Save the Children

MID-TERM EVALUATION REPORT

Innovation for Scale: Enhancing Ethiopia's Health Extension Package in the Southern Nations and Nationalities People's Region (SNNPR)

Shebedino and Lanfero Woredas

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ACRONYMS

ACT	Artemisinin Combination Therapy
ANC	Antenatal Care
ARI	Acute Respiratory Infection
ASO	Awassa Sub Office
AWD	Acute Watery Diarrhea
BoFED	Bureau of Finance and Economic Development
CCM	Community Case Management
CCM/P	Community Case Management/Pneumonia
CDD	Control of Diarrheal Diseases
C-IMNCI	Community-Integrated Management of Newborn and Childhood Illnesses
CMO	Community Mobilization Officers
CS	Child Survival
CS-23	Child Survival-23 (USAID CSHGP 23rd cycle project)
CSHGP	Child Survival and Health Grants Program
CSTF	Child Survival Task Force
DHO	District Health Office
DIP	Detailed Implementation Plan
DPO	District Program Officer
EPI	Expanded Program of Immunization
EtCO	Ethiopia Country Office
FMOH	Federal Ministry of Health
GO-NGOs	Government Organization- Non Government Organization
HC	Health Center
HFA	Health Facility Assessment
HEP	Health Extension Package
HEW	Health Extension Worker
HMIS	Health Management Information System
HP	Health Post
HPC	Health Program Coordinator
HR	Human Resource
ICD	International Statistical Classification of Diseases
IEC	Information Education Communication
IFHP	Integrated Family Health Program
IMNCI	Integrated Management of Newborn and Childhood Illnesses
IR	Intermediate Result
ITN	Insecticide Treated Bednets
JSI	John Snow, Inc.
kebele	Community/catchment area of approximately 5,000 inhabitants
KPC	Knowledge, Practices and Coverage

M & E	Monitoring and Evaluation
MNCH	Maternal Newborn and Child Health
MOH	Ministry of Health
MTE	Mid-term Evaluation
NGO	Non-Governmental Organization
NS	Neonatal Sepsis
ORS	Oral Rehydration Salt
ORT	Oral Rehydration Therapy
OTP	Outpatient Therapeutic Program
PNC	Post-natal Care
PSI	Population Services International
RDT	Rapid Diagnostic Test
RHB	Regional Health Bureau
R-HFA	Rapid Health Facility Assessment
SC	Save the Children Federation, Inc.
SCD	Safe and Clean Delivery
SNL-II	Saving Newborn Lives-II
SNNPR	Southern Nations Nationalities People's Region
SS	Supportive Supervision
TA	Technical Assistance
TAG	Technical Advisory Group
TBAs	Traditional Birth Attendants
TOT	Training of Trainers
TTBA	Trained Traditional Birth Attendants
UNICEF	United Nations Children's Fund
USAID	United State Agency for International Development
vCHW	Volunteer Community Health Workers
WHO	World Health Organization
woreda	District
ZHD	Zonal Health Department

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A. Executive Summary

Background: Save the Children (SC) was awarded a five-year Standard USAID/CSHGP Child Survival Project (CS-23) - *Innovation for Scale: Enhancing Ethiopia's Health Extension Package in the Southern Nations and Nationalities People's Region (SNNPR)* - to address four main causes of child death: (1) pneumonia, (2) malaria, (3) diarrhoeal diseases (that together account for 68% of under-five mortality); and (4) neonatal infection, responsible for half of all neonatal mortality. The project is implemented in the SNNPR of Ethiopia, in the districts of Shebedino (Sidama Zone) and Lanfero (Silti Zone) and reaches 69,491 children 0-59 months of age; and 87,496 women of reproductive age. The overall goal of the project is to reduce childhood mortality, with a strategic objective to increase use of key childhood services and behaviors. The project focuses on the implementation of the three pillars of the Integrated Management of Neonatal and Childhood Illness (IMNCI) strategy in health centers (HCs) and health posts (HPs), including: 1) clinical IMNCI; 2) health systems support; and 3) community and family practices. Table 1 presents the intermediate results and activities in more detail.

Main accomplishments at mid-term include:

- Successful implementation of all pillars of IMNCI, including; clinical IMNCI training of HC staff, and Health Extension Workers (HEWs) in HPs; provision of supervision and supplies for IMNCI; and training and support to volunteer community health workers (vCHWs) and others to improve family practices through community-IMNCI;
- Increased access to IMNCI services and community promotion of family practices;
- Introduction of zinc treatment for childhood diarrhea at HCs and HPs; and
- Strong partnership and collaboration with local health authorities in the implementation of project activities.

Primary constraints include: 1) lack of continuous and sufficient supplies of essential medicines at HCs and HPs; 2) variability quality of supervision for IMNCI to HPs; 3) turn-over of HC staff and HEP supervisors; 4) poor care seeking for maternal and postnatal services and neonatal illnesses; and 5) routine monitoring systems in need of strengthening.

Conclusions and key recommendations: Overall, the CS-23 project has successfully supported the implementation of the complete package of IMNCI in facilities and the community. Its activities have and will serve as a model for implementation of comparable initiatives in Ethiopia and are on-track at mid-term. The grant to Save the Children from UNICEF to implement IMNCI in the community in 62 additional districts using a similar approach, is a good measure of the CS-23 project's success. The CS-23 project should now: 1) continue fostering strong partnerships with national and local health authorities; 2) strengthen implementation and routine monitoring; 3) improve utilization; 4) introduce pneumonia management in the community in light of the recent policy change; and 5) develop a transition plan to ensure sustainability after the close of the project. The CS-23 project should build on its success in introducing and supporting INMCI to develop, introduce and implement stronger strategies to improve neonatal health.

Table 1: Summary of Major Project Accomplishments

<table>
<tr><th colspan="4">Strategic Objective: Improved use of key child health services and behaviors</th></tr>
<tr><th>Inputs</th><th>Activities</th><th>Outputs</th><th>Outcome</th></tr>
<tr><td colspan="4">IR-1: Increased availability and access to child health services and supplies</td></tr>
<tr><td>IMNCI training packages</td><td>Training of HEWs and HC staff in IMNCI;</td><td>84% (103/121) of HEWs trained in IMNCI (1 HP per 1000 U5s);
90% (9/10) HCs with IMNCI trained staff;</td><td rowspan="3">14,700 U5s treated with antimalarials annually (291 malaria/fever cases treated per 1000 U5s) ;
10,346 U5s treated with antibiotics annually (205 pneumonia cases treated per 1000 U5s);
7,017 U5s treated with ORS annually (1,927 with ORS+zinc) annually (139 diarrhea cases treated per 1000 U5s)</td></tr>
<tr><td>IMNCI supplies (referral slips, timer, chartbooks, registers)</td><td rowspan="2">Provision of IMNCI supplies and drugs to HCs and HPs (initial & through supervision visits)</td><td>>80% of HPs with IMNCI supplies (except timer);</td></tr>
<tr><td>IMNCI drugs (ORS, zinc, ACTs, ABs, CQ) & logistics support (transport, petrol)</td><td>91% of HPs with zinc, 100% with ORS, 100% with chloroquine, 18% with ACTs on day of assess. visit</td></tr>
<tr><td colspan="4">IR-2: Improved quality of child health services</td></tr>
<tr><td>Transport, supervision tools/checklists, joint planning; Joint supervision
Job aids to improve adherence to protocols</td><td>Supervision visits, provision of job aids</td><td>100% of HEWs/HPs report supervision in previous month;
97% of HPs meet FMOH "functional" criteria</td><td>In case scenario of pneumonia at 11 HPs: 100% of HEWs would classify & refer/treat correctly; 82% classify correctly & 9% reported full assessment;
93% of U5 cases at HPs with complete & consistent classification & treatment recorded</td></tr>
<tr><td colspan="4">IR-3: Improved knowledge and acceptance of key child health services and behaviors</td></tr>
<tr><td>c-IMNCI training packages and IEC materials</td><td>Training of vCHWs and HEWs in c-IMNCI</td><td>72% (1080/1500) of target vCHWs trained;
68% (82/121) of target HEWs trained</td><td>Caretakers report knowledge of key family practices & illness danger signs*</td></tr>
<tr><td colspan="4">IR-4: Improved child health social and policy environment</td></tr>
<tr><td>Key partnerships with health authorities at regional, zonal, district and local levels</td><td>Meetings, technical working groups, joint planning, trainings and supervisions, etc</td><td colspan="2">Substantial engagement and buy-in for child survival and IMNCI activities at all levels</td></tr>
<tr><td>Technical updates, policy briefs, publications, presentations (evidence & feasibility of CCM/P)</td><td>Policy dialogue & advocacy for CCM/P;
Participate in orientation, development & training for CCM/P at national level ('10)</td><td colspan="2">Pneumonia management at the community level now allowed per FMOH policy, SC and other NGOs to implement in ~600 districts in 2010</td></tr>
</table>

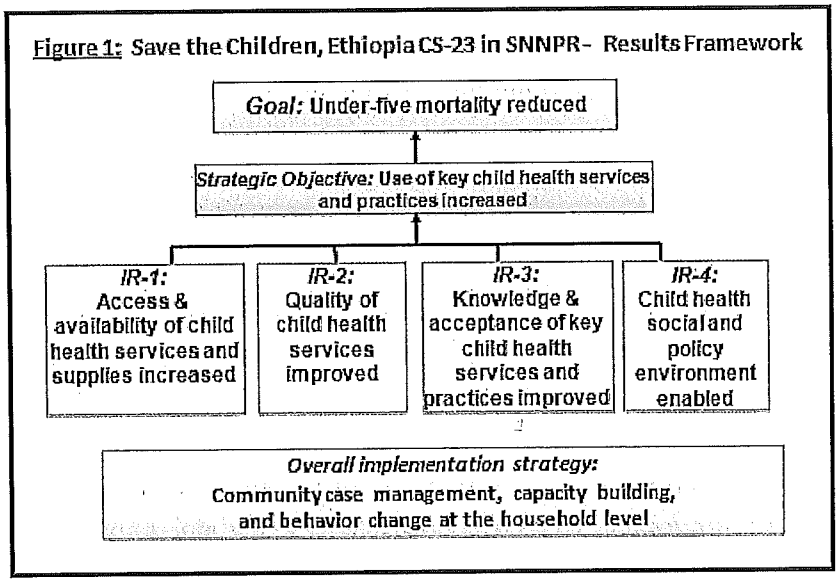
*Focus group reports not representative and a convenience sample of caretakers chosen by HEWs and vCHWs

B. Save the Children Child Survival-23 Project in SNNPR, Ethiopia

Nearly 400,000 Ethiopian children die each year before their fifth birthdays. Save the Children (SC) was awarded a five-year Standard USAID/CSHGP Child Survival Project (CS-23) - *Innovation for Scale: Enhancing Ethiopia's Health Extension Package in the Southern Nations and Nationalities People's Region (SNNPR)* - to address four main causes of child death: (1) pneumonia, (2) malaria, (3) diarrhoeal diseases (that together account for 68% of under-five mortality); and (4) neonatal infection, responsible for half of all neonatal mortality.

B1. Goal, Objectives and Results

Figure 1 presents the results framework for the SC CS-23 project. The project **Goal** is "Under-five mortality reduced" and its **Strategic Objective** is "Use of key child health services and behaviors improved." The project has four **Intermediate Results (IRs):** IR-1: Access and availability of child health services and supplies increased; IR-2: Quality of child health services increased; IR-3: Knowledge and acceptance of key child health services and behaviors increased; IR-4: Child health social and policy environment enabled. This framework serves as the basis for the project monitoring and evaluation (M&E) plan and this mid-term evaluation (MTE) report.



B2. Project location and target population

This project is implemented in the SNNPR in the districts (*woredas)* of Shebedino (Sidama Zone) and Lanfero (Silti Zone). The project reaches a total population of 366,898 in Shebedino (255,209) and Lanfero (111,689) districts, including 16,645 infants 0-11 months of age; 13, 948 children 12-23 months of age; 40,815 children 24-59 months of age; 69, 491 children 0-59 months of age; and 87,496 women of reproductive age.

B3. Technical and Cross-cutting Interventions

Technical interventions addressed in CS-23 include:

Pneumonia case management (35%): Management of pneumonia with antibiotics at health centers (HCs), assessment and referral at health posts (HPs) and promotion of early care-seeking; Advocacy at the regional and national level for inclusion of pneumonia management at health posts (HPs) within the Health Extension Program (HEP);

Control of Diarrheal Diseases (20%): Promotion of early care seeking, appropriate case management in home and at HP, introduction of zinc/ORS treatment protocol at HPs and HCs;

Prevention and Treatment of Malaria (20%): Prevention through appropriate use of insecticide treated nets (ITNs), early care seeking, appropriate case management at HP, including rapid diagnostic tests (RDTs) and Artemisnin Combination Therapies (ACTs);

Newborn Care (20%): Recognition of danger signs, birth preparedness, promotion of use of antenatal care (ANC), delivery and postnatal (PNC) at HPs, HCs and in the community;

Immunization (5%): Promotion of immunization through Health Extension Workers (HEWs) and volunteer community health workers (CHWs).

Interventions integrated across the main technical areas include:

- **Capacity building, training and supervision** for improved systems and provider performance;
- **Integrated management of neonatal and childhood illness (IMNCI) and strengthened Expanded Program of Immunization (EPI)** in the community, at HPs and HCs;
- **Promotion of Health Extension Package for 16 key behaviors** at the community and household levels delivered by HEWs and vCHWs;
- **Technical communication, policy dialogue and advocacy** at the regional and national level for child survival activities, IMNCI, and pneumonia case management at the community level;
- **Monitoring and evaluation** (M & E) of progress toward objectives in conjunction with local health systems, the local community and other key stakeholders.

B4. Project Design

The Ethiopian Federal MOH Health Extension Program (HEP) aims to achieve universal primary health care coverage. **Health Extension Workers (HEWs)** receive approximately one year of basic training and two HEWs are posted to a peripheral health post located in almost every *kebele* (a community/catchment area of approximately 5,000 habitants). Within the HEP, HEWs are responsible for both curative and preventative services. In each *kebele*, HEWs work with volunteer community health workers (vCHWs) in health promotion activities and in model household activities.

In Lanfero and Shebedino districts, SC enhances the existing HEP system by implementing and supporting the three pillars of IMNCI,[1] in coordination with local health authorities. This is one

[1] Clinical, health systems and community and family practice – see Gove, S. Integrated management of childhood illness by outpatient health workers: technical basis and overview. The WHO Working Group on Guidelines for Integrated Management of the Sick Child, Bul WHO, 1997.

of the first projects in Ethiopia to implement all three pillars.[2] SC provided initial ***clinical IMNCI*** training to HEWs working in rural *kebeles*, including the diagnosis of malaria with RDTs and treatment with either ACTs (falciparum) or chloroquine (vivax), treatment of diarrhea with Oral Rehydration Salts (ORS) and zinc and the assessment of respiratory illness and referral for pneumonia. The IMNCI trainings for HC staff and HEWs had a high facilitator to participant ratio (1:4 for HC staff, 1:5 for HEWs); trainings used the Ethiopian adapted WHO IMCI training package which includes participatory teaching methods and 4-6 clinical practice sessions. To support clinical IMNCI, SC provided IMNCI registers, chart books, timers, referral slips and other supplies to all HCs and HPs. HC staff also received clinical IMNCI training, including treatment of pneumonia with antibiotics, and job aids. SC staff, in coordination with the Regional Health Bureau (RHB) and District Health Offices (DHO), provide regular, ongoing support and supervision to health workers providing IMNCI clinical services. The Outpatient Therapeutic Program (OTP) to manage acute severe malnutrition was not integrated with IMNCI services. In 2010, SC worked with the DHOs to provide on-the-job training to HEWs in the integration of OTP and IMNCI services.

In promoting ***community and family practices,*** HEWs coordinate with vCHWs in the communities to promote behavior change in use of available services and early care seeking, immunization, growth promotion and appropriate feeding practices, hygiene and sanitation and home management of illness. The HEWs meet with vCHWs on a bi-monthly or monthly basis to coordinate activities. SC provided initial trainers' training in community-IMNCI to HEWs who then trained 1080 vCHWs. SC also provides ongoing support through community visits and supervision meetings. The vCHWs and HEWs received Information, Education and Communication (IEC) materials and counseling cards from CS-23 to support this work. Additionally, the CS-23 project coordinates with the RHB and DHOs to support preventive practices, such as distribution of ITNs, EPI and sanitation campaigns, etc.

The SC CS-23 project promotes ***health systems support*** for IMNCI services. In addition to providing ongoing support for supervision and training, SC also has assisted with supplies and drug stocks. These activities include working with the RHB and DHO to ensure adequate drug supplies and the purchase of ORS, ACTs and chloroquine for HPs and HCs when adequate stocks were not available. SC facilitated the introduction of zinc for diarrhea management in IMNCI algorithms in coordination with PSI. Lanfero and Shebedino are among the first in Ethiopia to pilot the introduction of zinc for diarrhea.

[2] The Bolosso Sore Project in Wolayita Zone supported by USAID through the Integrated Family Health Program also implemented the three pillars of IMNCI in 2006 to 2008 [***Implementing Integrated Management of Neonatal and Childhood Illness within the Health Extension Program, Bolosso Sore, SNNPR, Ethiopia***. November 2009.]

In addition to the full implementation of IMNCI, SC CS-23 conducted ***advocacy at the international, national and regional*** levels to promote child survival activities, with an emphasis on policy to include pneumonia management in the community (within HEWs' responsibilities).

Annex 4 presents the Mid-Term Evaluation (MTE) review of the project activities and achievements in relation to the Detailed Implementation Plan (DIP) work plan. There have been no significant changes in the program design, strategies, indicators, intervention mix, activities or location.

B5. Partnerships and USAID mission collaboration

The key partners of the project are collectively the local health authorities, including: 1) the ***SNNRP Regional Health Bureau (RHB)***, especially the Family Health Department, the Child Health and Nutrition Team, the RHB HEP and Planning and Programming Department; 2) the ***Sidama and Silti Zone Health Departments***; and 3) the ***Lanfero and Shebedino District Health Offices***. These partners have been involved since project start-up, through briefing meetings, the DIP workshop, the baseline Knowledge, Practices and Coverage (KPC) survey, a dissemination workshop, district-based planning and capacity building trainings for health professionals (facilitated by experts from the Federal Ministry of Health (FMOH), and integrated supportive supervision, as well as participating in the MTE. The key implementers of the IMNCI strategy are HEWs and vCHWs, which ensures local partnership and capacity building at the community level. SC also strengthens local partnerships by participating in the Regional Child Survival Task Force, the Technical Advisory Group (TAG) meetings and the EPI working group chaired by the RHB. In interviews conducted as part of the MTE, all RHB and government stakeholders cited the participatory nature of the project, highlighting the importance of the joint training, integrated supervision, joint meetings, and support for health systems (drugs, transport, etc). For example, one District Health Officer stated: "[We] work together for under-five children.....Save the Children [staff] are like members of our staff." A recent mandatory mid-term review conducted by the Regional Bureau of Finance and Economic Development (BoFED) and RHB found that the integrated nature of the CS-23 project implementation in coordination with local health services was a real strength of the project (Annex 12).[3]

SC has also worked in collaboration with other non-governmental organizations (NGOs) and development partners at the local and national levels. There is a strong collaboration with the USAID-bilateral ***Integrated Family Health Program (IFHP)*** in the use of IEC tools, IMNCI training for HEWs and sharing key child survival (CS) job aids for health facilities. IFHP, managed by John Snow International (JSI), provided training of trainers (TOT) for the SC CS-23 team to build its capacity in the facilitation of IMNCI training for HEWs. SC is collaborating

[3] SNNPR, Regional Health Bureau. ***Mid-term evaluation for: Enhancing Ethiopia's Health Service Extension Program in the Southern Nations and Nationalities People's Region (SNNPR), Save the Children Child Survival Project.*** June 2010.

with ***UNICEF*** to provide essential medical supplies to health posts and with ***WHO*** on the joint effort for policy influence on CCM/P. **Population Services International** (PSI) provided zinc for piloting in Lanfero and Shebedino districts, which were among the first in the country to introduce zinc into IMNCI protocols. SC works closely with ***GOAL Ethiopia*** to share ideas and organize joint trainings (i.e., zinc treatment).

The ***USAID Mission, Ethiopia*** has been engaged in the CS project since its initial stages through provision of technical advice and revision of the project document. The SC national health unit periodically meets with USAID-Ethiopia's CS focal person, the Health Population and Nutrition Officer at the Mission, to provide updates on the status of the CS projects and interventions.

C. Data Quality: Strengths and Limitations

Section D presents the M & E matrix. This section comments on the strengths and limitations of the M & E indicators included in the plan and the data collected as part of the project and used to assess progress in the MTE. Section D briefly describes the MTE methods; Annex 9 includes full details of the MTE methods, including strengths and weaknesses.

C1. Description of routine project monitoring and evaluation information

Evaluation data: The M & E matrix includes mostly indicators that are best collected through household surveys; the project conducted a household KPC survey at baseline (2008) and plans to conduct a KPC at endline (2012). A rapid Health Facility Assessment (rHFA), conducted in April 2008, provided information about: 1) quality of care given to sick children; 2) availability of supplies, supervision, staffing and other health systems supports; 3) knowledge of caretakers on medication administration. The CS-23 project plans to conduct a follow-up HFA at endline, and the MTE collected some comparable information. The SNNPR RHB and Regional BoFED conducted a mandatory mid-term review of the CS-23 project in June 2010; Annex 13 includes the full report of the review.

Routine monitoring data: The project uses routine data to monitor progress, presented in internal quarterly and annual reports, as well as annual reports to USAID. The monitoring plan includes reporting on: 1) health communication activities; 2) findings (successes and gaps) observed during integrated supervision; 3) use of curative child health services by illness at HCs and HPs; 4) advocacy activities. The project found that the data regarding processes and health service utilization collected through the routine Ethiopian Health Management Information System (HMIS) needs strengthening and definitions of collected information often do not correspond with standard IMNCI or maternal, neonatal and child health (MNCH) definitions.[4] Therefore, the CS-23 project staff extracts information from the IMNCI registers in each HC and HP on a

[4] For example, the current HMIS uses International Statistical Classification of Diseases (ICD) codes to classify illness. In Lanfero district from July 2008 to June 2009 there were only 42 total cases of childhood diarrheal illness reported through the HMIS because ICD codes do not include a category for non-disease specific childhood diarrhea. Information on deliveries is collected, but does not specify the place of birth, mixing deliveries at the health center, health posts and in the home. Post-natal visits are also collected, but do not specify when the visit occurred (i.e. can be any time after birth).

routine basis. A newly revised HMIS is being introduced in Ethiopia. The CS-23 project organized a five-day training with the RHB to ensure coordination of CS-23 activities and supportive supervision with the planned improvements to the MOH HMIS. During the MTE, key informants reported that all necessary indicators within the new HMIS may not use IMNCI definitions, for example, treatment of pneumonia does not currently use the IMNCI classification criteria. WHO is working to better harmonize IMNCI classifications and the new HMIS. A full review of the current or newly planned HMIS and the overlap with IMNCI supervision checklists and indicators was beyond the scope of the MTE.

Special studies and operational research: To address operational issues that have arisen in the course of the CS-23 project, SC conducted formative research to assess the existing HEP supervision plans and actual implementation. This research identified areas for improvement, and is being used to formulate a larger operational research agenda related to HEP supervision.

C2. Use and dissemination of routine project monitoring and evaluation information

Results from the baseline KPC survey were used to set targets, and the rHFA was used to better understand the context and target project activities. The project uses routine data to document project progress and to identify gaps that can be addressed through project activities. The M & E data from the various sources (KPC, rHFA, routine monitoring) has been collected in collaboration with MOH partners and shared through written reports, review meetings and workshops (Annex 2).

C3. Assessment of routine project monitoring and evaluation data

Many of the CS-23 project indicators are based on household surveys, making it more difficult to track progress routinely. ***Indicators not based on household surveys***, such as those proposed by the community case management (CCM) indicators' working group,[5] should be further ***incorporated into the CS-23 project's monitoring plans.***[6] Some indicators currently used for routine monitoring do not link back to the target population (i.e. number of sick child visits or number of malaria cases treated). These utilization and treatment indicators, both existing and proposed for incorporation, should ***relate back to the target population*** where feasible and appropriate. Monitoring indicators and information should always be analyzed and presented ***disaggregated by district*** to avoid masking important differentials in utilization of services (see section E) and to better understand bottlenecks in implementation and contextual factors by district. Additionally, in the next phase of the CS-23 project routine monitoring reports and annual reviews should ***examine time trends*** to assess the progress from the previous year's estimates that are now available.

CS-23's routine monitoring data collection should ***support the government HMIS***, ideally not collecting information through parallel systems. The introduction of the new HMIS over the

[5] The CCM Indicators Working Group is a global effort led by USAID and UNICEF and with participants from NGOs, PVOs, universities and WHO that aims to standardize CCM indicators used for tracking progress at the global and country levels.

[6] The process of selecting non-survey CCM/IMNCI indicators to incorporate into the CS-23 project monitoring plans started during the MTE.

next year presents an opportunity to integrate the CS-23 data collection activities with the government HMIS.

D. Assessment of Progress Toward the Achievement of Project Results

Table 2 presents the monitoring and evaluation matrix included in the DIP and an assessment of progress based on the data collected and analyzed during the MTE. Briefly, the MTE 2010 used the results framework to guide data collection and was a participatory process. The methods of data collection included: 1) review and further analysis of existing routine monitoring and program data; 2) rapid assessment at HCs and HPs of supplies and infrastructure, as well supervision frequency and content; 3) key informant interviews with health system staff and key partners; and 4) focus groups with caretakers and vCHWs. The MTE addressed all aspects of the project; however, we gave special attention to the intermediate result related to quality of services and associated supervision and support processes, as the CS-23 project team and MOH partners identified these aspects as the largest ongoing challenge in project implementation. We did not conduct a KPC survey, and there was none planned or budgeted, as part of the MTE. Annex 9 presents full details of the MTE methodology.

In addition to the original project objectives and indicators presented in Table 2, we also used a "beta" version of the proposed global CCM benchmarks indicators to examine the CS-23 activities and accomplishments related to IMNCI/CCM, and to provide early feedback on an application of the indicators to USAID and MCHIP. Annex 14 presents "beta" version of the CCM benchmark indicators with associated values for the CS-23 in Ethiopia.

Table 2: Monitoring and Evaluation Matrix – Progress at Mid-Term

SO	Indicator	Source	Base-line Value	EOP Target	Associated Activities	MTE indicator / evidence	Explanation of progress
IR-1: Access and availability of child health services and supplies increased	***Access to immunization:*** % of children age 12-23 months who received a DPT1 vaccination before they reached 12 months	KPC, 2011 EDHS	80%	80%	Routine vaccination at health posts; vaccination campaigns	No indicator of DPT1 available at MTE, see indicator below for DPT3/Penta3	
	Clinical IMNCI coverage: % of HEWs/VCHWs trained in IMNCI	Docum-entation¥	0%	60%	Training of HEWs in clinical IMNCI	**84%** (103/122 HEWs trained in IMNCI versus target HEWs - *Lanfero= 37/50* Shebedino= 66/72*)***	***Progress:*** Almost full training of targeted HEWs; ***Gaps:*** Due to some target HEWs not yet introduced/deployed in urban areas* (or on leave) during training period and 5 HEWs transferred or left/died
	Community IMNCI coverage: % of HEWs/VCHWs trained in c-IMNCI	Docum-entation¥	0%	60%	Training of HEWs/VCHWs in c-IMNCI	**68%** (82/121 HEWs trained in c-IMNCI/target HEWs)** **72%** (1080/1500 vCHWs trained in c-IMNCI/target vCHWs)**	***Progress:*** Almost full training of targeted vCHWs in 2008/9; ***Gaps:*** Due to govn't/MOH policy change to 1 vCHW per 20 HHs (increased number of target vCHWs), lower proportion of targeted vCHWs trained; HEP policy now changed to 1:20 HHs
	Availability of zinc: % of health posts that report no stock out of zinc in previous month	Docum-entation;¥ Inventory of HPs	0%	75%	Monitoring of stock and supply chain; trouble shooting; facilitation	**64%** (7/11 HPs with no zinc stock-out in previous 3 months – *Lanfero=3/7 Shebedino=0/4)*** **91%** (10/11 HPs with zinc on the day of assessment visit) **	***Progress:*** Introduction of zinc in collaboration with PSI; ***Gaps:*** Drug supplies remain an ongoing challenge, as described in section E; ***Note:*** MTE indicator is longer period of stock-out than original indicator (therefore, 1 month stock out likely better then 64%)
	IR-1 Notes: *Only 40 HEWs deployed in Lanfero and 69 in Shebedino at MTE, although targeted HEWs were higher; strategy of HPs/HEWs posted in urban kebeles recently introduced **More details available in text and Annex 13. ¥ Documentation includes RHB/ZHD/DHO documentation and reports, project training records, stock out reports, etc						

SO	Indicator	Source	Base-line Value	EOP Target	Associated Activities	MTE indicator / evidence	Explanation of progress
IR-2: Quality of health services improved	***Health system performance regarding immunization:*** % of children age 12-23 months who received a DPT3 vaccination before they reached 12 months	KPC	47%	75%	Routine vaccination at health posts; community vaccination campaigns	Approximately 989 Penta-3 vaccination per 1000 estimated births (proxy for infants) annually in Q3 2009 to Q2 2010(See Annex 13, Table 2 for more information & time-trend)	***Progress:*** Support for vaccination at HPs, HCs and outreach; ***Gaps:*** Some stock-outs of penta at HCs
	Measles vaccination: % of children age 12-23 months who received a measles vaccination regardless of age	KPC, 2011 EDHS	60%	75%	Routine vaccination at health posts; community vaccination campaigns	No indicator of measles available at MTE	
	Child with fever receives appropriate anti-malarial: % of children age 0-23 months with a febrile episode during the last two weeks who were treated with an effective anti-malarial drug within 24 hours after the fever began	KPC, R-HFA, HF records review	17%	60%	HEW/VCHW training in IMNCI/c-IMNCI ; *BCI:* HEP "16 packages", c-IMNCI (model families, community conversations, one-on-one counseling in household)	No specific indicator available at MTE; 14,700 children treated with antimalarial in 1 year period– See Annex 13, Tables 6-8 Only, approx 10-20% of children receive prompt (within 24 hours of fever) treatment as reported through routine systems (marked in register by HP/HC)	***Progress:*** Promotion of careseeking and services through c-IMNCI, routine activities & campaigns ***Gaps:*** High levels of stock-outs of ACTs preclude prompt treatment and discourage careseeking
	Use of medicine during diarrhea: % of children 0-23 months with diarrhea in the last two weeks who were no treated with anti-diarrheals or antibiotics	KPC, health facility record review	41%	22%	HEW/VCHW training in IMNCI/c-IMNCI; *BCI:* HEP "16 packages", c-IMNCI (model families, community conversations, one-on-one counseling in household)	No indicator of appropriate HH diarrhea management available at MTE; few incorrectly treated diarrhea cases seen in register review of HCs or HPs	

SO	Indicator	Source	Base-line Value	EOP Target	Associated Activities	MTE indicator / evidence	Explanation of progress
IR-2: Quality of child health services improved	***HEW performance*** **:** % of trained HEWs who followed correct IMNCI steps to assess, classify, treat, refer childhood illness	R-HFA, observations, supervisory records	0%	60%	HEW/VCHW training in IMNCI/c-IMNCI; Supportive supervision	In pneumonia case scenario among 11 HEWs/HPs: **Assess Respiratory Rate:** 82%** **Full Assessment (danger signs, chest indraw):** 9%** **Classify:** 100%** **Refer/treat:** 100%**	***Progress:*** Quality IMNCI training with close follow-up by supervisors and staff; ***Gaps:*** Supervision needs to focus more on full danger sign assessment and provision of timers ***Note:*** Case scenario a rough proxy for quality of services in practice
	Functional supervisory system % of health posts that have received supportive supervision at least once in past quarter (according to MOH criteria)	R-HFA, monthly *woreda* reports	98%	100%	Accompany, provide transport, ensure check list supply and use, give feedback	**100%** received supervision visit in last month**	***Progress:*** High frequency of supervision by many actors; SC supports joint supervisions & provides >50% of supervision ***Gaps:*** Quality of supervision is variable & low motivation for HEP supervisors
	Functional health system % of health posts meeting FMOH "functional" criteria	Documentation¥	80%	90%	Provide limited supplies, equipment, support, facilitation	**97%** of HPs meet FMOH "functional" criteria (33/35 HPs in Shebedino & 25/25 HPs in Lanfero)	
	Functional health system % of health posts that have met all reporting requirements in past quarter (according to MOH criteria); % HEWs whose register records adequate information (age, dx, Rx)	R-HFA	54%	90%	Remind, review, provide feedback	No indicator available at MTE **93%** registers with complete/adequate information**	***Progress:*** Standard IMNCI registers provided by CS-23 and supported through trainings & supervision; ***Gaps:*** Sporadic and inconsistent reporting through govn't HMIS; no reporting of sick child management done in HHs
	IR-2 Notes: **More details available in text and Annex 13. ¥ Documentation includes RHB/ZHD/DHO documentation and reports, project training records, stock out reports, etc						

SO	Indicator	Source	Base-line Value	EOP Target	Associated Activities	MTE indicator / evidence	Explanation of progress
IR-3: Knowledge and Acceptance of key child health services and practices improved	***Maternal danger signs:*** % of mothers who report knowledge of at least 2 maternal danger signs requiring immediate intervention	KPC	8%	30%	*BCI:* HEP "16 packages", c-IMNCI (model families, community conversations, one-on-one counseling in household)	No indicator available at MTE	***Gaps:*** Less program emphasis on maternal health, more on child and neonatal health
	Neonatal danger signs: % of mothers who report knowledge of at least 2 neonatal danger signs needing treatment	KPC	29%	60%	*BCI:* HEP "16 packages", c-IMNCI (model families, community conversations, one-on-one counseling in HH)	No indicator available at MTE: Caretakers report some knowledge, but failure to seek care***	***Progress & Gaps:*** Despite knowledge, large challenges remain in "Acceptance" of careseeking for NN illness.
	Child danger signs: % of mothers who know at least 2 signs of illness in children needing treatment	KPC, 2011 EDHS	51%	75%	*BCI:* HEP "16 packages", c-IMNCI (model families, community conversations, one-on-one counseling in household)	No indicator available at MTE, although mothers in focus groups report knowledge of key child illness danger signs***	***Progress:*** Emphasis on promotion of careseeking and recognition of danger signs by vCHWs; ***Gaps:*** Relatively low utilization for sick children (i.e. knowledge not translating to acceptance/ practice), esp in Shebedino (see below)
	IR-3 Notes: ***Focus group reports not representative and a convenience sample of caretakers chosen by HEWs and vCHWs						

SO	Indicator	Source	Base-line Value	EOP Target	Associated Activities	MTE indicator / evidence	Explanation of progress
IR-4: Policy and social environment enabled	***Policy change:*** HSDP-IV includes CCM as HEP strategy at level of health post - including antibiotics for treatment pneumonia, dysentery, neonatal sepsis	FMOH/ RHB policy	None	Partial	Facilitate policy dialogue, debate, technical updates; provide evidence of feasibility	HEP strategy now includes antibiotics for treatment of pneumonia	***Progress:*** Advocacy by development partners, including SC, resulted in change of pneumonia policy in late 2009 ***Gaps:*** Neonatal sepsis mgmt delayed by SNL research delays
	Joint planning for sustainability: Joint planning takes place on annual basis with RHB/ZHD/DHO, SC, ESHE, and relevant key community stakeholders	Documentation*	N/A	Yes	Participate in region, zonal, district planning	Yes	***Progress:*** Joint planning and review meetings occurring in collaboration with stakeholders ***Gaps:*** None
	IR-4 Notes: ¥ Documentation includes RHB/ZHD/DHO documentation and reports, project training records, stock out reports, etc						
Strategic Objective: Use of key child health services and practices increased	***Appropriate hand washing practices :*** % of mothers of children 0-23m who live in a HH with soap or locally appropriate cleanser at the place for hand washing and who washed their hands with soap at least 2 of the appropriate times during the day or night before the interview	KPC	28%	45%	*BCI:* HEP "16 packages", c-IMNCI (model families, community conversations, one-on-one counseling in household); HEW/VCHW training in IMNCI/c-IMNCI	No indicator available at MTE, although mothers in focus groups reported knowledge of key practices	
	Increased feeding during diarrheal episode: % of children aged 0-23 months with diarrhea in the last two weeks who were offered the same amount or more food during the illness	KPC, 2011 EDHS	29%	43%	*BCI:* HEP "16 packages", c-IMNCI (model families, community conversations, one-on-one counseling in household); HEW/VCHW training in IMNCI/c-IMNCI	No indicator available at MTE, although mothers in focus groups reported knowledge of key practices	

SO	Indicator	Source	Base-line Value	EOP Target	Associated Activities	MTE indicator / evidence	Explanation of progress
Strategic Objective: Use of key child health services and practices increased	***Increased fluid intake during diarrheal episode:*** % of children 0-23 months with diarrhea in the last two weeks who were offered more fluids during the illness	KPC, 2011 EDHS	20%	36%	*BCI:* HEP "16 packages", c-IMNCI (model families, community conversations, one-on-one counseling in household); HEW/VCHW training in IMNCI/c-IMNCI	No indicator available at MTE, although mothers in focus groups reported knowledge of key practices	
	Appropriate care seeking for pneumonia: % of children age 0-23 months with chest-related cough and fast and/ or difficult breathing in the last two weeks who were taken to an appropriate health provider	KPC, 2011 EDHS	32%	60%	*BCI:* HEP "16 packages", c-IMNCI (model families, community conversations, one-on-one counseling in household) HEW/VCHW training in IMNCI/c-IMNCI	No specific indicator available at MTE; 10,346 children with pneumonia treated in 1 year period (155% of expected cases in Lanfero; 15% of expected cases in Shebedino) – See Annex 13, Tables 6-8**	***Progress:*** Training for appropriate treatment and referral at HC and HP; promotion of careseeking ***Gaps:*** Low careseeking in Shebedino
	ORT use: % of children age 0-23 months with diarrhea in the last two weeks who received ORS and/or recommended home fluids.	KPC, 2011 EDHS	57%	72%	*BCI:* HEP "16 packages", c-IMNCI (model families, com. conversations, one-on-one counseling in HH); HEW/VCHW training in IMNCI/c-IMNCI	No specific indicator available at MTE; 7,017 children treated with ORS in 1 year period (6% of expected cases in Lanfero; 1% of expected cases in Shebedino) – See Annex 13, Tables 6-8**	***Progress:*** Training for appropriate treatment and referral at HC and HP; promotion of care seeking ***Gaps:*** Unclear from available information at MTE if home therapy is occurring
	Zinc therapy: % of children 0-23 months with diarrhea in the last two weeks who were treated with zinc supplements	KPC, 2011 EDHS, DHO/RHB service data	7%	25%	*BCI:* HEP "16 packages", c-IMNCI (model families, community conversations, one-on-one counseling in HH); HEW/VCHW training in IMNCI/c-IMNCI; Dialogue, monitoring, trouble shooting, facilitation of zinc supply to health posts/health centers	No specific indicator available at MTE; 1,927 children treated with ORS & zinc in 1 year period – See Annex 13, Tables 6-8**	***Progress:*** Introduction of zinc at HCs & HPs; promotion of care seeking ***Gaps:*** Many fewer children with diarrhea treated with zinc than seen at HCs & HPs - Stock-outs a large challenge

SO	Indicator	Source	Base-line Value	EOP Target	Associated Activities	MTE indicator / evidence	Explanation of progress
Strategic Objective: Use of key child health services and practices increased	***ITN use by child:*** % of children age 0-23 months who slept under an insecticide-treated bed net (in malaria risk areas, where bed net use is effective) the previous night	KPC, 2011 EDHS	40%	65%	*BCI:* HEP "16 packages", c-IMNCI (model families, community conversations, one-on-one counseling in household); HEW/VCHW training in IMNCI/c-IMNCI	No indicator available at MTE	CS-23 project collaborated with on malaria campaigns giving logistics support and promotes preventive and treatment practices through HEP and vCHWs
	Post-natal visit to check on newborn within first 3 days after birth: % of children age 0-23 who received a post-natal visit from an appropriate trained health worker within three days after the birth of the youngest child	KPC, 2011 EDHS	4%	30%	*BCI:* HEP "16 packages", c-IMNCI (model families, community conversations, one-on-one counseling in household); HEW/VCHW training in IMNCI/c-IMNCI	No indicator available at MTE; HEWs & HCs report postnatal care, BUT not usually/always within 3 days	***Progress:*** Some promotion of PNC; HEWs working with TBAs & vCHWs ***Gaps:*** Few assisted deliveries and late notification of births at home; No standardized birth notification and TBA coordination structure
	Immediate and exclusive breastfeeding of newborns): % of newborns who were put to the breast within one hour of delivery and did not receive prelacteal feeds	KPC, 2011 EDHS	62%	69%	*BCI:* HEP "16 packages", c-IMNCI (model families, community conversations, one-on-one counseling in household); HEW/VCHW training in IMNCI/c-IMNCI	No indicator available at MTE; although caretakers in focus groups (not representative) reported practicing better IYCF due to promotional activities	
	Exclusive breastfeeding: *(0-5 months):* % of children age 0-5 months who were exclusively breastfed during the last 24 hours	KPC, 2011 EDHS	3%	25%	*BCI:* HEP "16 packages", c-IMNCI (model families, community conversations, one-on-one counseling in household); HEW/VCHW training in IMNCI/c-IMNCI		
	SO Notes: **More details available in text and Annex 13.						

