



## **CS-17, Ethiopia Fourth Annual Report**

***Essential Services for Maternal and Child Survival in Ethiopia:  
Mobilizing the Traditional and Public Health Sectors and  
Informing Programming for Pastoralist Populations***

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## Acronyms and Terms

ACNM	American College of Nurse-Midwives
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
BCC	Behavior Change Communication
BF	Breastfeeding
BHT	Bridge-to-Health Team
CBO	Community-Based Organization
CCM	Community Case Management
CCMW	Community Case Management Worker
CDD	Control of Diarrheal Disease
CHBC	Community Home-Based Care
CHW	Community Health Worker (BHT and HAC members, TBAs, CMWs, CBDs)
C-IMCI	Community-Integrated Management of Childhood Illness
CMW	Case Management Worker (CHW trained to do case management)
CS-13	Child Survival-13, <i>WomanWise</i> , the previous CS project in Liben District, funded through the 13 <sup>th</sup> cycle of the PVO CS Grants Program.
CS-17	The current child survival project in Liben District, <i>Essential Services for Maternal and Child Survival in Ethiopia: Mobilizing the Traditional and Public Health Sectors and Informing Programming for Pastoralist Populations</i> , funded as a cost-extension of the CS-13 grant, mainly through the 17 <sup>th</sup> cycle of the PVO CS Grants Program, is referred to as “CS-17” throughout this document to distinguish it from the previous “CS-13” grant, and for the sake of brevity.
CSV	Community Surveillance Volunteer
CYP	Couple Year of Protection
DAP	Development Assistance Program (current FFP-funded Liben Title II program)
DHMT	District Health Management Team
DHO	District Health Office/Officer
DIP	Detailed Implementation Plan
DPT3	Diphtheria/Pertussis/Tetanus Vaccine, 3 <sup>rd</sup> dose
EFO	Ethiopia Field Office of Save the Children

ENC	Essential Newborn Care
EPI	Expanded Program on Immunization
FMOH	Federal Ministry of Health
FOD	Field Office Director of Save the Children
FP	Family Planning
FY	Fiscal Year
HAC	Health Action Committee
HBLSS	Home-Based Life-Saving Skills
HEP	Health Extension Package
HF	Health Facility
HR	Human Resources
HRD	Human Resources Director
IA	Impact Area
IEC	Information, Education and Communication
IMCI	Integrated Management of Childhood Illness
KPC	Knowledge, Practice, and Coverage
LMS	Logistics Management Information System
LSS	Life-Saving Skills
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MCM	Malaria Case Management
MNC	Maternal and Newborn Care
MOH	Ministry of Health
MTE	Midterm Evaluation
OVC	Orphans and Vulnerable Children
PA	Peasant Association ( <i>kebele</i> ), an administrative division
PCM	Pneumonia Case Management
PDME	Program Design Monitoring and Evaluation
PLWHA	People Living with HIV/AIDS
PMTCT	Prevention of Mother-to-Child Transmission
PVO	Private Voluntary Organization
RDF	Revolving Drug Fund

RH	Reproductive Health
SC	Save the Children Federation, Inc. (USA)
SC-LIA	Liben Impact Area
SMT	Senior Management Team
SNL	Saving Newborn Lives Initiative
SNNPR	Southern Nations and Nationalities People's Region
SPA	Senior Program Assistant (SC staff in Liben District)
STI	Sexually Transmitted Infection
TA	Technical Assistance
TBA	Traditional Birth Attendant
TTBA	Trained Traditional Birth Attendant
TOT	Training of Trainers
TT2	Tetanus Toxoid, 2 <sup>nd</sup> dose
UP	Universal Precautions
WRA	Women of Reproductive Age
ZHO	Zonal Health Office

## **Introduction**

CS-17, *Essential Services for Maternal and Child Survival in Ethiopia: Mobilizing the Traditional and Public Health Sectors and Informing Programming for Pastoralist Populations* is a cost extension of the CS-13 grant, funded mainly through the 17<sup>th</sup> cycle of the USAID/GH/HIDN/NUT PVO Child Survival and Health Grants Program. The dates of this five-year extension are from October 1, 2001 through September 30, 2006, and project activities are being implemented in the Liben District of Guji Zone of Oromia National Regional state in Ethiopia, by Save the Children Federation, Inc. (SC).

The project's broad goal is the sustained reduction of under-five and maternal mortality in Liben District. Additionally, CS-17's approaches inform policy and programming for pastoralist areas of Ethiopia in Community-Integrated Management of Childhood Illnesses (C-IMCI) and reproductive health (RH).

These goals will be achieved through program results and intermediate results that include:

- 1) Improved Liben district capacity to effectively support community health services and activities;
- 2) Improved community capacity in Liben to effectively address priority health needs of mothers and children under five years old;
- 3) Increased use of key health services and improved maternal and child health (MCH) practices at the household level in Liben District;
- 4) Adoption of CS-17 approaches by the Ministry of Health (MOH) or by other organizations in Ethiopia; and
- 5) Dissemination of the feasibility and results of implementing innovative CS-17 approaches.

## **A. Main Accomplishments**

This is the fourth (FY 05) annual report for CS-17, *Essential Services for Maternal and Child Survival in Ethiopia: Mobilizing the Traditional and Public Health Sectors and Informing Programming for Pastoralist Populations*. It demonstrates the progress of planned health interventions that were accomplished for the period October 1, 2004-September 30, 2005. The major areas of intervention during this time were: Expanded Program on Immunization (EPI), Maternal and Newborn Care (MNC), Community-Based Case Management and Capacity Building of the District Health Office (DHO) and the community in order to enable them to manage the health services at the district and health facility (HF) levels, to improve the uptake of essential services, and to adopt healthful practices at the household level.

Almost all of the activities that were planned for the year have been successfully accomplished, with the exception of MOH staff training on Integrated Management of Childhood Illnesses (IMCI) that was designed to increase the number of MOH staff members trained on IMCI. This training was planned to be given by high-level professionals with expertise and special training on IMCI program implementation. Unfortunately, such advanced training was too expensive within the existing budget and so had to be cancelled. Despite this, orientation workshops were provided to front line health workers who did not have basic IMCI training in order to enable them to support, supervise and monitor the activities of community-based Case Management Workers (CMW) in the district.

Basic and refresher training of C-IMCI workers were conducted during the period covered in this report in order to more effectively manage childhood illnesses such as pneumonia, diarrhea, malaria and measles at the community level. For this training, participants were recruited from members of Health Action Committees (HAC) and Bridge-to-Health Teams (BHT) who took basic training on health interventions and generally have higher educational levels than other community members. This training took eight days and included classroom lecture and hands on experience in Negelle Hospital and in the nearby peasant association (PA) or “kebele”. In addition to the basic and refresher trainings, the Community Case Management Workers (CCMWs), including members of the Revolving Drug Fund (RDF) Committees from pilot PAs, were oriented on their duties and responsibilities, and on the management of the RDF.

