in Kanat PA 16 Participants MTMSG facilitator, VCHW, and mothers group. 3 MTMSG facilitators from Maynet, Atasifatra and Awuzet PAs

July 4: Health Post at Semina interview with MOH Health staff and focus group with 19 MTMSG members

Agenda for TA visit, CARE HQ Child Health Technical Advisor
February 2005

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
	1 Arrive Addis	2 Meetings with: Marcy, Dr. Tadesse, Sister Belaynesh, Quality Officer Amdie, Regional Coordinator	3 Travel to Debre Tabor with Tadesse Meeting with Aynalem Gizaw CARE Hiv/Aids Meeting with CARE CS staff-General project review	4 Meetings with MOH, Orthodox Church, Nurses Training School (1)	5 Meeting with CARE CS staff Development of BCC Activities matrix (Annex 2)	6 Development of preliminary report
7 Plan Workshop M&E Orientation	8 Meeting with CARE CS staff M&E and Quality (Annex 2) Meeting with Tadesse, Amdie and Mandefro	9 Tadesse leaves Kanat HF and community meeting School Club Training	10 Buro Teraroch HF and community meeting	11 Debretabor Hospital Kimir Dingay HF and community meeting	12 Meeting with CARE CS staff IMCI (Annex 2) Workshop preparation	13 Workshop preparation
14 Workshop with CARE CS and partners to review DIP (2)	15 Meeting with other CARE projects, Amdie Meeting with CARE CS staff	16 Meeting in Bahar Dar with JSI Travel to Addis	17 Coordination meetings (3)	18 Coordination meetings (3) Debrief CARE Marcy, Dawn, Tadesse	19	20 Travel to US

Annex D.
List of persons interviewed and contacted

Partners

Name	Position	Organization
Tefera Birara	Head	Woreda Health Office
Kess Eshete and 15 EOC priests including Woreda Representatives	Head	EOC-Woreda level
Bekure Tiguhan	Head	EOC-Zonal level
Ato Zemdu Baye	Director	Debretabor Nursing College
Tsega Gelawneh	Head	South Gondar Zone Health Office
Alehegn Wube	Coordinator of Malaria and Communicable Diseases	South Gondar Zone Health Office
Birhanu Menber	Medical Director	Debretabor Hospital

CARE Ethiopia

Marcy Vigoda	Country Director
Dawn Wadlow	Assistant Country Director
Tadesse Kassaye	HIV/AIDS Coordinator- Addis Ababa
Amdie K/Wold	Program Area Coordinator- Debretabor
Sister Belaynesh	Quality of Care Officer-Addis Ababa
Mandefro Mekete	Program Manager, Food Security and Water and Sanitation
Shitahun Bayle	Acting Program Manager, Institutional Capacity Building
Aynalem Gizaw	Program Manager for HIV/AIDS for Youth-Bahar Dar
Nina Negash	Acting Program Manager, M&E Officer, FCSP
Mulualem Gete	Immunization Officer, FCSP
Zelalem Mehari	Nutrition Officer, FCSP
Getachew Asradew	Partnership Officer, Community Mobilizer, FCSP
Berhanie Aregie	Community Mobilizer, FCSP
Tibebu Getachew	Community Mobilizer, FCSP
Melaku Tedesse	Community Mobilizer, FCSP
Nibiyu Esayas	Community Mobilizer, FCSP

Coordination Meetings

Organization	Contact
MOST	Dr. Teshome
IMCI Taskforce	
Save the Children	Dr. Tedbabe Degefie
JSI-ESHE	Dr. Mary Carnall-Addis Dr. Tadele Bogale-Bahir Dar
Linkages	Dr. Agnes Guyon
Engender Health	Wuleta Betemariam
UNICEF	Iqbal Kabir, Nutrition Officer and Rory Neft, IMCI/Malaria/Emergency Officer

The following additional contacts were made during the follow-up visit by CARE Technical Advisor Khrist Roy in July 2005 as part of the MTE process.

CARE Ethiopia

Dr. Alemayehu Seifu	Health Unit Team Leader
Zemene Menistie	Project Officer
Mr. Alemayehu	Finance Officer CARE Derbre Tabor

Other Contacts

Dr. Filimona	CORE Ethiopia
Cirma Gonshi	Health and Sanitation Officer FWHO
Mr. Ketema	Debra Tabor Health College
Merigeta Musie	Zonal EOC
Dr. Tesfay	WHO C-IMCI Trainers Team
Mr. Lemma	Regional Health Bureau C-IMCI Trainer
Mr. Solomon	Health Officer, Ankesha Woreda
Mr. Melesawe	Malaria Unit, Regional Health Bureau
Mr. Berhanu	Netmark Representative, Regional Health Bureau

Annex E.
Project Data Sheet

Country	Ethiopia
Project title	CHILD-E: Child Health Initiatives for Lasting Development in Ethiopia
Cooperative Agreement No:	HFP-A-00-02-0004600
Total project budget	USD 1,758,080.00
Location of project	Farta Woreda, S/Gondar Administrative Zone, Amhara National Regional State (ANRS)
Target population	Children of <5 yrs and women of reproductive age, especially pregnant and lactating mothers residing in 40 PAs of the Farta Woreda
Thematic area	C-IMCI: 20% IMM, 35% Nutrition, 25% PCM, 20% CDD
Project Objective	Improve the health status of children <5 yrs & women of reproductive age
Project components	▪ Nutrition, ▪ Diarrheal illnesses, ▪ ARI –Acute Respiratory Infection ▪ EPI – Immunization
Strategies:	▪ Skill Development; ▪ Community Mobilization to promote ownership. ▪ BCC-Behavior Change Communication approaches ▪ Quality Assurance for service delivery. ▪ Improve access and availability of services and supplies
Project duration (approved)	5 years, October 2002 – September 2007
Local implementing agency	CARE International in Ethiopia
Implementing partners	Zonal – Woreda Health Offices, NGOs, CHA/Ws, VHCs, school clubs, women's associations.
Contact Person(s) of the local implementing agency	CARE Ethiopia P.O. Box 4710, Addis Ababa, Ethiopia Phone: ++251 1 538040; Fax ++251 1 538040 E-mail: care.eth@telecom.net.et Marcy Vigoda, Country Director Dawn Wadlow, Program Director