E. Discussion of Progress Toward Achieving Results

E1. Contribution toward objectives-overall

This section discusses the progress toward achieving the intermediate results (IR) and strategic objective (SO) as outlined in the results framework. Annex 13 presents additional detailed quantitative results, with key results presented in section D and discussed in the text. We discuss the remaining challenges and recommendations for potential strategies to overcome these challenges.

E2. Contribution toward objectives- IR1: Access to services

E2.a. Access to IMNCI services for sick children at HPs and HCs and c-IMNCI through vCHWs

Overall access and referral: The project has achieved its targets for improving access to IMNCI services for sick children at HCs and HPs. All HCs in the two districts offer full IMNCI services and nine out of 10 have at least one IMNCI nurse on-staff, although turnover of IMNCI-trained HC staff has been a challenge. Approximately 84% of the targeted HEWs are trained in IMNCI (management of malaria and diarrhea, with referral of pneumonia), with approximately two HEWs trained in IMNCI (and one IMNCI functional HP) deployed for every 1000 children under five years of age.[7] (see Annex 13, Table 1 for more details). National policy now permits the management of pneumonia in the community, with implementation scheduled to start in the third and fourth quarters of 2010. Key stakeholders, local health authorities and project staff considered the IMNCI training for health center staff and HEWs, as well as the ongoing support to trained health workers, to be one of the most significant achievements of the project to date. Likewise, community members in focus groups also expressed appreciation for the availability of services through HPs: "HEWs and HPs benefit the community [through a variety of services].....they come near to us and our home—God bless them."

A referral system is in place at each level in the community; vCHWs promote the use of HEWs and HPs and refer children to health posts using improvised referral slips provided by CS-23. At the next level, HEWs refer severely ill children or those with pneumonia to health centers using referral slips provided by SC. HEWs also refer children from HPs to HCs because of drug stock-outs, especially CoArtem®, resulting in unnecessary referral. Referral from HCs to hospitals for severely ill children is a large challenge due to costs and transportation; there is no ambulance in either district. At the HP to HC level, families may refuse to accept referral due to fear of contamination and disease, as reported in MTE focus groups. Back referral from HCs to HPs posts happens infrequently and lack of feedback was reported to demoralize some HEWs.

Challenges and recommendations: A small number of HEWs have left or transferred to other posts, and some HPs currently have only one HEW. Additionally, the government of Ethiopia

[7] Based on population estimates projected from 2007 census

has introduced health posts manned by HEWs in "urban"[8] *kebeles,* and these HEWs have not yet received initial IMNCI training. Although most HEWs deployed in Lanfero and Shebedino are trained in IMNCI, there is a need for the full complement of HEWs to receive ***initial IMNCI training*** in order to further expand IMNCI services.

HEWs provide IMNCI services in the HPs, but many also reported treating sick children during house-to-house visits in the community. It was unclear how many curative services are provided in community by HEWs (in house-to-house visits) and if and how these treatment encounters are registered. Introducing more ***standardized tracking of sick children treated during household visits*** allow MOH and partners to better track these encounters. Although the MTE did not observe or explore management of child illness given in house-to-house visits, standardizing this practice reported by some HEWs also might increase access and use of sick child services.

Overcoming challenges linked to referral is difficult; lack of resources within communities and in the health system is a large constraint. Save the Children should consider ***supporting more facilitation of referral*** by HEWs and health workers at HCs. Although all levels reported referral of cases, albeit relatively low, they infrequently reported counseling or helping families complete the referral process. In order to improve the system for referral feedback, stakeholders suggested ***creating awareness (increase demand)*** in the community to ask for feedback slips at HCs, so that families can return feedback to HPs and vCHWs. Strengthening this system to give feedback on referrals could provide incentive to HEWs and vCHWs by demonstrating the importance of their work at higher levels. Additionally, the project should ensure that ***referral slips have feedback sections*** and that IMNCI referral slips are available and used at all levels.

E2.b. Availability of IMNCI supplies and drugs at Health Posts and Health Centres
This section presents on the availability of supplies and drugs at HPs and HCs, drawing on the quantitative results of the rapid assessment (inventory) conducted during the MTE. Annex 13 includes the full quantitative results from the MTE assessment.

MTE - Availability of Supplies: ***HPs*** in both districts were well equipped with most IMNCI equipment and supplies on the day of the assessment during the MTE, including IMNCI chartbooks and registers, referral slips, thermometers, MUAC strips, scales, counseling cards and RDTs (Annex 13, Figure 1). Only half of the HPs visit had timers able to count seconds. Save the Children opted to provide 60-minute kitchen timers due to the non-availability of UNICEF timers. One observed test of a kitchen timer in Lanfero showed it to be ineffective because it did not "ring" after one minute, although others in Shebedino appeared functional. The timers' ability to measure 60 seconds precisely seems unlikely. Some HEWs relied on personal digital

[8] "Urban" does not refer to cities or metropolitan areas, rather areas that are more densely populated and usually close to the district town.

watches or timers (precise to one second) in mobile phones. No HP had a functioning refrigerator on the day of observation. ***HCs*** were also well supplied (Annex 13, Figure 2) except for RDTs, which were present in only two of seven inventoried facilities. HCs reported use of microscopy for malaria diagnosis, thus stocks of RDTs are not necessarily required. All HCs had functioning refrigerators.

Although not formally assessed, most HPs and HCs appeared to have a functioning ORT corner. The general maintenance of some HP buildings, such as small rooms, lack of furniture and absence of clean water, negatively influences the functioning of these health posts. For example, some HPs visited did not have adequate conditions for drug storage and management.

MTE - Availability of Drugs: On the day of MTE visit, all ***HPs*** (100%) in both districts had ORS and chloroquine (Annex 13, Figure 3) and ten out of 11 HPs had zinc on the day of the visit. The availability of ORS at baseline (rapid HFA) was 73%,[9] thus the MTE observed an improvement in ORS availability. During the MTE, CoArtem® was generally unavailable (present in only two of 11 health posts), and this was less available than at baseline (83% of health posts has 1st line antimalarial at baseline).[3] HPs do not yet have cotrimoxizole for pneumonia management, since the change in national policy is so recent. Stock-outs in the last three months of chloroquine, zinc and CoArtem® were more common in Lanfero than in Shebedino (Annex 13, Figure 4).

All ***HCs*** (100%) had ORS, zinc and cotrimoxazole on the day of MTE visit, which is an improvement over the baseline rapid HFA.[9,10] There were gaps for chloroquine, pentavalent vaccine and especially CoArtem® (present in only four of seven facilities) (Annex 13, Figure 5). The availability of a first-line antimalarial drugs at HCs on the day of the visit was higher (76%) at baseline than during the MTE (57%).[9] Stock-outs in the last three months were reported for all six items – all stock-outs were for 15 days or less except for CoArtem® in Lanfero, with average stock-outs of 30 days (Annex 13, Figure 6).

Contribution of CS-23 project: Overall, almost all health posts and centers have adequate supplies to provide IMNCI services, as well as ORT corners, and this can be attributed to the CS-23 project support and supervision activities. Key stakeholders and almost every service provider noted the provision and follow-up on supplies as a large contribution of the CS-23 project. But, all key informants from the regional level and zonal level to vCHWs and caretakers in the community reported maintaining adequate drug supplies as one of the largest challenges to child health activities. The provision of kitchen timers without second hands occurred due to unavailability of UNICEF standard timers; UNICEF will provide standard UNICEF timers with the introduction of community-based pneumonia management in the 3rd or 4th quarter of 2010.

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[9] For more details, see: Save the Children/USA. ***Rapid Health Facility Assessment (R-FHA) Baseline Report, Lanfero and Shebedino Woredas, SNNPR, Ethiopia.*** April 2008.

[10] Baseline rapid HFA at Health Centers found 14% ORS availability, 86% Cotrim availability, 76% first-line antimalarial and no zinc available (not yet introduced).

Adequate supplies of zinc, chloroquine, and ORS were observed at HPs and HCs, with few reported stock-outs. Zinc has been introduced and supplied in coordination with PSI, with PSI providing zinc in-kind for pilot testing in the CS-23 districts. Using matching funds, the CS-23 project has supplied ORS, zinc, chloroquine and CoArtem®, as adequate drug supply through government health systems is an ongoing challenge in Lanfero and Shebedino Districts. However, private funds for drug supply will soon be depleted. Additionally, the SC project often provides supervision and logistical support, such as transportation resources, to ensure adequate drug supplies in peripheral health posts and health centers. The shortage of RDTs and CoArtem®, especially in Lanfero district, appears to be a combination of a large number of malaria cases in the district, alongside a weak stock management systems at the district, zonal and regional levels. Interviews with the FMOH and RHB revealed that stocks of CoArtem® should be available at the regional level, but are not reaching districts for distribution to health service delivery points.

Challenges and recommendations: Relatively weak stock management systems within government structures and lack of drug supplies at all levels of the health system are ongoing challenges within the CS-23 project and threaten the sustainability of progress currently and at the completion of the project. Additionally, the shortage of transportation and petrol for activities within the government health system negatively impacts logistics and the provision of supplies to health posts and centers. The sustainability of zinc supply is also a large challenge; UNICEF and international bodies currently do not approve the only zinc supplier approved by the government of Ethiopia. Thus, currently all zinc must be procured through private channels.

The project should work to ***strengthen the stock management system,*** including support for systematic monitoring of the drug stocks system at the HP and HC levels during integrated supervision and the introduction of stock control balance cards/sheets for health posts, which have recently been developed. For the life of the project, Save the Children should ***leverage additional private funds***, to cover supplemental drug supplies.[11] ***Greater coordination*** at the different levels of MOH around drug supply, especially the regional level, may be needed to ensure that drugs—especially CoArtem®—reach districts and eventually health post. This coordination may need to involve in-kind contributions of transportation resources to overcome logistical challenges within the government health system. The project in coordination with government health partners should ***rapidly assess the causes of the current CoArtem®*** shortages and stock-outs and potential solutions, especially in Lanfero district. In order to address further issues and challenges with stock and supplies, the project may consider ***coordination with Supply Chain for CCM (SC4CCM),*** a new JSI project implemented in Ethiopia and other countries, at the country and global levels. The project and its partners need to develop a ***zinc supply transition plan*** to ensure the sustainability of zinc supplies for the remaining project period and after.

[11] The recent grant from UNICEF for implementation of pneumonia management by HEWs (CCM/P) will cover some supplementary drugs in Shebedino.

E2.c. Access to (and use of) maternal and neonatal services at Health Posts and Health Centres

Overall: Access to maternal and neonatal services within Lanfero and Shebedino Districts is more limited than for IMNCI services. All health centers provide ANC and delivery services, but very few health posts offer delivery services and only 10 HEWs (five in each district) had received training in Safe and Clean Delivery (SCD) at the time of the MTE. Due to delays in the Saving Newborn Lives (SNL) research on newborn sepsis management in Ethiopia, the sepsis management training for HEWs originally planned as part of the CS-23 project will now not take place. Health center staff and HEWs have received basic essential newborn care training within IMNCI, but have not received training on management of the sick neonate or extensive training for essential newborn care.

Women report using ***antenatal care (ANC) services*** at the health post and center levels, and promotion of these services is also reported at all levels. Promotion of ***assisted delivery*** at HCs was reported to occur at all levels—health centers, health posts (by HEWs) and in the community (by vCHWs). However, most women do not use assisted delivery at HPs and HCs. For example, in Shebedino routine service statistics show about 25 institutional deliveries per 1000 expected births from July 2009 to June 2010.[12] A number of reasons for very low utilization rates were cited during the MTE. First and foremost, families cited home delivery as a more culturally appropriate practice, and mothers reported detesting the delivery Tables, as one HEW also noted: "Mothers hate the couch.....God will help them deliver at home." Families cannot afford razors, gloves, towels and drugs, which is a barrier to delivery at health centers. For example, one mother stated "we go to health facility [only] when labor is difficult... especially due to lack of money and [because] the community does not support us to go." Messages about assisted delivery and newborn care almost exclusively target young women. Fathers and older women (grandmothers) often make key decisions about delivery and newborn care; however, they are not specifically targeted for key messages.[13]

HEWs deliver ***postnatal care (essential newborn care)*** in the community, but visits often happen many days after the birth. Notification of the birth is often informal and late due to the overwhelming majority of deliveries in the home. For example, one HEW reported notification mostly through informally encountering vCHWs or TBAs. Tracking of post-natal visits within the routine HMIS does not differentiate timing of visit. Sick or healthy newborns are not brought to the HP or HC, and one HEW noted, "[Care is] not necessary for very young."

Challenges and recommendations: The neonatal technical component of the CS-23 is the weakest in terms of progress; assisted delivery and careseeking for the newborn are abysmally

[12] Routine service statistics on assisted deliveries at HCs were not readily available in Lanfero district or for previous periods in Shebedino.

[13] All caretakers who come for care seeking irrespective of their age and sex are targeted at gatherings, at HPs, at church, etc, but no specific strategy has been implemented to reach fathers or grandmothers.

low due to a myriad of factors (see utilization section below), including cultural and health systems barriers. Management of sick newborns, essential newborn care and post-natal care messages are included for one day in the IMNCI training packages, although treatment of the sick newborn is not allowed at the health post level. There are gaps in the capacity of HEWs to deliver maternal and neonatal services in the community, and needs for training in Clean and Safe Delivery, Essential Newborn Care, Postnatal Care and counseling. The CS-23 project should leverage and ***advocate with other partners for Safe and Clean delivery training for HEWs.*** Because of the delay in SNL's sepsis management research, the CS-23 project should instead provide ***essential newborn care training using the postnatal visitation package from WHO/UNICEF/SC.***

In order to promote assisted delivery and care for the newborn, the project should ***target messages and behavior change activities to fathers and grandmothers*** in addition to young women. The message that "every newborn is a human being with a right to survive" should be included in the package in order to promote use of services for newborns. The inclusion of ***more female volunteer CHWs***, in addition to government chosen male volunteers, may assist in better delivery and targeting of messages and behavior change activities to promote assisted delivery and newborn care. Finally, the project should explore options and advocate with partners who could assist in the provision of ***clean delivery kits*** to families.

E3. Contribution toward objectives- IR2: Quality of services

In this section, we explore factors related to the quality of services, first describing the results from the MTE related to supervision and activities to improve quality of services and then we present results from the MTE rapid assessment of quality of services. Within each section, we discuss the challenges and recommendations to improve health systems support and quality of services.

E3.a. Supervision to ensure quality of services at Health Posts and Health Centres

Supervision – overall: The CS-23 team and MOH partners identified supervision as a large challenge within the implementation of IMNCI; therefore, we focused on supervision of IMNCI services during the MTE.[14] The supervision of HEWs and HPs within the HEP system includes joint supervision from the DHO, from the HCs and weekly supervision by HEP supervisors. HEP supervisors are supervised monthly by the DHO HEP Coordinator. SC supports and joins many of these supervision visits, as well as SC staff conducting supervision visits. In fact, SC provides over 50% of supervision to HPs. The joint supervision with local health authorities was reported to be a large contribution of the CS-23 project, enabling high supervision completion rates at HC and HP levels. Key informants cite lack of transportation (old or no motorbikes) and resources for maintenance and petrol at the district and HC levels as major challenges to completing supervision. Additionally, government workers also have high workloads that present challenges to completing scheduled joint supervisions. Supervision checklists are advantageous when used, and HEWs reported appreciating good supervision. One HEP supervisor summed up his

[14] The information on supervision will also assist in further developing an operations research protocol.

experiences with SC: "We've good interaction especially in the training, supervision, provision of supplies and drugs, IEC materials. There are some improvement areas, like filling gaps when needed, and notifying of visits and schedules."

MTE Results - Frequency and content of Supervision: At the time of the MTE, HEWs at all *Health* ***HPs*** visited reported having received supervision in the last three months, many within the last week per HEP policy. HEWs reported that that content of the last supervision visit received at their HPs was good (Annex 13, Figure 7). Most HEWs from both districts reported that the supervisor checked records, corrected errors, and gave training (8 of 10). Likewise, most reported that the supervisor gave positive feedback, brought one or more supplies, and observed care (6-7 of 10). Observation of care of *sick children* was somewhat less common (5 of 10) perhaps because of the relatively uncommon occurrence of cases (see "utilization" below). However, few HEWs reported that the supervisor used a checklist (2 of 10). Supplying HEWs seemed better in Lanfero, while giving positive feedback seemed more common in Shebedino. Supervision reported as received at ***HCs*** over three months differed by district – with supervision in the last quarter at only two of four HCs visited in Lanfero versus at all of three Shebedino facilities. Informants at HCs reported that the content of the last supervision visit received at their facilities was also good (Annex 13, Figure 8). All parameters were reported to have occurred in at least four of five surveyed HCs, except bringing supplies, observation of care of sick children (3 of 5) and use of checklist (2 of 5, both in Lanfero).

MTE - HEP Supervisors: During the MTE, we closely examined the responsibilities and challenges of HEP Supervisors, as they are the primary support cadre to HEWs within the MOH's HEP system.[15] Lanfero and Shebedino Districts have experienced very high rates of turnover of HEP supervisors. For example, in Lanfero District, of five HEP supervisors recruited and trained in 2008, only one remains. The HEP has deployed new HEP supervisors; these individuals have not received the standard two month HEP supervisor training for the 16 HEP packages or IMNCI training, although SC staff do provide "on-the-job" training for IMNCI and child survival activities. The "new" HEP supervisors only receive five days of training to serve as a supervisor for the entire HEP program.

Current HEP supervisors stated during MTE interviews that the work is tiring and hard, especially due to lack of transportation resources; they are expected to walk to each HP in their catchment areas (on average 1-7km) every week. HEP supervisors' salaries are lower than similar cadres in other sectors (such as education or agriculture), and key informants noted HEP supervisors lack the opportunity to "top-up" their salary through supplemental work, such as clinical nurses who are paid for night duty. Two of the four HEP supervisors stated they needed at least enough money to "buy food." One HEP supervisor in Lanfero summed up his experiences: "[I am a HEP supervisor to] take part in main disease problems that can be solved....but, I would go elsewhere for more money or to a more comfortable area than if that

[15] There is a recent initiative to strengthen the Primary Health Care unit (comprised of 1HC and 5HPs), as a consequence the HC will be responsible for all HPs under it, rather than relying solely on the HEP supervisor for HEW supervision.

opportunity came." All these factors, as well as remote postings, lead to low motivation of HEP supervisors and high turnover rates.

Despite the challenges of HEP supervisor motivation which appeared to influence performance, we also encountered high performing HEP supervisors. A "positive deviant" HEP supervisor in Lanfero district who received only the minimal (5 day) training had a good plan and good completion of his plan. Additionally, he reported sharing best practices among HPs and developing criteria for "competition" among HPs in order to motivate the HEWs.

Challenges and recommendations: Supervision frequency is high at HPs; however challenges remain with the quality and sustainability of supervision, as well as HEP supervisor motivation. Supervision plans, documents and tools are often not reliably available at Health Centers and supervision checklists are not consistently used at any level. HEP and DHO supervision checklists currently do not include all IMNCI components. Save the Children has adapted and shared an IMNCI checklist with regional health authorities and the checklist is currently under review. The very high frequency of supervision, often with variable quality, within the MOH system, raises concerns over the sustainability of this approach and the balance between quantity and quality of supervision. The challenges of HEP turnover and motivation, as well as transportation constraints, discussed above, invariably contribute to the challenges and variable quality of supervision. Additionally, frequent supportive supervision by SC staff has contributed greatly to the CS-23 project objectives, but also raises concerns over sustainability at the close of project.

Save the Children should provide ***initial or refresher training in IMNCI*** and IMNCI supervision (checklists) for HEP supervisors and other staff involved in supervision, with preference given to recently recruited HEP supervisors.[16] Save the Children may consider initiating discussions with the RHB and other health authorities about the initial, two month HEP supervisor training curriculum, length, etc. and the potential of alternative, lower cost options to the two-month in-residence trainings. Once approved by the RHB, CS-23 should provide ***IMNCI supervision checklists***[16] to the HEP supervisors and other supervisory staff, with SC staff providing on-the-job training through joint supervision visits. Planning for joint supervision visits with opportunities for on-the-job training could be strengthened.[17] The high frequency of variable quality supervision and the less than adequate incentive structure for HEP supervisors are institutionalized within the government's HEP system; thus, these challenges are difficult for the CS-23 project to address. The project may consider ongoing ***advocacy and discussions*** at the national and regional level to test alternative supervision approaches.

[16] The new IMNCI/iCCM training will incorporate a one-day training with practical session for HEP supervisors on supervision of HEWs in IMNCI/iCCM. The associated checklist is already developed and agreed for use.
[17] Other alternatives for on-the-job training could be considered, such as filming a role play of a high-quality supervision visit that could be shown locally to HEP supervisors and program managers.

Most traditional incentives to motivate HEP supervisor have large budget implications (e.g., salary, per diems, cash incentives, refresher training) and are outside the scope of the CS-23 project or may not be feasible within the HEP system. However, ***low cost incentives***, such as certificates, recognition or small awards (such as phone credits) for high performing HEP supervisors could recognize their work.[18] The CS-23 project has started development of an operational research proposal to address supervision challenges, including the motivation of HEP supervisors. This ***operational research proposal*** should be finalized and implemented in coordination with national, regional and local health offices. Finally, in the next phase, Save the Children should work with the MOH partners to ***develop a transition plan*** for supervision of health posts and health centers in IMNCI.

E3.b. Quality of services at Health Posts and Health Centres

MTE - Quality of Case Management: MTE team members administered a structured case scenario to providers in order to assess reported management of a "six-month old infant brought for cough and difficult breathing." Although HEWs do not treat pneumonia, they have been trained to assess acute respiratory infections (ARI) and refer children with fast breathing or danger signs. The reported case management of HEWs at ***HPs*** was spotty, with few checking for general danger signs, chest indrawing or duration of cough (Annex 13, Figure 9). Most HEWs reported they would check the respiratory rate, but not all of these had the equipment to do so. When informed that the infant's respiratory rate was, in fact, 55 breaths per minute, all HEWs correctly classified the child as having fast breathing or pneumonia and opted for referral. Thus, complete assessment (all the steps of which are specified in the IMNCI Register) was poor, but classification – when provided the respiratory rate – and response (i.e., referral for treatment) were perfect (Annex 13, Figure 10). Overall, Shebedino HEWs seemed to perform a bit better than their Lanfero counterparts.

Reported case management at ***HCs*** was good (Annex 13, Figure 11). The main gaps – less commonly observed than at HPs – were checking for general danger signs, chest indrawing or duration of cough. As observed among HEWs, assessment was not strong, but classification and treatment were perfect (Annex 13, Figure 12). Again, Shebedino HC staff may have slightly out-performed their Lanfero counterparts.

Quality of Case Management Recording: The MTE members also reviewed selected details from the IMNCI Registers for the last 10 sick children under age five years of age to assess both the completeness of recording and the consistency between recorded classification and treatment. Recording in each district was slightly better at ***HPs*** than at ***HCs*** (93 vs. 87% complete and consistent) – although both were high (Annex 13, Figure 13). Levels were similar between the districts. This indicator, though easy to obtain, is at best an indirect measure of quality because – among other factors – the unverifiable validity of what is recorded.

[18] Similar to those examined in for vCHWs in: Amare, Y. ***Non-Financial Incentives for Voluntary Community Health Workers: A Qualitative Study.*** Addis Ababa: JSI Research & Training Institute, Inc. 2010.

Challenges and recommendations: The quality observed through our rapid assessment was relatively good. However, project staff and MOH partners reported gaps in capacity of HEWs and the need for ***IMNCI refresher training,*** with emphasis on assessment of danger signs. With the new FMOH policy allowing management of pneumonia with antibiotics in the community, the HEWs should be ***trained in the treatment of pneumonia with antibiotics*** as soon as possible. This training has already commenced with funding from UNICEF in some areas, and it may present an opportunity to refresh HEWs skills in other IMNCI and c-IMNCI components.

E4. Contribution toward objectives- IR3: Knowledge of key services and practices

Overall: The project activities to promote the knowledge of key services and practices are progressing as planned. The CS-23 project has trained HEWs and 1080 vCHWs in c-IMNCI and provided job aids and counseling cards to support their activities; c-IMNCI refresher training was provided to 831 vCHWs in 2009 (see Annex 13, Table 1 for more details). Additionally, the CS-23 project conducted community sensitization activities before c-IMNCI trainings and provides ongoing supervision to HEWs and vCHWs in c-IMNCI. Save the Children recently (March 2010) recruited two community mobilization officers (CMOs) to support the community work in each district (Annex 3) and to allow for more intensive follow-up of c-IMNCI activities in communities.

vCHWs are using job aids to promote family practices in communities and there appears to be strong relationships between HEWs and vCHWs in their work. Communities report appreciating the work of the HEWs and vCHWs. During the MTE, mothers in focus groups reported knowledge of appropriate behaviors about early careseeking for childhood illnesses, use of ITNs, infant feeding, etc., and they report changing practices; however, due to cultural factors care for mothers during delivery and newborns remains a challenge.

Community-based workers (HEWs and vCHWs) reported being relatively motivated in their work; the community appreciates them and workers report changes in practices and outcomes that motivate them. However, vCHWs did ask for refresher trainings and in-kind incentives, such as boots, bags, etc.

Challenges and recommendations: The government structure dictates one vCHW per 30-40 households or approximately 25 vCHWs per health post. Thus, some vCHWs under this structure remain untrained in c-IMNCI (e.g. in Lanfero 249 vCHWs trained, out of 625 current vCHWs). The new vCHWs should receive ***initial training in c-IMNCI.*** Existing vCHWs should receive a short ***refresher training in c-IMNCI,*** both to reinforce skills and to incentivize their work in the community.[19]

[19] The refresher training recognizes their work formally with the health system and also provides small allowances that serve as an incentive.

Although vCHWs report relative job satisfaction and intrinsic motivation to continue their services, some ***incentives for vCHWs*** needs to be institutionalized in the CS-23 project to ensure quality and sustainability over the life of the project. Giving *certificates to well-performing vCHWs* would be close to cost-neutral and could more formally recognize vCHWs' work in their communities. Additionally, local health authorities agreed that awarding certificates would be feasible; such low resource incentives could also be continued after the close of CS-23. *Local radio spots,* where well-performing vCHWs were interviewed about their work, could serve as both a motivator for vCHWs and an additional channel of communication for promotion of key family practices. Save the Children should also consider giving vCHWs small *in-kind incentives*—such as t-shirts, calculators, or bags—to recognize and help with their work. Ongoing SC initiatives, such as Ethiopia's EveryOne campaign, could potentially provide the in-kind incentives with few costs to the CS-23 project. Ideally, the CS-23 project and local health authorities should define a ***package of incentives for vCHWs over time*** that includes some of the above, and perhaps other feasible, locally appropriate incentives to recognize the vCHWs' work. A recent study conducted by JSI exploring motivation and provision of non-financial incentives among vCHWs in Ethiopia and the role of institutions in sustainability of the approach, recommends a similar strategy: a mixture of recognition in their communities, non-financial incentives, and sufficient support from the health system (e.g. mentoring, training and advancement opportunities).[20]

The promotion and community acceptance of key practices related to the perinatal period (ANC, assisted delivery and newborn care), remain one of the largest challenges within the CS-23 project. As noted above under access, promotional activities target young women, although fathers and grandmothers may be the main decision makers in households. The project should ***explore how to better target the decision-makers in households*** with appropriate messages about careseeking, assisted delivery, and newborn care. Additionally, far less than half (37%) of the government selected, c-IMNCI-trained vCHWs are female (684 male; 396 female) and it may be more difficult for male volunteers to convey messages about appropriate practices in the perinatal period. The HEWs and communities primarily selected vCHWs and the gender gap cannot be remedied easily within the existing structures. However, the project should consider the recruitment and support to ***supplemental female vCHWs***, who perhaps would concentrate on key maternal and neonatal health messages. Additionally, GOAL-Ethiopia's experience with ***mother-to-mothers group*** may be a promising strategy to promote these key practices. CS-23 should collaborate with GOAL to explore the feasibility and development of the mothers' group strategy to promote key practices in the perinatal period. Although this strategy is resource intensive, it could be tested for feasibility in a few *kebeles*; the newly recruited CMOs could facilitate the groups.

[20] Amare, Y. ***Non-Financial Incentives for Voluntary Community Health Workers: A Qualitative Study.*** Addis Ababa: JSI Research & Training Institute, Inc. 2010.

E5. Contribution toward objectives- IR4: Policy Environment

SC has engaged in policy dialogue and advocacy at the international, national and regional/local levels in order to foster a positive policy environment.

International level: At the international level, SC advocates for child survival programming and best practices. Health workers from Shebedino and the CS-23 project team are featured in a US-based campaign for child and neonatal survival sponsored by the Ad Council that aims to garner support and funding for MNCH services. An Italian donor group visited the project in 2010, and based on this successful mission will support Ethiopia's EveryOne Campaign.[21]

National level: SC is a member of the National Child Survival and CCM Task Forces, and has presented experiences from CS-23 and other related projects at the regional, national and international levels (Annex 2). Much of this advocacy has focused on fostering policy change to permit management of pneumonia with antibiotics at the community (HEW) level. In late 2009, the government of Ethiopia changed the HEP policy to allow pneumonia management with antibiotics in the community. This achievement in the policy environment was likely influenced, in combination with political and contextual factors, by a myriad of advocacy activities by many development partners, including SC's. IMNCI at the HP level (CCM), including treatment of pneumonia, will be introduced at-scale in Ethiopia through support from UNICEF. SC has been awarded a grant from UNICEF-Ethiopia to implement IMNCI with pneumonia treatment in 62 districts in the Oromia and SNNP regions, including Shebedino district.

Regional and local level: Save the Children has a strong partnership with the regional and local health authorities and frequently carries out joint supervision and collaborative planning and review meetings. These activities likely influence the prioritization of child survival activities in the region and districts—as one. The recent mid-term review of the CS-23 project conducted by the BoFED and RHB found that collaboration and partnership with the DHOs supports efficient resource use, and contributes to the success of the program.[22]

Additionally, Save the Children participates on the Regional Child Survival Task Force and facilitated the formation of district-level Child Survival Task Forces. Save the Children participates in related regional and local task forces, such as the EPI technical support group, as

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[21] EveryOne is Save the Children's new five-year global campaign to reduce child and maternal mortality in 36 program countries, with a goal that the Millennium Development Goal 4 is achieved and five million children will have been saved. In order to achieve its vision that within five years, no child dies from preventable causes and that public attitudes will *not* tolerate a return to high levels of child and maternal deaths, it employs four integrated campaign strategies: 1) Programmes; 2) Popular mobilization; 3) Political and policy changes; and 4) Resource mobilization. [http://www.savethechildren.net/alliance/what_we_do/every_one/index.html, accessed Sept 30th, 2010]

[22] SNNPR, Regional Health Bureau. ***Mid-term evaluation for: Enhancing Ethiopia's Health Service Extension Program in the Southern Nations and Nationalities People's Region (SNNPR), Save the Children Child Survival Project.*** June 2010.

well as assisting the regional and local health offices with child survival related emergencies and activities, such as illness outbreaks and malaria campaigns (see Annex 12 for the report from the Acute Watery Diarrhea Outbreak activities).

E6. Contribution toward objectives-Strategic Objective: Use of services

Although use of services is best measured in relation to the population in need (i.e., coverage estimates through a population-based survey as indicated in the M & E matrix), we present utilization and treatment ratios compiled from routine monitoring data and register extractions during the MTE as proxy measures of coverage.

Overall Utilization of Curative Services: Annex 13, Table 3 presents the overall utilization of sick child services at health posts and centers as collected through CS-23 routine service monitoring. Almost 6,000 children were seen at ***HPs*** in Lanfero over a one-year period, while less than 2,000 were seen at HPs in Shebedino, despite almost double the population. Average visits per HP per month also exhibit this differential; on average HPs in Shebedino saw five children per month from mid-2009 to mid-2010, while HPs in Lanfero saw an average of 20 children per month (Annex 13, Table 3). The register extraction for the period of April to June 2010 observed more sick child visits per HP per month in Shebedino (on average 13 visit per HP per month) than for the yearly period (on average 5 visits per HP per month),[23] with similar workloads observed in Lanfero (average of 19 cases per HP per month) (Annex 13, Tables 3-4). Average visits per month (workloads) were similar among HPs visited in Shebedino (mean 13 with a range from 10 to 17), while HPs in Lanfero ranged from three to 39 sick child visits per month at different HPs (mean=19 sick child visits at HP per month). HEWs in Lanfero HPs recorded treating more sick children in the month of June than those from Shebedino (Annex 13, Table 4). There were no important sex differences among cases; however, *no HEW in either district recorded treating an infant less than age two months.* Annex 13, Table 4 shows the case mix in each district; Lanfero had more presumed malaria ("fever"). Many HPs treated many cases of acute malnutrition; however, the data collection tool was not designed to tally this; therefore, these were included in the "other" category.