Additionally, program staff hosted a high-level study tour led by JSI. The tour included representatives from the Federal Ministry of Health (FMOH), Addis Ababa University, Regional Health Bureaus, USAID and an external consultant who is a renowned expert in CCM. The objective of this visit was to provide a learning opportunity based on local experience in implementing CCM. In general, the team’s feedback was positive and team members felt that the program would be a good model for informing similar programs in other parts of the country. The FMOH staff recommended linking interventions with the Health Extension Package (HEP) Program which is considered sustainable.

Other projects like Saving Newborn Lives (SNL), the Development Assistance Program (DAP), Flex Fund, and EPI support funded by CORE Ethiopia are implemented in coordination with each other in order to strengthen certain aspect of maternal, neonatal and child health in the district. The major activities of these projects include: logistics support for the DHO, capacity building for the MOH and community strengthening of the newborn and maternal components of the program. All

of these activities which complement CS-17 program activities facilitated the achievement of program goals.

In order to supplement CS-17 activities and to ensure the sustainability of C-IMCI programming, SC has purchased and supplied the initial stock of drugs for the RDF kits. SC has also provided additional supplies such as medicine cupboards through other funding sources, in order to address the problem childhood morbidity and mortality in the district. SNL provided 10,800 liters of sodium hypochloride solution to Negelle Hospital, and all clinics and health posts in the district for the disinfection of delivery instruments, in order to improve the quality of delivery services and to reduce the risk of transmission of HIV/AIDS and other related diseases in the HFs. Community surveillance volunteers were trained by CORE Ethiopia to support the EPI activity and disease surveillance which mainly focuses on polio, measles, and neonatal tetanus at the community level. Moreover, CS-17 funded quarterly review meetings with community surveillance volunteers, in order to assess the progress of program activities.

The Zonal Health Office (ZHO) acknowledges the project's significant contribution for improved achievement of vaccination coverage. According to data provided by the Guji ZHO, the trend of EPI coverage over the past three years in Liben District, is better than the other districts of Guji Zone. The 2004 administrative report indicated 80% coverage for DPT3, 65% for measles, and 52% for TT2 for pregnant women. These figures are higher than both regional and national levels.<sup>1</sup> The main contributing factors for better coverage include: program support with per diem, other logistical support, cold chain maintenance training, community capacity building to raise awareness around EPI services, and promotion of immunization days for inaccessible areas, by DAP II funding.

The efforts to strengthen maternal health, such as antenatal care (ANC) at the community level are encouraging. In one the PAs (Nurahumba) where ANC is provided to pregnant mothers, the community has built a small hut on its own to be used during outreach ANC services. This is a good indication for program sustainability.

Two reviews of home-based life-saving skills (HBLSS) were conducted by internal and external staff.<sup>23</sup> The reviews indicated that the program has succeeded in creating a good working relationship with the DHO by enhancing the link between the HFs and the trained traditional birth attendants (TTBAs) in regard to referral services, and by enhancing the relationship of CHWs with TTBAs to support this activity. The reviews also indicated that the TTBAs have retained (one year later) their skills in identifying complications, providing simple care and timely referrals, that mothers cared for by TTBAs have received better care, and that knowledge transferred to pregnant women and their families is improving. During the evaluation, the major challenges identified by the team which still need to be addressed include a shortage of delivery kits in clinics and health posts, and that in some HFs there were no health workers with training in life-saving skills (LSS). In response to these findings and with SNL funds, SC purchased and supplied delivery kits, manual suction machines and antiseptics to the HFs. In addition, LSS training was provided to health workers from clinics and from the Negelle Borena Hospital.

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<sup>1</sup> Health and Health related indicators FMOH, 2003/2004

<sup>2</sup> Saving Newborn Lives Initiative Ethiopia Evaluation of the Home-Based Life Saving Skills (HBLSS) Activities In Liben Impact Area, Oromia Region, Ethiopia, October 11-24, 2004, Barbara Kinzie, CNM.

<sup>3</sup> Ethiopia SNL final evaluation, Tigist Lemma and SNL team, January 2005.

The project has also faced some challenges during the project year, including the lack of a working car at the DHO, to conduct outreach health services, which especially impacted EPI and ANC outreach services. This remains a challenge for the DHO in terms of ensuring the sustainability of the health service program. The severity of the drought season in the second quarter of the year also negatively affected EPI service delivery since people were moving from place-to-place in search of water and pasture. There was also a shortage of the polio vaccine and a shortage of BCG needles at the district level which affected routine EPI service delivery. Experienced DHO and zonal hospital staff transferred or resigned from their positions, which also negatively impacted program activities. These individuals had worked closely with SC and had participated in a number of trainings organized by the project to support community health services. The departure created an institutional gap as new staff members have less experience in community health service provision, which impacts project activities.

Another project concern is that despite the fact that community-based CMWs are providing health education, there are no Information, Education and Communication (IEC)/Behavior Change Communication (BCC) materials developed on pneumonia, diarrhea and malaria/fever. Although there is no budget allocated to develop IEC/BCC materials on C-IMCI, it is important to include this component in FY'06 in order to ensure program effectiveness and sustainability.

**Table 1. Summary of Activities Planned vs. Accomplished in FY'05**

	<b>Key Process Indicators</b>	<b>Unit</b>	<b>Annual Plan</b>	<b>Achievement</b>	<b>%</b>	<b>Remark</b>
<b>I</b>	<b>MOH SUPPORT</b>					
	<b>EPI</b>					
1	Children < 1 yr fully vaccinated	Number	3690	4635	126	Because of strengthened health education. One of the reason for the overachievement could be use of services by neighboring woredas as well
2	Pregnant Women received TT2+	Number	3223	3291	102	
3	Non-pregnant Women received TT2+	Number	4500	5419	120	
<b>II</b>	<b>MCH</b>					
1	ANC at Health Facility	Number	3690	2728	74	
2	ANC at outreach	Number	1230	617	50	Some outreach sites were missed due to vehicle problem.
3	Delivery service at Health Facility	Number	1168	420	36	Mothers do not prefer to use HF; distance is one factor.
4	Delivery service by TTBA's	Number	2727	1847	68	
<b>III</b>	<b>HIV/AIDS/STI</b>					
1	Quarterly edutainment sessions organized by Coached facilitators	Sessions	96	102	106	
2	Stationery support for school anti-HIV/AIDS clubs	clubs	32	39	122	
3	Supervision of HIV/AIDS activities and field activity support for DHAC	Freq.	20	17	85	
4	Support CBOs anti-AIDS clubs for home based care	Kit	0	77		Supported through SCALE UP HOPE and DAP
5	Care and Support for PLWHA	No.	0	60		
6	Care and support for OVC	No.	0	2010		
<b>IV</b>	<b>TRAINING</b>					
<b>A</b>	<b>HIV/AIDS/STI</b>					
1	School anti HIV/AIDS clubs training on HIV/AIDS/STI (Coaching)	Trainees	68	39	58	Ongoing national election pushed the training towards school closure
2	TBA training on Universal Precautions (UP) and PMTCT	Number	150	190	127	Previously missed TTBA's are included
3	MOH/SC staff training on STI Syndromic Management and Counseling	Trainees	15	0	0	Other several training HF's did not submitted STI drug utilization report to conduct the next training
4	District HIV/AIDS counsel member training on PDME	Trainees	7	10	143	Participants also included from Negelle special administration
5	Kebele HIV/AIDS subcommittee (counsel member) training on PDME	Trainees	84	56	67	Covered by SCALE UP due to budget limitation
6	CBO training on home based care(CHBC) and follow up		10	0	0	
7	MOH/SC staff training on STI Syndromic Management and Counseling	Trainees	15	0	0	Other several training HF's did not submitted STI drug utilization report to conduct the next training
<b>B</b>	<b>Maternal and Newborn Care</b>					
1	HAC orientation workshop on HBLSS	Number	74	246	>100	Integrated with all health interventions training.