At ***HCs*** the same differential in utilization was present. Over 31,000 children were seen at HCs in Lanfero over a one-year period, with only 4,300 seen in Shebedino HCs (Annex 13, Table 3). Similarly, the average number of visits per HC per month were over ten times fewer in Shebedino in this one year period (average of 60 sick child visits per HC per month) than in Lanfero (763 visits per HC per month). Register extractions from the MTE showed similar trends (Annex 13, Table 5). This differential in utilization between the two districts was also observed at baseline.[24] Lanfero HCs treated more males than females (mean: 431 vs. 331)

[23] This discrepancy may be due to the quality of data available through the routine systems—e.g. yearly estimates of average utilization per HP per month are less due to missing data, or could be due to seasonally fluctuations in the incidence of child illness.

[24] For more details, see: Save the Children/USA. ***Rapid Health Facility Assessment (R-FHA) Baseline Report, Lanfero and Shebedino Woredas, SNNPR, Ethiopia.*** April 2008.

compared to Shebedino (mean: 51 males and 50 females). Young infants under two months of age were uncommonly treated: only 3 in Shebedino and 31 in Lanfero, *nearly all of whom (30) were male*. The case-mix was similar in both districts (Annex 13, Table 5).

Child treatment and treatment ratios for each IMNCI illness: Annex 13, Tables 6 to 8 present the number of child treatments and the treatment ratios by district over the last Ethiopian calendar year.[25] Shebedino District reported 1,434 cases of pneumonia treated with antibiotics, 2,293 children treated for clinical (presumptive) or RDT+ malaria and 1,520 children treated with ORS for diarrhea (544 with both ORS and zinc) over the one-year period. In Lanfero, the majority of children seeking services were treated for malaria (12,407 children treated), likely due to malaria outbreaks in the district. However, a large number of children were also treated with antibiotics for pneumonia (8,912 cases) and ORS for diarrhea (5,497 cases). In relation to the population of children under five years of age, Lanfero treated almost ten times more cases of pneumonia than Shebedino (465 cases treated per 1000 estimated population of under-fives in Lanfero versus 45.7 cases per 1000 estimated population of under-fives in Shebedino). The trend was similar for malaria cases treated, whereas Lanfero treated five times more cases of diarrhea with ORS than Shebedino in relation to its population of under-fives (Annex 13, Tables 6 and 7). Trends in the utilization of sick child services and provision of treatments are difficult to interpret given the limited availability of estimates prior to the third quarter of 2009 – due to seasonality, annual estimates are needed for interpretation.

The last column of Annex 13, Tables 6,7 and 8 present "treatment ratios," which in simple terms is the ratio of the number of reported cases treated per the number of cases expected given the estimated incidence of illness and population of children under-five over a one year period. This measure can give a general idea about the coverage of services among the population needing the services, *but* it also must be interpreted cautiously given the use of service statistics and very rough estimates of illness incidence and catchment area population. In Shebedino, approximately 15% of expected pneumonia cases were treated with antibiotics; 7% of expected malaria cases and 1% of expected diarrhea were treated at health centers and posts. The observed results from Lanfero were more impressive, with 155% of expected pneumonia cases treated, 65% of expected malaria cases treated and 6% of diarrhea cases treated at health centers or posts (Annex 13, Tables 6 and 7).

Interpretation and recommendations: Sick child services (for children 2-59 months), especially for pneumonia and malaria, appear to be reaching a significant proportion of the children in Lanfero district. The lower rates of care for diarrhea in Lanfero and Shebedino may be due to home management of the majority of simple episodes of diarrhea. Although illness incidence is likely higher in Lanfero, we found in all assessment methods that utilization of sick child services in Shebedino was considerably lower at both HCs and HPs, despite a much larger population. Key informants noted that the CS-23 team had explored the causes of low use of

[25] From July 2009 to June 2010

services in Shebedino but have not been able to identify contextual factors—such as a larger private sector or long distances to facilities—that would account for the low utilization of HCs and HPs. In addition to ***continuing the implementation of IMNCI*** at all levels and ***promoting higher utilization of HPs,*** the CS-23 project should further ***explore and document the causes of low utilization in Shebedino*** in order to address these issues through project implementation. The utilization of services preferentially for male children in Lanfero is addressed below under "equity."

Very few cases of neonatal illness were seen at HCs and almost none were seen at HPs. This evidence of appallingly low careseeking for newborns is likely related to low rates of assisted delivery and lack of awareness that health services are available for newborns (discussed above). In addition to the recommendations outlined above, such as further training in essential newborn care and safe delivery and targeted health promotion activities, the CS-23 project should draw on ***lessons from the SNL research*** as well as consider a ***rapid assessment*** to explore and address low rates of care seeking for neonatal illnesses.

E7. Contextual Factors

Contextual factors influence the implementation, sustainability and potential impact of the CS-23 project. Many of the *implementation-related contextual factors* have been discussed above. For example, weak health systems for HMIS and drug supply within the government structures challenge IMNCI implementation. The chronic lack of logistical resources for support activities—e.g., neither of the DHOs has a vehicle and there were only 1-2 old motorbikes for all their activities and petrol is often not included in the operating budget—threaten the sustainability of progress at the close of the project, constrain the day-to-day functioning of DHOs and challenge the CS-23 project coordination with MOH partners. Health staff in both districts have many competing demands on their time; with many staff absent from their posts to engage in other, sometimes non-health related activities. Additionally, the new Business Process Reengineering is a relatively new government initiative that aims to improve the accountability of government services.[26] The restructuring of health system management and services at the health center level and lower has the potential to support or impede delivery of MNCH services.

Positive and negative *impact-related contextual factors* are also present. Positive synergies with other projects are present in Shebedino district, where local NGOs support maternal and neonatal health programming. Lanfero has few complementary health projects. The recent policy change to allow pneumonia management in the community is promising; however, the previous policy precluding the use of antibiotics in the community delayed the introduction of this important intervention in the project areas. Current policy does not allow neonatal sepsis management at

[26] Debela, T. ***Business process reengineering in Ethiopian public organizations: the relationship between theory and practice.*** JBAS, Vol.1 No.2 Sept. 2009. (accessed from http://ajol.info/index.php/jbas/article/viewFile/57348/45731, 2nd October 2010)

the HEW level. The delay in the community management of pneumonia policy change and continued dialogue on HEW sepsis management could negatively influence the potential impact of the project. Low utilization for sick child services at HPs and HCs—especially in Shebedino—constrains the potential impact of IMNCI implementation, even if services are available and provided at high quality.[27] The high levels of acute malnutrition in the CS-23 project areas, especially Lanfero, and the integration of the IMNCI curative package with OTP visits (the Ethiopian government program to manage acute severe malnutrition) increase the likelihood of an impact of the CS-23 project strategies.

E8. Role of Key Partners

As discussed above, the MOH at all levels is the main partner in project implementation. Other PVOs and multi-lateral agencies are also partners; the role of each partner in the project, results of the collaboration and suggestions for improvements are presented in Table 3.

Table 3. CS-23 Ethiopia Key Partners

Partners	Role in Project	Result of Overall Collaboration Activities/ Suggestions for Improvements
Regional Health Bureau and Zonal Health Offices and Lanfero and Shebedino District Health Offices	• Approval and support for CS-23 activities, particularly with HEWs and communities. • Participate in joint planning and progress review; • Lead and participate in CS Task Force and TAG meetings; • Participate in training activities and provide follow-up on service provision after training; • Conduct joint supportive supervision of HEWs periodically; • Ensure that Health Posts have essential supplies and medicines for maternal and child health; • Appropriate distribution to Health Posts within the target area of any equipment donated and/or essential medicines;	**Results:** • Activities for building the capacity of HEWs and vCHWs have proceeded as planned; • Introduction of IMNCI supports and strategies have proceeded as planned; • High level of buy-in for IMNCI and child survival activities **Suggestions for improvements:** • Increase coordination and frequency of joint supportive supervision suggested; • Increase coordination on monitoring data and use of HMIS systems for child survival interventions; • Develop jointly a transition plan for the end of project
Population Services International in Ethiopia	• Provide orientation training for zinc treatment and provide initial stocks of zinc.	• Introduction of zinc has proceeded as planned; no suggestions for improvement
GOAL-Ethiopia	• Provide assistance for orientation training for zinc treatment; • Collaborate in sharing plans and results for child survival programming.	• GOAL staff have readily collaborated with SC, CS-23, sharing available information and experiences.

[27] Bryce J, Victora CG, Habicht JP, *et al.* ***Programmatic pathways to child survival: results of a multi-country evaluation of Integrated Management of Childhood Illness.*** *Health Policy Plan* 2005;20 Suppl 1:i5-i17.

E9. Overall design factors that are influencing progress toward results

The CS-23 project's choice to implement simultaneously all three components of IMNCI (clinical, community and health systems) at HCs and HPs *for one of the first times in Ethiopia* is commendable. This design serves as a model for future programming in caring for the sick child in the community in Ethiopia and beyond. This design is considered best practice to achieve results in improving access and utilization of sick child services,[28] although it is rarely implemented in practice.

The newborn care technical component has received less attention in design and implementation. The CS-23 project planned to train HEWs in management of sepsis and neonatal infections based on results and lessons learnt in an SNL-funded randomized control trial to be carried out in SNNPR and Oromia, but this activity has been delayed and now does not expect findings within the life of CS-23. Because of this delay and the need for stronger emphasis on the neonate in order to achieve the CS-23's ultimate goal of impacts on under-five mortality, the project will need to re-work the original design and strategy for improving neonatal health, perhaps strengthening postnatal visitation, recognition of danger signs, and referral.

F. Potential for Sustained Outcomes, Contribution to Scale, Equity, Community Health Worker Models & Global Learning

F1. Progress toward Sustained Outcomes

The SC CS-23 project has fostered sustained outcomes primarily by working closely with national and local health authorities. Although sustainability may be a challenge due to limited logistical resources for health systems supports such as drug supply and transport for supervision, the CS-23 project has contributed to the prioritization of child survival-related issues and programming within the routine government systems in Lanfero and Shebedino Districts. Likewise, because the CS-23 project built on the existing HEP system, providing additional support to this existing government strategy, the project activities will continue beyond the close of the project. Because of the insistence of government authorities that HEWs do not handle money, no efforts of cost-recovery or community-based financing are feasible at this time.

SC has secured other funding to continue the strategies developed under the current cooperative agreement. UNICEF granted the Ethiopia Country Office (EtCO) almost three million US dollars to implement community-based IMNCI (CCM) in Shebedino and 61 additional districts in Oromia and SNNP regions over the next three years. SC-Italy has awarded a grant of four million US dollars to continue similar work in Konso and Derashe Special Districts of SNNPR.

[28] Clinical, health systems and community and family practice – see Gove, S. Integrated management of childhood illness by outpatient health workers: technical basis and overview. The WHO Working Group on Guidelines for Integrated Management of the Sick Child, Bul WHO, 1997.

In the next phase of SC's CCM initiative, staff should work with government and other PVO partners to develop a ***phase-out plan*** to ensure the sustainability of project.

F2. Contribution to replication or scale-up

The CS-23 project has been an example for Ethiopia in that it has implemented all three pillars of the IMNCI strategy at the HP level. The strategy implemented by CS-23, with the addition of management of pneumonia in the community, will be scaled-up in over 600 districts within the Ethiopian FMOH HEP strategy for CCM, with support from UNICEF. CS-23 promoted this strategy through advocacy at the national and regional levels (Annex 2).

F3. Attention to Equity

SC's CS-23 project focuses on expanding access of sick and healthy child services to disadvantaged rural areas as part of the FMOH HEP strategy. The districts chosen, although not the poorest districts in SNNPR, are considered disadvantaged within Ethiopia. The MTE was not able to assess the socio-economic equity impacts of the project; however, the baseline KPC included measurement of household characteristics and assets. The ***endline KPC*** should include these same measures to enable analysis of changes in the equitable distribution of intervention coverage in the project areas.

The project focuses specifically on the health of women and children. However, the CS-23 team is almost all male, as are the vast majority of MOH counterparts. In the second phase of the CS-23 project, ***attention to gender equity*** should be emphasized in the recruitment of any positions within the CS-23 project.

We reviewed utilization of services by gender of the child (section E) in the MTE and observed no gender preference in Shebedino District. However, in Lanfero districts, it appears that families may be utilizing care for boy children much more often than for girl children, especially for neonatal illness. We were not able to explain this finding during the MTE and it merits ***further assessment*** to confirm the magnitude of gender preference in careseeking and determine potential causes and programming options to overcome this inequity.[29]

F4. Role of Community Health Workers

Above we have discussed the community-based health workers in great depth; the HEWs who provide services and promotional activities at health posts, in the community and through household visits, and the vCHWs who promote key family practices in the community and households. The CS-23 project, during the MTE, completed the beta version of the

[29] Soon after the MTE field work, the CS-23 team did a review of all sick children who visited 2 health posts in Lanfero, for a total of nearly 500 cases from IMNCI registers and did not find this sex difference; the full assessment will be completed soon.

URC/USAID "CHW assessment and improvement matrix (CHW AIM)"[30] in order to better describe the cadres of community workers. Annex 7 includes the CSHGP CHW matrix and the CHW AIM as applied to the CS-23 project.

F5. Contribution to Global Learning

The implementation of IMNCI at the health posts, even in the absence of pneumonia management, is one of the first in the SNNPR and serves as a learning experience at the regional and national levels. Lanfero and Shebedino Districts are among the first in the country to introduce zinc treatment for management of diarrhea. In coordination with PSI, SC trained health providers and provided zinc supplies in 2009. The CS-23 project continues to support the introduction of zinc and is collecting data related to zinc treatment at health posts and caretakers' follow-up visits to HPs. The CS-23 project and MOH partners should ***further document their experiences with zinc***, drawing on the quantitative data collected at health posts, and share with local and national stakeholders in the beginning stages of zinc introduction. Additionally, the CS-23 project conducted formative research to assess and propose potential improvements to supervision within the HEP system; a full operational research proposal for HEP supervision strategies is under development.

G. Conclusions and Recommendations

Overall, the CS-23 project has successfully supported the implementation of the complete package of IMNCI in facilities and the community. Its activities have and will serve as a model for implementation of comparable initiatives in Ethiopia. The grant to SC from UNICEF to implement IMNCI in the community in 62 districts using a similar approach is a good measure of the CS-23 project's success. The activities and implementation are on track at mid-term; however, utilization of maternal, child and neonatal services remain a challenge. In IMNCI, the CS-23 project can now progress to: 1) strengthen implementation further; 2) improve utilization; 3) introduce pneumonia management in the community in light of the recent policy change; and 4) develop a transition plan to ensure sustainability after the close of the project. The transition plan may include consideration to develop a follow-on child survival project that could leverage, inform, and scale up best practices found in CS-23. The CS-23 project should build on its success in introducing and supporting INMCI, as well as reinforcing capacity and relationships with the MOH at all levels, to introduce and implement stronger strategies to improve neonatal health. In summary, the primary recommendations at mid-term include: [31]

IMNCI service availability, quality and health practices

□ Continue support to DHOs and health workers in the implementation of IMNCI.

[30] University Research Co. and USAID. ***Assessing and Improving Programs Extending Health Services to Communities: The Community Health Worker Program Assessment and Improvement Matrix (CHW AIM), DRAFT FOR BETA TESTING.*** April 2010.

[31] See sections C and E for more details regarding recommendations.

□ Conduct initial and refresher training through CS-23 or in coordination with partners, including:

- Initial IMNCI training for newly assign HEWs and HEP supervisors;
- Pneumonia management and treatment training for all the HEWs[32] and HEP supervisors;
- Refresher training in IMNCI for HEWs, HEP supervisors and health center staff; and
- Initial and refresher c-IMNCI training for new and previous vCHWs and HEWs.

□ Propose standard guidelines for treatment and tracking of sick children seen by HEWs in household visits.

□ Strengthen the system for referral and referral feedback through: a) strategies to facilitate referral; b) creating community demand for referral feedback; and c) provision of referral slips (with feedback sections) to all levels.

□ Strengthen stock management system and coordination with RHB and local health officials to ensure adequate IMNCI drug availability; including rapid assessment of causes of CoArtem® stock-outs.

□ Ensure availability of IMNCI supervision checklists (pending review of RHB and new HMIS) at all levels and provide "on-the-job" training for the use of checklists where necessary.

□Review two-month supervision training package with government partners and advocate for inclusion of IMNCI supervision in package; in interim ensure 5-day training for HEP supervisors.

□Develop a package of low cost incentives—such as certificates and in-kind incentives from child-survival related campaigns—for HEP supervisors, HEWs and vCHWs in coordination with local health authorities and communities.

Neonatal Health Component

□ Provide essential newborn care training using postnatal visitation package from WHO/UNICEF/SC reprogrammed from treatment of sepsis activities due to delay SNL research.

□ Promote postnatal home visits and peri-natal promotional activities by team of female volunteers and mothers-to-mothers groups led by HEWs.

□ Target perinatal behavior change activities to fathers and grandmothers.

□ Leverage and advocate with other partners for Safe and Clean Delivery training for HEWs.

Partnerships, advocacy and transition plan

□ Continue the strong collaboration with the national FMOH and regional and local levels health authorities.

□ Continue child survival advocacy activities at international, regional and local levels.

□ Coordinate and leverage with partners to: a) strengthen drug supply availability and stock systems; b) provide clean and safe deliver training; and c) supply clean delivery kits.

[32] This is supported by UNICEF through Save the Children in Lanfero and Shebedino districts; therefore there may be opportunities to re-program funds to other, unfunded needs.

□ Develop a transition plan for the close of CS-23 project in coordination with partners and stakeholders that addresses: a) drug supply, with emphasis on zinc; and b) continued supervision of IMNCI activities at HCs, HPs and in the community.

Monitoring, evaluation and operational research

□ Improve CS-23 routine monitoring through: a) incorporation of non-survey based indicators; b) indicators linked to the target population; c) district-disaggregated estimates; and d) analysis of time trends.

□ Support the government HMIS in coordination with routine CS-23 monitoring where feasible.

□ Assess, verify and explore causes of gender preferences in Lanfero District.

□ Investigate and document reasons for low utilization of child health services in Shebedino in order to develop approaches to increase utilization.

□ Carry-out operations research to test alternative, promising strategies for motivation and supervision within the HEP strategy pending DHO, RHB, and FMOH concurrence.

H. Action Plan

Please see Annex 15.

ANNEX 1: RESULTS HIGHLIGHT

***Best Practice:* Implementation of the comprehensive IMNCI strategy in health centers, health posts and communities in Shebedino and Lanfero Districts of SNNPR, Ethiopia.**

Save the Children (SC) is implementing a USAID/CSHGP Child Survival Project (CS-23) to reduce under-five mortality among 69,491 children 0-59 months of age in Lanfero and Shebedino districts, SNNPR, Ethiopia. Through CS-23, Save the Children has implemented all three pillars of the Integrated Management of Neonatal and Childhood Illness (IMNCI) to improve curative services for sick children, especially in the community.[1] The three-pronged IMNCI strategy is considered a best practice, although is very rarely implemented in practice.[2] A baseline health facility assessment found that health posts (HPs) did not have the training or supplies to deliver IMNCI services to children in the community. In collaboration with the Regional Health Bureau (RHB) and NGO partners, Save the Children:

- Trained and supports 102 Health Extension Workers (HEWs) in IMNCI at 55 health posts, resulting in coverage of approximately 2 HEWS and 1 HP per 1000 children under five;
- Supports the health system to provide supplies, drugs and regular supportive supervision for IMNCI , including the introduction of zinc for diarrhea management; and
- Trained, equipped and supports volunteer community health workers (vCHWs) and HEWs to promote essential family practices, including careseeking and home care.

HEWs now have the skills, supplies and support to appropriately assess, classify and treat cases presenting with fever and diarrhea; assess and treat children with malnutrition and assess, classify and refer children with pneumonia or danger signs. The results over the first year of full IMNCI implementation in the two districts include:[3]

- **14,700 children under-five treated** with antimalarials for RDT+ or clinical malaria (fever) annually (291 malaria/fever cases treated per estimated 1000 children under-five) ;
- **10,346 children under-five treated** with antibiotics for pneumonia annually (205 pneumonia cases treated per estimated 1000 children under-five);
- **7,017 children under-five treated** with ORS for diarrhea annually (1,927 with ORS and zinc) annually (139 diarrhea cases treated per estimated 1000 children under-five)

The implementation of the comprehensive IMNCI strategy, especially among HEWs at HPs, was the *first kind in the region* and recognized by the RHB and in National IMNCI review meeting as a model for scale up. UNICEF will support a similar strategy of IMNCI in communities in 600 districts, implemented by the Ethiopian health system and NGO partners, including SC. The IMNCI strategy now includes pneumonia management/treatment by HEWs in the community.

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[1] See Gove, S. ***Integrated management of childhood illness by outpatient health workers: technical basis and overview.*** Bul WHO, 1997.

[2] Bryce J, Victora CG, Habicht JP, *et al.* ***Programmatic pathways to child survival: results of a multi-country evaluation of Integrated Management of Childhood Illness.*** *Health Policy Plan* 2005;20 Suppl 1:i5-i17.

[3] Utilization also takes into account IMNCI services provided at health centers; Health centers also received IMNCI training and supplies and are part and parcel of IMNCI strategy.

ANNEX 2: LIST OF PUBLICATIONS AND PRESENTATIONS

As an active member of the national child survival working group; SC has played an advocacy role, generated and shared knowledge about local best practices and widely disseminated their experiences to a wide range of audiences during annual review meetings, professional association's annual conference and other relevant workshops at the international, national and regional levels. These include:

List of presentations/publications	To whom	Date
1. CS23 project overview for partners	Regional Health Bureau, Sidama & Silti Zone Health Departments, to lanfero & Shebedino DHOs, UNICEF, JSI/ESHE, GOAL, Plan International	March 2008
2. CS23 project over view	Regional CS task force which includes RHB, UNICEF,WHO, JSI and international NGOs in SNNPR	March 2008
3. Community Case Management Improves Use of Treatment for Childhood Diarrhea, Malaria and Pneumonia in a Remote District of Ethiopia	Annual conference of the Ethiopian Pediatric Society, close to 100 pediatricians in attendance. (SC also distributed articles on pneumonia CCM)	May 2008
4. CS23 project overview	CS Technical Advisory group which includes MoH, UNICEF, GOAL Ethiopia, JSI/IFHP, Malaria Consortium	November 2008
5. CS23 project overview and achievements presentation	Regional, Zonal and District Health offices review meetings	June 2009, March 2010
6. Dissemination workshops on KPC and HFA baseline findings	RHB, Sidama and Siliti ZHD, Lanfero & Shebedino DHO	August 2009
7. Experience of operationalizing Zinc treatment in CS23 project	GOAL CS MTE workshop	September 2009
8. Community Case Management Improves Use of Treatment for Childhood Diarrhea, Malaria and Pneumonia in a Remote District of Ethiopia	International Multilateral Initiative on Malaria symposium November 2-6, 2009 in Nairobi Kenya	Nov 2009
9. CS23 project overview and achievements presentation	Africa Regional *Pan-Africa Every One Campaign Workshop,* February 18-20, 2010 Addis Ababa	Feb 2010
10. CS23 project overview and achievements presentation	National Orientation and launching workshop on CCM: Nazareth, Ethiopia. Donors, implementing partners and RHBs	Feb 2010
11. Presentation on CCM esp of Pneumonia	Regional level workshops and CS task force	April 2010
12. Evidence, Advocacy, and Partnerships for Community Case Management of Childhood Infection in Ethiopia: T*he End of the Beginning*	Save the Children Program Learning Group Norwalk, CT, USA.	June 2010
List of reports/publications		
1. Formative research on the HEP supervision	(unpublished report)	September 2009
2. Degefie T, Marsh D, Gebremariam A, Tefera W, Osborn G, Waltensperger K. *Community Case Management Improves Use of Treatment for Childhood Diarrhea, Malaria and Pneumonia in a Remote District of Ethiopia Ethiop. J. Health Dev.* 2009;23(2)	Peer-review publication in Ethiopian Journal of Health and Development from previous project to advocate for inclusion of pneumonia treatment	2009
3. Quarter and annual activity and financial	RHB, Sidama and Siliti ZHD, Lanfero & Shebedino	Jan, Apr, Jul

reports to government partners	DHO and to Regional Bureau of Finance	& Oct 2008-10
4. KPC and HFA baseline reports to key partners	RHB, Sidama and Siliti ZHD, Lanfero & Shebedino DHO	August 2009
5. Integrated/Joint supervision reports	Sidama and Siliti ZHD, Lanfero & Shebedino DHO	Aug, Oct, Mar 2009
6. Training reports in IMNCI	RHB, Sidama and Siliti ZHD, Lanfero & Shebedino DHO	July 2009
7. Training report in C-IMNCI	RHB, Sidama and Siliti ZHD, Lanfero & Shebedino DHO	Feb & Nov 2009
8. AWD outbreak reports Lanfero	RHB, Siliti ZHD & Lanfero DHO	Dec 2009

ANNEX 3: PROJECT MANAGEMENT EVALUATION

PLANNING

Project documentation and interviews with government partners and other key stakeholders confirm that the project's planning process has been inclusive since inception, engaging at the national, regional, zonal, and district levels. Development of the original application and DIP, the MTE team, and MTE workshop held 9 August 2010 were all participatory events. Save the Children participates on the SNNPR Regional Child Survival Task Force and on several technical working groups at the national level.

The DIP and work plan are coordinated with district planning and guide implementation in the two districts. Going forward for the last two years of the project, the work plan will be adjusted in the area of training and strengthened for tracking and monitoring.

SUPERVISION OF PROJECT STAFF

Save the Children's EtCO supervisory system for SC staff, as described in the DIP, is adequate, fully institutionalized, and maintained. Challenges of the supervisory system for service delivery, as it applies to the project and its service providers, is described in detail in the MTE report.

HUMAN RESOURCES AND STAFF MANAGEMENT

In February 2010, the project added two field positions for Community Mobilization Officers to strengthen coordination with local community leadership and follow up of the vCHWs trained in c-IMNCI. The presence of CMOs in the field has paid off in increasing structure and routine meeting schedule and monthly planning for delivery of key messages by vCHWs. Annex 3, figure presents an updated organigram and the CMO job description is presented in Annex 3, Box.

Shortly after the MTE, it was announced that Dr. Tedbabe Degefie, Head of Save the Children's Health Unit in the Ethiopia Country Office, would be leaving in October 2010 to take a position at UNICEF in Ethiopia. Dr. Degefie has been with Save the Children since May 2000. The EtCO and CS-23 team looks forward to working with Dr. Degefie in her new role in Child Health/Newborn Health at UNICEF.

FINANCIAL MANAGEMENT

Save the Children's financial management system, as detailed in the DIP, appears to be adequate and accountable at headquarters, country, and field levels. Save the Children's

spending is on track; it has not submitted a budget amendment, and no major budgetary adjustments are planned at this time. Adequate resources are in place to finance operations and activities planned for the remaining two years of the project.

One challenge cited by the project team is that per diems for IMNCI facitators/trainers were under-budgeted and are below current market standards. For this reason, Save the Children has found it difficult to recruit facilitators/trainers. The project team is working with the EtCO in Addis Ababa to secure special approvals to adjust per diem payments to at least the level of the Ethiopian Pediatric Society approved standard for IMNCI facilitators/trainers.

Logistics

Early in the project, a delay in raising private funds for procurement of the project vehicle was a major challenge. This delay lasted nearly a year until Save the Children's Survive to Five Campaign (now called Where the Good Goes) agreed to raise the necessary funds for the vehicle, as well as to cover procurement of zinc and other essential drugs to fill supply gaps.

Information Management

Section C in the body of the report details the project's research, use of data, and outcomes, including system for collecting, reporting and using data and measuring progress toward project objectives.

Technical and Administrative Support

The team reported that technical and administrative support have been adequate to meet project needs. Dr. David Marsh, Save the Children's Senior Child Survival Advisor and Community Case Management Team Leader, continues to backstop the project technically from headquarters. Additional programmatic support (match) is provided by Africa Regional Health Advisor Karen Z. Waltensperger based in South Africa, and by Westport-based staff who assist with finance, documentation, and coordination.

Annex 3, Box: Community Mobilization Officer Job Description

SC/USA – ETHIOPIA COUNTRY OFFICE: JOB DESCRIPTION

Position Title:	**Community Mobilization Officer**
Location:	**Shebedino (Sidama Zone) and Lanfero (Siliti Zone)**
Reports to:	**Child Survival (CS-23) Health Program Coordinator**
Grade:	**C1**

General description: Incumbent is expected to provide a consistent and high quality technical support in relation to community mobilization activities. The position holder will assist the program officers in each PU to build strong and workable community mobilization intervention packages and there by strengthening the implementation of one of the key CS23 strategy Community IMNCI to deliver key health messages at community level.

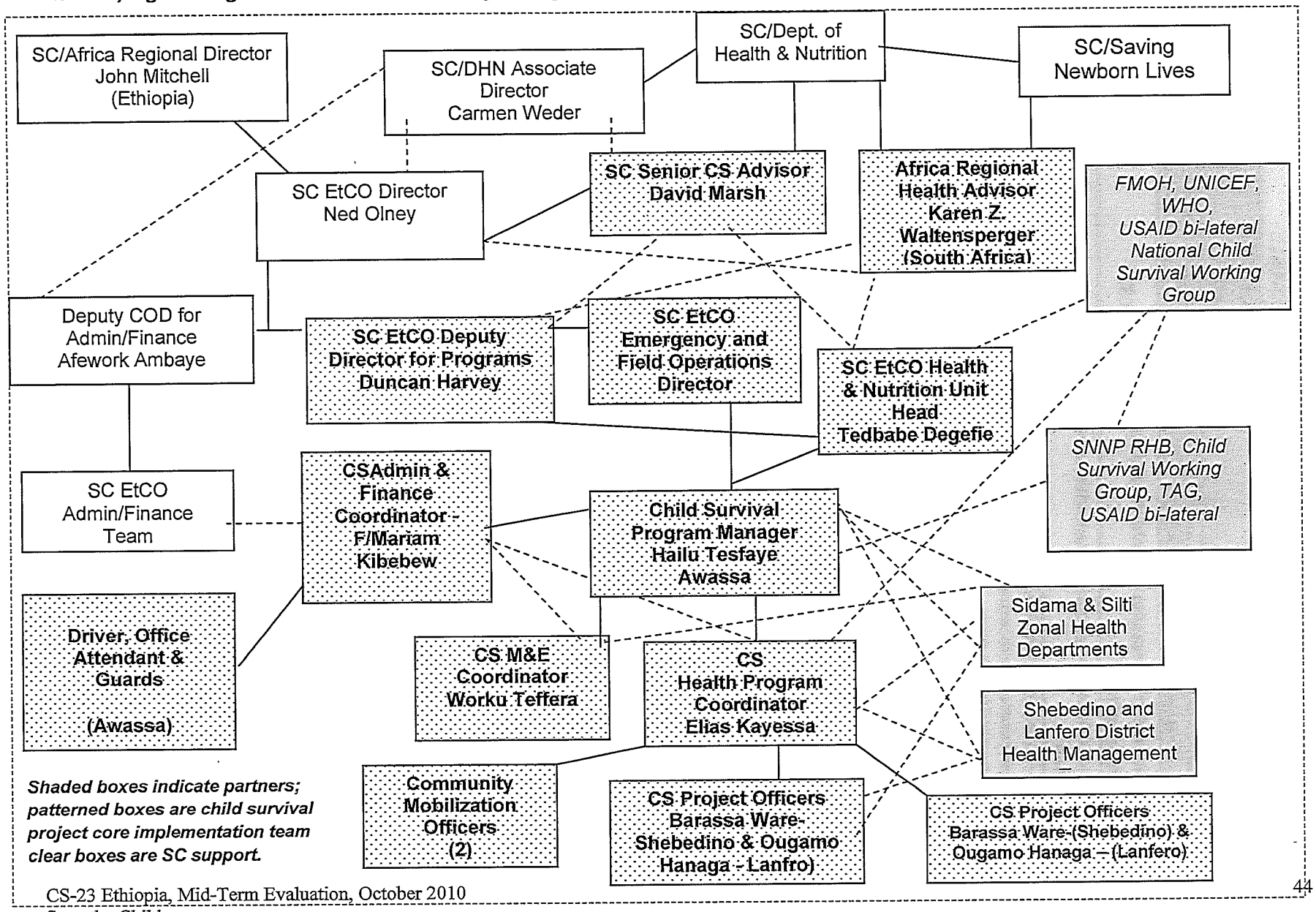
Specific Responsibilities:

- Organize community groups, generate community resources and educate them on sustainable community involvement in the uptake of C-IMNCI interventions
- Using the behavior change strategy in CS23 for the C-IMNCI implementation, mobilize the community around the promotion of key newborn, child and maternal health key messages
- Educate community groups on C-IMNCI promotion and implementation
- Organize communication activities such as workshops, focus groups seminars, and other training activities for HEWs, volunteers and among local community groups.
- Support on-going monitoring of capacity building and effectiveness of mobilized community interventions
- Adapting and developing appropriate training manuals for community voluntaries.
- Develop and disseminate experience-based learning on community mobilization specific to CS23 program in SNNPR
- Together with the Health Program Coordinator and District Health Officers conduct an assessment of community structures, local service providers, peer educators and social mobilizes who can assist the incumbent to implement wide ranging community mobilization activities in maternal, newborn and child health
- Coordinate with project coordinator to ensure consistent community mobilization in the target districts
- Prepare and submit routine project activity reports.
- Document lessons learned and success stories.
- Demonstrate effective team building and communication skills to maintain harmony and work efficiency in the unit.
- Work closely in C-IMNCI implementation with Health Extension workers and volunteer community health workers (VCHW) to deliver the key maternal, newborn and child health messages
- Work on feasible strategies to effectively reach households and Plan and implement C-IMNCI with HEWs and VCHWs
- Work closely with ME officer and the District HEW supervisors for close monitoring of C-IMNCI implementation

Minimum Requirements:

- Bachelor Degree in Social Sciences/Public Health/Nursing/Communications or any other related field with 4 years of relevant work experience of Diploma in one of these fields with 5 years of relevant experience.
- Knowledge, training and experience in C-IMNCI and community mobilization/BCC
- Demonstrated skills in program planning, implementation and monitoring.
- Demonstrated skills in peer group training, Training of Trainers and development of training materials.
- Proficiency in spoken and written Amharic and English.
- Strong computer and interpersonal skills.
- Demonstrated ability to work effectively in a team environment.

Annex 3, Figure: Organizational Chart and Project Organigram



ANNEX 4: WORK PLAN TABLE

MAJOR ACTIVITIES	OBJECTIVE MET?	ACTIVITY STATUS
NOTE: "Completed/on-going" signifies that the activity has been successfully carried out in the first phase of the project and will continue in the next phase of the project as well		
Intermediate result I: Access and availability of services and supplies increased	**YES**	
Activity 1. Train health workers including Health Extension Workers in IMNCI	Completed	109 HEWs & 13 HC workers trained in IMNCI in 2009
Activity 2. Provide standard IMNCI algorithms to assess, classify and treat symptoms of diarrhea, malaria and pneumonia for health centers and health posts	Completed	All HCs and HPs equipped in 2009 with IMNCI job aids; available in 2010 MTE (see results section)
Activity 3 . Train community health promoters in C-IMNCI	Completed	1080 vCHWs trained in 2009
Activity 4. Facilitate prompt referral of sick children from community to health post & severe cases from HP to health center	Partial	
Activity 5. Strengthen prompt & effective assessment and appropriate treatment of diarrhea and malaria by trained HEWs	Completed/ On-going	No
Activity 6. Strengthen prompt & effective assessment and referral of pneumonia by trained HEWs	Completed/ on-going	New FMOH permits the treatment of pneumonia with antibiotics by HEWs; in remaining years of project, HEWs will treat pneumonia
Activity 7. Provide/facilitate for health centers and health posts with essential IMNCI drugs to treat diarrhea and malaria	Completed/ on-going	IMNCI drugs procured & distributed; Stock shortages and financial resource constraints threaten on-going support
Activity 8. Provide/facilitate availability of first line antibiotic to treat pneumonia at health centers	Completed/ on-going	
Activity 9. Ensure adequate supply of antimalarial and new formula ORS at health center and health post level	Completed/ on-going	
Activity 10. Ensure adequate zinc supply/stock at health post (HP) & health center (HC)	Completed/ on-going	
Activity 11. Start zinc treatment for diarrhea at HC and HP	Completed/ on-going	
Activity 12. Advocate at regional & national level through established child survival groups and UN organization to start CCM/pneumonia by trained HEWs	Completed	Policy change in 2010 to include CCM/P by HEWs, implementation scheduled to start in Sept/Oct 2010
Activity 13. Ensure adequate supply/stock of first line antibiotic for pneumonia at health posts	Not completed	MOH policy/practice did not support AB treatment by HEWs until late 2010; to be started in 2010 with support from UNICEF and completed in 2011, 2012
Activity 14. Start community case management of pneumonia at health posts by trained HEWs	Not completed	
Activity 15. Follow up for adequate supply and distribution of ITN at HC & HP	Completed/ on-going	Support for ITN distribution in transportation; LL ITNs primarily supplied through campaigns
Activity 16. Follow up for adequate supply and stock of childhood vaccines at HC & HP	Completed/ on-going	Supportive supervision; larger stock issues remain a challenge

MAJOR ACTIVITIES	OBJECTIVE MET?	ACTIVITY STATUS
NOTE: "Completed/on-going" signifies that the activity has been successfully carried out in the first phase of the project and will continue in the next phase of the project as well		
Activity 17. Promote routine and outreach immunization	Completed/ on-going	Done by HEWs and vCHWs with support from MOH partners & CS-23
Activity 18. Avail a trained HEW and a health professional in essential new born care and assessment of sick new born	Partial	Essential newborn care include in IMNCI training; Sick NN Activity on hold pending results from SNL research
Activity 19. Avail a trained HEW & health professional in safe delivery, newborn care, assessment, resuscitation & postnatal care	No/partial	Only 10 HEWs trained in clean and safe delivery (5 in each district)
Activity 20. Strengthen the link between TBAs & HEWs in follow up of deliveries, newborns to provide essential newborn care & postnatal care	Partial	Reporting formats provided; HEWs liaising with TBAs well for follow-up, although links not standardized or institutionalized
Activity 21. Strengthen the referral link of sick newborns to health centers for early & prompt management	Partial	Few sick newborns seeking care at either HPs or HCs
Activity 22. Follow up for availability of safe delivery kit and newborn resuscitation equipment at health post & health centers	Partial	Supplied by UNICEF; Partial availability of safe delivery kits - no resuscitation equipment supplied
Activity 23. Support TT immunization and availability at health post	Completed/ on-going	Through supportive supervision
Activity 24. Avail standard Job aids (IMNCI reference materials, wall charts, teaching aids, IEC materials) in child health	Completed	All standard IMNCI job aids & registers distributed & available day of MTE visit
Activity 25. Avail standard registers and reporting formats	Completed	
Activity 26. Monitor and follow up for essential drugs & supply & facilitate corrective actions	Completed/ on-going	Through supervision and coordination; on-going challenge to ensure drug stocks at all levels
Intermediate Result 2: Quality of services increased		
Activity 1. Train health professionals in IMNCI case management skill (how to assess, classify, treat & counsel) pneumonia, malaria & diarrhea, newborn & sick young infant	Completed	13 HC workers trained in IMNCI in 2009
Activity 2. Train HEWs in IMNCI case management and referral skill (assess, classify, treat, counsel)of pneumonia, diarrhea, malaria, newborn/sick young infant	Partial	109 HEWs HC workers trained in IMNCI in 2009; HEWs not trained in pneumonia or sick newborn mgmt due to policy issues
Activity 3. Facilitate/provide with IMNCI essential drugs & supplies for health centers and health posts.	Completed/ on-going	Drug shortages are on-going challenge (purchased with supplementary finds)
Activity 4: Follow up for appropriate drug treatment at HP & HC level	Completed/ on-going	
Activity 5: Follow up for proper counseling and follow up at health post & HC	Completed/ on-going	Provided with IEC job aids
Activity 6. Facilitate rehydration therapy with the new ORS formula	Completed/ on-going	ORT corners set-up & ORS formula available
Activity 7: Facilitate zinc treatment for diarrhea	Completed/ on-going	In coordination with PSI

MAJOR ACTIVITIES	OBJECTIVE MET?	ACTIVITY STATUS
NOTE: "Completed/on-going" signifies that the activity has been successfully carried out in the first phase of the project and will continue in the next phase of the project as well		
Activity 8. Give regular on the job trainings and technical assistance in IMNCI implementation at health post & health centers	Completed/ on-going	During joint supervisions and visits by SC staff
Activity 9: Train HEWs in assessment of sick newborn, in essential newborn care messages (TT immunization, cord care, thermal management & recognition of newborn danger signs)	Completed	This was provided to HEWs as part of the IMNCI training
Activity 10: Support/build capacity of health workers and District Health Office staff in proper supervision and routine monitoring, in sustaining facility & community level activities	Completed/ on-going	Regular joint supervision and review meeting occurring
Activity 11: Review quality improvement options with partners in delivery of MCH services and design OR protocol	On-going	Review of challenges and options, protocol under development
Activity 12: Review regional data collection/HMIS in standard documentation and reporting to make them user friendly	Completed / on-going	Review mtg held in 2009, new HMIS requires on-going efforts
Activity 13: Conduct baseline rapid health facility assessment survey	Completed	
Activity 14: Strengthen existing supportive supervision for HEWs jointly with district health office health center staff	Completed/ on-going	Joint supervision for IMNCI conducted throughout project
Activity 15: Facilitate use/adoption of standard supervision checklists inclusive of curative services and counseling services	Partial	Supervision checklists specific to IMNCI under review by RHB
Activity 16: Avail Standard job aids for reference and documentation (registers, reference job aids for key messages delivery, IMNCI reference materials/algorithm)	Completed	Supplies distributed and available at HCs and HPs
Activity 17: Conduct joint review meetings and feed backs on performance on regular basis (recognize best performances)	Completed/ on-going	Conducted regularly throughout project
Activity 18: Ensure use of standard reporting formats and registers	Completed/ on-going	
Activity 19: Strengthen the link between HEWs &TBAs/TTBAs in essential newborn care and post natal care	Partial	Links established, but not standard
Activity 20: Support & facilitate child immunization	Completed/ on-going	Promotion of immun, facilitation of stocks, and member of EPI TF
Activity 21: Promote on early treatment of sick child for fever, diarrhea & pneumonia	Completed/ on-going	vCHWs
Activity 22: Planning, design monitoring & evaluation and KPC training for child survival M&E officer	Completed	
Activity 23: Facilitate annual technical updates with professional associations on child survival	Completed/ on-going	Membership, participation and presentations at national, regional and district child survival task forces
Activity 24: Annual progress review & planning meeting	Completed/ on-going	Close relationship with RHB & local health authorities
Activity 25: Performance progress monitoring survey	Planned	It is included in year 3 plan
Activity 26: Participatory midterm evaluation led by external consultant	Completed	
Activity 27: Review midterm assessment and MTE findings & recommendations with MOH and partners, prioritize &	Completed	MTE was participatory, with results and recommendations workshop;

MAJOR ACTIVITIES	OBJECTIVE MET?	ACTIVITY STATUS
NOTE: "Completed/on-going" signifies that the activity has been successfully carried out in the first phase of the project and will continue in the next phase of the project as well		
schedule actions to address recommendations, & plan for required actions		
Activity 28: Conduct end line rapid health facility assessment	Not yet completed – planned for endline	
Activity 29: Conduct endline KPC survey		
Activity 30: Final evaluation led by external consultant		
Intermediate Result 3: Knowledge and acceptance of key services and behaviours increased	**YES**	
Activity 1: Train HEWs and VCHWs in delivery of key messages in child health, nutrition, care seeking behaviors/practices, child/maternal/newborn danger signs, essential newborn care, postnatal care, hygiene & sanitation	Completed	
Activity 2: Adopt/develop education materials/teaching aids for key messages in child health, in appropriate behaviors & practices	Completed	Counseling cards, leaflets and booklets distributed
Activity 3: Conduct community leaders sensitization workshop	Completed	
Activity 4: Provide health promotion activities in health facilities in child health, nutrition, care seeking, hygiene and sanitation during one to one sessions or during health education	On-going	Health Education sessions; Using IEC materials
Activity 5: Deliver key behaviors & practices in appropriate care seeking for ill child, in recognition of signs needing proper treatment, in recognition of danger signs through trained HEWs and VCHWs at household level	On-going	
Activity 6 : Promote on appropriate hand washing practices	On-going	
Activity 7: Promote standard immunization services during health facility visits	On-going	
Activity 8: Promote on proper oral rehydration at health facilities and home during diarrhea	On-going	
Activity 9: Counsel/advise caretakers on proper feeding and fluid during diarrhea episodes	On-going	
Activity 10: Counsel caretakers in proper breast feeding, proper feeding for infant & young child and feeding during illness	On-going	
Activity 11: Counsel caretakers in one to one and in groups about household sanitation & hygiene (proper hand washing, safe waste disposal & safe water storage/treatment) using trained HEWs & VCHWs	On-going	
Activity 12: Inform community on ITN availability and proper utilization by children & pregnant women	On-going	
Activity 13: Ensure caretakers understanding of importance of referral and follow up of sick child	On-going	
Intermediate Result 4: Social and policy environment enabled and sustainability of all activities improved	**YES**	
Activity 1: Develop project agreement with Regional Health Bureau (RHB) and key stakeholders	Completed	

MAJOR ACTIVITIES	OBJECTIVE MET?	ACTIVITY STATUS
NOTE: "Completed/on-going" signifies that the activity has been successfully carried out in the first phase of the project and will continue in the next phase of the project as well		
Activity 2: Collaborate with RHB and other partners on child survival working groups at regional and national level	On-going	
Activity 3: Work with GoE/NGO/UN partners for policy improvement in HSDP-IV, esp CCM of pneumonia by HEWs	Completed	
Activity 4: Document and disseminate evidence based best practices in CCM using MoH guidelines and documents	On-going	17 CCM best-practices disseminated
Activity 5: Conduct joint planning with relevant & key partners and community stakeholders in CCM (develop detailed implementation plan)	Completed (on-going for routine planning)	
Activity 6: Lead regular partners coordination, advocacy and policy dialogue in CCM and evidence based new born & child practice	On-going	
Activity 7: Adopt proven child health interventions and strategies in to regional and national policies and programs	Completed/ on-going	
Activity 8: Conduct joint and integrated supportive supervisions and TAs	Completed/ on-going	
Activity 9: Follow up of health facilities functionality in IMNCI implementation and reporting	Completed/ on-going	
Activity 10: Facilitate proper health service delivery by health posts in collaboration with MoH and partners	Completed/ on-going	
Activity 11: Support and facilitate standard documentation and regular reporting by health posts & health centers	On-going	Documentation and reporting at HPs needs further strengthening
Activity 12: Standardize the referral link between HEWs and TBAs/VCHWs in safe & clean delivery & postnatal visit	Not yet completed	HEWs (except X) not trained in SCD, some links between TBAs/CHW & HEWs, but not standardized
Activity 13: Participate and advocate through Save the Children Health & Nutrition (PR3) Program Learning Group	Completed	(see presentations list)
Activity 14: Conduct first regional dissemination workshop (Awassa)	Completed	
Activity 15: Final dissemination workshop	Not yet completed, planned at endline	
Activity 16: Participate in periodic regional child survival taskforce meetings	Completed/ on-going	2-4 times per months
Activity 17: Document and share child survival interventions & updates in regional review meetings	Completed/ on-going	Reports shared regularly with RHB, ZHD and DHO
Activity 18: Support and participate in national child survival taskforce to advocate for policy change in CCM	Completed/ on-going	
Activity 19: Establish regional TAG (Technical Advisory Group with representation from RHB, Regional Child Survival Coordinator, Hawassa University, UNICEF, WHO, ESHE, Malaria Consortium)	Completed	
Activity 20: Conduct regional TAG meeting	Completed/ on-going	
Activity 21: Establish district level child survival team (MoH, SC, others working on CS)	Completed	Established in 2009
Activity 22: Document of the CCM/P experience to inform	Completed	Documentation/presentations of

MAJOR ACTIVITIES	OBJECTIVE MET?	ACTIVITY STATUS
NOTE: "Completed/on-going" signifies that the activity has been successfully carried out in the first phase of the project and will continue in the next phase of the project as well		
regional level scale up		experiences in Liban (CS-17)
Activity 23: Advocacy and policy dialogue to promote uptake at the regional level	Completed/ on-going	

Action plan notes:

1. Map out current resources among partners in districts, gaps, etc and see how training gaps can be filled
2. Asses each level of worker, training needs and cost – and split between partners.
3. Re-program money for SCD or essential newborn care training (Cost out and plan) for HEWs (because newborn sepsis will not be possible because of delays) – will need to engage districts
4. Rapidly assess gender differential in Lanfero district to see if real
5. Coordinate with the district level to see about CoArtem stocks and availability
6. Follow-up on Zn pilot data – document and disseminate
7. Detail and follow-up on plans for HEP supervision training (assess 2 months)

ANNEX 5: RAPID CATCH TABLE

Not applicable

ANNEX 6: MID-TERM KPC REPORT

Not applicable

ANNEX 7: CHW TRAINING MATRIX AND URC/USAID CHW AIM

Annex 7, Table 1: CSHGP CHW Training Matrix

Project Area	Type of CHW	Official Government CHW or Grantee-developed Cadre	Paid or Volunteer	Number Trained over the Life of the Project	Focus of Training
Lanfero and Shebedino Districts	Health Extension Worker (HEW)	Government	Paid	102	• Integrated Management of Neonatal and Child Illness (IMNCI): o Essential Newborn Care o Diagnosis & treatment of malaria with RDTs; treatment of diarrhea with zinc and ORS; Assessment and referral of pneumonia o Counselling and feeding practices
Lanfero and Shebedino Districts	Volunteer Community Health Workers (vCHW)	Government	Volunteer	1080	• Community-IMNCI in 20 key practices, including: o Growth Promotion and nutritional practices o Hygiene and sanitation and malaria prevention o Home management of child illness (continued feeding and fluids) o Early care seeking o Promotion of immunization, ANC, and family planning

Annex 7, Table 2: URC/USAID "Beta" CHW – AIM Functionality Assessment[4]

#	Component	vCHW		HEW	
		Score	Comment	Score	Comment
1	Recruitment	3		3	
2	Role	3		3	
3	Initial Training	3	Initially 3 (when 10-25/kebele), but when # increased to 25, not trained on IMNCI	3	
4	On-going Training	0		2	Equal mix of 1 and 3
5	Equipment and Supplies	3	Their 3 items (1) CIMNCI/Family Booklet from MoH; (2) Child Survival/Family Booklet and (3) leaflets supplied at training (1) or orientation (2, 3). No complaints of booklet loss yet – reserves exist if necessary.	1	
6	Supervision	2.6	All 3, except supervisors (HEW) not trained in supportive supervision	3	3 except for not always trained in supportive supervision (i.e., in 5-day SC training)
7	Individual Performance Evaluation	2.3	Lack national monitoring (maximum to district); community gives informal feedback; no rewards	1.75	3 except for no rewards for good performance and no national review
8	Incentives	1.5	"Token" = spoken appreciation only	3	Salaried
9	Community Role	3		2.7	
10	Referral	1.3	There is a new referral system (x 3 mos) with simple slip (different from HEW slip), but no training	2	But back-referral is weak
11	Advancement Opportunities	0		3	Mostly a plan, but Safe Delivery is a current example.
12	Documentation	3	But document in "exercise book" and no real problem-solving	3	
13	Linkages to Health System	2		2	
14	Program Performance Evaluation	3		2	

[4] University Research Co. and USAID. ***Assessing and Improving Programs Extending Health Services to Communities: The Community Health Worker Program Assessment and Improvement Matrix (CHW AIM), DRAFT FOR BETA TESTING.*** April 2010.

	Overall Functionality Scores	**2.2**		**2.5**	

Application of the Community Health Worker Program Improvement and Assessment Matrix (CHW-AIM)

Methods We applied selected tools from University Research Company's "Community Health Worker Program Improvement and Assessment Matrix" (draft for beta testing, April 2010)[5] to characterize HEWs and vCHWs. Two members of the evaluation team, one intimately familiar with MoH strategies and project activities, applied the CHW Program Functionality Matrix to score each of 14 components according to the categories provided (non-functional = 0, partly functional = 1, functional = 2, and highly functional or "best practice" = 3). We adapted the scoring procedure thus: if a component was best described by statements from different scoring columns, we calculated the mean of the statements (see Comment below). We also used the CHW MNCH Intervention Matrix to identify which of the 57 specified interventions that HEWs or vCHWs deliver, including the relevant activities (counselling, provision, or referral) for each. We assumed that providing or referring for interventions also included counselling – except for mapping immunizations – although the guidelines were silent on this.

Results The HEW and vCHW programs both had high overall functionality (mean score: 2.2 and 2.5, respectively) (Annex 7, Figure and Annex 7, Table 2). High scoring components for both programs included recruitment, role, initial training, and community role. The weakest components were on-going training and advancement opportunities for vCHWs and equipment and supplies for HEWs. The vCHWs and HEWs delivered many interventions (36 and 44, respectively) (Annex 7, Table 3). vCHWs mainly counselled (36) or referred for interventions (16) – actually providing only one: insecticide treated nets during campaigns. On the other hand, HEWs provided 26 interventions.

Findings The URC functionality methodology calls for in-depth document review, a day-long workshop of 5-25 people, and field visits to 8-10 communities to validate the findings. Our half-day in-depth interview *following* a similar number of field visits is not a proper test. On the other hand, the functionality findings are consistent with those from the preceding site visits. The generally high scores are also consistent with a well designed and implemented community-based strategy to deliver high impact interventions – noting important areas for improvement. Process All aspects of a given component are commonly not necessarily at the same level of function. The guidance calls for selecting the lowest function level represented by any sub-component, which is conservative. For example, we circled four of the five sub-components of vCHW supervision from the "3" column and one from the "1" column. Scoring the component as "1" seems rather stringent. The interventions matrix is a helpful method to summarize much complexity; however, guidance is lacking regarding the criteria for "counselling."

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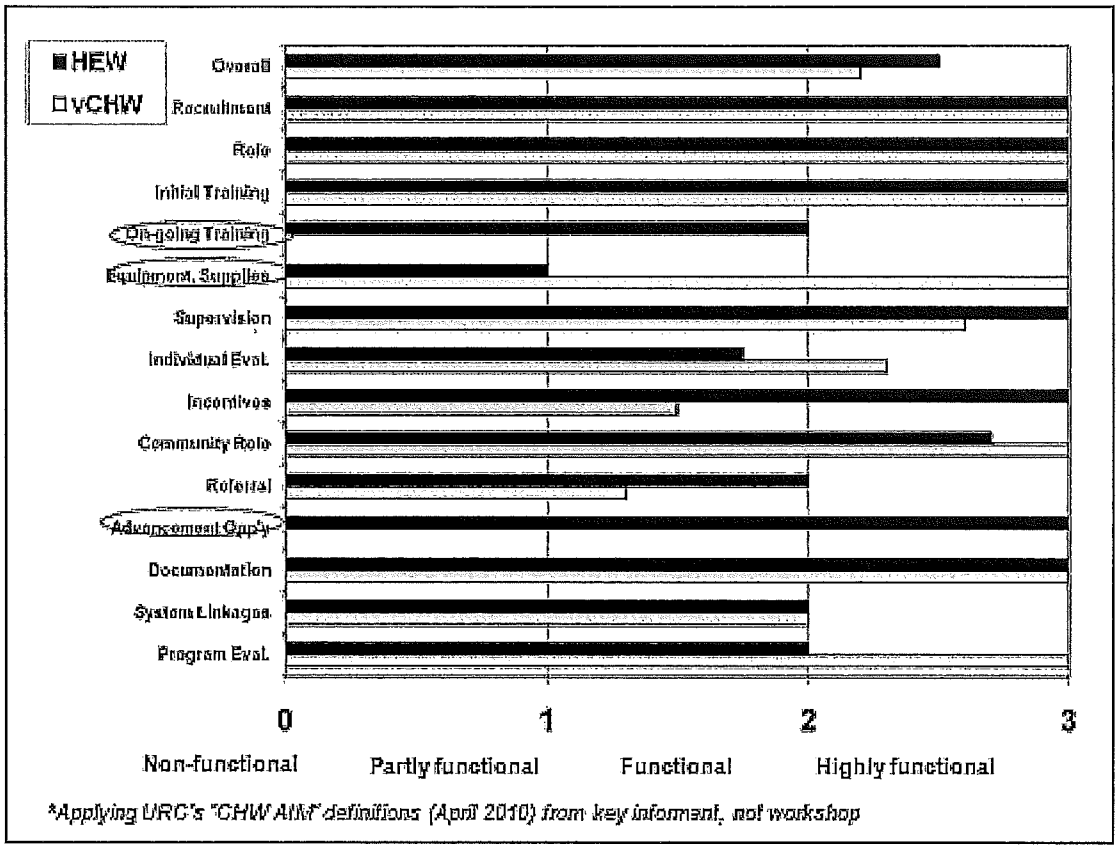
[5] University Research Co. and USAID. ***Assessing and Improving Programs Extending Health Services to Communities: The Community Health Worker Program Assessment and Improvement Matrix (CHW AIM), DRAFT FOR BETA TESTING.*** April 2010.

Annex 7, Figure: Volunteer Community Health Worker and Health Extension Worker "Functionality" in Lanfero and Shebedino Districts in SNNPR, Ethiopia (August 2010)*



Annex 7, Table 3: URC/USAID "Beta" CHW – AIM Intervention Assessment[6]

Interventions	vCHW						HEW				
	Counsel	Provide	Refer	NA	Not Done		Counsel	Provide	Refer	NA	Not Done
Maternal and Newborn Care: Antenatal Care											
Birth preparedness; ENC	X						X		X		
Maternal nutrition	X						X				
TT	X		X				X	X			
De-worming					X		X	X			
Malaria: ITN	X	X	X				X	X			
Malaria: IPTp					X						X
Maternal and Newborn Care: Delivery											
Clean delivery	X						X	X			
AMTSL					X						X
ENC	X						X	X			
DS	X		?				X				
NBR					X						X
Abx for NB Sepsis	X		X				X		X		
LBW care	X		X				X				
Abx for Maternal Sepsis	X		X				X		X		
Refer for pre-eclampsia	X						X		X		
Stabilize/refer hemorrhage	X						X		X		
Maternal and Newborn Care: Postpartum and Postnatal Care											
PPC/PNC within 3 d	X		X				X	X			
ENC	X						X				
NB EPI	X		X				X	X			
NB eye care					X						X
Maternal nutrition	X						X				
LBW care					X		X				
PP FP	X		X				X	X			
Child Health: Nutrition											
IYCF	X						X				
VAC	X		X				X	X			
GMP					X		X	X			
CMAM	X		X				X	X			

(Con't next page)

NOTE: Grey shading = interventions and activities supported by SC in CS23

[6] University Research Co. and USAID. ***Assessing and Improving Programs Extending Health Services to Communities: The Community Health Worker Program Assessment and Improvement Matrix (CHW AIM), DRAFT FOR BETA TESTING.*** April 2010.

Interventions	vCHW						HEW				
	Counsel	Provide	Refer	NA	Not Done		Counsel	Provide	Refer	NA	Not Done
Child Health: Immunizations											
Mapping/tracking					X			X			
Campaign	X						X	X			
BCG	X						X	X			
Pentavalent	X		X				X	X			
Polio	X		X				X	X			
Hib	X			X			X	X			
Hepatitis B	X		X				X	X			
Measles	X		X				X	X			
Child Health: Illness											
Pneumonia: DS/care-seek	X						X				
Pneumonia: Assess					X		X	X			
Pneumonia: Treat					X						X
Pneumonia: Refer	X		X				X	X			
Pneumonia: Rx x 1 & Refer					X						X
Diarrhea: Hygiene	X						X				
Diarrhea: POU Water	X						X				
ORS	X						X	X			
Zinc	X						X	X			
Malaria: ITN	X						X	X			
Malaria: DS/care-seek	X						X				
Malaria: RDT					X		X	X			
Malaria: Treat	X		X				X	X			
HIV: PMTCT											
Antibody testing							X				
Prophy ARV/HAART							X		X		
Prophy ARV to infant							X		X		
Early infant Dx											X
Tracking HIV+ pregnancy											X
Tracking HIV exposed inf											X
HIV: Pediatric											
Cotrimoxazole prophy											X
HAART											X
Tracking, adherence, supp											X
Total	**36**	**1**	**16**	**1**	**12**		**44**	**26**	**7**	**0**	**12**

NOTE: Green shading = interventions and activities supported by SC in CS23

ANNEX 8: EVALUATION TEAM MEMBERS AND THEIR TITLES

S/n	Name	Organization	Position
1	Hashim Aman	Silti Zonal Health Department	Disease Prevention & Health Promotion
2	Bilal Kamil	Silti Zone Bureau of Finance	Expert of NGO's Affairs
3	Tsegaye Yutamo	Sidama Zone Finance	Planning Officer
4	Chiksa Sultan	Lanfero District Health office	Disease Prevention & Health Promotion
5	Yonas Mechara	Shebedino District Health Office	Health Extension Program Coordinator
6	Abraham Rikiba	Sidama Zone Health Department	DPHP Work Process Officer
7	Dr. Kate Gilroy	Johns Hopkins University	MTE leader (Consultant)
8	Barassa Ware	SC/US – Awassa Sub Office	Shebedino District Program Officer
9	Karen Waltensperger	SC/US	Africa Regional Health Advisor
10	Yachiso Yamo	SC/US – Awassa Sub Office	Shebedino District Community Mobilization Officer
11	Abdulmuhin Nuri	SC/US – Awassa Sub Office	Lanfero District Community Mobilization Officer
12	Habtamu Tilahun	SC/US – Awassa Sub Office	Lanfero District Program Officer
13	Worku Tefera	SC/US – Awassa Sub Office	CS M & E Coordinator
14	Elias Kayessa	SC/US – Awassa Sub Office	CS Health Program Coordinator
15	Dr. Hailu Tesfaye	SC/US – Awassa Sub Office	CS Program Manager
16	Dr. David Marsh	SC/US	Child Survival Senior Advisor

ANNEX 9: EVALUATION ASSESSMENT METHODOLOGY

The Mid-term Evaluation (MTE) aimed to assess progress to date (third quarter 2010) in Save the Children's implementation of the Child Survival 23 project carried out in the Shebedino and Lanfero districts in SNNPR in Ethiopia. We used the CS-23 project results framework to guide the evaluation design and data collection. The MTE addressed all aspects of the project; however, we gave special attention to the intermediate result related to quality of services and associated supervision and support processes, as the CS-23 project team and MOH partners identified these aspects as the largest on-going challenge in project implementation. The MTE was a participatory process, led by the external consultant and composed of Save the Children international, regional and district staff, partners from the zonal and district level health offices (Annex 8), with a participatory workshop to review the preliminary results with the MTE participants and representatives from NGOs and bilateral programs (annex 12, section 4). Representatives from USAID-Ethiopia and UNICEF-Ethiopia were invited to participate, but unable to attend.

Objectives: The objectives of the MTE were to:

- Assess progress in implementing the detailed implementation plan (DIP);
- Assess progress toward achieving intermediate results and the strategic objective;
- Identify facilitating factors and barriers to achieving the results and objective;
- Identify potential solutions to implementation barriers and provide associated recommendations.

Overall design: We conducted a retrospective review of the project to date by examining project activities, barriers and facilitating factors to implementation, and progress on key indicators through key informant interviews, focus groups, document review and extraction and further analysis of available data. Key informant interviews included national, regional, zonal and district officials and program managers, staff at health centers and HEWs; focus groups were conducted with vCHWs and caretakers. The sampling strategy and sample is described further below. Key documents reviewed included: 1) annual and quarterly reports; 2) baseline KPC and rHFA reports; 3) district health office annual reports; 4) the mandatory project assessment by the RHB; 5) training materials; and 6) formative research report on HEW supervision.

We also conducted a cross-sectional health services assessment in Lanfero and Shebedino districts. Inventories of equipment, supplies, and drugs were undertaken at health posts and health centers; we also extracted information from IMNCI registers at both locations, asked a

series of structured questions about supervision frequency content and administered simple case scenario to health center staff and HEWs. We did not conduct a KPC survey, and there was none planned or budgeted, as part of the MTE.

We selected *variables* and *components* to examine based on the project's results framework at each level, including: 1) Use of life-saving interventions; 2) Access to and availability of interventions; 3) Quality of intervention delivery; 4) Demand for interventions; 5) Policy environment; and 6) Inputs and Activities, Drugs, Equipment, Supplies, Training. Annex 9, Attachment 1 presents the guiding indicators and questions we aimed to assess in the MTE.

Annex 9, Table 1: Sampling strategy for MTE

Facility or Informant	Sampling Strategy
Region, Zone, District Official, National Officials & program officers	Available, knowledgeable experts
Health Center	Accessible higher and lower overall performance*
HC Staff	Head, Under Five Nurse and HEW Supervisor
Health Post	Accessible higher and lower overall performance*
HEW	All available at visited Health Posts
vCHW	HEWs called all cIMNCI-trained
Caregiver	HEWs called mothers/caretakers of <5s accessible to HP

*supplemented by unplanned opportunity ; Attachment 2 provides an example from Lanfero of selected healths centers and posts

Sample: For key informant interviews and focus groups, we employed a convenience sample. For the inventories at health posts and health centers, we attempted to select high and low performers that were accessible by vehicle using a participatory process with program and MOH implementers. Annex 9, table 1 above presents the sampling strategy at each level; Annex 9, table 2 presents the number participants at each level of data collection outside of the national level, where we interviewed an additional 8 key informants.

Annex 9, Table 2: Participants included in MTE sample

a. Key Informant Interviews

District	Region	Zone	District	Head & <5	HEPSup	HEW	Total
Lanfero	1	2	1	4	4	7	19
Shebedino		1	1	3	1	3	9

b. Group Interviews (# participants)

District	vCHWs	Mothers	Total
Lanfero	5 (32)	4 (17)	9 (49)
Shebedino	4 (30)	4 (24)	8 (54)

c. Inventories and Register Extractions

District	Health Center	Health Post	Total
Lanfero	4	8	12
Shebedino	3	3	6

Field methods: The MTE data collection was conducted by teams of seven to eight members per district, with two sub-teams of three to four members in each district. Teams were a balance of Save the Children staff and government partners, external versus internal staff, and members with varying language, experiences and skills. Data collection forms were reviewed briefly by Save the Children staff/team leaders before the start of data collection. Each team spent two and one-half days per district, each day targeting at least 1 HC, 1 HP, vCHW groups, and mother groups.

Interviews, inventories and focus groups were carried out after signed informed consent. Interviews were conducted by native speakers of Amharic or the local language or by non-native speakers through translation. The teams took hand-written notes in English and digital photographs of illustrative documents, such as registers, reports, wall charts, etc. At the end of each day of fieldwork, the MTE teams spent approximately one hour reviewing that day's findings, highlighting strengths and gaps identified, and planning the field work for the following day.

Analysis: The Lanfero Team entered qualitative notes in Excel by pre-determined themes; the Shebedino Team summarized findings into nearly identical emerging themes. The quantitative data from the inventories, register reviews and structured questions about supervision were entered in Excel to calculate counts and proportions. The CS-23 project M&E Officer calculated some indicators from service statistics and project records. The MTE team reviewed both sets of qualitative data and quantitative data to prioritize main achievements and challenges of themes over a one-half day meeting. A one-half day workshop presented the MTE key

preliminary findings and small groups organized and discussed the findings to develop preliminary recommendations. Each team presented its interpretations and preliminary recommendations for discussion. This workshop allowed for partners to validate, interpret and contextualize the findings and propose next steps (Annex 12).

Strengths and weaknesses: The participatory nature of the MTE was both a strength and weakness. Data collection by project and partner staff allowed for better interpretation and uptake of the MTE results, and was logistically expedient given the diversity of languages spoken in Lanfero and Shebedino district and the need to inform and locate selected HPs and HCs. However, the presence of project and partner staff during data collection may have positively biased the responses from participants. If feasible, future exercises may consider deploying members of the MTE team to areas outside their responsible (e.g. staff from district A collect data in district B). The MTE relied on available data, much from routine project and DHO monitoring. The weaknesses of this data are described in the body of the report.