	<b>Key Process Indicators</b>	<b>Unit</b>	<b>Annual Plan</b>	<b>Achievement</b>	<b>%</b>	<b>Remark</b>
2	BHT orientation workshop on HBLSS	Number	74	146	>100	Integrated with all health interventions training.
<b>C</b>	<b>Community Based Case Management</b>					
1	Case management workers training on PCM/MCM/CDD	Number	20	35	>100	The number of pilot PAs increased from 5 to 24 PAs.
2	Case management workers refresher training on PCM/MCM/CDD	Number	10	27	>100	The number of pilot PAs increased from 5 to 24 PAs.
3	HAC refresher training in PAs with community-based case management	Number	120	104	87	
4	BHT refresher training in PAs with community-based case management	Number	120	111	92	
5	MOH staff training on IMCI	Number	10	0	0	Insufficient budget for training additional MOH staff.
<b>V</b>	<b>3.3 Program supportive trainings (all interventions)</b>					
1	MOH/SC staff TOT on teaching methodology	Number	15	15	100	
2	HAC refresher training on all health interventions	Number	444	440	99	
3	BHT refresher training on all health interventions	Number	444	443	99.7	
<b>VI</b>	<b>IEC/BCC Material Development</b>					
1	Flip chart	Number	100	100	100	

## **IR1: Increased Availability of Selected MCH Services in Liben District**

### **Maternal and Child Health Care**

Maternal and newborn care (MNC) initiatives are designed to improve essential newborn care practice at the household and community levels, in order to reduce maternal, newborn and childhood morbidity and mortality. One of the strategies used to reduce maternal, newborn and childhood mortality is the training of TTBA on Basic Home-Based Life-Saving Skills (HBLSS). This includes selected MNC activities such as safe delivery, identification of danger signs during pregnancy and labor, and strengthening referral services between CHWs and HFs.

In addition to service delivery, TTBA are educating and supporting mothers to initiate immediate breastfeeding (BF) so that the newborn receives colostrum. TTBA also educate mothers about exclusive breastfeeding for the first six months, child care and the importance of using family planning service.

As part of increasing access to selected MCH services, CCMWs have increased the availability of sick baby services for major childhood illness by educating community caregivers about pneumonia, diarrhea and malaria prevention, timely care seeking, and clinical management of different illnesses. According to community feedback, morbidity and mortality for children under five is decreasing in the pilot PAs because of timely interventions by CCMWs and HFs.

## **ANC Services at Health Facility and Outreach Sites**

ANC is one of the primary health services used to reduce maternal and infant morbidity and mortality through counseling mothers and the provision of quality ANC services. Most HFs in the district, including Negelle Hospital, are providing ANC and other health services despite staff shortages. In order to increase accessibility of this service for mothers, 14 ANC outreach sites were opened and staffed. In the district, there are 14 outreach sites and 11 working HFs which offer ANC and other health services. In the current project year, 2,728 new antenatal clients have been received services at the HF level, or 74% of the goal. In addition, only 617 clients have received ANC services at outreach sites (50% of the annual goal) for a variety of reasons, including staff shortages at the HFs, shortages of reliable vehicles, and difficulty traveling to outreach sites during the rainy season as the majority of the roads are only passable in the dry season.

Outreach ANC services are primarily integrated with EPI and FP services, and are implemented in collaboration with the DHO with personnel from Negelle Hospital. In order to increase the effectiveness of antenatal outreach service, SC-Liben IA is paying per diem for health workers and also supplying fuel for vehicles. The Nurahumba PA community worked closely with CHWs and constructed an ANC hut for the delivery of ANC services, thereby enhancing the potential for program sustainability in the area.

Health professionals, including CHWs, provide health education to mothers and fathers in order to increase service seeking behavior among pregnant women and other community members. TTBAAs who mainly provide ANC service delivery, play a leading role at the PA level. TTBAAs use pictorial teaching aids and demonstration materials like models of babies and placentas to teach women and other community members about safe delivery. According to the feedback received from community and HF staff, the number of women seeking ANC services is gradually increasing as a result of the effective BCC activities that are undertaken in the community. This is confirmed by the ZHO data which indicates that ANC performance is higher in Liben District than in other districts in Guji Zone.

In order to improve the quality of both ANC and labor and delivery care at HFs, 13 health workers (eight of which were female) were trained on Basic Life-Saving Skills (BLSS). During this project year, and additional 12 female health workers from rural HFs and Negelle Hospital were trained.

## **Delivery Service by TTBAAs and Health Facilities**

One of the strategies used to reduce maternal and newborn mortality and morbidity is the training of TTBAAs on Home Based Life Saving Skills (HBLSS) so that they are better able to provide quality ANC, safe delivery and neonatal care. In the fiscal year, an additional 84 TTBAAs from 32 pastoralist associations, were trained in phase I and phase II HBLSS, through SNL project support to strengthen CS-17 activities.

Also during this project year, a total of 2,267 deliveries occurred at the HFs or were attended by TTBAAs. Of these, 81% were attended by TTBAAs and only 19% occurred at HFs. Although it requires further research and discussion with the DHO to identify the reasons why mothers prefer to be attended by TTBAAs, some of the reasons can be attributed to the following: great distances to HFs, lack of public transportation, and insufficiently staffed HFs. Additionally, many mothers are

using untrained TBAs because there are few trained TTBA's relative to the number of women of reproductive age (WRA) and the communities are highly dispersed.

In addition to service delivery, TTBA's are educating mothers on exclusive breastfeeding for at least six months, complementary food for children starting at six months old, nutrition during pregnancy, danger signs of pregnancy, preparation before delivery and child care. The TTBA's utilize different opportunities like public gatherings, women's meetings, coffee ceremonies and funerals to educate mothers and other community members. During health education sessions, TTBA's use teaching booklets to enhance understanding and as a result, TTBA acceptance is increasing.

Further, to improve the quality of service delivery and to reduce the risk of transmission of HIV/AIDS and other related diseases in the HFs, 10,800 liters of sodium hypo chloride solution was provided by SNL and supplied to Negelle Hospital, and all clinics and health posts in the district for the disinfection of instruments used during delivery. As a result, the risk of transmission of HIV/AIDS and other diseases through contaminated medical equipment has been reduced.