Annex 9, Attachment 1: Guiding indicators and questions for MTE

Table A: Indicators and methods to assess progress toward strategic objective and intermediate results

Intermediate Result	Indicator	Source/ Method of Measurement	Base-line	EOP Targt	Associated Activities
IR-1: Access and availability of child health services and supplies increased					
Clinical IMNCI coverage	% of HEWs trained in IMNCI	RHB/ZHD/DHO documentation, project training records	0%	60%	Training of HEWs in clinical IMNCI. 109 (96.4%) HEWs trained in Yr 2
	# of HEWs trained, equipped and available for IMNCI services per estimated population of U5s in each district / sub-district				
Community IMNCI coverage	% of VCHWs trained in c-IMNCI	Documentation, project training records	0%	60%	Training of vCHWs in c-IMNCI. 1080 (94% of the target) trained in cIMNCI in Yr 2
IR-2: Quality of child health services improved					
HEW performance	% of trained HEWs who followed correct IMNCI steps to assess, classify, treat, refer childhood illness	Performance observations, supervisory records	0%	60%	HEW/VCHW training in IMNCI/c-IMNCI Supportive supervision
	% HC staff and % HEWs able to count respiratory rates?				
Functional supervisory system	% of health posts that have received supportive supervision at least once in past quarter (MOH criteria)	R-HFA, *woreda* reports;interviews with HEWs)	98%	100%	Accompany, provide transport, ensure check list supply and use, give feedback
Functional health system	% of health posts meeting FMOH "functional" criteria (refer to Annex 18)	RHB/ZHD/ DHO records, reports	80%	90%	Provide limited supplies, equipment, support, facilitation
IR-3: Knowledge and acceptance of key child health services and practices improved					
	All only available from KPC/HH surveys				
IR-4: Policy and social environment enabled					
Policy change	HSDP-IV includes CCM as HEP strategy at level of health post - including antibiotics for treatment pneumonia, dysentery, neonatal sepsis	FMOH/RHB policy documents and operational guidance	None	Partial	Facilitate policy dialogue, debate, technical updates; provide evidence of feasibility

Strategic Objective: Increased use of child services and practices

Technical area	Indicator	Source/ Method of Measurement	Associated Activities
X-cutting	Avg. # of sick child visits per month/yr at HPs (HCs) per estimated pop of 1000 U5s	Routine HMIS data & population estimates	
Pneumonia mangmt	# of children treated with antibiotics (for pneumonia) per month/year at HCs per estimated pop of 1000 U5s		
Malaria treatment & prevention	# of febrile children seen & tested with RDT per months/year at HPs per estimated pop of 1000 U5s		
	# of children treated with ACT/CQ per month/year at HPs per estimated pop of 1000 U5s		
	# ITNs distributed in previous 1 and 2 years per 1000 U5s		
Diarrhea control	# of children treated with ORS & zinc per month/year at HPs per estimated pop of 1000 U5s		
Newborn health	# of deliveries occurring in HPs (HCs) per month/year per estimated pop. of 1000 pregnancies		
	# of postnatal visits per month/year per estimated pop. of 1000 pregnancies		
Immunization	DPT3 vaccination coverage (routine statistics based on pop. estimate)		

Table B: Activities, assessment of program and methods for illness management components of CS-23

Intermediate Result	Activities to support this result	Components/questions to assess progress	Methods / indicators
IR1: Access/ availability	Train HEWs in IMNCI, including assessment & referral of pneumonia & newborn illness Train HCs in IMNCI, including all illnesses (& pneu)	What are the training materials and training schedule for IMNCI? For HPs? For HCs?	**Document:** Training reports (cross-check through observation & questions)
		What is the number of HEWs trained? What proportion of HCs have staff trained in IMNCI? What is the average proportion of staff trained in each HC?	
		Are timers available at HPs for assessment? At HCs?	**Observation:** HP & HC
		Are children being referred for pneumonia? For newborn illnesses?	**Observation:** (review routine data at HPs and HCs) **KII:** Program staff, district, HC and HP staff
		At HPs: What is the proportion of children (or number) referred for pneumonia? For NN illness?	
		Is referral "facilitated"? How? Do caretakers accept referral? Why or why not?	
		How many children referred by HEWs are seen at HCs?	
		Are children being assessed and treated for pneumonia at HCs? Why or why not?	
	Provide IMNCI algorithms wall charts & counselling materials	Are IMNCI charts and counselling materials available? Are they visible and used?	**Observation:** HPs and HCs
	Supply/Availability of AB at HCs	Do HCs have ABs to treat pneu? Have there been stock-outs in previous month, 3 months, and 6 months? Why or why not?	**Observation:** HCs (& questions to staff) **Document:** review records/reports where possible
	Supply of essential drugs for malaria	Do HCs have RDTs to test for malaria? Do HPs have RDTs? Have there been stock-outs in previous month, 3 months, and 6 months? Why or why not?	**Observation:** HCs & HPs (& questions to staff) **Document:** review records/reports where possible
		Do HCs have ACTs and CQ to treat malaria? Do HPs have ACTs and CQ? Have there been stock-outs in previous month, 3 months, 6 months? Why or why not?	
	Supply of essential drugs for diarrhea / supply zinc	Do HCs have (new) ORS and zinc to treat diarrhea? Do HPs have ORS and diarrhea? Have there been stock-outs in previous month, 3 months, 6 months? Why/ why not?	
	HEWs and HCs available to provide essential newborn care	What are local strategies for promoting delivery at HPs and HCs? What are local strategies for visiting mothers within 3 days of delivery?	**KII:** Program staff, district, HC and HP staff & commun
		Are HCs and HPs equipped to provide basic delivery assistance and essential newborn care? (i.e. infection control, clean cord care, etc?)	**Observation:** HCs & HEWs (& questions to staff) **Document:** review records/reports where possible
		Do HCs have appropriate drugs in stock to manage NN sepsis and other NN infections?	
	Links between HEWs and TBAs	What are the links? Are they working? What is the outcome of fostering these links?	**KII:** HEWs and HP staff, communities, TBAs
	Other/contextual	What is the retention or turn-over rate of HEWs? HC staff?	**Document:** review records where possible (KII where

Intermediate Result	Activities to support this result	Components/questions to assess progress	Methods / indicators
			not possible)
IR2: Quality	Initial and on-going training	Proportion of clinical practice included in the IMNCI training at HCs and HPs	**Document:** Training reports (cross-check through observation & questions)
	Supportive Supervision	What is the system for supervision to HCs? What are the strengths and weaknesses of this system?	**KII:** Regional, district & HC level **Document:** Supervision plan
		What is the proportion of HCs supervised in previous quarter? % of planned supervisions conducted?	**Document:** Supervision reports (cross-check through observation & questions) **KII:** HCs & supervisors
		What happens at HC supervisory visits? Are consultations observed?	
		What is the system for supervision to HPs? What are the strengths and weaknesses of this system?	**KII:** Regional, district, HC, HP level **Document:** Supervision protocol/document done by STC-Ethiopia; supervision plan
		What is the proportion of HPs supervised in previous quarter? % of planned supervisions conducted?	
		What happens at HC supervisory visits? Are consultations observed?	
		What are other ways that HCs and HPs are followed up (e.g. peer meetings, other meetings, on-the-job training, etc) to ensure quality of services and counselling?	
	Capacity building in supervision and monitoring	Have staff been trained in supervision? How? Has this been useful and put into practice?	**KII:** Regional, district, HC, HP level **Document:** Supervision protocol/document done by STC-Ethiopia; supervision plans and reports
		Is there supervision or monitoring of supervisors at the various levels? How does this work and what are the constraints?	
		Are supervision checklists available? Are they used and completed properly? If no, why?	
	Provide standard registers and reporting formats	Are registers/reporting forms available? Are they used properly?	**Observation:** HC and HP level (extract related info from documents as needed)
	Data collection/HMIS/review meetings	What is the monitoring plan? How is the quality and quantity of services tracked with the program? In what form and what forums is the monitoring information shared back at each level?	**KII:** Regional, district, HC, HP level & program managers **Observation & documents** where appropriate

Intermediate Result	Activities to support this result	Components/questions to assess progress	Methods / indicators
	Cross-cutting	What are other quality assurance activities? What are other opportunities for quality assurance?	
IR3: Knowledge and practices	Train vCHWs & HEWs in c-IMCI / EFP and provide IEC materials ***(combine with preventative practices below)***	What do IEC / c-IMCI materials include? Are they appropriate to the context and targeted to key CS interventions?	**Document:** IEC materials, adaptation report and training materials
		How many vCHWs have been trained? HEWs? What proportion of vCHWs / HEWs does this represent? What is the coverage (i.e. # per village) of vCHWs?	**Document:** Training reports (cross-check through observation & questions)
		How do vCHWs promote EFPs? What are the main constraints or barriers to this?	**Document:** IEC **KII (light):** Regional, district, HC, program managers **KII (heavy):** HEWs & vCHWs
		What is the proportion of vCHWs have been visited/ supervised in previous quarter? % of planned visits/supervisions conducted? What happens at visits?	**Document:** Supervision reports /program documents (cross-check through observation & questions) **KII:** HEWs & vCHWs
		What are the incentives given to vCHWs?	
IR4: Policy	Work with partners on child survival activities and promote CCM of pneumonia (various mtgs, advocacy, etc)	What documents have been shared by CS-23? What other sorts of evidence and information has been disseminated by CS-23? What has the CS-23 contribution been to child survival programming and policies in Ethiopia and SNNPR? How has CS-23 contributed to adoption of CCM pneumonia policy? Other policies? What is the most significant change in CS programming as a result of CS-23?	**KII:** National, Regional, district & program manager levels **Document:** Any policy briefs, reports, etc disseminated at any level

Table C: Activities, assessment of program and methods for prevention components of CS-23

Intermediate Result	Activities to support this result	Measures to assess progress	Methods
IR1: Access/ availability	Ensure adequate supply & distribution of ITNs at HCs and HPs	What are CS-23's activities to "ensure" ITN supply & distribution?	**KII:** Region, district, HC, HP & program managers
		Are there ITNs present in HCs? HPs? If no, why? Have there been stock-outs in previous 3, 6 and 12 months? If yes why?	**Document:** Routine reporting verified through observation & KII
		How many ITNs have been distributed in previous 6 months? 12 months? If few, why?	**KII:** Region, district, HC, HP
	Ensure adequate supply & distribution of vaccines at HCs and HPs	What are CS-23's activities to "ensure" adequate supply & distribution of vaccines?	**KII:** Region, district, HC, HP & program managers
		Are routine vaccines in stock in HCs? HPs? If no, why?	**Document:** Routine reporting verified through observation & KII
		How many outreach immunization activities have been carried out in each district?	
IR2: Quality IR3: Knowledge and practices	Promote appropriate health promotion activities and practices	What do IEC / c-IMCI materials include? Are they appropriate to the context and targeted to key CS interventions? How were the messages adapted? Are they appropriate?	**Document:** IEC materials, adaptation report and training materials
		How are prevention / promotion activities (ITNs, EBF/cont BF, handwashing, vaccination, feeding practices, etc) carried out at each level (HC, HP, villages)? Are counselling sessions / IEC activities actually happening?	**KII:** Region, district, HC, HP, vCHWs & program managers (verified where possible through documents and observations)
IR4: Policy	See table 2 – activities and questions similar across curative and preventative interventions		

	TOTAL	126,940	48	10					

Annex 9, Attachment 2: Kebeles/HPs and Health Centers in Lanfero district *(included in MTE*

	Name of kebeles	Population	# HEWs	IMNCI trained HEWs	Trained Clean & Safe delivery	General functioning (poor, ok, good)	Utilization for U5	Distance to facility (km)	Cell phone reception (yes/no)
1	Amchie	4766	1	1	0	poor	med	3	yes
2	Wonte Sostoro	4399	1	1	0	ok	med	7	no
3	Luke Kudussa	5158	2	2	0	good	high	9	no
4	Rephe	6578	1	1	0	ok	med	4	no
5	Girar	5370	2	2	0	good	high	3	yes
6	Rephe Chefuna	4680	1	1	0	good	high	5	no
7	Meded Gagebo	5806	2	2	0	ok	high	7	no
8	Meded Kussaya	4831	2	2	1	ok	high	4	yes
9	Torra Qiqora	4321	2	1	1	good	high	4	yes
10	Meja Torra	4723	1	1	0	ok	med	6	yes
11	Gebaba	5851	2	2	0	poor	med	1	yes
12	Shanqa Tuffa	5269	2	2	0	ok	med	6	yes
13	Warsha Shanqa	5279	1	1	0	poor	med	5	yes
14	Wotambo Gobe	3776	2	2	0	good	high	10	no
15	Wotambo Balchie	5053	1	1	0	good	high	12	yes
16	Archuma Wonte	4421	2	1	0	ok	med	1	yes
17	Archuma Golla	3442	2	2	0	good	high	5	yes
18	Wonte Lolla	4064	1	1	1	ok	med	8	no
19	Wonte Doye	4205	2	2	1	good	med	8	no
20	Wonte Boditi	4991	1	1	0	good	med	7	yes
21	Shofode Debar	5601	2	2	1	ok	med	6	yes
22	Grinzilla Gogillo	6093	2	2	0	ok	med	8	no
23	Edeneba Agawe	6972	2	2	0	ok	high	7	no
24	Sesso	6229	2	1	0	ok	high	15	no
25	Grinzilla Shofode	5062	1	1	0	ok	med	6	no
	TOTAL	**126,940**	**40**	**37**	**5**				

	Name of HC catchment area		# HWs	IMNCI trained staff		General functioning (poor, ok, good)	Utilization for U5	Distance to Woreda centre (km)	Cell phone reception (yes/no)
1	Mito HC	29,957	10	1		good	high	25	yes
2	Tora HC	41,587	15	6		good	high	0	yes
3	Archuma HC	26,176	13	3		ok	high	16	yes
4	Gababa HC	29,219	10	0		good	med	8	yes

(sample highlighted in orange)

ANNEX 10: LIST OF PERSONS CONTACTED AND INTERVIEWED

The list /number of persons interviewed is included in the description of the MTE methods (Annex 9). We also conducted formal and informal interviews with members of the MTE team, as well as stakeholders in Addis Ababa at UNICEF, PSI, JSI and IFHP, the FMOH and the Save the Children country office.

ANNEX 11: UPDATED PROJECT DATA FORM

Child Survival and Health Grants Program Project Summary
Oct-19-2010
Save the Children
(Ethiopia)

General Project Information	
Cooperative Agreement Number:	GHS-A-00-07-00023
SC Headquarters Technical Backstop:	David Marsh
SC Headquarters Technical Backstop Backup:	
Field Program Manager:	Hailu Tesfaye
Midterm Evaluator:	Kate Gilroy
Final Evaluator:	
Headquarter Financial Contact:	
Project Dates:	10/1/2007 - 9/30/2012 (FY07)
Project Type:	Standard
USAID Mission Contact:	Mulugeta Wolde Yohannes
Project Web Site	
Field Program Manager	
Name:	Hailu Tesfaye (CS Program Manager)
Address:	Ethiopia
Phone:	
Fax:	
E-mail:	htesfaye@savechildren.org.et
Skype Name:	
Alternate Field Contact	
Name:	Tedbabe Degefie (CS Program Manager)
Address:	Ethiopia
Phone:	011 372 0030
Fax:	011 372 8045
E-mail:	tdegefie@savechildren.org.et
Skype Name:	
Grant Funding Information	
USAID Funding: $1,500,000	**PVO Match:** $400,000

General Project Description

Nearly half a million Ethiopian children die each year before their fifth birthday. Save the Children was awarded a five-year Standard USAID/CSHGP Child Survival Project (CS-23) - Innovation for Scale: Enhancing Ethiopia's Health Extension Package in the Southern Nations and Nationalities People's Region (SNNPR) - to address four main causes of child death: (1) pneumonia,(2) malaria, (3) diarrheal diseases (that together account for 68% of under-five mortality); and (4) neonatal infection, responsible for half of all neonatal mortality. This project is being implemented in the two SNNPR woredas of Shebedino (Sidama Zone) and Lanfero (Silti Zone) with the potential of taking the interventions to scale at the regional level in SNNPR. Program location and population The project reaches a total population of 368,252 in Shebedino and Lanfero districts, including 16, 645 infants 0-11; 13, 948 children 12-23 months; 40,815 children 24-59 months; 69, 491 children 0-59 months; and 87,496 women of reproductive age.

Estimated level of effort Selected CSHGP interventions are: Pneumonia Case Management 35%; Immunization (5%); Control of Diarrheal Diseases 20%; Prevention and Treatment of Malaria (PTM) 20%; and Newborn Care 20%. The project's key implementation strategy is Community Case Management (CCM), supported by behavior change at the household and community level. Problem statement Ethiopia's most recent Demographic and Health Survey (2005 EDHS) reports an under-five mortality rate (U5MR) of 123/1,000 live births, a third (32%) of which is neonatal mortality (39/1,000). While reflecting a welcome 15-year decline in under-five mortality, the rate of decline is attenuated by entrenched environmental and socio-economic conditions: low access and availability of quality health care; poor illness recognition, child health practices, and care seeking behaviors at the household-level; and a weak social and policy enabling environment. Like most high mortality countries, Ethiopia is not on track to achieve Millennium Development Goal (MDG) 4 by 2015. SNNPR is a USAID priority geographic area with significant Save the Children history and presence.

Our principle partner is the MOH, comprised of the SNNPR Regional Health Bureau (RHB), Sidama and Silti Zonal Health Desks (ZHD), and District (woreda) Health Offices (DHO). Save the Children collaborates closely with the USAID Mission-funded health sector bil-lateral - currently ESHE II (Essential Services for Health in Ethiopia II) - being carried out by John Snow International and partners. ESHE II will be followed by a new bi-lateral cooperative agreement integrating family planning and maternal, newborn, and child health to begin in FY09 or earlier. In this child survival project, Save the Children is enhancing an existing government package already operating at national scale. The HEP is the government's pro-poor strategy that ensures increased efficiency, expanded coverage, and equitable access. Through the HEP, the Ministry of Health (MOH) strives to bring a set of evidence-based promotive, preventive, and limited curative interventions closer to the household level. Under the current Ethiopian government HSDP-III, the HEP is being taken to scale nationally. Delivered by trained community-based government-salaried HEWs – who assisted with behavior change interventions by Volunteer Community Health Workers (VCHWs) - the HEP comprises "16

packages" comprising HIV/AIDS prevention, water and sanitation, hygiene, immunization, and best practices for maternal, newborn, and child health at the household level.

A limited set of curative interventions includes use of oral rehydration solution (new formula ORS) and zinc therapy (as yet not operationalized) for diarrhea; Rapid Diagnostic Testing (RDT) for malaria with Coartem® for falsiparum and chloroquine for vivax; and assessment and referral of pneumonia, dysentery, and neonatal infection. Government policy does not yet authorize use of antibiotics at the health post level; so HEWs are currently unable to treat pneumonia, dysentery, or neonatal infection. Advocacy for policy change and evidence of feasibility are necessary to complete a basic but full package of life-saving community case management interventions to the health post level. Relatively high SNNPR population density means that high coverage for targeted interventions is achievable for this project. Long-term sustainability and cost-effectiveness are ensured by planning jointly with MOH partners, drawing upon local resources, reinforcing in-country capacity, and using available community assets (e.g., TBAs, volunteers). The project's targeted communication and advocacy strategy, as well as linkage to a national-level newborn health evidence-generating initiative, strengthens the social and enabling policy environment. Proposed operations research The following two questions have emerged as particularly critical to project success potential to inform scale up:

(1) With optimal information, education, and communication - how much can we increase care-seeking at the health center level for cough and fast or difficult breathing? and

(2) What are some feasible Supervision Packages, in terms of content, process, and schedule? Concept papers have been developed for these two questions to be reviewed at the first meeting of the project's Technical Advisory Group (TAG). Program goals, objectives, results Goal: Under-five mortality reduced; Strategic Objective: Use of key child health services and behaviors improved; Intermediate Result (IR)-1: Access and availability of child health services and supplies increased; IR-2: Quality of child health services increased; IR-3: Knowledge and acceptance of key child health services and behaviors increased; IR-4: Child health social and policy environment enabled. Major strategies per IR IR-1: Community case management and strengthened Expanded Program of Immunization (EPI) at the health post level; IR-2: Capacity-building, training, and supervision for improved systems and provider performance; IR-3: HEP "16 packages" for behavior change delivered at health post and household levels by HEWs and VCHWs; IR-4: Technical communication and advocacy directed at government, professional associations, civil society, and MOH for policy change to support use of antibiotics by HEWs at the level of the health post.

Project Location

Latitude: 9.67 **Longitude:** 38.78

Project Location Types: (None Selected)

Levels of Intervention: (None Selected)

Province(s): --

District(s):	Southern Nations and Nationalities People's Region (SNNPR). Shebedino District (Sidama Zone) and Lanfero District (Silti Zone).
Sub-District(s):	--

Operations Research Information

OR Project Title:	--
Cost of OR Activities:	--
Research Partner(s):	--
OR Project Description:	--

Partners

MOH (federal, regional, district levels) (Collaborating Partner) $0

Strategies

Social and Behavioral Change Strategies:	Interpersonal Communication
Strategies for Enabling Environment:	Advocacy for policy change or resource mobilization
Tools/Methodologies:	Rapid Health Facility Assessment LQAS

Capacity Building

Local Partners:	National Ministry of Health (MOH) Dist. Health System Health Facility Staff

Interventions & Components

Immunizations (5%) - Classic 6 Vaccines - Mobilization - Measles Campaigns - Community Registers	IMCI Integration	CHW Training HF Training
Nutrition	IMCI Integration	CHW Training HF Training
Vitamin A	IMCI Integration	CHW Training HF Training
Micronutrients	IMCI Integration	CHW Training HF Training

Pneumonia Case Management (35%) - Case Management Counseling - Access to Providers Antibiotics - Recognition of Pneumonia Danger Signs - Zinc	IMCI Integration	CHW Training HF Training
Control of Diarrheal Diseases (20%) - Hand Washing - ORS/Home Fluids - Feeding/Breastfeeding - Care Seeking - Case Management/Counseling - POU Treatment of water - Zinc	IMCI Integration	CHW Training HF Training
Malaria (20%) - Training in Malaria CM - Access to providers and drugs - Care Seeking, Recog., Compliance - ACT	IMCI Integration	CHW Training HF Training
Maternal & Newborn Care (20%) - Recognition of Danger signs - Newborn Care	IMCI Integration	CHW Training HF Training
Healthy Timing/Spacing of Pregnancy	IMCI Integration	CHW Training HF Training
Breastfeeding	IMCI Integration	CHW Training HF Training
HIV/AIDS	IMCI Integration	CHW Training HF Training
Family Planning	IMCI Integration	CHW Training HF Training
Tuberculosis	IMCI Integration	CHW Training HF Training

Operational Plan Indicators

Number of People Trained in Maternal/Newborn Health
There is no data for this project for this operational plan indicator.
Number of People Trained in Child Health & Nutrition
There is no data for this project for this operational plan indicator.
Number of People Trained in Malaria Treatment or Prevention
There is no data for this project for this operational plan indicator.

Locations & Sub-Areas
Shebedino District 255,209
Lanfero District 111,689
Total Population: 366,898

Target Beneficiaries

	Shebedino District	Lanfero District	Total
Children 0-59 months	0	0	0
Women 15-49 years	60,897	26,599	87,496
Beneficiaries Total	72,482	31,659	104,141

Rapid Catch Indicators: DIP Submission

Sample Type: 30 Cluster

Maternal TT Vaccination
Description -- Percentage of mothers with children age 0-23 months who received at least two Tetanus toxoid vaccinations before the birth of their youngest child.
Numerator: Enter the number of mothers with children age 0-23 months who received at least two tetanus toxoid vaccinations before the birth of their youngest child.
Denominator: Enter the total number of mothers of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent (calculate)	Confidence Limits
Shebedino District	269	300	89.7%	11.3
Lanfero District	289	300	96.3%	11.3

Skilled Birth Attendant
Description -- Percentage of children age 0-23 months whose births were attended by skilled personnel
Numerator: Enter the number of children age 0-23 months whose birth was attended by a doctor, nurse, midwife, auxiliary midwife, or other personnel with midwifery skills
Denominator: Enter the total number of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent (calculate)	Confidence Limits
Shebedino District	3	300	1.0%	1.6
Lanfero District	7	299	2.3%	2.4

Post-Natal Visit to Check on Newborn Within the First 3 Days After Birth
Description -- Percentage of children age 0-23 months who received a post-natal visit from an appropriately trained health worker within three days after birth
Numerator: Enter the number of children age 0-23 months who received a post-natal visit within three days after birth by an appropriate health worker
Denominator: Enter the total number of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent (calculate)	Confidence Limits
Shebedino District	12	300	4.0%	3.2
Lanfero District	7	299	2.3%	2.4

Exclusive Breastfeeding
Description -- Percentage of children age 0-5 months who were exclusively breastfed during the last 24 hours
Numerator: Enter the number of children age 0-5 months who drank breast milk in the previous 24 hours AND did not drink any other liquids in the previous 24 hours AND was not given any other foods or liquids in the previous 24 hours
Denominator: Enter the total number of children age 0-5 months in the survey

Sub Area Name	Numerator	Denominator	Percent (calculate)	Confidence Limits
Shebedino District	1	56	1.8%	4.9
Lanfero District	4	99	4.0%	5.5

Infant and Young Child Feeding
Description -- Percentage of infants and young children age 6-23 months fed according to a minimum of appropriate feeding practices
Numerator: Enter the number infants and young children age 6-23 months fed according to a minimum of appropriate feeding practices
Denominator: Enter the total number of children age 6-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent (calculate)	Confidence Limits
Shebedino District	145	244	59.4%	11.5
Lanfero District	57	200	28.5%	9.7

Vitamin A Supplementation in the Last 6 Months
Description -- Percentage of children age 6-23 months who received a dose of Vitamin A in the last 6 months: card verified or mother's recall
Numerator: Enter the number of children age 6-23 months who received a dose of Vitamin A in the last 6 months (mother's recall or card verified)
Denominator: Enter the total number of children age 6-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent (calculate)	Confidence Limits
Shebedino District	120	244	49.2%	10.8
Lanfero District	131	200	65.5%	13.0

Measles Vaccination
Description -- Percentage of children age 12-23 months who received a measles vaccination
Numerator: Enter the number of children age 12-23 months who received a measles

vaccination by the time of the interview as seen on the card or recalled by the mother
Denominator: Enter the total number of children age 12-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent (calculate)	Confidence Limits
Shebedino District	72	126	57.1%	15.8
Lanfero District	80	122	65.6%	16.7

Access to Immunization Services
Description -- Percentage of children age 12-23 months who received DTP1 according to the vaccination card or mother's recall by the time of the survey
Numerator: Enter the number of children age 12-23 months who received a DTP1 at the time of the survey according to the vaccination card/child health booklet or mother's recall
Denominator: Enter the total number of children age 12-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent (calculate)	Confidence Limits
Shebedino District	96	126	76.2%	17.0
Lanfero District	80	122	65.6%	16.7

Health System Performance Regarding Immunization Services
Description -- Percentage of children age 12-23 months who received DTP3 according to the vaccination card or mother's recall by the time of the survey
Numerator: Enter the number of children age 12-23 months who received DTP3 at the time of the survey according to the vaccination card/child health booklet or mother's recall
Denominator: Enter the total number of children age 12-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent (calculate)	Confidence Limits
Shebedino District	62	126	49.2%	15.0
Lanfero District	50	122	41.0%	14.3

Treatment of Fever in Malarious Zones
Description -- Percentage of children age 0-23 months with a febrile episode during the last two weeks who were treated with an effective anti-malarial drug within 24 hours after the fever began
Numerator: Enter the number of children age 0-23 months with a febrile episode in the last two weeks AND whose mother/caretaker sought treatment for the child within 24 hours AND who were treated with an appropriate anti-malarial drug
Denominator: Enter the total number of children age 0-23 months with a febrile episode in the last two weeks

Sub Area Name	Numerator	Denominator	Percent (calculate)	Confidence Limits
Shebedino District	9	300	19.1%	16.8
Lanfero District	32	49	65.3%	26.3

ORT Use

Description -- Percentage of children age 0-23 months with diarrhea in the last two weeks who received oral rehydration solution (ORS) and/or recommended home fluids

Numerator: Enter the number of children age 0-23 months with diarrhea in the last two weeks AND who received oral rehydration solution (ORS) and/or recommended home fluids

Denominator: Enter the total number of children age 0-23 months who had diarrhea in the last two weeks

Sub Area Name	Numerator	Denominator	Percent (calculate)	Confidence Limits
Shebedino District	61	97	62.9%	18.5
Lanfero District	26	62	41.9%	20.3

Appropriate Care Seeking for Pneumonia

Description -- Percentage of children age 0-23 months with chest-related cough and fast and/or difficult breathing in the last two weeks who were taken to an appropriate health provider

Numerator: Enter the number of children age 0-23 months with chest-related cough and fast and/or difficult breathing in the last two weeks who were taken to an appropriate health provider

Denominator: Enter the total number of children with chest-related cough and fast and /or difficult breathing in the last two weeks

Sub Area Name	Numerator	Denominator	Percent (calculate)	Confidence Limits
Shebedino District	27	84	32.1%	15.7
Lanfero District	16	51	31.4%	20.0

Point of Use (POU)

Description -- Percentage of households of children age 0-23 months that treat water effectively

Numerator: Enter the number of households of mothers of children 0-23 months that treat water effectively

Denominator: Enter the total number of households of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent (calculate)	Confidence Limits
Shebedino District	49	300	16.3%	6.2
Lanfero District	16	300	5.3%	3.6

Appropriate Hand Washing Practices

Description -- Percentage of mothers of children age 0-23 months who live in households with soap at the place for hand washing

Numerator: Enter the number of mothers with children age 0-23 months who live in households with soap at the place for hand washing
Denominator: Enter the total number of mothers of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent (calculate)	Confidence Limits
Shebedino District	100	300	33.3%	8.4
Lanfero District	50	300	16.7%	6.3

Child Sleeps Under an Insecticide-Treated Bednet
Description -- Percentage of children age 0-23 months who slept under an insecticide-treated bednet (in malaria risk areas, where bednet use is effective) the previous night
Numerator: Enter the number of children age 0-23 months who slept under an insecticide-treated bednet the previous night
Denominator: Enter the total number of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent (calculate)	Confidence Limits
Shebedino District	109	300	36.3%	8.7
Lanfero District	144	300	48.0%	9.7

Underweight
Description -- Percentage of children 0-23 months who are underweight (-2 SD for the median weight for age, according to the WHO/NCHS reference population)
Numerator: Enter the number of children 0-23 months with weight/age -2 SD for the median weight for age, according to the WHO/NCHS reference
Denominator: Enter the total number of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent (calculate)	Confidence Limits
Shebedino District	46	277	16.6%	6.5
Lanfero District	65	271	24.0%	7.7

Rapid Catch Indicators: Mid-term

				Sample Type:
Maternal TT Vaccination Description -- Percentage of mothers with children age 0-23 months who received at least two Tetanus toxoid vaccinations before the birth of their youngest child Numerator: Enter the number of mothers with children age 0-23 months who received at least two tetanus toxoid vaccinations before the birth of their youngest child Denominator: Enter the total number of mothers of children age 0-23 months in the survey				
Sub Area Name	Numerator	Denominator	Percent (calculate)	Confidence Limits
Shebedino District			%	
Lanfero District			%	
Skilled Birth Attendant Description -- Percentage of children age 0-23 months whose births were attended by skilled personnel Numerator: Enter the number of children age 0-23 months whose birth was attended by a doctor, nurse, midwife, auxiliary midwife, or other personnel with midwifery skills Denominator: Enter the total number of children age 0-23 months in the survey				
Sub Area Name	Numerator	Denominator	Percent (calculate)	Confidence Limits
Shebedino District			%	
Lanfero District			%	
Post-Natal Visit to Check on Newborn Within the First 3 Days After Birth Description -- Percentage of children age 0-23 months who received a post-natal visit from an appropriately trained health worker within three days after birth Numerator: Enter the number of children age 0-23 months who received a post-natal visit within three days after birth by an appropriate health worker Denominator: Enter the total number of children age 0-23 months in the survey				
Sub Area Name	Numerator	Denominator	Percent (calculate)	Confidence Limits
Shebedino District			%	
Lanfero District			%	
Exclusive Breastfeeding Description -- Percentage of children age 0-5 months who were exclusively breastfed during the last 24 hours Numerator: Enter the number of children age 0-5 months who drank breast milk in the previous 24 hours AND did not drink any other liquids in the previous 24 hours AND was not given any other foods or liquids in the previous 24 hours Denominator: Enter the total number of children age 0-5 months in the survey				

Sub Area Name	Numerator	Denominator	Percent (calculate)	Confidence Limits
Shebedino District			%	
Lanfero District			%	

Infant and Young Child Feeding
Description -- Percentage of infants and young children age 6-23 months fed according to a minimum of appropriate feeding practices
Numerator: Enter the number infants and young children age 6-23 months fed according to a minimum of appropriate feeding practices
Denominator: Enter the total number of children age 6-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent (calculate)	Confidence Limits
Shebedino District			%	
Lanfero District			%	

Vitamin A Supplementation in the Last 6 Months
Description -- Percentage of children age 6-23 months who received a dose of Vitamin A in the last 6 months: card verified or mother's recall
Numerator: Enter the number of children age 6-23 months who received a dose of Vitamin A in the last 6 months (mother's recall or card verified)
Denominator: Enter the total number of children age 6-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent (calculate)	Confidence Limits
Shebedino District			%	
Lanfero District			%	

Measles Vaccination
Description -- Percentage of children age 12-23 months who received a measles vaccination
Numerator: Enter the number of children age 12-23 months who received a measles vaccination by the time of the interview as seen on the card or recalled by the mother
Denominator: Enter the total number of children age 12-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent (calculate)	Confidence Limits
Shebedino District			%	
Lanfero District			%	

Access to Immunization Services
Description -- Percentage of children age 12-23 months who received DTP1 according to the vaccination card or mother's recall by the time of the survey
Numerator: Enter the number of children age 12-23 months who received a DTP1 at the time of the survey according to the vaccination card/child health booklet or mother's recall

Denominator: Enter the total number of children age 12-23 months in the survey				
Sub Area Name	Numerator	Denominator	Percent (calculate)	Confidence Limits
Shebedino District			%	
Lanfero District			%	

Health System Performance Regarding Immunization Services
Description -- Percentage of children age 12-23 months who received DTP3 according to the vaccination card or mother's recall by the time of the survey
Numerator: Enter the number of children age 12-23 months who received DTP3 at the time of the survey according to the vaccination card/child health booklet or the mother's recall
Denominator: Enter the total number of children age 12-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent (calculate)	Confidence Limits
Shebedino District			%	
Lanfero District			%	

Treatment of Fever in Malarious Zones
Description -- Percentage of children age 0-23 months with a febrile episode during the last two weeks who were treated with an effective anti-malarial within 24 hours after the fever began
Numerator: Enter the number of children age 0-23 months with a febrile episode in the last two weeks AND whose mother/caretaker sought treatment for the child within 24 hours AND who were treated with an appropriate anti-malarial drug
Denominator: Enter the total number of children age 0-23 months with a febrile episode in the last two weeks

Sub Area Name	Numerator	Denominator	Percent (calculate)	Confidence Limits
Shebedino District			%	
Lanfero District			%	

ORT Use
Description -- Percentage of children age 0-23 months with diarrhea in the last two weeks who received oral rehydration solution (ORS) and/or recommended home fluids
Numerator: Enter the number of children age 0-23 months with diarrhea in the last two weeks AND who received oral rehydration solution (ORS) and/or recommended home fluids
Denominator: Enter the total number of children age 0-23 months who had diarrhea in the last two weeks

Sub Area Name	Numerator	Denominator	Percent (calculate)	Confidence Limits
Shebedino District			%	
Lanfero District			%	

Appropriate Care Seeking for Pneumonia
Description -- Percentage of children age 0-23 months with chest-related cough and fast and/or difficult breathing in the last two weeks who were taken to an appropriate health provider
Numerator: Enter the number of children age 0-23 months with chest-related cough and fast and/or difficult breathing in the last two weeks who were taken to an appropriate health provider
Denominator: Enter the total number of children with chest-related cough and fast and /or difficult breathing in the last two weeks

Sub Area Name	Numerator	Denominator	Percent (calculate)	Confidence Limits
Shebedino District			%	
Lanfero District			%	

Point of Use (POU)
Description -- Percentage of households of children age 0-23 months that treat water effectively
Numerator: Enter the number of households of mothers of children 0-23 months that treat water effectively
Denominator: Enter the total number of households of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent (calculate)	Confidence Limits
Shebedino District			%	
Lanfero District			%	

Appropriate Hand Washing Practices
Description -- Percentage of mothers of children age 0-23 months who live in households with soap at the place for hand washing
Numerator: Enter the number of mothers with children age 0-23 months who live in households with soap at the place for hand washing
Denominator: Enter the total number of mothers of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent (calculate)	Confidence Limits
Shebedino District			%	
Lanfero District			%	

Child Sleeps Under an Insecticide-Treated Bednet
Description -- Percentage of children age 0-23 months who slept under an insecticide-treated bednet (in malaria risk areas, where bednet use is effective) the previous night
Numerator: Enter the number of children age 0-23 months who slept under an insecticide-

treated bednet the previous night Denominator: Enter the total number of children age 0-23 months in the survey				
Sub Area Name	Numerator	Denominator	Percent (calculate)	Confidence Limits
Shebedino District			%	
Lanfero District			%	
Underweight Description -- Percentage of children 0-23 months who are underweight (-2 SD for the median weight for age, according to the WHO/NCHS reference population) Numerator: Enter the number of children 0-23 months with weight/age -2 SD for the median weight for age, according to the WHO/NCHS reference population Denominator: Enter the total number of children age 0-23 months in the survey				
Sub Area Name	Numerator	Denominator	Percent (calculate)	Confidence Limits
Shebedino District			%	
Lanfero District			%	

Rapid Catch Indicators: Final Evaluation

Sample Type:

Maternal TT Vaccination
Description -- Percentage of mothers with children age 0-23 months who received at least two Tetanus toxoid vaccinations before the birth of their youngest child
Numerator: Enter the number of mothers with children age 0-23 months who received at least two tetanus toxoid vaccinations before the birth of their youngest child
Denominator: Enter the total number of mothers of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent (calculate)	Confidence Limits
Shebedino District			%	
Lanfero District			%	

Skilled Birth Attendant
Description -- Percentage of children age 0-23 months whose births were attended by skilled personnel
Numerator: Enter the number of children age 0-23 months whose birth was attended by a doctor, nurse, midwife, auxiliary midwife, or other personnel with midwifery skills
Denominator: Enter the total number of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent (calculate)	Confidence Limits
Shebedino District			%	
Lanfero District			%	

Post-Natal Visit to Check on Newborn Within the First 3 Days After Birth
Description -- Percentage of children age 0-23 months who received a post-natal visit from an appropriately trained health worker within three days after birth
Numerator: Enter the number of children age 0-23 months who received a post-natal visit within three days after birth by an appropriate health worker
Denominator: Enter the total number of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent (calculate)	Confidence Limits
Shebedino District			%	
Lanfero District			%	

Exclusive Breastfeeding
Description -- Percentage of children age 0-5 months who were exclusively breastfed during the last 24 hours
Numerator: Enter the number of children age 0-5 months who drank breast milk in the previous 24 hours AND did not drink any other liquids in the previous 24 hours AND was not given any other foods or liquids in the previous 24 hours
Denominator: Enter the total number of children age 0-5 months in the survey

Sub Area Name	Numerator	Denominator	Percent (calculate)	Confidence Limits
Shebedino District			%	
Lanfero District			%	

Infant and Young Child Feeding
Description -- Percentage of infants and young children age 6-23 months fed according to a minimum of appropriate feeding practices
Numerator: Enter the number infants and young children age 6-23 months fed according to a minimum of appropriate feeding practices
Denominator: Enter the total number of children age 6-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent (calculate)	Confidence Limits
Shebedino District			%	
Lanfero District			%	

Vitamin A Supplementation in the Last 6 Months
Description -- Percentage of children age 6-23 months who received a dose of Vitamin A in the last 6 months: card verified or mother's recall
Numerator: Enter the number of children age 6-23 months who received a dose of Vitamin A in the last 6 months (mother's recall or card verified)
Denominator: Enter the total number of children age 6-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent (calculate)	Confidence Limits
Shebedino District			%	
Lanfero District			%	

Measles Vaccination
Description -- Percentage of children age 12-23 months who received a measles vaccination
Numerator: Enter the number of children age 12-23 months who received a measles vaccination by the time of the interview as seen on the card or recalled by the mother
Denominator: Enter the total number of children age 12-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent (calculate)	Confidence Limits
Shebedino District			%	
Lanfero District			%	

Access to Immunization Services
Description -- Percentage of children age 12-23 months who received DTP1 according to the vaccination card or mother's recall by the time of the survey
Numerator: Enter the number of children age 12-23 months who received a DTP1 at the time of the survey according to the vaccination card/child health booklet or mother's recall

Denominator: Enter the total number of children age 12-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent (calculate)	Confidence Limits
Shebedino District			%	
Lanfero District			%	

Health System Performance Regarding Immunization Services
Description -- Percentage of children age 12-23 months who received DTP3 according to the vaccination card or mother's recall by the time of the survey
Numerator: Enter the number of children age 12-23 months who received DTP3 at the time of the survey according to the vaccination card/child health booklet or the mother's recall
Denominator: Enter the total number of children age 12-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent (calculate)	Confidence Limits
Shebedino District			%	
Lanfero District			%	

Treatment of Fever in Malarious Zones
Description -- Percentage of children age 0-23 months with a febrile episode during the last two weeks who were treated with an effective anti-malarial within 24 hours after the fever began
Numerator: Enter the number of children age 0-23 months with a febrile episode in the last two weeks AND whose mother/caretaker sought treatment for the child within 24 hours AND who were treated with an appropriate anti-malarial drug
Denominator: Enter the total number of children age 0-23 months with a febrile episode in the last two weeks

Sub Area Name	Numerator	Denominator	Percent (calculate)	Confidence Limits
Shebedino District			%	
Lanfero District			%	

ORT Use
Description -- Percentage of children age 0-23 months with diarrhea in the last two weeks who received oral rehydration solution (ORS) and/or recommended home fluids
Numerator: Enter the number of children age 0-23 months with diarrhea in the last two weeks AND who received oral rehydration solution (ORS) and/or recommended home fluids
Denominator: Enter the total number of children age 0-23 months who had diarrhea in the last two weeks

Sub Area Name	Numerator	Denominator	Percent (calculate)	Confidence Limits
Shebedino District			%	
Lanfero District			%	

Appropriate Care Seeking for Pneumonia
Description -- Percentage of children age 0-23 months with chest-related cough and fast and/or difficult breathing in the last two weeks who were taken to an appropriate health provider
Numerator: Enter the number of children age 0-23 months with chest-related cough and fast and/or difficult breathing in the last two weeks who were taken to an appropriate health provider
Denominator: Enter the total number of children with chest-related cough and fast and /or difficult breathing in the last two weeks

Sub Area Name	Numerator	Denominator	Percent (calculate)	Confidence Limits
Shebedino District			%	
Lanfero District			%	

Point of Use (POU)
Description -- Percentage of households of children age 0-23 months that treat water effectively
Numerator: Enter the number of households of mothers of children 0-23 months that treat water effectively
Denominator: Enter the total number of households of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent (calculate)	Confidence Limits
Shebedino District			%	
Lanfero District			%	

Appropriate Hand Washing Practices
Description -- Percentage of mothers of children age 0-23 months who live in households with soap at the place for hand washing
Numerator: Enter the number of mothers with children age 0-23 months who live in households with soap at the place for hand washing
Denominator: Enter the total number of mothers of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent (calculate)	Confidence Limits
Shebedino District			%	
Lanfero District			%	

Child Sleeps Under an Insecticide-Treated Bednet
Description -- Percentage of children age 0-23 months who slept under an insecticide-treated bednet (in malaria risk areas, where bednet use is effective) the previous night
Numerator: Enter the number of children age 0-23 months who slept under an insecticide-

treated bednet the previous night Denominator: Enter the total number of children age 0-23 months in the survey				
Sub Area Name	**Numerator**	**Denominator**	**Percent (calculate)**	**Confidence Limits**
Shebedino District			%	
Lanfero District			%	

Underweight Description -- Percentage of children 0-23 months who are underweight (-2 SD for the median weight for age, according to the WHO/NCHS reference population) Numerator: Enter the number of children 0-23 months with weight/age -2 SD for the median weight for age, according to the WHO/NCHS reference population Denominator: Enter the total number of children age 0-23 months in the survey				
Sub Area Name	**Numerator**	**Denominator**	**Percent (calculate)**	**Confidence Limits**
Shebedino District			%	
Lanfero District			%	

Rapid Catch Indicator Comments
Child spacing was not collected. This was an oversight.

ANNEX 12: SPECIAL REPORTS

Attached as a separate PDF document are the following reports:

1) Report on outbreak of Acute watery diarrhea (AWD) response at Lanfero District, December 2009.
2) 9th Annual Regional Health Partners Forum & EFY 2002 Mid-year Review Meeting Report, 8-10 March, 2010
3) SNNPR, Regional Health Bureau. *Mid-term evaluation for: Enhancing Ethiopia's Health Service Extension Program in the Southern Nations and Nationalities People's Region (SNNPR), Save the Children Child Survival Project.* **June 2010.**
4) Note for the record: MTE Participatory workshop for preliminary results & recommendations, Awassa, Aug 2010

ANNEX 12 – Section 1

Report on outbreak of Acute watery diarrhea (AWD) response at Lanfero District, December 2009.

Epidemic report, AWD

Save the Children

Report on outbreak of Acute watery diarrhea (AWD) response at Lanfuro District A CS23 Project District

Reported by Habtamu Tilahun
CS23 District Health Officer

December 2009

1 Introduction

Save the children is implementing five year child survival project with project title, Innovation for scale: Enhancing health extension program in the southern nationalities people's Region, in Silit Zone, Lanfuro district project site.

The major project strategy is community case management of pneumonia, Malaria,Diarrhea and Neonatal Sepsis.

There had been an out break of AWD in the district in December 2009 first week and Save the Children has given both technical and financial support to Lanfero district Health Office to control the outbreak with in 2 weeks time. This report will summarize some details in the response.

2 General Situation of the AWD outbreak

As of December 6, 2009 a total of 12 cases of AWD were reported. One case is admitted to a Health Center. One adult death was reported. It is thought that the cases were imported by pilgrimages to Bale for the Dire Sheika Hussein trip. The first case of AWD was reported to district health office and the source of the epidemic was confirmed to be related to Bale cultural trip traveler and more than 500 peoples were involved in the trip.

The first case was a pregnant woman and she has been a part of the traveler and she died at Butajira Hospital. Through integrated effort of the government and Save the Children and the community, the outbreak was controlled with in 2 weeks with no further death and one severe case admission to HC and recovered.

3 Action taken for the Epidemic response

A rapid response has been given by coordinated effort of District health office, Zonal health Desk, Save the Children and Regional health bureau in both preventive and curative activities.

3.1 Community mobilization and sanitization on AWD

Health education and sensitization on the occurrence, sign and symptom of the epidemic, how to prevent and control acute watery diarrhea to the community while they gather for exchange of items, on Safety net program and on "Ware" cultural ceremony.

Through coordinated effort more than 23,000(twenty three thousand) community members have got health education and 7000 flayer leaflets on AWD and its prevention that express the transmission, seriousness of the disease, the prevention and control mechanism were distributed to the community.

Students at their school were also the focus of the health education to teach their parents and neighbor on the transmission and control activities by focusing on proper utilization of latrine and hand washing practice.
We also mobilized the students in active case finding at the community level and early referral of sick ones to the health facility and to enforce their parent to construct new latrine if they don't have and for proper waste deposal.

3.2 Establish task force prevention and control activities

Acute watery diarrhea task force established at each kebeles to mobilize the community on the prevention and control of the outbreak. This task force includes the following;

1 Kebeles administrator	Chair person
2 Kebeles school director	Member
3 Health extension workers	Member
4 Development agent (two)	Members
5Water committee chair man	Member
6 Kebeles manager	Member
7 One community volunteer	Member
8 Kebeles primary organization chair man	Member

The task of the committee was to mobilize the community to construct new latrine, to give health education by linking with the community volunteers. They really played great role in the construction of new latrine and to increase the community awareness on the transmission, prevention and control of the disease .Due to this coordinated effort 1316 (one thousand and three hundred sixty) new latrines .were constructed at the community with 10 public latrines.

3.3 Established temporally epidemic Treatment site

As an urgent response to the epidemic of acute watery diarrhea management, temporary treatment centers were established at Luke kudessa health post and Tora health center.
Health professional assigned to the site day and night for any emergency setup with well organized medical supply like Ringer lactate, ORS, Antibiotic and Examination glove. A total of 63 case seen and treated at Six epidemic site called Luke Kudessa ,Wonte Sestoro Lanfuro Gebaba, Meja Tora, Tora kilkora and Repe. There was no additional death and only one severe case admission at Tora health center and he was discharge with full recovery.

Table 1.1 Number of AWD cases by sex and site/Kebele

NO	Kebeles	Population at risk	Cases by sex distribution		Total cases	Death
			Male	Female		
1	Luke kudessa	3851	23	29	59	01(2%)
2	Wonte Sestoro	3284	1	5	6	0
3	Lanfuro Gebaba	4368	1	0	1	0
4	Meja Tora	3526	2	0	2	0
5	Tora Kikora	3226	0	1	1	0
6	Repe	4951	0	1	1	0
	Total	-	27	36	63	1

Table 1.2 Acute watery diarrhea cases by age and sex distribution

No	Age	Disease occurrence by age and sex distribution		Total	Percent
		Male	Female		
	U5 Children	01	01	02	3%
	5-14 yrs	3	7	10	16%
	15-44 yrs	16	25	41	66%
	45-64 yrs	7	3	10	16%
	Total	27	36	63	100%

4 Save the children support for the AWD outbreak control

The main objective of our engagement in the response was to support the District Health Office in provision of essential drugs, supplies and transportation to halt the epidemic and prevent deaths due to AWD. The Woreda Health office has identified their gaps and need support on these areas:Transportation, Fuel for motorbike, Printing cost for key AWD Messages and Water guard for 3500 HH

Save the children has responded accordingly to the outbreak and the district health office has given it appreciation and acknowledgment for Save the Children and Hawassa Sub office and I personaly thanks Dr, Hailu Tesfaye and Elias Kayessa for fast response to control the outbreak. Our District Project Officer for CS23 , Ato Habtamu Tilahune has contributed a lot as a member of the response team at Woreda level and has given technical support in AWD treatment and prevention.

Save the children supports were.

- Rented a vehicle for outbreak activities for three weeks.
- Supply 4000 water guard
- Supply 3500 Flayer/ leaflet about AWD
- Supply 440 liter of petrol to the district health office for motor bikes

Table 2.5 Activities and financial expense by Save the Children for AWD

No	Activities	Quantity	Budgeted in Birr	Expense in Birr	Balance (%)
1	Supply water guard	4000	16000	16000	0 (100%)
2	Supply Flayer/Leaflet on AWD	3500	7000	1400	5600 (20%)
3	Rent a Vehicle	22 days	17850	17380	470 (97.4%)
4	Supply petrol for District H.Office	440 liters	6160	6160	0 (100%)
5	Fuel for the rented vehicle		4000	2000	2000 (50%)
	Total		***51010 ($3997)***	***42940 ($3365)***	***8070birr/$632 (84.2%)***

ANNEX 12 – Section 2

9th Annual Regional Health Partners Forum & EFY 2002 Mid-year Review Meeting Report, 8-10 March, 2010.

Conference Report

9th Annual Regional Health Partners Forum

&

EFY 2002 Mid-year Review Meeting Report

8—10 March, 2010

Hawassa, SNNPR

Reported By:

Elias Kayessa Health Program Coordinator

Worku Tefera Monitoring & Evaluation Coordinator

8-10 March, 2010

Hawassa

Part I: 9th Annual Regional Health Partners Forum

(March 8, 2010)

Place of Meeting: Hawassa

Venue: Sidama Cultural Hall

Date: 8 March, 2010

Organized by: Regional Health Bureau

Participants: RHB SMT member, WHO, UNICEF, International and Local NGOs, Zonal Health Department Heads, Woreda Health Office Heads, Hospital Managers Hospital Medical directors and Health Extension Workers representatives

Purpose of partners Forum discussion:

- To build common understanding and consensus on key health and related problems and their interventions
- To coordinate and harmonize of individual partners activity in order to avoid duplication of effort and efficient utilization of limited resources
- To introduce and discuss on CCM of pneumonia policy change

Proceedings of Annual Regional Health partners Forum

Partners' forum meeting was started with welcome opening remark of RHB head and followed by key note address of UNICEF, WHO, Ireland Aid representatives focusing on their program areas and appreciating the policy change on CCM of Pneumonia treatment by health extension workers at health post level especially by UNICEF.
Presentations on partners' forum progress to date, donors mapping, Implanon and IMNCI initiative progress challenge and the way forward, research and technology transfer issues and 2003 EFY Woreda based National planning and HSDP-IV strategic themes were presented by different RHB representatives and discussion made point by point. Finally on CCM of pneumonia the participants discussed point by point and appreciated the change made to save the life of children with treatable disease where there is well trained HEWs.

Good points

- ✓ Partners mapping document prepared in collaboration with BoFED
- ✓ 165 CSOs Regional HIV?AIDS partners resource mapping was conducted
- ✓ HMIS Technical Working Group reformed
- ✓ Emergency response to epidemics was good
- ✓ Harmonization and coordination of partners at Woreda and community level improved
- ✓ Integrated supportive supervision done by partners together with RHB

Weaknesses raised during discussion were:

- ✓ only one RJSC meeting
- ✓ Uncoordinated trainings at Woreda level and overburdened the staff
- ✓ Weak participation of few partners on planned activities e.g. MSH
- ✓ Irregular training payment creating discrepancy at lower level
- ✓ Zonal level poor ownership on coordination

Point given more emphasis

- In Woreda based planning partners should participate in their respective project area
- Use One plan, One budget and One report principle at each level
- Training guides, time schedule and payment needs uniformity
- Integrated supportive supervision has to be appreciated at each level

Partners Forum assignment (elected)

1. Dr. Haile Mariam Legesse (from UNICEF- Coacher)
2. Dr. Gebre (from WHO – Secretary)

Part II: RHB EFY 2002 Mid-Year Activity Progress Review Meeting Conference

(March 9-10, 2010)

Highlights of the conference

Participants of the conference

RHB SMT member, WHO, UNICEF, International and Local NGOs, Zonal Health Department Heads, Woreda Health Office Heads, Hospital Managers Hospital Medical directors and Health Extension Workers representatives

Objectives of the conference

- To reviewing EFY 2002 mid year plan versus achievement
- To discuss on HSDP-IV themes and woreda based EFY 2003 health sector annual plan development
- To brain storm on CCM policy change and how to proceed with
- To discuss on the need of re-planning on poorly performed activities of EFY 2002 activities for the remaining months of the fiscal year
- To discuss on previous quarters supervision findings and next improvement actions
- To discuss on the need of strengthening one plan, one budget, one report

Important points raised on the conference *(selected for the purpose of this report)*

After opening speech by RHB head, the EFY 2002 mid year report was presented by the concerned process owner of the Regional Health Bureau using PowerPoint segregating by Zones and special woredas plan versus achievement.

After presentation of the report participants asked questions that need clarification and also raised their concerns on the content of the report and challenges they faced during activity implementation. ***The participants raised vaccine and kerosene as a major problem; however, the RHB head replied that the RHB do not have the problem of vaccine and kerosene shortage except lack of timely settlement of accounts to get the next round money on regular basis.*** He underlined, "woredas have the mandate and allocated budget to purchase kerosene; no room to expect budget from Zone or Region." Also it has identified that there are Zones and special woredas that are not requesting supplies and logistics before the stock is nil that has great impact on performance. The participants agreed up on to re-plan the poorly performed activities.

Later on, supervision feedback report has presented and discussions were made on the strengths, weaknesses and on the areas that need to be improved. ***As of the findings of the supervisory team, capacity building trainings are given by different organizations or government on the same and similar topics at the same place and for the same people that need to be improved by implementing one plan, one budget, one report to organize the implementation of trainings and other activities too.*** The RHB head has suggested that before the implementation of all trainings the Zonal health desk and woreda health offices have to recognize and approve the training for effective and efficient use of the scarce resource and to avoid training duplications.

ITN supply and use: the conference participants and key officials from the RHB have acknowledged the existing ITN has supplied before three years and obsolete to be used by households. ***The consensus on ITN issue is, there is a plan and preparation by the RHB to re-distribute in this EFY (2002) for rural households.***

Problem of water supply: there is high shortage of water in Welayeta Zone including the capital of the Zone, Sodo, as of the presented report.

Availability of training registration books: As reported on the conference, there are training registration books at health facility level to monitor and control the categories and composition of trainees to prevent giving repetitive chance for a single individual, however, reported that there are no registration books in some health facilities. ***This is very good experience to be adapted by our office to control the status of training in all our projects under ASO.***

Partners extra support: In some woredas there are some NGOs that are rendering support like maintaining motorbikes out of their agreed activities. Such activities are appreciated and recognized by the RHB officials by announcing the names of NGOs in some woredas supported the government.

Health Education Impact Assessment (Welayeta Zone experience): Welayeta Zone presented its experience on how they are monitoring behavioral change among the community. Depending on their pre set schedule, every week they go out to visiting

HPs and also visit 10 PAs under the health post to inquire mothers to assess their knowledge and skills on key indicators using checklists.

Institutional delivery: Overall in the region, institutional delivery is less than 5% while delivery by Health Extension Workers is 32% (from 6 months plan) compared to 6.8% in EFY 1994. However, it has emphasized that a lot of work is in front to mobilize the community to use health facilities for delivery service.

Brain storming on CCM policy change: Basically the participants were not against CCM policy, but have doubt whether it can be managed by HEWs or not, also there were some participants who were arguing that this is additional burden on health extension workers to fulfill the 16 packages as of the HEP policy. Finally the RHB head summarize and commented that there will be launching meetings and trainings at all levels to clear how to proceed with CCM.

One plan, one budget, one report issue: As a summary the following points were given attention and discussed: need of all partners to plan with the government, submitting their budget to the government on paper for common understanding, submitting quarter and annual reports to the government (RHB, BoFED and DHO), need of participating on government Integrated Supportive supervision (ISS). Complaint raised from the RHB is, some NGOs have started to participate on ISS, but some are disappearing before the completion of the supervision activity which is quoted as unfair.

ANNEX 12 – Section 3

SNNPR, Regional Health Bureau. Mid-term evaluation for: Enhancing Ethiopia's Health Service Extension Program in the Southern Nations and Nationalities People's Region (SNNPR), Save the Children Child Survival Project. June 2010.

MID TERM EVALUATION FOR

Enhancing Ethiopia's Health Service Extension Program in the Southern Nations and Nationalities People's Region (SNNPR), Child Survival Project

Save the Children USA

June 2010

Background

The Lancet Neonatal Series showed Ethiopia to be one of the six countries that together account for more than half of U5 mortality in the world. Ethiopians U5 mortality stands at 123/1000 live births and the infant mortality rate at 77/1000 with wide regional variation. Nearly half (47%) of children U5 are stunted, maternal mortality rate is 673/1000 and less than 30% of mothers receive antenatal care at least once during pregnancy and only 6% of deliveries are attended by a health professional.

At 107/1000 and 157/1000 SNNPR reports Ethiopia's second highest IMR and U5MR - Neonatal. The region Neonatal Mortality Rate that contributes nearly half of infant mortality 49/1000 is higher than the National Rate 39/1000. SNNPR serves its population through a network of 19 hospitals, 161 health centers 194 upgraded health centers staffed by 110 medical doctors, 215 health officers, 2,945 nurses, 289 health assistance, 11 pharmacist and 250 pharmacy technicians by the time. 1,876 health posts are currently by 3,711 HEWs, which will increase to 7,708 by 2009. Shebedino and Lanfaro wereda chosen for the project operational area because of the presence of SC and Community Based Working Experience over the past three-year's continuously and Zone Health Department and District Health Office willingness to house SC staff. The project reaches a total population of 366,898(255,209 and 111,689 children 0-59 months and women of reproductive age live in Shebedino and Lanfaro districts respectively

Shebedino District: 37% of the population has access to health services. It has one health center, four upgraded health centers, three clinics and ten health posts staffed by a number of health professionals except medical doctor.

Lanfaro Districts: 47% of the population has access to health service. It has 2 health centers, one upgrade health center, and 15 health posts, staffed by a number of health professionals except medical doctor.

The project aims

- To reduce morbidity and mortality of U5 children through provision of Community Case management of Pneumonia, , Malaria, Diarrhea and Improving of New Born Care, Assessment and Early referral and

- To adopt proven child health interventions and strategies at national and regional policies and programs

Midterm Evaluation has carried out from June 21-25 2010 to assess the staus of the project achievement. A team organized at regional level composed of BoFED and Health Bureau, line organizations at zone and wereda level are members. At the end of the evaluation, the team prepared report that could indicate the performance of the project and its intended impact.

1.2 PROJECT IDENTIFICATION

- **Name of the Project:**

Enhancing Ethiopia's Health Service Extension Program in Southern Nations and Nationalities People Region, Child Survival Project

- **Location of the Project :**

Siltie Zone Lanfaro wereda and Sidama zone Shebedino Wereda

- **Funding Agency:**

USAID

- **Executing Agency:**

Bureau of Finance and Economic Development, and Bureau of Health,

- **Implementing Agency:**

Save the Children USA, Ethiopian Country Office

- **Duration of the project:**

October 1, 2007- Sept 30, 2012

- **Total allocated Budget:**

14,010,010

- **Beneficiaries:**

Direct Beneficiaries 69,968 U5 Children

1.3. Project Description

1.3.1 General Objective:

- Morbidity and mortality in U5 children is reduced through provision of community case management of pneumonia, malaria diarrhea and improving new born care, assessment and early referral. Proven child health interventions and strategies adopted into regional and national policies and programs

1.3.2 Specific Objective:

The HEP is strengthening through addition of evidence based new interventions and to demonstrate the feasibility of enhancing the current HEP for expanded impact by adding the following interventions;

- Community Case management of Pneumonia (CCM/P) with antibiotics
- Zinc treatment for diarrhea
- Use of new formula ORS for dehydrating diarrhea and
- Improved assessment referral of Neonatal Sepsis (NS) which possibly of CCM/NS to be added

1.3.3 Main Components:

- Increasing access and availability of service and supplies
- Increasing quality of service
- Increasing knowledge and acceptance of key service and behaviors increased
- Enabling social and policy environment

1.4 Objective of the evaluation

- To evaluate whether the expected out put is achieved or not
- To evaluate how far the target population are beneficiaries
- To assess the efficient and effectiveness of the out put
- To assess the outcome and impact of the project and
- To organize information that enables to make decision about the project

Objective

The evaluation aims to assesses the performance in the first half of the project life in order to

- Determine whether it is functional in accordance to the agreement
- Predict its effectiveness and efficiency at the end of the project and
- Recommend for any thing, which needs improvement.

Methodology

Sample health facilities selected from the two districts, the district health office and zone health departments are samples to collect data for the evaluation

- Document Reviewing
- Field assessment
  - Briefing from the project owner

- Focus group discussion (Health extension workers and other health professionals)
- Site visiting
- Interviewing health professionals
- Discussion with zone and woreda officials.

Team composition:

Finance and Economic Development Bureau, Health Bureau and line organizations at zone and woreda level are members of the evaluation team.

Chapter Two

Physical and Financial Accomplishment

Table 1- Physical Accomplishment

No	Activities	Unit	Planned			Accomplishment			Remark
1	ACCESS and Availability of Services and Supplies increased								
	Provide pneumonia case management when regional Health Bureau agrees		√	√		√			At health centers level
	Diarrhea and malaria management skill building at Health Post and Community level		√	√		√			
	IMNCI training for health professional in the Health Center		√	√		√			
	Skilled delivery service, newborn care& assessment, postnatal care training		√	√					
	Follow up for proper ITN distribution utilization for households		√	√		√			
	Provide better immunization service at Health Post and Health Centers		√	√		√			
	Ensure an integrated intervention at health post and health centers for child health nutrition and sanitation		√	√		√			
	Conduct baseline KPC survey		√	√					
	Monitor and follow up for essential drug supply &facilitate corrective actions		√	√		√			
	Avail proper newborn care, assessment, postnatal visit strategies by HEWs/ CHPs/CRPs at health post level		√	√		√			

Table 1- continued

No	Activities	Unit	Planned			Accomplishment			Remark
2	Quality of Service Increased								
	IMNCI case management skill training for health professional		√	√		√			
	IMNCI case management and referral skill training for Health Extension Workers		√	√		√			
	IMNCI essential drug provision for Health Posts and Health Centers		√	√		√			
	Zinc treatment provision for diarrhea		√	√		√			
	Provision of rehydration therapy with the new ORS		√	√		√			
	Provision of on the job training, supportive supervision, and technical assistance in IMNCI		√	√		√			
	Health Extension Worker Training on assessment of sick newborn, in key newborn messages		√	√		√			
	Provision of standard job aids, guidelines and supplies for IMNCI/C-IMNCI		√	√		√			
	Provision of essential drugs for pneumonia, diarrhea and fever management		√	√		√			
	Supporting/building the capacity of health workers and DHO staff in proper supervision and routine monitoring, in sustaining facility &community level activities		√	√		√			

Table 1- continued

No	Activities	Unit	Planned			Accomplishment			Remark
7	Reviewing quality improvement options with partners in delivery of MCH services		√	√					
7	Reviewing regional data collections/HMIS in standard documentation, reporting to make them user friendly toolkits		√	√					
3	**Knowledge and acceptance of key services increased**								
	Provide health promotion activities in health facilities in child health, nutrition, care seeking, hygiene and sanitation during one to one session or during health education		√	√		√			
	Deliver key behaviors &practices in appropriate care seeking for ill child, in recognition of signs needing proper treatment, in recognition of danger signs through trained CRPs/ CVs/ HEWs at household level		√	√		√			
	Promote standard immunization services during health facility visits		√	√		√			
	Counsel Care takers in proper breast feeding, proper feeding for infant & young child and feeding during illness		√	√		√			
	Counsel caretakers one to one and in groups about household sanitation &hygiene		√	√		√			
	Inform Community on ITN availability and proper utilization		√	√		√			

Table 1 continued

No	Activities	Unit	Planned			Accomplishment			Remark
	Ensure care takers understanding of importance of referral and follow up of sick child		√	√		√			
	Conduct community leaders sensitization workshop		√	√		√			
4	**Social and Policy Environment Enabled**								
	Work with GO/NGO/UN partners for policy improvement in HSDP-IV particularly in CCM of pneumonia by HEWs		√	√		√			
	Document and disseminate evidence based best practices in CCM using MoH guidelines and documents		√	√		√			
	Conduct joint planning with relevant &key partners and community stakeholders in CCM		√	√		√			
	Lead regular partners coordination, advocacy and policy dialogue in CCM		√	√		√			
	Adopt proven child health interventions and strategies in to /Regional and National policies and programs		√	√		?			
	Work closely with RHB for adequate budget allocation for IMNCI training, supervision and supplies		√	√					
	Conduct participatory DIP preparation		√	√		√			
	Conduct joint and integrated supportive supervision and TAs		√	√		√			
	Follow up of health facilities functionality in IMNCI implementation and reporting		√	√		√			
	Conduct periodic Regional child health taskforce meetings		√	√		√			

.1.2 Field Assessment

he implementation takes place in 58 health posts and 10 health centers found in the two weredas. The rget health facilities are 33 health posts and 6 health centers in Shebedino and 25 Health posts and 4 ealth centers in Lanfaro. The project addresses 100 % of the health facilities found in each wereda. hough 5 Health posts and 2 health centers from Lanfaro and 3 health centers and 6 Health Post from hebedino selected for the evaluation purpose, the team reachs at 2 health centers and 3 Health posts in anfro and 2 Hcalth centers and 4 Health posts in Shebedino. A total of 17 health professionals, 42 health ctension workers, and 248 community health workers including community leaders and local authorities ained in Lnafaro wereda and 66 health extension workers,23 health workers and 830 community health orkers including community leaders and local authorities trained in Shebedino wereda. The two health ofessionals assigned for each wereda to facilitate the activities play a vital role to implement the project. ipportive supervision carried regularly with the wereda health office is mechanism to strengthen the rvice.

ıe project performs

- The IMNCI training that aims to extract a number of cases that affect children at one time and/or enable to differentiate the major and real cause of child sickness that protects misdiagnosis.
- IEC/BCC distribution, community health workers, community leaders and local authorities training that is helpful to increase the awareness of the community to increase their care seeking behavior.
- Drug and medical supplies helps to increase the capacity of the health facilities to deliver the service nearby and increase quality of the service.
- Strengthening the ORT corner. The corner is more active in health centers and health posts since the IMNCI training. It serves as a demonstration center that helps mothers to understand the use of drug and ORS easily.

ing the discussion, the team understood that the organization works closely with the health offices and lth facilities found in the two weredas by integrating the program with wereda plan. The IMNCI gram is a newly developed approach implemented as pilot in the two weredas integrated with the 20 messages developed in the health extension package. According to the project coordinator expressions Federal Government and Bureau of Health accept the program to implement in the country and in the on respectively which is opportunity to strengthen and expand the service through out the region.

During the field visit the team understood that all of the Health Extension Workers and some Health Workers in the health center and wereda health offices trained IMNCI. Currently they delivered the services in the health posts in its initial stage and health centers also provide the service including pneumonia treatment. According to the program coordinator suggestion the progress of the service is on going.

By the time of the filed visit in both weredas the team observed that malaria and malnutrition as a major problems. Health Extension Workers suggest that the training and the drug supplied to the health posts help them much to facilitate their day to day activity. They said that the community awareness about child illness and symptom increases, besides their trust developed on the health extension workers. Most health extension workers in Shebedino wereda said that communities' care seeking behavior increase; recently they prefer to bring their child to the health posts rather than traditional healers. Health extension workers in Lanfaro suggested that, they bring children soon which is easy to control, save the life of children, minimize risks arise from complication which help to decrease the number of patient flow towards health center beside it helps to control diseases timely.

During the visit the team observed that the existence of proper utilization of standard registration books, chart booklet, and counseling card in the health facility approved by MOH and distributed by the organization. However the small rooms in some of the health posts, absence of pure water supply and shortage of furniture and maintenance requirements of the buildings may influence the quality of the services. Collecting feedback by health extension workers and community health workers in some of the health posts is a means to strengthen the services and creates strong network among the health post, health center and the community which needs attention to strengthen in all health facilities at all, by paying attention in Shebedino to internalize the outcome and impact of the services.

2.2. Financial Utilization

A total amount of Birr 14,010,010.86 birr allocated for the whole project life. Table 2 indicates the financial utilization of the project during the first half of its life.

NO	Activities	Unit	Plan		The 1st half Life Utilization	Remark
			Project life	1st half life		
1	Capital Costs					
	Laptops	Birr	43,524.40			
	Desktop computers	" "	46,233.00			
	Printer	" "	6,444.60			
	Office furniture	" "	21,902.30			
	Total Capital Cost	" "	118,104.30			
	Salary and Benefit	" "	5,433,640.00			
	Thermometer, Weight scale, etc	" "	109,558.42			
	Training	" "	1,480,165.84			
	Total Training and Thermometer Cost	" "	1,589,724.26			
	Intern Consultant fees	" "	344,795.44			
	National consultant	" "	48,493.66			
	National staff travel-Local	" "	929,758.96			
	National staff travel-International	" "	276,874.96			
	Total Monitoring and Evaluation	" "	1,599,923.02			
	Salary & Benefit Interna. staff	" "	1,209,016.30			
	Headquarter staff travel	" "	407,896.48			
	Total Headquarter salary and travel	" "	1,616,912.78			
	Vehicle & Motorbike maintenance	" "	185,791.00			
	Total Program Cost	" "	10,425,991.34			
	Indirect Cost	" "				
	Office supplies, photocopy, printing	" "	272,176.94			
	Head quarter office supply and other	" "	107,699.54			
	Total Indirect Cost	" "	379,876.48			
	Overhead Cost	" "				
	Telephone, Utilities, Bank service, Rental	" "	551,181.42			
	Indirect charges	" "	253,4857.32			
	Total overhead cost		3,086,038.74			
	Grand Total		14,010,010.86			

2.3 Human and Material Resource Utilization

2.3.1. Human Resource

No	Title	Qualification	Planned	Achieved	%
1	Sub office CS Program manager	MD, Mphil, Pedatrician	1		
2	CS Health Program Coordinator	BA Degree/	1		
3	M&E officer II	BA Degree	1		
4	District program officer	Degree / Diploma	2		
5	Office Attendant	Diploma	1		
6	Cashier/secretary	Diploma	1		
7	Admin & finance coordinator	~~Diploma~~ Degree	1		
8	Procurement and Logistic officer	Diploma	1		
9	Security guard	9th &7th grade	3		
10	Driver	8th grade	1		
11	Community mobe officer	Diploma	2 ~~15~~ 15		

2.3.2. Material Resource

No	Item	Unit	Planned	Achieved	%	Remark
	Vehicle	No	1	1	100	
	Desktop computers	No	??			
	Printer	No	2	??		
	Office furniture	Set	6	??		

2.4. Strength:

- Working together with the Wereda Health Offices is a means to integrate the plan with the government sector program.
- Planning to strengthen the health service targeting all health facilities found in the two weredas including the newly established health facilities.
- Training all health extension workers, Volunteer Community health workers and most health workers in the health centers and health facilities is helpful to provide the service easily in all of the health facilities found in the two weredas at the same time.
- Supportive supervision and technical supports to increase the quality of their day to day performance
- Planning for policy enabling environment is helpful to expand the service all over the region and to synergize the program with the regular health service program, which should have positive impact for the sector development program.
- Using standard formats and job aids prepared by Ministry Of Health.

- Establishing a network among the Health workers found at different government administration structure.
- Creating strong link with other stakeholders to avoid resource duplication.

5. Drawbacks:

- Absence of quantified output that helps to measure the achievement of the project effectiveness
- Absence of activity based financial plan that increase the transparency and unable to measure the efficiency of its achievement.
- Absence of initiation to internalize the problem in Shebedino Wereda Health Workers influences the strength of the network to have sound outcome and impact.
- The existence of small, crowded and not well-furnished health posts that need maintenance is not favorable to deliver the services, as the type and degree of service delivery increases.
- Absence of planning for replacement training when there is trained staff turnover or and establishing else.
- Absence searching means of permanent drug supply for health posts.
- Absence of a well organized structure to distribute IEC/BCC material

CHAPTER THREE
Findings and Lesson Learnt

3.1 Findings:

- Integration with the wereda health office and its program is helpful for efficient resource utilization by avoiding resource duplication; and to be inline with the government policy that could support the success of the development program.

- Incorporating all health facilities found in the two weredas is helpful to provide the service for all communities who live in the weredas at the same time. The service is helpful to increase the community awareness about child health and the service given in the health facilities and it minimizes risk arise by complication.

- Training capacitates the health workers found at different administration structure to provide standard quality services based on the guideline. It will create quality service that could diminish problem of misdiagnosis besides it creates access for the service provision.

- The continuous follow up and supportive supervision made by the group is helpful for the health workers to have lesson that enable them to check the quality of their service and its progress.

- Policy enabling environment is helpful to expand the service all over the region and to synergize the program with the regular health service program. It should have positive impact in the sector development program besides it should help to provide services at similar standard all over the region.

- The network established among the Health Workers found at different administration structure level is helpful to strengthen the system and to collect well-organized information that could use as input for sound planning besides it creates common understanding among all stakeholders.

- Though the team comments the project performance in its validity and relevance to the existing problem the non -existence of quantified out put in the plan hinder to measure the achievement of the project and to determine its effectiveness.

- There is no activity based financial plan attached with the main document. It hinders to measure the efficiency of the project besides it will hampered transparency.

- There are small, crowded and not well-furnished health posts that need maintenance, and unmotivated health workers especially in Shebedino. It will influence the quality of the service and its achievement negatively.

- However, all health workers at the health post level and most of them from the health center trained to deliver the service, in order to sustain and strengthen the service establishing means for replacement training and expansion is required since the skill training is not incorporated in the curriculum.

- Provision of essential drug for the health posts helps them to deliver the service timely and avoid the shortage of drug in the health posts. However there is no plan to look alternatives to supply the health posts regularly and establishing means for proper drug supply management

3.2 Lesson Learnt:

ANNEX 12 – Section 4

Note for the record: MTE Participatory workshop for preliminary results & recommendations. Awassa, SNNPR August 2010.

Save the Children

CHILD SURVIVAL PROJECT (CS-23):
Enhancing Ethiopia's Health Extension Package in the Southern Nations and Nationalities People's Region (SNNPR) in the Districts of Shebedino (Sidama Zone) and Lanfero (Siltie Zone)

MID-TERM EVALUATION (MTE): REVIEW OF OBSERVATIONS FROM THE FIELD AND DEVELOPMENT OF PRELIMINARY RECOMMENDATIONS
9 August 2010

Note for the Record from the Participatory Meeting

Venue: Haroni International Hotel, Awassa

Agenda: Listed in Annex 1.

Participants: Listed in Annex 2.

Purpose of the Review Meeting:
1. Present selected preliminary findings
2. Validate, interpret, and contextualize the findings with stakeholders
3. Strengthen the SC-Government partnership and own the findings together

Objectives:
1. Participatory interpretation of the preliminary findings
2. Propose preliminary recommendations (near, mid-, and long-term), including budget implications and point persons

Highlights from the meeting:
The meeting had a series of short presentations related to the CS-23 project and the MTE, followed by small group work to develop recommendations, with groups reporting back and discussing the findings and recommendations. Annex 4 includes the power-point presentations presented at the meeting.

1. CS-23 Project Overview

Dr. Hailu Tesfaye, CS-23 Program Manager, presented an overview of the Save the Children CS-23 project including: the location, duration, and funding of the CS-23 project, the CS-23 project results framework and interventions by intermediate results, achievement of the project, partners and the overall implementation strategy (Annex 4).

2. CS-23 MTE Methods

Worku Tefera, the CS-23 Coordinator of Monitoring and Evaluation, presented the methods used in the Mid-Term Evaluation (MTE). Health services staff (from zonal and district levels) participated in the conduct of the MTE and a list of the MTE team is presented in Annex 3. Annex 4 presents the detailed methods and sampling used in the MTE.

3. CS-23 MTE Preliminary Findings and Observations

Dr. Kate Gilroy, the external consultant from Johns Hopkins University, presented the preliminary findings from the CS-23 MTE based on the results framework. She also provided guidelines for the small group discussions. Discussion groups were formed around the Intermediate Results (IR1: Service Delivery; IR2: Quality/Supervision; IR2: Quality/Supplies; IR3: Knowledge and promotion) Annex 4 includes the preliminary findings presented at the meeting and the instructions for the group work.

4. Recommendations from the small group work

The table below presents the recommendations from the small group work by Intermediate Result. Discussions were had about the feasibility and short-term versus long-term nature of the recommendations, who could carry-out the recommendation and at what cost.