Before the implementation of HBLSS, nobody knew about birth planning and preparation. However, since the implementation of program activities, according to community feedback, this has changed dramatically. During a complication audit conducted as part of a TTBA's performance evaluation, one of the women from Chanamansa PA explained the life threatening experience she faced that was effectively addressed as a result of HBLSS. She stated,

*"Before TTBA's training nobody know about birth preparation and immediate care after delivery. A few years ago when I was pregnant with my 2<sup>nd</sup> baby, I was performing my daily routine activities such as fetching water, collecting firewood and looking after cows which is far away from my house. I know that I was pregnant but didn't know the time and the place where I would give birth. Finally my labor pain started and I gave birth alone under the tree, and nobody was around me to cut and tie the cord. I attempted to cut the cord with my finger nails and hold the cord with my hand for a few hours. A few days later I developed pain and fever with foul smelling discharge and finally my husband and neighbors contributed money and took me to the nearest health facility and my life was saved. But now we know what we should prepare for birth and where to give birth, and we know that we should minimize hard work when we are pregnant and also our husbands appreciate our challenges without doubt, after this wonderful program (HBLSS)."*

## **HIV/AIDS/STI**

### **TTBA Training on Universal Precautions (UP) and Prevention of Mother-to-Child Transmission (PMTCT)**

One of the potential routes of HIV/AIDS transmission in rural settings is direct contact with blood and other bodily fluids and tissue during labor and delivery, as a result of different injuries, and while caring for HIV/AIDS patients with bare hands. TTBA's are volunteer service providers who have a high risk of exposure to, and possible infection with, HIV/AIDS and other diseases since they frequently come in contact with blood and other bodily fluids while attending labor and deliveries, and while caring for both mothers and neonates at home, without gloves. They can also transmit diseases to mothers and newborns if they do not use all universal precaution measures. They are an important target groups for the prevention of mother-to-child transmission, and are a tremendous resource for counseling and educating mothers on primary prevention.

The risk of acquiring HIV/AIDS during delivery is not unique to TTBAAs. As a result of the mobile nature of pastoralist communities and due to the limited number of TTBAAs to cover the wide geographic area of the district, many untrained TBAs and other mothers with many children also attend laboring women who are inaccessible to TTBAAs and health workers. Also, in the absence of complications, laboring women do not generally seek TTBAAs for care during labor and delivery unless she is in the same olla/village. Therefore, the risk of HIV transmission is even more widespread since many TBAs and other women come into direct contact with blood and share the same risk of HIV transmission faced by TTBAAs.

In order to address this issue and reduce possible transmission, it is very important to train TTBAAs, other untrained birth attendants, and the general community on UP. As such, a two-day training was conducted for 190 TTBAAs on the general prevention of HIV/AIDS transmission, UP and PMTCT. This is 127% of the project goal as it includes many of the previously missed TTBAAs.

During discussions held with this group and previous trainees, the subject of making gloves available for TTBAAs was sensitive for all participants. During the discussions among TTBAAs, they agreed to teach the community UP and to at least use a plastic bag as a glove until a sustainable system of supplying gloves can be established. Almost all TTBAAs recognize the importance of UP measures and started to apply them both to protect themselves as well as their communities by directly applying and sharing what they learned from this training.

To improve the availability of gloves, some kebeles began collecting community contributions for the purchase of gloves, while other kebeles used existing resources from their kebele HIV/AIDS fund to purchase gloves for TTBAAs. This is an indication of increased community support for the prevention of HIV/AIDS transmission. At the same time, using SNL funding, gloves were purchased for RDF kits. For PAs where there are no C-IMCI workers to sell the gloves, the communities can buy gloves from nearby HFs or from C-IMCI workers in nearby PAs.

### **Care and support for PLWHAs and OVCs**

In order to address households chronically affected by the impact of HIV/AIDS, food support was provided three times in the reporting period, for 60 PLWHAs (72% were women) and 2,010 orphans and vulnerable children (OVC) (approximately 49% female) depending on the severity of the need identified by community groups during the reporting period. This support was provided by SCALE UP and DAP grants and will help children to continue their education and reduce potential dropout. This support will help relieve OVC and their caregivers from the psychosocial and economic burdens that they are experiencing.

### **Edutainment Sessions Organized by Coached Facilitators**

School anti-HIV/AIDS club edutainment sessions are one of the means used to disseminate HIV/AIDS information in schools as well as in the community, since students come from different parts of the district. In this project year, 96 edutainment sessions were organized in 39 schools, from an annual goal of 102 sessions in 32 schools (1 session in each school in a quarter). The achievement of this activity is high due to the fact that the number of schools in the district increased this year. The clubs have used different methods during these sessions including; competitions among children through prepared questions/quizzes (HIV/AIDS and ARH), poetry, drama and other activities which entertain students while also increasing their awareness. In order

to support school anti HIV/AIDS club efforts in raising awareness, special stationery was supplied for 39 schools in the district.

## **R-1: Improved Liben District Capacity to Effectively Support Community Health Services and Activities**

### **District HIV/AIDS Council Training on Program Design Monitoring and Evaluation (PDME)**

A five-day training was provided for ten members (three female) of the Liben District and Negelle Special Administration HIV/AIDS Councils in order to build their capacity in program design (planning), monitoring and evaluation. The initial plan was to train only seven members from the Liben District and members from the Negelle Special Administration were added later. The participants reported that they gained valuable practical knowledge that will help them to improve the quality of their current programs and to train, mentor and provide technical support to community-based groups in care and support, as well as in the design, monitoring and evaluation of other HIV/AIDS related activities.

Currently, the trained District HIV/AIDS Council members are assigned to train, mentor and provide technical support to SCALE UP HOPE supported community-based groups in eight target kebeles. They are also expected to train kebele-based HIV/AIDS council members in order to build their capacity.

### **MOH/SC Staff Training on STI Syndromatic Management and Counseling**

In many cases, STI transmission can be attributed to unsafe/unprotected sex with multiple partners. In the IA, the prevailing high risk sexual behavior known as *jalla jalletu*, can contribute to the transmission of STIs as well as HIV/AIDS. In order to prevent STIs and reduce their transmission, it is important to promote safe sex behaviors. It is also important to provide STI treatment and counseling in order to reduce the prevalence of STIs as well as to minimize the risk of HIV/AIDS transmission. In this project year, CS-17 planned to conduct training for 15 MOH/SC staff members on STI Syndromatic Management and Counseling. However, it was impossible to conduct this training as most of MOH/SC staff were attending different trainings.

## **Maternal and Neonatal Care**

### **HACs and BHTs Orientation Workshop on HBLSS**

To maximize the use of trained CHWs and to strengthen health education at the community and household levels, orientation workshops on HBLSS were given for 246 HACs (77 women) and 146 BHTs (83 women). The goal was to enable them to expand the delivery of maternal and newborn care (MNC) interventions in their communities and to supervise/monitor and support TTBAAs to compile reports in their respective PAs. According to the feedback from the community after the implementation of HBLSS, there has been a great reduction in maternal and newborn mortality and morbidity. The acceptance of TTBAAs by the community is increasing because the community highly values their provision of services to save the lives of mothers and their newborns. In order to further improve the quality of services, SNL funds were used to purchase and distribute delivery

kits, models (including baby, placenta and breast models), soap, razor blades, cord ties, gloves, towels, rubber sheets, aprons, cups and hand torch, as well as a delivery kit caring bag. These were used to educate the community, especially WRA and their families about birth preparedness planning.

### **Basic and Refresher Training for Community Based Case Management Workers**

The training of CMWs was essential in increasing access to affordable, quality services in the community, while also bringing a sustained reduction in mortality and morbidity in children under-five in Liben District. Although the project initially planned to provide basic training for 20 CMWs in the fiscal year, 35 male trainees were trained from 19 PAs since additional RDF supplies were obtained, and to compensate for the first two years of project activities where targets were not met before the start of CCM. This results in a 65% accomplishment of the targets included in the DIP. The training of these CMWs was conducted by MOH staff who received TOT in IMCI. SC's EFO Health Specialist and other IA staff participated in the training.

Topics covered by the training were: general danger signs of childhood illnesses, assessment, classification, treatment and follow of up of cough/difficult breathing, diarrhea, and fever according to case management algorithms adapted from those developed by CARE for the CS project in Siaya, Kenya. The C-IMCI trainees were also given training on how to provide advice to mothers and refer children with very severe cases of childhood illnesses to the nearby HFs for better treatment. The training included audio-visual materials that helped participants practice assessment and classification of the childhood illnesses. In addition, the participants had hands-on experience in Negelle Hospital, as well as field case management practice in two rural villages. The teaching methodology followed by trainers/facilitators relied on two-way communication that encouraged participant involvement in the classroom as well as in the demonstration and re-demonstration sites at Negelle Hospital, Haro Settlement and Gobicha PA.

In addition to the basic C-IMCI training courses, the CCMWs also received orientation on their duties and responsibilities as community IMCI workers, as well as how to manage RDFs with PA RDF Committees.

In order to ensure the availability of IMCI drugs at the community level, an RDF system was established to enhance sustainability. EFO provided the necessary support to search for potential funding sources for this purpose. The RDF draft guidelines were prepared by the EFO Health and Nutrition Specialist to help strengthen the pilot C-IMCI program in the IA. These guidelines were used to establish the District RDF Committee which conducted two meetings. During these meetings, the Committee determined the voucher and receipt system for the district and PA levels, established RDF Committees for each pilot PA, and determined the profit margins for the sale of IMCI drugs in the pilot PAs to ensure uniformity of drug prices and avoid confusion.

During the project year, 27 CMWs from 14 pilot PAs received refresher training to update their knowledge, skills and attitude on IMCI, prior to the start of case management service to children under-five. Participants also received an orientation on how to implement the management of RDFs at their respective PAs. After the workshop, the CCMW received the medicines and other necessary supplies such as shelves, registration book, vouchers, and documentation materials, and all have begun case management services in their respective PAs. CMWs receive TA from IMCI-trained health workers from Negelle Hospital, and there is close and frequent supervision by the

district and HF level staff to enable them to provide quality services. Although at least one health worker from each facility was trained, most have left their post and thus it has become necessary to provide training in IMCI case management to the new staff. However, these training costs are very high and so had to be moved from FY'05 to FY'06. As a result, a three-day orientation which includes the IMCI video and practical experience is planned for the next project year.

In addition to C-IMCI workers, the orientation workshop has been provided to RDF Committee Chairpersons from 14 pilot PAs, and to HF staff who supervise C-IMCI workers. The goal of this RDF orientation workshop was to create common understanding of the established C-IMCI RDF system among core members of the RDF Committee at the pilot PAs. As a result, the RDF Management Committee and the HFs have started to support and monitor CMWs' activities.

IMCI refresher training was also conducted for 104 HAC members (27 women) and 111 BHT members (49 women) from pilot PAs with CCMWs. The objective of refresher training was to mobilize their support of CCM workers and to provide BCC messages to the community. Workshop participants (HACs and BHTs) also discussed the advocacy role they should play in relation to C-IMCI interventions by CCMWs in their respective PAs. They are expected to explain the importance of the IMCI program to the community, especially to the mothers, to disseminate key family practice messages, and to raise community awareness around RDFs. They also received an explanation of the RDF system, the responsibilities of committee members at different levels and the activities done so far at the district, PA and SC/LIA. After the orientation workshop, the HAC and BHT members began disseminating messages about C-IMCI services so that families may seek early medical service from CCMWs for their children. As indicated in the table below, the first group of CCM workers are treating children in their PAs.

**Table 2. Children Under Five Treated for Major Childhood Illnesses at Five Pilot PAs Over a Five-Month Period**

Ser No	Name of PA	Total Population	Total Under 5 (18.68% of Pop )	Children Managed For CHD	% Covered from Under 5 Population
<b>1</b>	Adadi	2789	521	37	7
<b>2</b>	Boba	3763	703	25	3.5
<b>3</b>	Gudba	3575	668	102	15.3
<b>4</b>	Raro	3137	586	75	12.8
<b>5</b>	Sokora	4240	792	183	23
<b>TOTAL</b>		<b>16504</b>	<b>3270</b>	<b>422</b>	<b>13</b>

Note

*The case management activity was performed with drugs supplied at the beginning of this year by Oromia Health Bureau. Majority of drugs were out of stock before the supply of RDF from the EFO. As a result, the number of cases treated by CCMWs is low for the FY.*

## **MOH Staff Training on IMCI**

The project planned to train ten additional MOH staff members on IMCI in the project year, however this was not possible as this training has to be conducted in Yirgalem Hospital which has a high case load, resulting in unaffordable training costs. Therefore, this training was cancelled and CS-17 provided orientation to the Senior Program Assistants (SPAs), with an additional three-day training planned for at least one health worker from every HF. This will enable them to supervise, support and monitor the CCMWs' activities.

## **R2: Improved Community Capacity in Liben to Effectively Address Priority Health Needs of Mothers and Children Under Five Years of Age**

### **HIV/AIDS Sub-Committee Training on Project Design and Management**

In order to build community capacity to effectively support community health services, particularly maternal and child HIV/AIDS and health issues, a five-day training was given for 56 (17 female) organized community members on project design and management. This training helped participants to develop proposals to access OVC care and support that will be granted through SCALE UP Hope. Although this training was expected to be supported through CS-17's access to a World Bank grant, it was supported through SCALE UP Hope due to shortage of CS-17 funding.

### **CBO Training on Home Based Care (CHBC) and Follow-Up**

In addition to awareness raising on HIV/AIDS prevention measures, the appropriate and cost effective home based care to people living with HIV/AIDS (PLWHA) needs to be strengthened. Unless a PLWHA is very seriously ill, institutional care is not preferable since it affects the psychological, social and economical status of the patient as well as the family. The expansion of CHBC through the provision of the appropriate training and supplementation of medical kits to family members and community based organizations is very important in order to minimize this problem.

During this project year, the project planned to conduct trainings for ten CBO members in the IA. However, due to an overlap with the MOH on training for the same topic, plans to conduct this training in the fourth quarter were cancelled. In order to support this effort by the ZHO, the SCALE-UP Hope Coordinator was involved in the training as a resource person. In addition to the training, the IA provided the ZHO with the necessary HBC kit. HBC kits are also being supplied to Negelle Hospital so that they will be able to conduct trainings and supply the material to CBO members

### **CBO Support of Anti-AIDS Clubs for Home Based Care**

Seventy-seven (77) HBC kits were supplied through appropriate government offices for community home-based volunteers trained by SCALE UP Hope and CS-17.