5. Next steps

The CS-23 Mid-Term Evaluation will not be complete until all the data and results are compiled and key informant interviews are completed at the national level. Once the results, MTE report and recommendations are finalized, they will be shared with all partners. Save the Children staff and partners will work collaboratively[1] to propose a joint action plan.

[1] Likely through a meeting or series of meetings

Table: Recommendations from small Group Work based on preliminary findings of CS-23 MTE in Shebedino and Lanfero, SNNPR

IR1: Service Delivery	IR2: Quality – Supervision & Motivation	IR2: Quality – Supplies	IR3: Health Promotion
Training • Train HEWs on Safe and Clean Delivery (SCD) and Essential Newborn Care (ESC) (only 5 HEWs in Shebedino & 5 in Lanfero trained in SCD currently) • Trained untrained HEWs (replaced) and newly assigned urban HEWs in IMNCI and C-IMNCI • Train untrained HEP supervisors in 2 months routine training • Provide Refresher training in IMNCI and cIMNCI • Provide pneumonia treatment training for HEWs, vCHWs and HEP supervisors **Referral** • No quick solution for regular referral as transportation is big issue and no transport • [For back referral]; Organize workshop about feedback because families don't request feedback from HC – we propose that community itself should request ⇨ create awareness to ask for feedback) • Increase back-referral through BPR targets – part of performance evaluation, included in new HMIS • Encourage back referral as feedback mechanisms and as an incentive & to increase belief in the HP • Provide motorbike ambulances – 3 wheel – ask for health support for emergencies • Cell phone for TBAs to call ambulance to call when there is a referral case at their locality(Cell phone service – covers most of Shebedino & Lanfero); e.g. Collaborate with FGI and integrate such systems with them to cost-share/leverage (consider)	**Short-term** • Provide Motorbike maintenance & fuel • Assess training need (assess skill gap) • Provide refresher training (monthly, quarterly?), both for skills improvement and per diems • Increase base salary of HEP supervisor (within the budget of project if increased to education sector) • Award certificates for best HEWs, best performing supervisors • Provide mobile card monthly (for support of car, emergency issues, etc) **Medium-term** • Purchase motorbikes • Review per diem rates **Long-term** • Further education status • Provide opportunity to upgrade status	**Short term** • Strengthening stock mgmt system (Joint SC/Govn't) • Forecast demand early and planning (Govn't/MOH) • Supply UNICEF timers or personal timers for short-term (facilitate that jointly) • Strengthen and integrate supervision of essential stocks and drugs; Strengthen stock mgmt system • Consider supply in annual planning & setting budget (District) • Trainings for stock management **Med/Long term** • Procure enough stock per demand (especially outbreaks) – (Govn't) • Provide transport (Gov &/or partner) • Plan supply transition from Sc to Govn't, especially for zinc (only supply coming from project – when project phases out, govn't should take over (partner)	**Short term** • Continue promotion of key messages by vCHWs ($) • Provide certificates for well-performing vCHWs ($) • Facilitate discussion among pregnant mothers and influential groups (mothers-to-mothers groups) ($$) **Medium term** • Provide refresher training in c-IMNCI for HEWs & vCHWs ($$) • Provide (initial) C-IMNCI training for new vCHWs, HEWs and HEP supervisors • Provide t-shirts or other small incentives for vCHWs ($$) • Collaborate with other NGOs to adopt promising strategies (e.g. GOAL care group model) ($-$$) • Place staff at grass roots level ($$$) **Long term** • Supply drugs and CoArtem ($$) • Provide transportation and motorbikes ($$) • Improve water supply and electricity ($$$)

Annex 1: Child Survival Project (CS23) MTE Debriefing Workshop Schedule

MID-TERM EVALUATION: REVIEW OF OBSERVATIONS FROM THE FIELD AND DEVELOPMENT OF PRELIMINARY RECOMMENDATIONS

CHILD SURVIVAL PROJECT (CS-23) ***Enhancing Ethiopia's Health Extension Package in the Southern Nations and Nationalities People's Region (SNNPR) in the Districts of Shebedino (Sidama Zone) and Lanfero (Siltie Zone)***

August 9, 2010

Time	Activity	Responsible
8:30-8:45	Participant Registration	Barassa
8:45-9:00	Opening Remarks	RHB head
9:00-9:15	Child Survival Project Overview	CS Program Manager
9:15-9:30	MTE Methods	CS M&E Coordinator
9:30-10:00	MTE Key Preliminary Findings	Consultant
10:00-11:00	Small Groups – Interpretation and preliminary recommendations with tea	Participants in 4-5 small groups
11:00-12:00	Small Group Presentations (each group 10 minutes)	Small group reporters
12:00-12:30	Wrap Up and Next Steps	CS Program Manager & Colleague
12:30-1:30	Lunch	

Annex 2: Child Survival Project MTE Debriefing Workshop Participants
August 9, 2010

S/n	Name	Organization	Position
1	Abdulkerim Kamil	Siltie Zonal Health Department	Plan & Programming Officer
2	Hashim Aman	Siltie Zonal Health Department	Disease Prevention & Health Promotion
3	Bilal Kamil	Siltie Zone Bureau of Finance	Expert of NGO's Affair
4	Yekesi Mosa	Siltie Zone Bureau of Finance	Deputy head
5	Melekot Tefera	Plan Ethiopia	Program Coordinator
6	Tsegaye Yutamo	Sidama Zone Finance	Planning Officer
7	Chiksa Sultan	Lanfero District Health Office	Disease Prevention & Health Promotion
8	Shemsu Sirmolo	Lanfero Finance & Economic Office	Head
9	Awel Badi	Lanfero District Health Office	Head
10	Esey Batimo	Malaria Consertum	Coordinator
11	Agaro Godana	Sidama Zone Health Department	DPHP Work Process Officer
12	Yonas Mechara	Shebedino District Health Office	Health Extension Program Coordinator
13	Bedilu Badego	Shebedino District Health Office	Head
14	Abraham Rikiba	Sidama Zone Health Department	DPHP Work Process Officer
15	Bekele Demissie	Integrated Family Health Program (IFHP)	System Program officer
16	Azeb Lelisa	GOAL Ethiopia	Child Survival Program Manager
17	Sheferaw Yelma	GOAL Ethiopia	Assistant Health Coordinator
18	Shitaye Hordofa	Sidama Zone Health Department	DPHP Coordinator
19	Kate Gilroy	Johns Hopkins University	MTE leader (Consultant)
20	Barassa Ware	SC/US – Awassa Sub Office	Shebedino District Program officer
21	Karen Waltensperger	SC/US	Africa Regional Health Advisor
22	Yachiso Yamo	SC/US – Awassa Sub Office	Shebedino District Community Mobilization Officer
23	Abdulmuhin Nuri	SC/US – Awassa Sub Office	Lanfero District Community Mobilization Officer
24	Habtamu Tilahun	SC/US – Awassa Sub Office	Lanfero District Program Officer
25	Worku Tefera	SC/US – Awassa Sub Office	CS M & E Coordinator
26	Elias Kayessa	SC/US – Awassa Sub Office	CS Health Program Coordinator
27	Dr. Hailu Tesfaye	SC/US – Awassa Sub Office	CS Program Manager
28	David Marsh	SC/US	CS Senior Advisor

Annex 3: Child Survival Project (CS23) MTE Team Members and Titles

S/n	Name	Organization	Position
1	Hashim Aman	Siltie Zonal Health Department	Disease Prevention & Health Promotion
2	Bilal Kamil	Siltie Zone Bureau of Finance	Expert of NGO's Affairs
3	Tsegaye Yutamo	Sidama Zone Finance	Planning Officer
4	Chiksa Sultan	Lanfero District Health office	Disease Prevention & Health Promotion
5	Yonas Mechara	Shebedino District Health Office	Health Extension Program Coordinator
6	Abraham Rikiba	Sidama Zone Health Department	DPHP Work Process Officer
7	Dr. Kate Gilroy	Johns Hopkins University	MTE leader (Consultant)
8	Barassa Ware	SC/US – Awassa Sub Office	Shebedino District Program Officer
9	Karen Waltensperger	SC/US	Africa Regional Health Advisor
10	Yachiso Yamo	SC/US – Awassa Sub Office	Shebedino District Community Mobilization Officer
11	Abdulmuhin Nuri	SC/US – Awassa Sub Office	Lanfero District Community Mobilization Officer
12	Habtamu Tilahun	SC/US – Awassa Sub Office	Lanfero District Program Officer
13	Worku Tefera	SC/US – Awassa Sub Office	CS M & E Coordinator
14	Elias Kayessa	SC/US – Awassa Sub Office	CS Health Program Coordinator
15	Dr. Hailu Tesfaye	SC/US – Awassa Sub Office	CS Program Manager
16	David Marsh	SC/US	Child Survival Senior Advisor

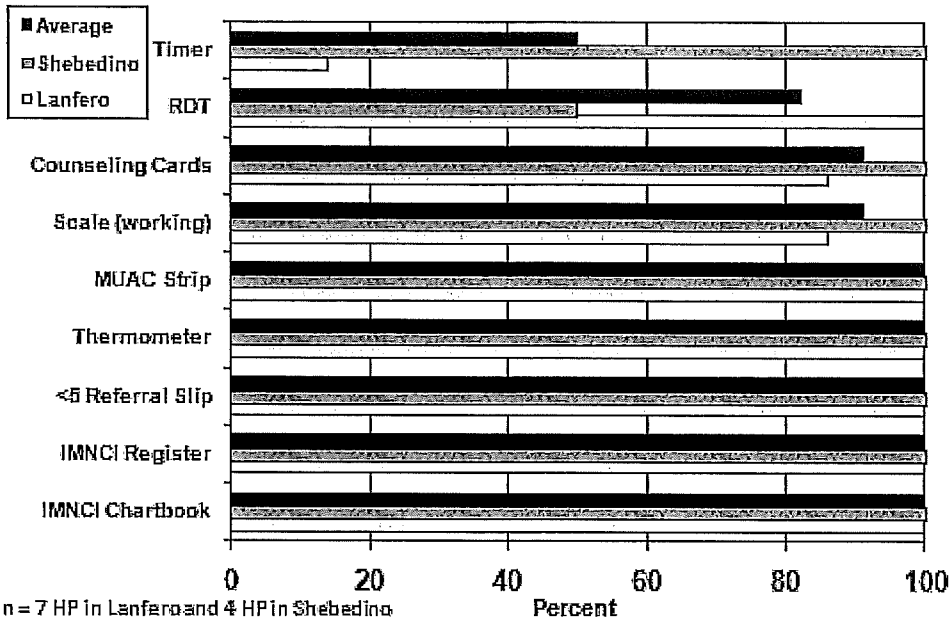
ANNEX 13: MTE QUANTITATIVE RESULTS FROM ROUTINE MONITORING AND RAPID ASSESSMENT

Annex 13, Table 1: Availability of IMNCI services in Shebedino and Lanfero districts, Ethiopia

Indicators of Availability of services	EC 2001 (Jul 08-Jun 09)			EC 2001 (Jul 09-Jun 10)		
	Shebedino	Lanfero	TOTAL	Shebedino	Lanfero	TOTAL
Estimated population of children under-five*	31,356	19,176	50,532	32,265	19,732	51,997
Health Centers (HCs)						
Number of HCs	5	3	8	6	4	10
Number of HCs per estimated 1000 population of children U5	0.16	0.16	0.16	0.19	0.20	0.19
Number of HC staff trained in IMNCI *(by CS-23 or others)*	?	?	23	37	10	47
Number of HC with IMNCI trained staff	5	3	-	6	3	9
Proportion of HCs with at least one IMNCI trained staff	1.00	1.00	-	1.00	0.75	0.90
Health Posts (HPs) & Health Extension Workers (HEWs)						
Number of HPs	32	25	57	35	25	60
Number of HPs per estimated 1000 population of children U5	1.02	1.30	1.13	1.08	1.27	1.15
Target Number of HEWs	66	50	116	72	50	122
Number of HEWs trained in IMNCI	66	43	109	66	37	103
Number of HEWs dropped out	-	1	1	-	2	2
Proportion of IMNCI trained HEWs	1.00		1.00	0.92	0.74	0.84
Number of HEWs trained in IMNCI per estimated 1000 population of children U5	2.10	2.24	2.16	2.05	1.88	1.98
HEWs trained in Safe & Clean delivery	-	-	-	5	5	10
Volunteer Community Health Workers (vCHWs)						
Target number of vCHWs	875	250	1,125	875	625	1,500
Number of vCHWs trained in c-IMNCI**	831	249	1,080	831	249	1,080
Proportion of c-IMNCI trained vCHWs	0.95	1.00	0.96	0.95	0.40	0.72
Number of vCHWs trained in c-IMNCI per estimated 1000 population of children U5	26.5	13.0	21.4	25.8	12.6	20.8

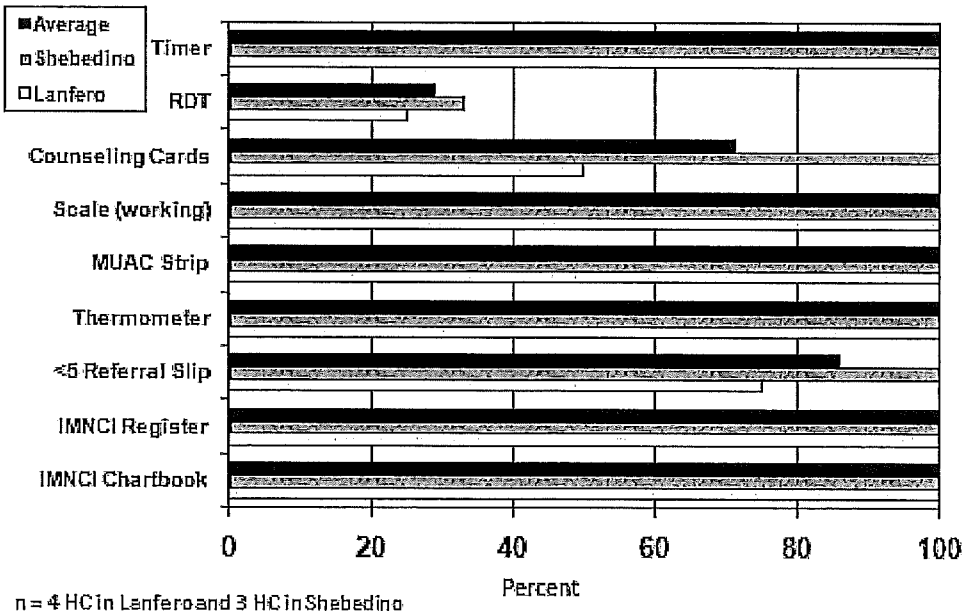
Notes: *based on population projections from 2007 census **625 vCHWs in Lanfero trained in community-based nutrition (with some similar themes to c-IMNCI)

Annex 13, Figure 1: Availability of Selected IMNCI Equipment and Supplies on Day of Evaluation at ***Health Post*** by District (%)



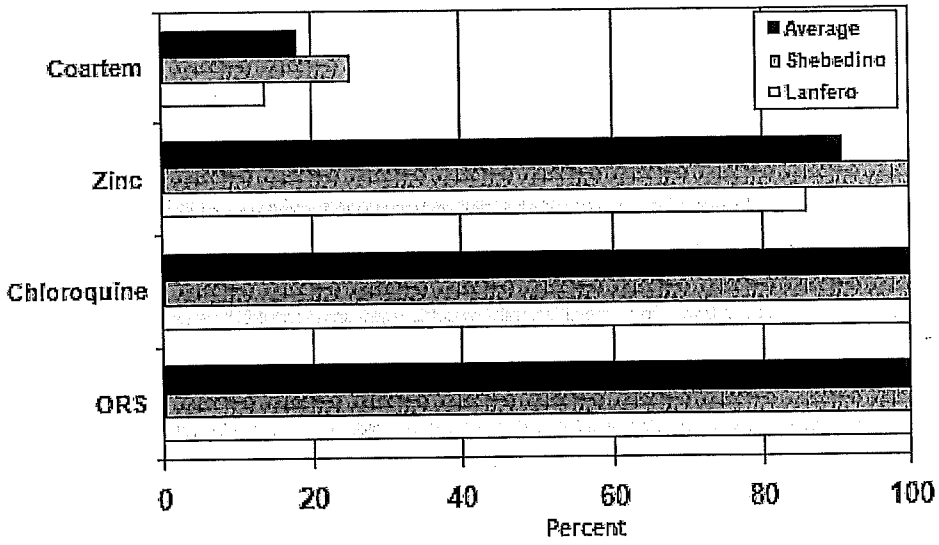
n = 7 HP in Lanfero and 4 HP in Shebedino

Annex 13, Figure 2: Availability of Selected IMNCI Equipment and Supplies on Day of Evaluation at ***Health Center*** by District (%)



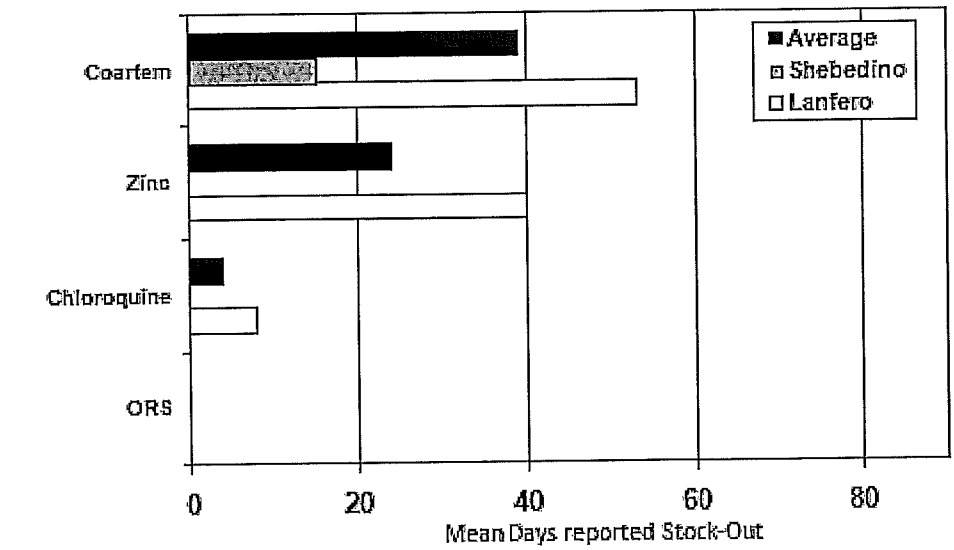
n = 4 HC in Lanfero and 3 HC in Shebedino

Annex 13, Figure 3: Availability of Selected INMCI Drugs on Day of Evaluation at ***Health Posts*** by District (%)



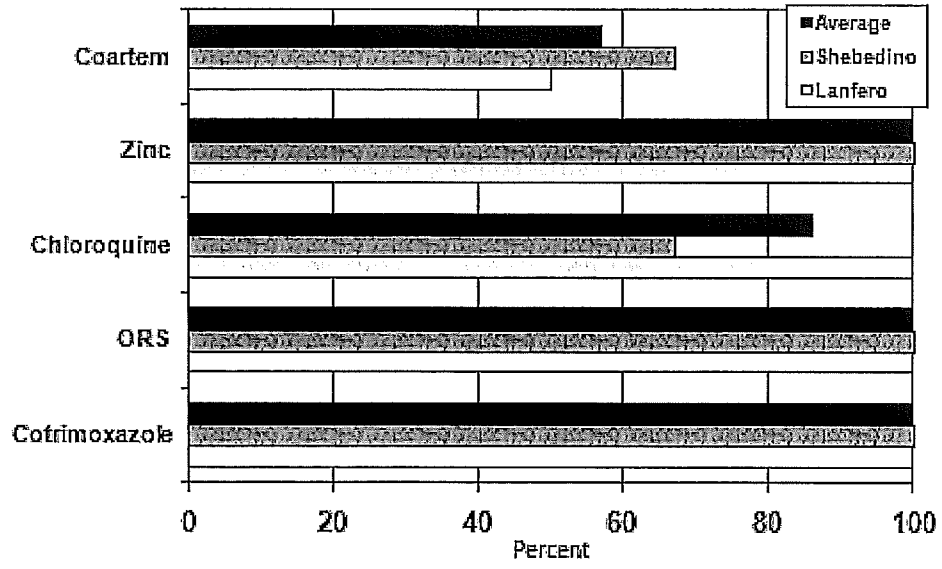
n = 7 HP in Lanfero and 4 HP in Shebedino

Annex 13, Figure 4: Stock-Outs of IMNCI Drugs in Last 90 Days at ***Health Post*** by District (mean # days)



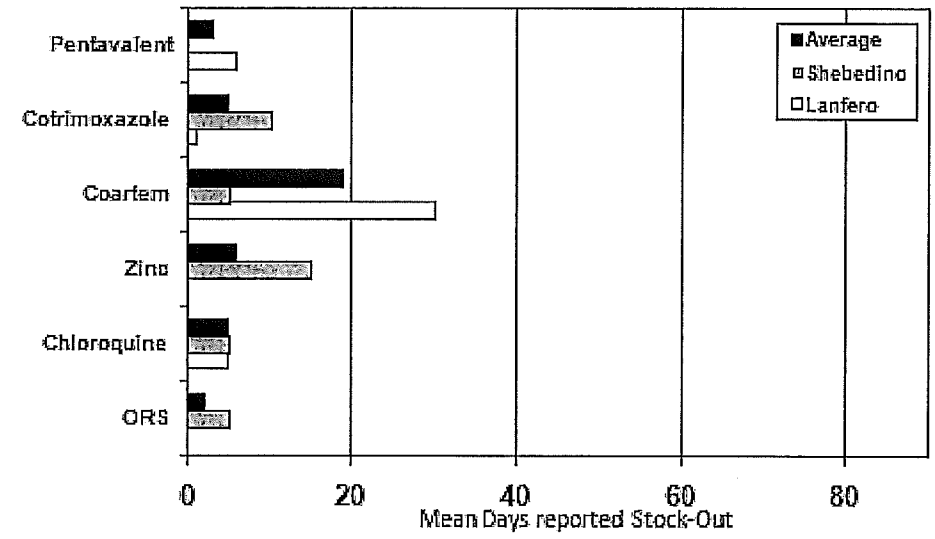
n = 7 HP in Lanfero and 4 HP in Shebedino

Annex 13, Figure 5: Availability of Selected IMNCI Drugs on Day of Evaluation at ***Health Center*** by District (%)



n = 4 HC in Lanfero and 3 HC in Shebedino

Annex 13, Figure 6: Stock-Out of IMNCI Drugs (and pentavalent vaccine) in Last 90 Days at ***Health Center*** by District (mean # days)

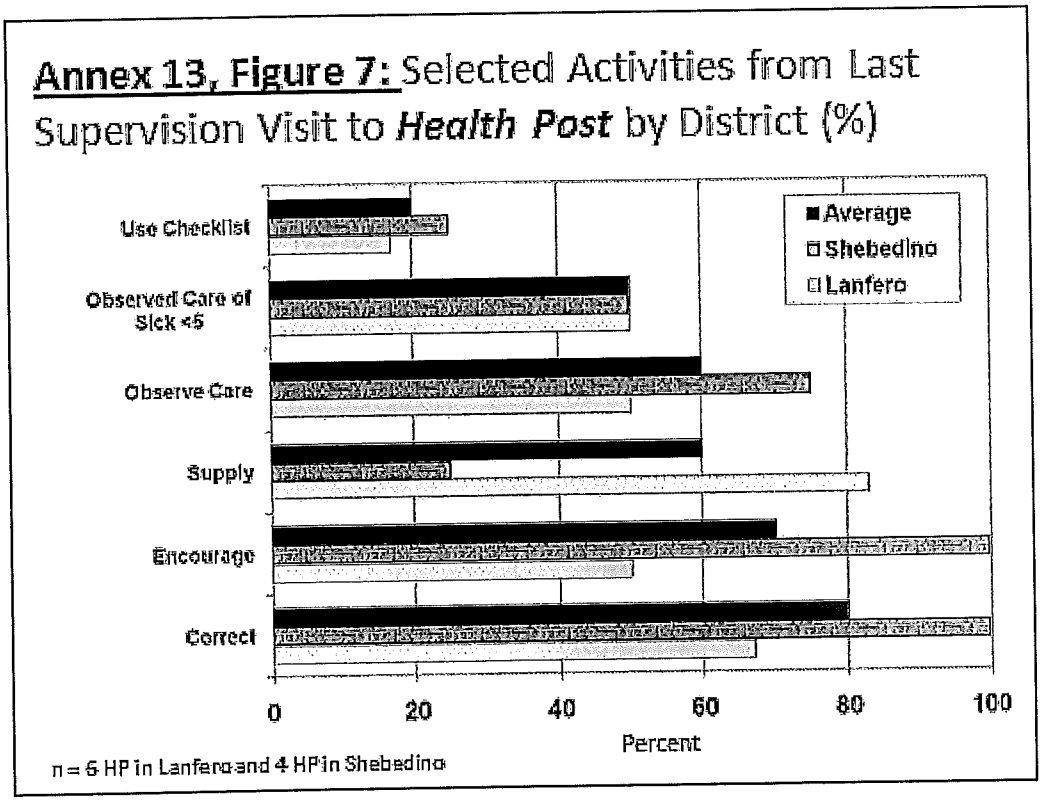


n = 4 HC in Lanfero and 3 HC in Shebedino

Annex 13, Table 2: Pentavalent-3 vaccination in Shebedino and Lanfero districts, Ethiopia[7]

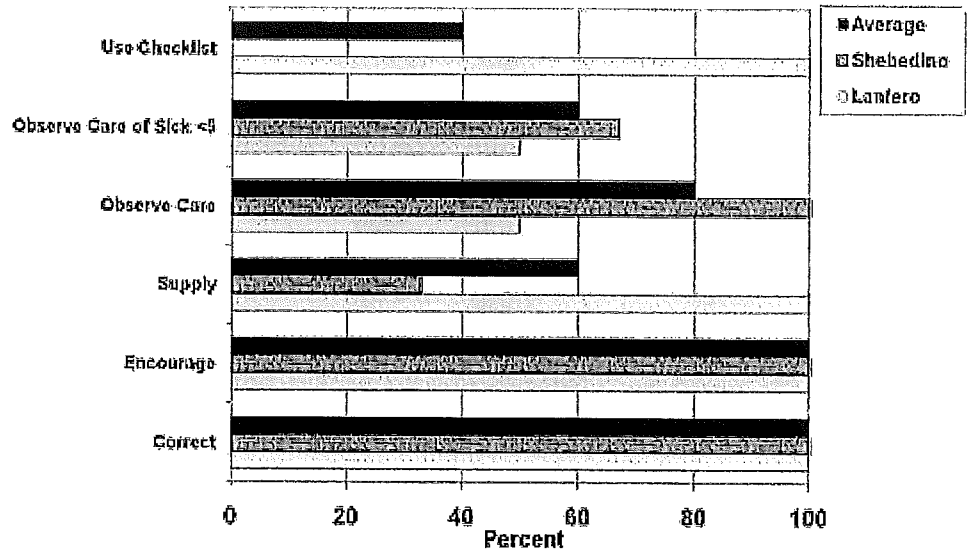
Pentavalent-3 Vaccination		Shebedino		Lanfero		TOTAL	
Indicators/data		Penta3 given	Per 1000 expected births*	Penta3 given	Per 1000 expected births*	Penta3 given	Per 1000 expected births*
2008	Q3	2156		1200		3356	
	Q4	1844		1099		2943	
2009	Q1	2257		1499		3756	
	Q2	3248		1398		4646	
	TOTAL	**9505**	**1050.9**	**5196**	**939.4**	**14701**	**1008.6**
2010	Q3	1771		277		2048	
	Q4	2555		869		3424	
	Q1	2962		1658		4620	
	Q2	2808		1930		4738	
	TOTAL	**10096**	**1084.8**	**4734**	**831.7**	**14830**	**988.7**

Notes: *used as proxy for infants <12 months: 9045 & 9307 in Shebedino & 5531 & 5692 in Lanfero



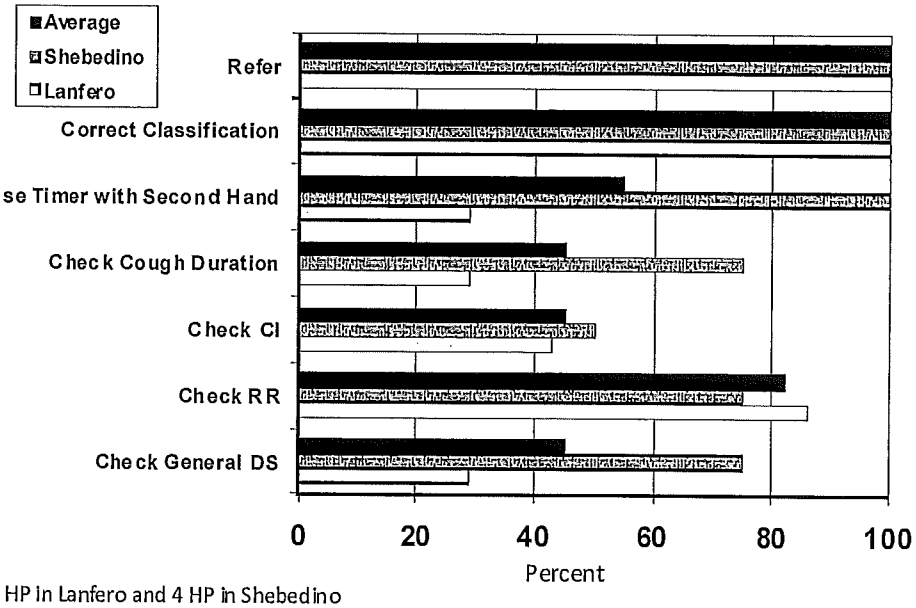
[7] Original indicator was DPT3, as selected before the introduction of pentavalent vaccination.

Annex 13, Figure 8: Selected Activities from Last Supervision Visit to ***Health Center*** by District (%)



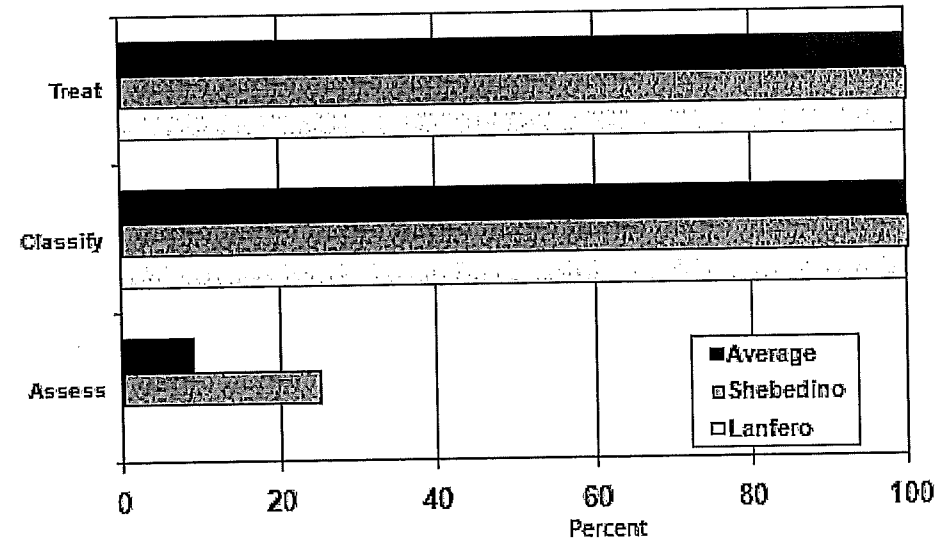
n=2 HC in Lanfero [Achumawonte excluded: in operation 3 months and no visit; 3 HC in Shebedino

Annex 13, Figure 9: Case Management of Non-Severe Pneumonia Scenario at ***Health Post*** by District (%)



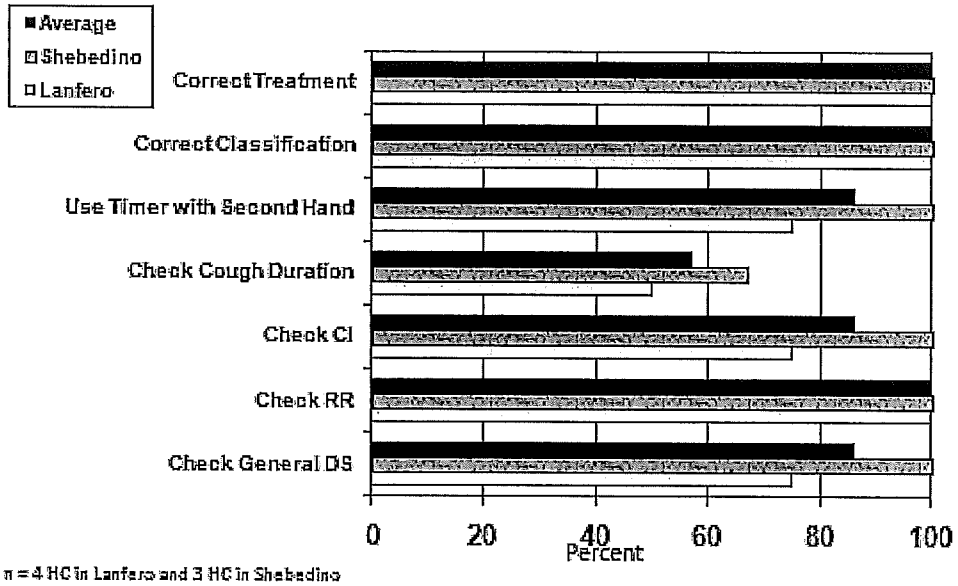
n= 7 HP in Lanfero and 4 HP in Shebedino

Annex 13, Figure 10: Assessment, Classification & Treatment of Non-Severe Pneumonia Scenario at ***Health Post*** by District (%)



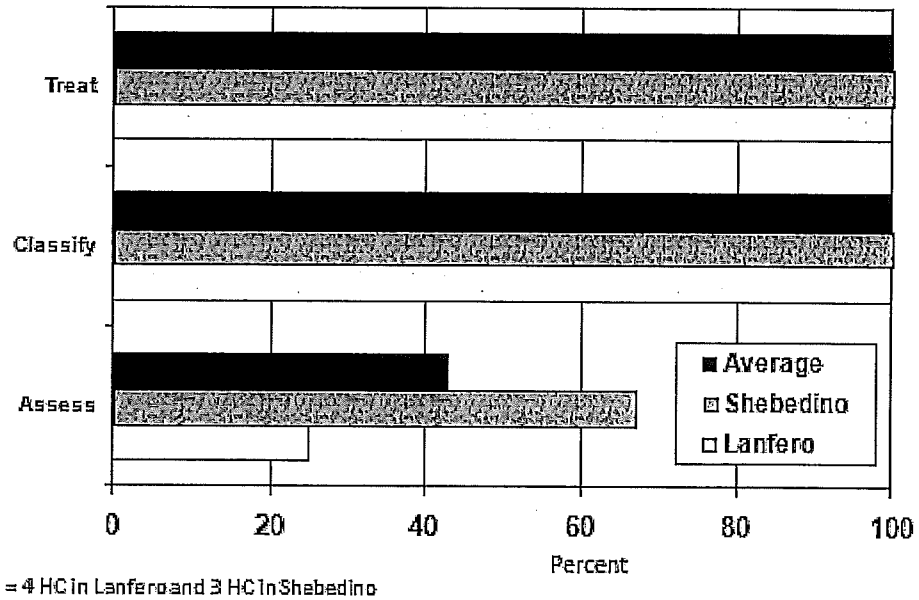
n = 7 HP in Lanfero and 4 HP in Shebedino

Annex 13, Figure 11: Case Management of Non-Severe Pneumonia Scenario at ***Health Center*** by District (%)

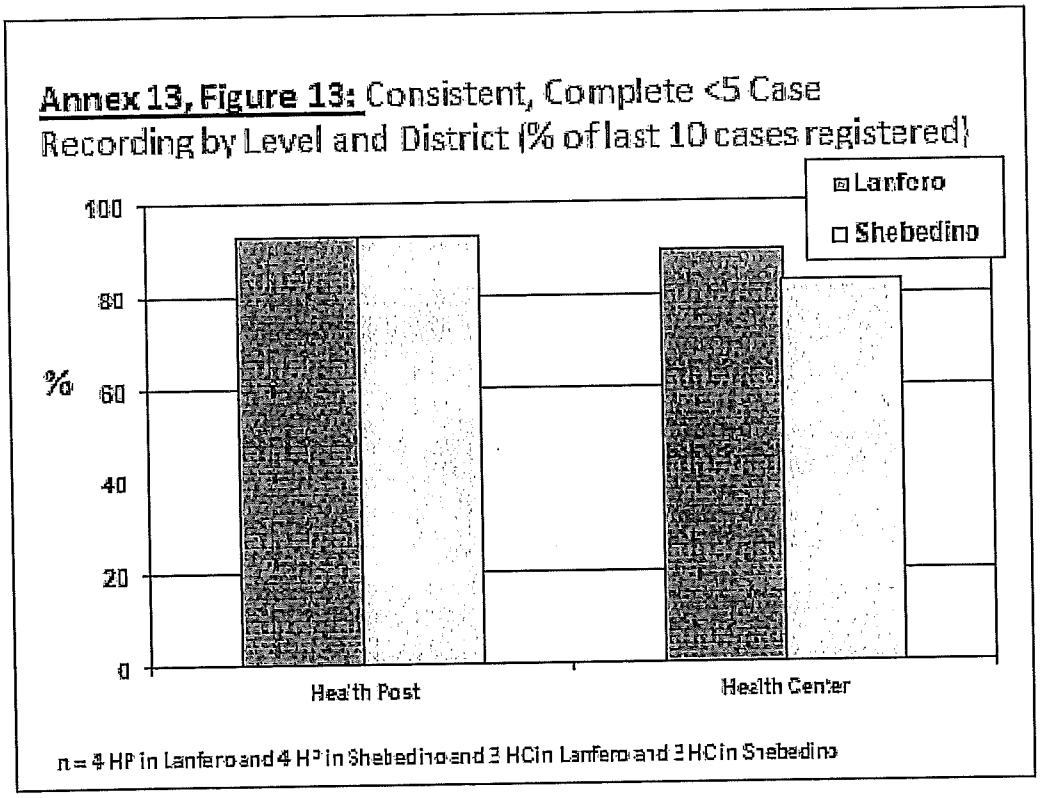


n = 4 HC in Lanfero and 3 HC in Shebedino

Annex 13, Figure 12: Assessment, Classification & Treatment of Non-Severe Pneumonia Scenario at ***Health Center*** by District (%)



n = 4 HC in Lanfero and 3 HC in Shebedino



Annex 13, Table 3: Utilization of sick child services and average use per health center and health post in Shebedino and Lanfero districts, Ethiopia