## **School Anti-HIV/AIDS Club Trainings on HIV/AIDS (Coaching)**

Training of school anti-HIV/AIDS club members creates good opportunities to reach school children and youth. It also facilitates information dissemination from school children to parents, to siblings who do not attend school, and other relatives and community members in the IA. The strategies that have been used by school anti-HIV/AIDS clubs to educate their communities include: role-plays, poetry, songs, question and answer sessions, and group education. Most of these strategies are not structured talks, rather they are in the form of entertainment to attract the attention of the school community and enhance learning.

However, the school anti-HIV/AIDS club members and facilitators require professional support to produce better dramas/plays, songs and poems with improved content in order to enhance BC in the school community. The facilitators also require professional coaching in selecting the relevant messages for their audiences. In addition, the clubs require follow-up to ensure that they are established and managed according to the legal guidelines which are required for their registration.

During the reporting period, of the 68 planned school HIV/AIDS club facilitators, 39 (10 females) from 39 schools, participated in the three-day training. This is 58% of the goal. This training was also an opportunity for joint planning for each club. At the end of the training, participants agreed to implement the following activities when they are returned to their respective schools:

- Orientation for other teachers on club formation and management;
- Reorganizing and reestablishing anti-HIV/AIDS clubs according to the guidelines;
- Improving the production and presentation of drama, poems and songs;
- Implementation of the planned activities and timely report submission;
- Improve club records and documentation; and
- Appropriate use of funds and stationery supplied.

## **Supply of Stationery Materials and Kebele HIV/AIDS Grant Utilization**

It is very easy and effective to use the school community for community mobilization, both for children and their families who are in and out of school. This works best if the capacity of facilitators is enhanced and if the club is supported by simple materials needed to run the activities. In coordination with Liben district and Kebele HIV/AIDS counsels, 250-400 Eth. Birr was given for 39 Liben district based anti HIV/AIDS clubs in schools, in order to support the club activities. SC also provided stationery supplies worth 5000 Eth. Birr to assist with documentation, edutainment sessions and for reporting.

## **Supervision of HIV/AIDS Activities and Field Activity Support**

In order to motivate and build the capacity of community based HIV/AIDS initiatives, regular follow up and supervision is mandatory at all levels. Different community and facility-based HIV/AIDS initiatives such as school anti-HIV/AIDS clubs, peer educators, kebele HIV/AIDS councils and HFs, need to be supported in order to improve their performance so that they can reach the target community and bring about BC at the household level. In order to support this, 20 supervision visits were planned during FY'05, with 12 (60% of the goal) being achieved. HIV/AIDS programming in the IA has expanded as a result of the SCALE-UP Hope Project and

staff previously working on the CS-17 HIV/AIDS program have been promoted to this projects, so that no additional staff was assigned to this program until recently.

### **HACs and BHTs Refresher Training on all Health Interventions**

Refresher training has been provided to 440 (99% of the planned) HACs and 443 (99.7% of the planned) BHTs on different health interventions. The goal of these trainings is to enhance participant knowledge in regard to community health care so that they can be better able to transfer knowledge to their communities and so that they can be role models for practicing healthy behaviors in their own families. During the refresher trainings, the major topics covered were: experience sharing among themselves, the progress of health activities, identification of health activities' strengths and weaknesses in their PAs, means for strengthening future activities, how to strengthen the reporting system, and updates on different health topics. After the refresher trainings they educate the community using flipcharts that were developed on each health intervention (EPI, Nutrition, FP and HIV/AIDS activities) in their respective PAs and they also conduct regular monthly meetings with CHWs to evaluate the progress of health activities. HACs support TTBAAs in preparing monthly reports and also in registering all deliveries that occurred in their respective PAs. In addition to health education, HACs also collect monthly reports from BHTs, TTBAAs and CBRHAs, and conduct a preliminary analysis before passing the report on to the HFs. As a result of strengthened BCC by CHWs, health service utilization by the community has increased in comparison to previous years. CHWs activities are supervised and monitored by MOH staff and SPAs who are assigned to HFs.

### **MOH/SC Staff TOT on Teaching Methodology**

The objective of this training is to increase the training capacity of health workers so that they can train different CHWs, and community and lower level health workers. This training was conducted and followed the participatory facilitation approach for better participant understanding. The training was given to 15 health workers (100% of the goal) in order to build the capacity of the DHO to conduct different training by themselves.

## **R3: Increased Use of Key Health Services and Improved MCH Practices at the Household Level in Liben District**

### **Expanded Program for Immunization (EPI)**

EPI is one of the interventions that improves access to MCH services. Based on the strategies developed to improve district access to MCH services, the IA provides per diem, fuel for vehicles and kerosene for refrigerators to implement outreach EPI services. DAP II funding was also used to support CS-17 program implementation including supplying refrigerators for rural HFs, DHO vehicle and HF motorbike maintenance, MOH/SC health staff training on cold chain management, supporting Immunization Days for inaccessible/hard to reach areas, and IEC/BCC material development. In addition, EPI diseases surveillance activities which are supported by CORE Ethiopia, facilitate routine EPI coverage through community mobilization and early defaulter detection by Community Surveillance Volunteers (CSVs). Training was provided on EPI and integrated health services to HF personnel from each HF in the district, to help them provide integrated MCH services at the HFs and to improve the quality of EPI services. This integration

helped to reduce the number of missed opportunities for immunization when community members visited the HF for other reasons. EPI and other health intervention training was provided to CHWs (HAC, BHTS, CSVs) in addition to the health workers. This enabled them to be effective communicators in their community on vaccine preventable diseases and also to help increase community awareness and acceptance around immunization, thereby playing a key role in program achievements.

As a result of the awareness raising and education efforts performed by the CHWs, community members were more apt to know about the advantages of immunization and their children's rights to be vaccinated by health workers. This increased awareness resulted in increased careseeking by the community and questioning of health workers about their absences from EPI outreach session in their PA. This suggests that the community has begun to internalize the importance of the program and ensures that health workers are more careful about scheduling EPI outreach sessions, so that they are available to provide this service. This contributes to better EPI coverage in the district.

According to the information from the zonal health department, EPI coverage in Liben District is very high when compared to other districts of Guji Zone. District ANC and delivery services are also the highest when compared with those of other districts in Guji Zone. The quick response to vehicle maintenance requests as well as the immediate supply of necessary supplies by the IA, contributed to high EPI coverage in the district. Hence, the quarterly integrated supportive supervision visits of the DHO by SC-LIA designed to monitor the achievement of different activities, including EPI, also contributed to its high coverage. Supportive supervision also facilitates the monitoring of EPI activities as it serves to detect problems in a timely manner and provide the necessary feedback.

In the fiscal year, 4,635 children under one year old were fully vaccinated, and 3,291 and 5,419 pregnant women and non-pregnant women respectively, received TT2+. The number of vaccinations for all antigens for the year are all above 100% of the goal.

### **Community Feedback on the Importance of EPI**

Amdiyo Yisak from Ardabururi PA said, *"In old age we did not have any idea about the importance of EPI. We were thinking that if a child takes vaccination at early age it will harm him/her and we were not taking our children to vaccination. Now, we understand the importance of EPI and we know that it protects children from different EPI preventable diseases locally that we called them Qufaa, Giffisa, Botote and gagii."*

When asked why she came for EPI services for her child, a woman from Dhakakalla said, *"Prior to the start of the vaccination program in the area, children were suffering from the disease locally called Finno, Qakkee, Lamshessaa, Gororsaa and Qufaa, but now-a-days thanks to the Government and SC, we have vaccination program and our children are not suffering from the above-mentioned diseases. We rarely see children who didn't get vaccination and attacked with these diseases."*

## **B. Challenges Encountered and Actions Taken**

The major implementation challenges that were encountered during the FY include:

- With DAP II phase-out, the CS-17 program is facing gaps in the support of program costs. This has required the elimination of two positions in the EPI Unit and the Community Relation Unit.
- MOH staff turnover has resulted in a shortage of capable and experienced health workers in the HFs. As a result, SC is forced to conduct additional trainings for new staff in order to run certain programs. For example, trainings on cold chain maintenance and management, and TOT on teaching methodology were additional trainings conducted as a result of this problem.
- Shortage of EPI BCG needles and DPT antigens for more than one quarter affected the coverage that could have been achieved by the district. SC continues to advocate for better logistics management and provides assistance for transporting vaccines from the center as well. The problem of proper logistics management has been an issue at different levels and DELIVER has started working on a Logistics Management Information System (LMIS) for FP commodities and plans to include EPI and essential drugs as well. SC has collaborated with DELIVER and has provided this training to DHO, zonal and project staff using Flex Fund resources.
- DHO vehicle and motor bike shortages affected EPI, ANC and FP outreach services. The DHO vehicle and most motorbikes are too old to fully rely up on them for outreach services throughout the district. With DAP II resources, SC maintained the DHO's vehicle and motorbikes.
- The delayed rainy season caused a shortage of water and pasture and increased the communities' mobility. As a result, it was difficult to serve communities in their villages for different health activities such as outreach services for EPI, ANC and RH. The delivery of outreach services was attempted as possible, once people returned to their villages.
- During the national election, the district government prohibited the holding of any trainings or community health meetings. As a result, SC could not implement activities as scheduled, resulting in activities being moved to the final project year and beyond.

## **C. Technical Assistance**

TA was provide from the EFO Health and Nutrition Specialist and the SNL Program Manager during the IMCI training for CCMWs. EFO staff also made frequent TA visits for follow up and review of CS-17 program implementation, as well as to other related projects such as SNL, FLEX FUNDS and CORE Ethiopia. Further, the Health and Nutrition Specialist, the SNL Program Manager, and the RH Specialist provided support to health program staff through different means such as telephone, fax and radio.

The EFO Food Security and Human Resources Unit provided additional TA for the design of the DAP II Health Program phase-out strategy. EFO Information Technology staff provided TA to program staff by installing different computers on the local email system. The IA received TA from

the Home Office Food Security Specialist who discussed impacts of health interventions with health sector staff, the community and CHWs.

Representatives from ACNM visited CS-17 during this project year to conduct internal and external evaluations of the impact of HBLSS activities. They also provided vital TA related to HBLSS program evaluation through enhanced involvement of unit staff.

## **D. Change from the Program Description**

Two staff positions were eliminated from the original design and the Impact Area Manager's support was reduced by 25%. These changes are made in response to the DAP II phase-out. With the exception of minor changes, it is expected that CS-17 program activities will proceed as outlined in the DIP.

## **E. and F. Sustainability and Phase-Out Plan**

### CS-17 Devolution / Phase-Out Strategy

While embracing the community-based approach to capacity building and phasing out of SC support for CS-17 community-level activities, SC does not believe that it is realistic to hope for a health system in Liben capable in the near future of reaching most of the population with quality essential MCH services without substantial external inputs. Until the Government of Ethiopia demonstrates the will and resources to adequately support the provision of health services to poor and marginalized communities in Borana Zone, external support will remain necessary to ensure that unnecessary lives are not lost and that people are afforded access to basic health services. However, SC's strategy in Liben does involve the gradual transition and reduction of external inputs required to maintain support for essential community health services and activities.

Prospects for other external support: In addition to receiving support from the DAP / DA Food Security funding pool, Liben District is currently included in USAID's "Southern Tier Initiative—Special Objective" (STI) catchment area. A primary component of the STI is maternal and child health, and thus, funding prospects for further strengthening core activities appear good. Additionally, SC has initiated contact with European donors to supplement revolving drug funds and continue refresher training activities.

Recurrent & Non-Recurrent Costs: Since the CS-17 initiative does not support the costs of drugs or medical supplies and conducts activities focused mainly on training and capacity building, SC does not anticipate a dramatic transition of management to our local partner, i.e. the Ministry of Health. Recurrent costs, such as drug supplies, are initially supported by the local MOH and as such SC's primary role is to support the management of revolving drug funds. It is anticipated that through trainings and technical support, local capacity to manage revolving drug funds will be enhanced and that recurring costs for re-supply of medicines will be recovered. Non-recurrent costs include the provision of multiple trainings and through a counterpart relationship with the MOH, the training of trainers should allow for the continued provision of both new and refresher trainings to clinical staffs.

Diversification of Funding: As mentioned above, in addition to receiving support from the DAP/DA Food Security funding pool, Liben District is currently included in USAID's special

objective known as the STI. A primary component of the STI is maternal and child health, and thus, funding prospects for further strengthening core activities appear good. Additionally, SC has initiated contact with European donors to supplement revolving drug funds and continue refresher-training activities. Finally, SC will reach into private moneys to further develop and sustain interventions initiated under CS-17.

It is important in any project to prepare plans for implementation, monitoring, evaluation and program sustainability. It is equally as important to design phase-out strategies for gradual withdrawal of funding by building stakeholder capacity during the life of the project, so that stakeholders will be able to take over program activities once the support of the implementing agency has ended. Despite the fact that optimum capacity building of the DHO has not been achieved, primarily due to a lack of staff over the past three years, SC has continued to train and involve all new staff assigned to the DHO. Currently, seven of the recommended 17 DHO team members are working in the DHO. This team is involved in joint project supervision, program review, and training. In the final project year, additional efforts will be made toward giving more responsibility to the DHO, to the extent possible.

To lay the groundwork for the sustainability of CS-17 health interventions, different capacity building activities were performed in the IA. Among these activities, the most notable one is the training of large number of community members, especially BHTs and HAC members, in order to develop their capability to delivery BC in their community. The knowledge and skills they gained to improve the health practices of their families, neighbors and community as a whole will be key to facilitating program sustainability. The other major capacity building activity carried out in the IA, was the support provided to the DHO and HFs, in the area of skill development through various trainings, thereby improving the chances for program sustainability. Moreover, the supply of basic medical equipment to the HFs which provide care to the largest portion of the population (mothers and children), was essential for sustaining future service provision.