Shebedino (from routine reports)	2008	2009				2010		One EC year total
	4th Q	Q1	Q2	Q3	Q4	Q1	Q2	
Health Centers								
# of sick child visits at HCs	457	614	1,836	811	1,380	1,081	1,073	4,345
Average # of SC visits per HC	76	102	306	135	230	180	179	724
Average # of SC visits per HC per month	25	34	102	45	77	60	60	60
Average number of visits per month at HCs from 3 month register extraction								101
Health Posts								
# of sick child visits at HPs				222	54	588	914	1,778
Average # of SC visits per HP				7	2	18	29	56
Average # of SC visits per HP per month				2	1	6	10	5
Average number of visits per month at HPs from 3 month register extraction (4 HPs April - July 2010)								13

Lanfero (from routine reports)	2008	2009				2010		One EC year total
	4th Q	Q1	Q2	Q3	Q4	Q1	Q2	
Health Centers								
# of sick child visits at HCs	1,885	2,865	5,508	5,375	7,706	11,080	7,322	31,483
Average # of SC visits per HC	628	955	1,836	1,792	2,569	3,693	1,831	9,687
Average # of SC visits per HC per month	209	318	612	597	856	1,231	610	807
Average number of visits per month at HCs from 1 month register extraction (3 rural HCs - month of June)								763
Health Posts								
# of sick child visits at HPs				298	3,215	1,210	1,219	5,942
Average # of SC visits per HP				12	129	48	49	238
Average # of SC visits per HP per month				4	43	16	16	20
Average number of visits per month at HPs from 3 month register extraction (April - July 2010)								19

Note: *All data (except in blue) extracted from routine monitoring data collected by CS-23*

Annex 13, Table 4: Average monthly services in health posts in Shebedino and Lanfero districts, Ethiopia

Classification	Male			Female			Grand Total
	2-11 m	12-59 m	Total	2-11 m	12-59 m	Total	
Shebedino District: Average of 4 HPs for June 2010							
Diarrhea	1	1	1	0	1	2	**3**
Pneumonia/FB	0	0	1	0	0	0	**1**
Fever	0	0	1	0	1	1	**2**
RDT+ Malaria	0	1	1	0	2	2	**3**
Malnutrition	0	1	1	0	0	0	**1**
Other	0	2	2	1	2	2	**4**
Total	**1**	**5**	**6**	**1**	**5**	**7**	**13**
Lanfero District: Average of 6 HPs for June 2010							
Diarrhea	1	1	3	1	2	3	5
Pneumonia/FB	0	0	0	0	0	0	0
Fever	1	5	6	1	3	3	9
RDT+ Malaria	0	0	0	1	1	2	2
Malnutrition	0	0	0	0	0	1	1
Other	1	0	1	1	0	1	2
Total	**3**	**6**	**10**	**4**	**5**	**9**	**19**

Note: No child under 2 months of age was recorded at the sampled HPs during the period of extraction;

Annex 13, Table 5: Average monthly services in health centers in Shebedino and Lanfero districts, Ethiopia

Classification	Male				Female				Grand Total
	0-1 m	2-11 m	12-59 m	Total	0-1 m	2-11 m	12-59 m	Total	
Lanfero: Average monthly visits per HC among 3 HCs*									
Diarrhea	0	21	25	46	0	18	22	40	**86**
Pneumonia/FB	7	37	50	94	1	23	37	60	**154**
Fever	0	39	77	116	0	33	61	94	**211**
lab+ Malaria	9	35	88	132	0	31	78	109	**241**
Malnutrition	0	0	0	0	0	0	0	0	**0**
Other	14	6	23	42	0	6	21	27	**70**
Total	**30**	**137**	**264**	**431**	**1**	**111**	**220**	**331**	**762**
Shebedino: Average monthly visits per HC among 3 HCs in June 2010									
Diarrhea	0	4	7	11	0	6	3	9	**21**
Pneumonia/FB	1	2	7	10	0	4	4	8	**18**
Fever	0	0	3	4	0	1	2	3	**7**
lab+ Malaria	0	4	14	18	0	4	17	20	**38**
Malnutrition	0	0	0	0	0	0	0	0	**0**
Other	1	4	4	8	0	3	6	9	**17**
Total	**2**	**14**	**35**	**51**	**1**	**18**	**32**	**50**	**101**

Annex 13, Table 6: Utilization, treatment and treatment ratios over time in Shebedino district, Ethiopia

Shebedino district *(Data from SC & HMIS routine reports)*	**2008**	**2009**				**2010**		**One EC year (Q3 2009 to Q2 2010) Total # of children**	**Treatment per est. 1000 U5 per year**	**Est. U5 cases per year in district* ¥**	**Treat-ment ratio**
	4th Q	Q1	Q2	Q3	Q4	Q1	Q2				
All sick child visits at HCs	457	614	1,836	811	1,380	1,081	1,073	4,345	138.6		
Under 2month visits at HCs				19	38	51	49	157	5.0		
All sick child visits at HPs				222	54	588	914	1,778	56.7		
Under 2month visits at HPs				0	0	0	0	0.00	0.0		
Children treated with antibiotics (for pneumonia) at HCs**		120	522	238	438	428	330	1434	45.7	9,407	**15.2%**
Children referred for pneumonia [to HC] at HPs				14	130	43	44	231	7.4	9,407	2.5%
Children treated for Fever/malaria at HC (clinical or RDT+)	76	93	702	311	637	415	502	1865	59.5	31,356	5.9%
Children treated for Fever/malaria at HP (clinical or RDT+)				71	35	82	240	428	13.6	31,356	1.4%
TOTAL Fever/Malaria				382	672	497	742	2293	73.1	31,356	**7.3%**
Children treated at HC with ORS for diarrhea				143	278	244	227	892	28.4	156,780	0.6%
Children treated with ORS at HPs for diarrhea					110	260	258	628	20.0	156,780	0.4%
TOTAL Diarrhea (with ORS)				143	388	504	485	1520	48.5	156,780	1.0%
Children treated at HC with ORS and Zinc for diarrhea		7	142	82	126	0	158	366	11.7	156,780	0.2%
Children treated with ORS and Zinc at HPs for diarrhea					110	0	77	187	6.0	156,780	0.1%
TOTAL Diarrhea (with zinc & ORS)				7	252	82	203	544	17.3	156,780	**0.3%**

*Based on population projections of under-five children: Shebedino: 31, 356 Lanfero: 19,176 Total: 50,532;

¥ Based on estimates of incidence: ***Pneumonia:*** Pneumonia, the forgotten killer of children (conservative estimate - estimated at >0.3 episodes per child per year; ***Malaria:*** Approximately 1 episode per child yr, as estimated for relatively low transmission area (Roca-Feltrer, Carneiro, Schellenberg TMIH, 2008) (NOTE - May be higher in Lanfero district); ***Diarrhea:*** Approx 5 episodes per child per yr in Africa, Boschi Pinto, Lanata & Black in International maternal and child health. Ehiri JE, Meremikwu M (Eds), Springer Pub., Washington, DC. In press.

**Includes cases treated for pneumonia and fever/malaria

Annex 13, Table 7: Utilization, treatment and treatment ratios over time in Lanfero district, Ethiopia

Lanfero district *(Data from SC & HMIS routine reports)*	2008	2009				2010		One EC year (Q3 2009 to Q2 2010) Total # of children	Treatment per est. 1000 U5 per year	Est. U5 cases per year in district* ¥	Treat-ment ratio
	4th Q	Q1	Q2	Q3	Q4	Q1	Q2				
All sick child visits at HCs	1,885	2,865	5,508	5,375	7,706	11,080	7,322	31,483	1641.8		
Under 2month visits at HCs				155	85	119	102	461	24.0		
All sick child visits at HPs				298	3,215	1,210	1,219	5,942	309.9		
Under 2month visits at HPs				0	0	3	6	9	0.5		
Children treated with antibiotics (for pneumonia) at HCs**		534	1,042	1,716	2,052	3,322	1,822	8,912	465	5,753	**155%**
Children referred for pneumonia [to HC] at HPs				21	261	174	58	514	27	5,753	9%
Children treated for Fever/malaria at HC (clinical or RDT+)	700	1,064	1,385	2,941	2,618	2,436	1,842	9,837	513	19,176	51%
Children treated for Fever/malaria at HP (clinical or RDT+)				141	1,439	510	480	2,570	134	19,176	13%
TOTAL Fever/Malaria				3,082	4,057	2,946	2,322	12,407	647	9,176	**65%**
Children treated at HC with ORS for diarrhea				849	853	1535	1254	4491	234.2	5,880	4.7%
Children treated with ORS at HPs for diarrhea				0	473	302	231	1006	52.5	5,880	1.0%
TOTAL Diarrhea (with ORS)				849	1326	1837	1485	5497	286.7	5,880	**5.7%**
Children treated at HC with ORS and Zinc for diarrhea			283	370	316	0	315	1001	52.2	5,880	1.0%
Children treated with ORS and Zinc at HPs for diarrhea				0	220	0	153	373	19.5	5,880	0.4%
TOTAL Diarrhea (with zinc & ORS)				370	536	0	468	1374	71.7	95,880	**1.4%**

*Based on population projections of under-five children: Shebedino: 31, 356 Lanfero: 19,176 Total: 50,532;

¥ Based on estimates of incidence: ***Pneumonia:*** Pneumonia, the forgotten killer of children (conservative estimate - estimated at >0.3 episodes per child per year; ***Malaria:*** Approximately 1 episode per child yr, as estimated for relatively low transmission area (Roca-Feltrer, Carneiro, Schellenberg TMIH, 2008) (NOTE - May be higher in Lanfero district); ***Diarrhea:*** Approx 5 episodes per child per yr in Africa, Boschi Pinto, Lanata & Black in International maternal and child health. Ehiri JE, Meremikwu M (Eds), Springer Pub., Washington, DC. In press.

**Includes cases treated for pneumonia and fever/malaria

Annex 13, Table 8: Utilization, treatment and treatment ratios over time in Shebedino and Lanfero districts (total), Ethiopia

Total: Shebedino & Lanfero district *(Data from SC & HMIS routine reports)*	**2008**	**2009**				**2010**		One EC year (Q3 2009 to Q2 2010) Total # of children	Treatment per est. 1000 U5 per year	Est. # of U5 cases per year in district* ¥	Treat-ment ratio
	4th Q	Q1	Q2	Q3	Q4	Q1	Q2				
All sick child visits at HCs	2,342	3,479	7,344	6,186	9,086	12,161	8,395	35,828	1142.6		
Under 2month visits at HCs	-	-	129	174	123	170	151	618	19.7		
All sick child visits at HPs	-	-	-	520	3269	1,798	2,133	7,720	246.2		
Under 2month visits at HPs	-	-	-	0	0	3	6	9	0.3		
Children treated with antibiotics (for pneumonia) at HCs	0	654	1564	1954	2490	3750	2152	10346	204.7	15,160	**68.2%**
Children referred for pneumonia [to HC] at HPs	0	0	0	35	391	217	102	745	14.7	15,160	4.9%
Children treated for Fever/malaria at HC (clinical or RDT+)	776	1,157	2,087	3,252	3,255	2,851	2,344	11702	231.6	50,532	23.2%
Children treated for Fever/malaria at HP (clinical or RDT+)	0	0	0	212	1474	592	720	2998	59.3	50,532	5.9%
TOTAL Fever/Malaria	0	0	0	3464	4729	3443	3064	14700	290.9	50,532	**29.1%**
Children treated at HC with ORS for diarrhea			1563	992	1131	1779	1481	5383	106.5	252,660	2.1%
Children treated with ORS at HPs for diarrhea				168	583	562	489	1634	32.3	252,660	0.6%
TOTAL Diarrhea (with ORS)				1160	1714	2341	1970	7017	138.9	252,660	**2.8%**
Children treated at HC with ORS and Zinc for diarrhea			425	452	442	0	473	1367	27.1	252,660	0.5%
Children treated with ORS and Zinc at HPs for diarrhea			0	0	330	0	230	560	11.1	252,660	0.2%
TOTAL Diarrhea (with zinc & ORS)			425	452	772	0	703	1927	38.1	252,660	**0.8%**

*Based on population projections of under-five children: Shebedino: 31, 356 Lanfero: 19,176 Total: 50,532;

¥ Based on estimates of incidence: ***Pneumonia:*** Pneumonia, the forgotten killer of children (conservative estimate - estimated at >0.3 episodes per child per year; ***Malaria:*** Approximately 1 episode per child yr, as estimated for relatively low transmission area (Roca-Feltrer, Carneiro, Schellenberg TMIH, 2008) (NOTE - May be higher in Lanfero district); ***Diarrhea:*** Approx 5 episodes per child per yr in Africa, Boschi Pinto, Lanata & Black in International maternal and child health. Ehiri JE, Meremikwu M (Eds), Springer Pub., Washington, DC. In press.

**Includes cases treated for pneumonia and fever/malaria

ANNEX 14: "BETA" VERSION OF CCM BENCHMARK INDICATORS (Country) APPLIED TO CS-23 IN ETHIOPIA

Country CCM indicators list - Applied to Ethiopia, and CS-23 in 2 districts

Overall in Ethiopia HEP

CS-23 (Lanfero & Shebedino Specific)

Not possible/or unlikely to collect in rapid assessment

Needs checked by Govn't and stakeholders

To be completed by Govn't and stakeholders

Did not collect in MTE, but could be collected in similar exercises

Compon-ent	Indicator	Definition	Num.	Den.	Notes	CS-23/Ethiopia overall	Lanfero	Shebedino	CS-23 Application Notes for review
Component 1: Coordination and Policy Setting	Supportive CCM policy	CCM is incorporated into national MNCH policy/guideline(s)			May need to be tracked for disease-specific policy	YES.			National level
	MOH leadership	CCM focal point/unit within MOH in place				YES.			National level
	CCM coordination	MOH-led CCM stakeholders coordination/working group established and meeting regularly				YES.			National level
	CCM partners map	List of partners, activities and locations available and up to date							Recommended within CS-23 project; few to no other NGOs/partners doing CCM right now - but will become more important as strategy rolls out

Compon-ent	Indicator	Definition	Num.	Den.	Notes	CS-23/Ethiopia overall	Lanfero	Shebedino	CS-23 Application Notes for review
	Cost estimates for CCM	Comprehensive costing for all components established (i.e. supply chain mgt, training, supervision, etc.)			Expert opinion needed from health finance experts; MOH or donor driven				National level
	MOH financial contributions to CCM	MOH budget includes line item(s) for CCM			Expert opinion needed on how/if CCM budget v. expenditure can be tracked	Govn't pays HEW salaries, HEP supervisor salaries, many supplies and support through UNICEF support for new pneumonia package			National level
Component 3: Human Resources	Percentage of active CHWs		# of CHWs providing CCM activities	Targeted # of CHWs	Blue indicator Progress towards CHW target Split between denominators	104/121 (86%): some HEWs not deployed (or on leave) during training period and 5 HEWs transferred or left/died	38/50 (only 40 HEWs currently deployed)	66/71 (only 69 deployed)	easily obtained in small area or if included in routine monitoring
	Retention Rate		# of CHWs actively providing CCM	# of CHWs trained in CCM	Needs a time dimension built in; Perhaps more useful in pilot/early phases	104/109 = 95% retention rate in period from early Mar-2009 to Jul-2010.	38/43 trained HEWs	66/66 trained HEWs	Need to specify a standard time period for the retention rate (1 year)

Compon-ent	Indicator	Definition	Num.	Den.	Notes	CS-23/Ethiopia overall	Lanfero	Shebedino	CS-23 Application Notes for review
	CHW density		# of CHWs trained in CCM	Total population in target communities per 1000		104/333,320 = 0.31 HEWs per est. pop of 1000; 104/51,997 = 2.0 HEWs per est. 1000 pop. Of U5s	38/126,487 = 0.3 HEW per 1000 est. pop.; 38/19,732 = 1.93 HEWs per 1000 est. U5s	66/206,833 = 0.32 HEWs per 1000 population ; 66/32,265 = 2.05 HEWs per est. 1000 U5s	Depends on denominator - which may vary by source of data (i.e. censuses/districts / etc - i.e. DOH estimates different than census projections) - used census projections for these estimates
	Community Coverage		# of targeted catchment areas with access to a CHW trained in CCM	# of targeted catchment areas	Unit of measurement catchment area? HH per x population? Requires a mapping of all target catchment areas		25/25 = 100%	32/35 = 91% (3 urban kebeles previously not targeted; will now be targeted in new HEP)	All kebeles mapped and supposed to be with HEW in Ethiopia - this will likely be harder to calculate in other countries without such a structure
	CHW recruitment and job criteria	CHW recruitment and job criteria developed and available			Important in early stages of program (advocacy and planning stage)	YES. HEWs a recognized cadre within Ethiopian and included in Health Sector Development Plan			

Compon-ent	Indicator	Definition	Num.	Den.	Notes	CS-23/Ethiopia overall	Lanfero	Shebedino	CS-23 Application Notes for review
	CHW training plan	Training plan for comprehensive CHW training and refresher training developed			1c	Plan for initial training, unknown for refresher training in broader HEP program for IMNCI, other	Plan for initial IMNCI training, but not refresher training in CS-23		
	CHW functionality	# of CHWs actively providing services		Total # CHWs		100% (104/104) based on reports received, etc.; could vary based on other responsibilities in the community			Need to specify denominator more clearly - is this out of trained CHWs, out of target CHWs, etc?
	Retention and motivation plan	CHW retention strategies, incentive/motivation plan developed			1d; Yes/No; Plan must be possible (per resources available)	FMOH has plan to upgrade to diploma level, but not implemented yet. Also plan Safe Delivery (trained 5 so far).			
	Sensitization activities	Percentage of target districts, facilities, and communities sensitized to role of CHWs	# of target districts, facilities, and communities sensitized as planned	# of target districts, facilities, and communities	2a	100% kebeles sensitized	100% kebeles sensitized (25/25)	100% kebeles sensitized (35/35)	

Compon-ent	Indicator	Definition	Num.	Den.	Notes	CS-23/Ethiopia overall	Lanfero	Shebedino	CS-23 Application Notes for review
	Retention and motivation plan review	CHW retention strategies, incentive/motivation plan implemented	# of CHWs receiving incentive/motivation as planned	# of functional CHWs	2c	NA - paid cadre			Even if paid cadre, should there be an examination of alternative or supplemental motivation strategies
	Continuing education plan	Ongoing training provided to update CHW on new skills, reinforce initial training	# of CHWs participating in refresher training in the last year	# of CHWs targeted for refresher training	3b; Needs a target dimension; Needs a time dimension; Different from check-in meetings, etc.	Safe Delivery training planned; NGOs, etc provide on-going training in various aspects; formal on-going education plans need checked	Refresher training part of recommendations of MTE, pneumonia management training to be provided in 4th quarter 2010		If there is no set plan for refresher training (or no refresher training planned, this denominator is difficult to obtain)
Component 4: Supply Chain Management	Registration of CCM medicines and diagnostics	CCM medicines and diagnostics are registered for use at community level				Drug Admin and Control Authority (DACA) approved Indian zinc (not certified by UNICEF); DACA approved ORS, cotrimoxazole, CoArtem, etc. Purchase not possible without DACA approval.			
		Percentage of stock-outs at implementation sites	# of CCM implementation sites with stock-outs of any CCM drugs or RDTs within the last 30 days (90 days)	# of CCM implementation sites	Blue indicator; Keep here but needs further discussion – important; Needs to be harmonized	Stock out of any of 4 drugs (CoArtem, Chloroquine, Zinc, ORS) in last 90 days = 10/11	Stock out of one of four drugs in last 90d = 7/7	Stock out of one of four drugs in last 90d = 3/4	Applied for last 90 days - so not totally consistent with this definition; Note in some cases CQ initial stocks were just

Compon-ent	Indicator	Definition	Num.	Den.	Notes	CS-23/Ethiopia overall	Lanfero	Shebedino	CS-23 Application Notes for review
					with standard definition of stock-outs; Or further define stock-outs as zinc, antimalarials, ...two more	Zinc SO in last 90d = 4/11	Zinc SO in last 90d = 4/7	Zinc SO in last 90d = 0/4	delivered so estimate of stocks-outs may be biased
						ORS SO in last 90d = 0/11	ORS SO in last 90d = 0/7	ORS SO in last 90d = 0/4	
						CoArtem SO in last 90 d = 10/11	CoArtem SO in 90d = 7/7	CoArtem SO in 90d = 3/4	
						Chloroquine SO in last 90 d= 1/11	CQ SO in 90 d= 1/7	CQ SO in 90 d= 0/4	
	Appropriate storage for CCM medicines	Percentage of CCM implementation sites with drugs and RDTs stored in an appropriate manner as compared to the total number of CCM sites	# of CCM implementation sites with drugs and RDTs stored in an appropriate manner	# of CCM sites	2b	NOT Collected - BUT, could be collected in similar exercise			
	Drug validity	Percentage of CCM implementation sites with any expired drugs or RDTs as compared to total number of CCM implementation sites	# of CCM implementation sites with any expired drugs or RDTs	# of CCM implementation sites	2b continued	NOT Collected - BUT, could be collected in similar exercise			

Compon-ent	Indicator	Definition	Num.	Den.	Notes	CS-23/Ethiopia overall	Lanfero	Shebedino	CS-23 Application Notes for review
Component 5: Service Delivery and Referral	Referral-treatment indicator	Number of children with danger signs or signs of severe disease referred as compared to the number of children with danger signs or severe disease	# of children with danger signs of severe disease referred	# of children with danger signs or severe disease	Appropriate referral ratio	NOT Collected - BUT, could be collected in similar exercise			
	Referral success	Number of referred children received at the referral facility/number of referred children	# of referred children received at referral facility	Total # of referred children	Very important but so many factors would also be involved that this is perhaps not a good core indicator; Harder to measure, optional, depending on system	Don't know; not possible to extract from IMNCI Register review because acceptance of referral not ticked.			May be difficult to collect, as requires careful tracking or follow-up of referral, which may not happen or be included in all CCM registers

Compon-ent	Indicator	Definition	Num.	Den.	Notes	CS-23/Ethiopia overall	Lanfero	Shebedino	CS-23 Application Notes for review
	Timely case management	Number of children who receive timely treatment (both drug and dose) for all diagnoses as compared to total number of children assessed			Is timeliness a feasible indicator; Keep this as a space holder for discussion on global indicators	Can derive from detailed IMNCI Register review because duration of cardinal signs is supposed to be recorded.			
	Projected treatment ratio per 1000 children **(IT SHOULD NOT BE PER 1000)**	# 4 on Save the Children (copy)	# of treatments given	# of illnesses expected (per 1000 children) in a given catchment area **(IT SHOULD NOT BE PER 1000)**	Difficult to measure for many countries (catchment areas); Should be done annually (due to seasonal morbidity); Numerator should be in HMIS	See attached tables for HC, HPs and overall for 3 diseases			

Compon-ent	Indicator	Definition	Num.	Den.	Notes	CS-23/Ethiopia overall	Lanfero	Shebedino	CS-23 Application Notes for review
	Case-load	Number of patient encounters at a given site in a given month	# of patient encounters at a given site	Month	Is program improving coverage in community?; Are CHWs over or under-utilized in community; Not sure if this is a good core indicator	Average of 11 sick child encounters per month for EC 2002	Average of 20 sick child encounters per HP per month for EC 2002	Average of 5 sick child encounters per HP per month for EC 2002	Should be average # of encounters at CCM site per month; no estimate of completeness of reporting - so this may be an over or underestimate
	Follow-up visits	# of follow-up visits compared to expected number of follow-ups per protocol			3a; Not necessarily follow-ups to facility; There should be a standardized set of indicators during the pilot and implementation phases	Could potentially be extracted using detailed register review, on the assumption that follow-up visits are recorded			
		# of sick children referred as compared to # of children assessed during home visits and at the facilities			3a	11 referred cases out of 110 extracted = 10%	9 referred cases out of 70 extracted = 13%	2 referred cases out of 40 extracted = 5%	From register extraction; A number of cases referred because of stock-outs of CoArtem

Compon-ent	Indicator	Definition	Num.	Den.	Notes	CS-23/Ethiopia overall	Lanfero	Shebedino	CS-23 Application Notes for review
	Correct treatment diagnoses	# of children correctly treated for all gold standard diagnoses as compared to total # of children assessed			3b	Not possible to collect in rapid assessment			
	Community Coverage	# of catchment areas with access to a CHW trained in CCM/ # of target catchment areas	# of catchment with access to a CHW trained in CCM	# of target catchment areas		See above			
	Consistent Case Management	Proportion of CHWs who showed consistency between registered classification of diagnosis and treatment in the last 10 cases of each CHW	# of CHWs whose registers show consistence between classification and treatment	# of CHWs supervised	#13	102 consistent cases out of 110 extracted =93 %	66 consistent cases out of 70 extracted =93 %	37 consistent cases out of 40 extracted =93 %	
	Correct Respiratory Rate Determination	Percentage of CHWs who correctly count respiratory rate	# of CHWs who correctly count (+/- 3 breaths per minute) the respiratory rate of live case, supervisor, community infant, or video	# of CHWs supervised	#15; Is it +/- 2 or 3 breaths per minute?; Evaluation criteria; Leave in as space holder; let Kate follow up	NOT COLLECTED - BUT, could be collected in similar exercise			

Compon-ent	Indicator	Definition	Num.	Den.	Notes	CS-23/Ethiopia overall	Lanfero	Shebedino	CS-23 Application Notes for review
	Communication strategy for CCM	Plan for communication developed and messages and materials for health staff and community tested and available			Global Potential	YES - HEWs and vCHWs trained in C-IMNCI for key messages			
	Knowledge of childhood illness	Proportion of care givers who know 2 or more signs of childhood illness				Survey only			
	First source of care	Proportion of caregivers of children U5 in CCM target areas who report using CHWs as first source of care for the sick child				survey only			
Component 7: Supervision and Performanc	Supervisory plans and tools	Supervisory checklists, guidelines, training materials, plans and SOPs available			Series of y/n	yes on all - see assessment - although HEP supervision checklist under review pending new HMIS			

Compon-ent	Indicator	Definition	Num.	Den.	Notes	CS-23/Ethiopia overall	Lanfero	Shebedino	CS-23 Application Notes for review
e QA	Routine supervision coverage	Number of CHWs who received at least 1 supervisory visit in the prior 3 months during which registers and/or reports were reviewed/ number of CHWs at community level (last supervision visit)			Timeframe determined locally	8/10 HEWs report observation of sick child care (80%)	5/6 HEWs report observation of sick child care (83%)	3/4 HEWs report observation of sick child care (75%)	Supervision indicators in our assessment were collected only for last supervision visit - and supervision is so frequent and done by many parties (DHO, HEP supervisor, and SC, that this is likely an underestimate).... .in contexts such as Ethiopia where CHWs/HEWs are supervised very often, it may be difficult to get a good estimate of these two indicators
	Clinical supervision coverage	Number of CHWs who received at least 1 supervisory visit in the community during the prior 3 months where a sick child visit was observed and skills coaching provided/ number of CHWs				5/10 HEWs report observation of sick child care (50%)	3/6 HEWs report observation of sick child care (50%)	2/4 HEWs report observation of sick child care (50%)	
	Supervisor to CHW ratio	Number supervisors / number of CHWs					5 HEP supervisors (5 day training)/38; 1 supervisor/ 38 HEW had 2m training	4 HEP supervisors trained for 5 days / 66 HEWs	Trained supervisor turnover (4/5 trained left in Lanfero and 4/8 trained left in Shebedino)

Compon-ent	Indicator	Definition	Num.	Den.	Notes	CS-23/Ethiopia overall	Lanfero	Shebedino	CS-23 Application Notes for review
	Correct treatment knowledge	Proportion CHWs (or proportion of cases) who correctly prescribe treatment for children with case scenarios					6/6 HEWs = 100%	4/4 HEWs = 100%	
	Correct treatment: practice	Proportion of sick children who are correctly prescribed treatment for corresponding illness				Only available through QoC survey with direct re-examination			
Component 8: Monitoring & Evaluation and Health Information Systems	Inclusion of CCM in HMIS	Concise list of CCM indicators available and incorporated into HMIS framework				KI report that iCCM indicators may not be totally incorporated into new HMIS - but a list exists			
	Standardization of reporting	Standardized CCM registers and reporting documents available for CHWs and HF				yes, mostly, especially in SC areas			
	District monitoring of CCM	Number of implementing districts providing CCM monitoring data/ number of implementation districts				2 districts/2 districts for SC monitoring (less clean and clear CCM monitoring for govn't district level)			

ANNEX 15: ACTION PLAN (September 2010) for Save the Children's Child Survival Project: "Innovation for Scale: Enhancing Ethiopia's Health Extension Package in the Southern Nations and Nationalities People's Region (SNNPR), Shebedino and Lanfero Districts"*

Recommendation	When				How	Who
	Oct-Dec 2010	Jan-Mar 2011	Apr-June 2011	Jul-Sep 2011		
Improve/strengthen access to and availability of child health services						
Assess training needs and cost for health professionals, health extension workers and volunteer community health workers	X				Use MTE findings, conduct stakeholders meeting	CS District Health Officers(DHOs)
Map current resources within SC and among partners in Shebedino & Lanfero Districts	X				Contact and discuss with partners in Lanfero & Shebedino (Plan International, JSI/IFHP,L10K)	CS Program Coordinator
Train newly assign HEWs and HEP supervisors in IMNCI	X	X			Integrate it with UNICEF/ICCM training	CS team
Train HEWs and HEW supervisors in pneumonia case management	X				Integrate it with UNICEF/ICCM training	CS team
Provide refresher training in IMNCI for HEWs, HEP supervisors and health center staff				X	Integrate it with UNICEF/ICCM training	CS team
Train new female vCHWS in c-IMNCI training for new and previous vCHWs and HEWs		X			Select female volunteers, leverage resource, use standard guidelines in Maternal and newborn care	CS team and HEWs
Provide refresher training of previous vCHWs in C-IMNCI		X			Use C-IMNCI guide & CS23 budget	CS team and HEWs
Propose standard guidelines for treatment and tracking of sick children seen by HEWs in household visits;	X	X			Use of IMNCI recording forms as a reference, document on a note book, drug kit	CS M&E Coordinator

Recommendation	When				How	Who
	Oct-Dec 2010	Jan-Mar 2011	Apr-June 2011	Jul-Sep 2011		
Strengthen the system for referral and referral feedback	X	X	X	X	Facilitate referral; creating community demand for referral feedback; provision of referral slips (with feedback sections) to all levels	CS M&E Coordinator
Improve/strengthen quality of child health services						
Conduct rapid assessment of causes of CoArtem stock out	X				Status assessment at Region, Zone & District level	CS Coordinator, DHOs
Strengthen stock management system and coordination with RHB and local health officials	X	X	X	X	Avail standard stock cards, check in supervision	DHOs and M&E Coordinator
Avail adequate stock of essential drugs for HPs in coordination with RHB & DHO	X	X	X	X	Monitor stock, Facilitate provision and logistics	CS team , DHOs
Ensure availability of IMNCI supervision checklists at all levels and provide "on-the-job" training for the use of checklists where necessary	X	X			Use ICCM checklists of MoH, train as part of IMNCI training	M&E Coordinator
Review two-month supervision training package with government partners and advocate for inclusion of IMNCI supervision in package;	X	X			Discuss and collect feedback with partners, being done under ICCM	CS M& E Coordinator, RHB
Develop a package of low cost incentives—certificates and in-kind incentives from child-survival related campaigns—for HEP supervisors, HEWs and vCHWs	X	X	X	X	Certificates for volunteers, recognition of active vCHWs,refresher trainings	CS team, EtCO, EveryOne campaign

Recommendation	When				How	Who
	Oct-Dec 2010	Jan-Mar 2011	Apr-June 2011	Jul-Sep 2011		
Neonatal Health Component						
Provide essential newborn care training using postnatal visitation package from WHO/UNICEF/SC		X	X	X	Leverage resource and conduct training	CS team and partners
Promote postnatal home visits and peri-natal promotional activities by team of female volunteers			X	X	Select female volunteers, leverage resource, use standard guidelines in Maternal and newborn care	CS team, CMOs
Pilot mother to mothers groups to promote perinatal and post natal promotions		X	X	X	Share GOAL experience, pilot in some Kebeles by community mobilization officers and MNCH facilitators	CS CMOs
Target perinatal behavior change activities to fathers and grandmothers	X	X	X	X	Retarget during key MNCH messages delivery	DHOs and CMOs
Leverage and advocate with other partners for Safe and Clean Delivery training for HEWs	X	X	X	X	Leverage resource and conduct training	EtCO,CS Coordinator, DHOs,Partners
Partnerships, advocacy and transition plan						
Coordinate and leverage with partners to strengthen drug supply availability and stock systems	X	X	X	X	Through CS TWG, Leverage resources	CS Coordinator
Coordinate and leverage with partners to provide clean and safe deliver training to HEWs	X	X	X	X	Through CS TWG, Leverage resources	CS Coordinator, DHOs,Partners
Coordinate and leverage with partners to supply clean delivery kits	X	X	X	X	Contact UNICEF and other partners	CS Coordinator,EtCO
Develop a transition plan on drug supplies/zinc and IMNCI supervision for the close of CS-23 project in coordination with partners and stakeholders			X			CS team and DHO

Recommendation	When				How	Who
	Oct-Dec 2010	Jan-Mar 2011	Apr-June 2011	Jul-Sep 2011		
Monitoring, evaluation and operational research						
Improve CS-23 routine monitoring	X	X	X	X	Incorporation of non-survey based indicators; indicators linked to the target population;district-disaggregated estimates; and analysis of time trends	M&E Coordinator
Support the government HMIS in coordination with routine CS-23 monitoring where feasible	X	X	X	X		M&E Coordinator
Assess, verify and explore causes of gender preferences in Lanfero District	X				Conduct register review for 6 months	DPOs
Investigate and document reasons for low utilization of child health services in Shebedino	X	X			Conduct assessment of service utilization	CS team and MoH partner
Carry-out operations research to test alternative, promising strategies for motivation and supervision within the HEP strategy			X	X		CS Manager, Health Unit Head, Senior CS Advisor
Follow-up on Zn pilot data – document and disseminate	X	X			Data analysis, share results and write up	DHOs and M&E Coordinator

*Workshop conducted at Awassa Haroni Hotel (0900 - 1400 on 9 August 2010) with the following participants:
Hashim Amanzona (Siltie zone Health Department [SiZHD]), Abdulkerim Kamil (SiZHD),Yekesi Mossa(Siltie Zone Finance and Economic Development Department[SiZFED], Bilale Kamil (SiZFED,NGO Affairs Officer), Awol Baid (Lanfero District, Health Office Head),Shemisu Sirmulo(Lanfaro District,Finance), Chiksa Sultan (Lanfero District Health office[DHO]),Tsegaye Yutamo(Sidama Zone FEDD,Abraham Rikiba (Sidama Zone Health Department[SZHD]), Shitaye Hordofa Yonas Hechera (SZHD)Agaro Godana (SZHD) Yonas Hechera (Shebedino DHO), Bedilu Badego (Shebedino DHO), Azeb Lelisa(Goal Ethiopia), Shiferaw Yelima(Goal Ethiopia),Bekele Demisse (JSI/IFHP/Ethiopis), Esey Batisso (Malaria Consortium/Ethiopia),
Hailu Tesfaye (SC/Ethiopia), Worku Tefera (SC/Ethiopia), Elias Kayessa (SC/Ethiopia), Barassa Ware (SC/Ethiopia),Habitamu Tilahun(SC/Ethiopia), Abdulmuhin Nuri(SC/Ethiopia), Yachiso Yaamo (SC/Ethiopia) David Marsh (SC/HQ), Karen Waltensperger (SC/Africa Region), and Kate Gilroy (JHU).