Although the above-mentioned interventions were achieved during past and present project years, the community, the DHO and HFs staff still require additional support to ensure program sustainability. The health problems faced by the pastoralist community as a result of drought, poverty, illiteracy, dispersed settlement and travel in search of water and pasture, harmful traditional practices, fragile natural resources, shortages of health infrastructure and health personnel, still require continued support such as that provided by CS-17 and other related projects, to fill the gaps of support by government sectors. It is therefore premature to exit from the IA at this phase of the country's development and when the programs are just gaining momentum. Rather, it would be very strategic to build on the learning and momentum gained from previous pastoralist health programming and scale up program activities to achieve additional health gains for this population. As such, the EFO is seeking additional resources to apply lessons learned and maximize the advances made in pastoralist health programming.

## **G. Indicators Reporting Table from Appendix 9**

Flex Fund indicators are being submitted in a full report also due on October 31, 2005. SC will forward an electronic copy to CSHGP at that time.

## **H. Program Management System**

### **Financial Management System**

The EFO is responsible for all financial transactions and budget control, and has a strong financial management system in place that utilizes Sun Systems software. There is a clear line of authority for financial payments. The CS-17 Program Manager can only authorize payments up to \$250 and the IA Manager up to \$6,250. Amounts above \$6,250 need to be authorized by the Field Office Director (FOD).

Project staff submit monthly budget requests based on planned activities and receive advances from the EFO to support implementation. The Liben IA has a computerized system for tracking all expenditures on a monthly basis. All requests for funds are based on activity registration, which must be completed at least one month before the advance request is submitted. Monthly financial reports are submitted to the EFO finance unit, where reports from all IAs are finalized and sent to the Home Office (HO). The M&E Unit has the responsibility for crosschecking that the registered activity is completed before more money is disbursed for a similar or subsequent activity by the sector.

### **Human Resources**

The EFO Human Resource Director (HRD) provides support to the IA on all HR issues. In addition, there is an HR Administrative Assistant located in the IA to link the IA with the EFO and address the day-to-day HR issues. This was supported through the DAP II. The Health and Nutrition Specialist and other EFO health staff visit Liben to meet with project staff, discuss concerns and constraints, and to find solutions to these problems. In the Liben IA, regular Senior Management Team (SMT) meetings are conducted which include the Health Sector Manager and Program Coordinators. Also, there are regular Health Sector staff meetings held on a monthly basis. The Addis Ababa-based Health and Nutrition Specialist also provides technical support and oversight for all health activities.

### **Communication System and Team Development**

The SC office in Addis Ababa provides procurement and human resource management support and ensures that all SC policies and procedures are observed at all levels of field office operations. The communication between the EFO in Addis Ababa and the Liben office has been improved by e-mail access. However at this time, this access is limited to one line and is expected to improve in the near future when the telecommunication service for the district is upgraded. There is also radio communication.

## **Local Partner Relationships**

SC works closely with the DHO on all CS-17 activities. Joint coordination meetings are held quarterly, and a joint supervision exercise is conducted biannually of all HFs in the district. However, in the previous years the coordination and involvement of the DHO has been critically limited, mainly due to a lack of DHO personnel. Compared to previous years, in the current project year, the DHO staffing situation has improved, however it remains far below the 17-person staffing plan. SC maintains a very strong and positive working relationship with the DHO and with the zonal Health Office, also located in Negelle. Through CHWs, such as BHTs and HACs, SC also works closely with communities to ensure that their expressed needs are incorporated into program planning and implementation.

## **PVO Coordination and Collaboration**

SC has a close relationship with other PVOs implementing Child Survival programs in Ethiopia. CARE has started a CS program in the north of the country and SC shared its experience at the start of implementation. The program is using workshops and meetings to share CS experiences. In previous years, project staff has provided HBLSS training to CARE program sites in the eastern part of the country. SC maintains close collaboration with JSI, IMC, GOAL Ethiopia, CONCERN, Pathfinder, ADRA, and PLAN International through information sharing, experience sharing and in CTC programming joint program implementation. In the fiscal year, non-government organizations which are working on similar programs (C-IMCI), have visited the Liben IA to share experiences.

## **I. Mission Collaboration**

SC has a positive and collaborative working relationship with the USAID Mission. The mission has visited the CS-17 IA as well as other SC program sites and has provided positive feedback. The mission has provided a letter of support to SC in its pursuit for additional central funding.

## J. CS-17 Activities and Targets for FY '06

S/ N	List of Activities	Unit	Plan		Quarter Breakdown				Remark
			LOA	FY 06	QI	QII	QII I	QIV	
<b>I</b>	<b>MOH support</b>								
	<b>EPI</b>								
	Fully immunized children(0-11 months)	No.	17415	3732	933	933	933	933	
	Pregnant women received TT2+	No.	15272	3340	835	835	835	835	
	Non pregnant women received TT2+	No.	22500	4500	1125	1125	1125	1125	
	<b>MCH</b>								
	ANC at Health Facility	No.	17993	3786	946	946	947	947	
	ANC at outreach	No.	5999	1262	315	315	316	316	
	Delivery conducted by TTBA's	No.	0	2101	525	525	525	526	
	Delivery conducted by Health Facilities	No.	0	1719	429	429	429	430	
<b>I</b>	<b>Training</b>								
	<b>HIV/AIDS/STI</b>								
	School anti HIV/AIDS clubs training on HIV/AIDS/STI(Coaching)	No.	346	39	39				
	Quarterly edutainment sessions organized by coached facilitators	No.	288	78		39	39		
	MOH/SC staff training on STI Syndromatic Management and Counseling	No.	30	15	15				
	District HIV/AIDS counsel member training on PDME	No.	21	7			7		
	CBO training on home based care(CHBC) and follow up	No.	40	10		10			
	Supervision of HIV/AIDS activities and field activity support for DHAC	freq	80	20	5	5	5	5	
<b>2.1</b>	<b>Community Based Case Management</b>								
	Case Management Workers(CMWs) refresher training on PCM/MCM/CDD	No.	74	45		23	22		
	Training for Mother Group facilitators who have < 5yrs children on when to seek care	No.	-	48		48			New plan to Strengthen C-IMCI
	Creating Mother Groups discussion to enable mothers recognize when to seek care	# of Group	-	24			24		New plan to Strengthen C-IMCI
	C-IMCI program supervision by HFs and District	Freq.	-	148	37	37	37	37	New plan to Strengthen C-IMCI
<b>2.2</b>	<b>Immunization</b>								
	Modular EPI training for MOH staff and SPAs	No.	45	15	15				
	Final evaluation-KPC survey							X	

## **K. Program Highlights**

The training and start up of the CCM with RDF schemes is the highlight of the program in this reporting period. In addition to this, high level delegates from the FMOH, regional health bureau heads and the university visited the program. JSI will pilot similar program in SNNPR in FY 06.

**Annex 1**  
**USAID PVO/NGO Family Planning and Reproductive Health Flexible Fund**

Flex Fund indicators are being submitted in a full report also due on October 31, 2005. SC will forward an electronic copy to CSHGP at that time.