



**CARE International in Ethiopia
CARE SOUTH GONDAR FIELD OFFICE**

**CHILD-E: Child Health Initiatives for
Lasting Development in Ethiopia**

**Farta Child Survival Project (FCSP)
Farta Woreda, South Gondar Administrative Zone
Amhara National Regional State (ANRS)
Ethiopia**

**Annual Report
October 2004 – September 2005 (FY'05)**

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ACRONYMS

AFP	Acute Flaccid Paralysis
ARI	Acute Respiratory Infections
BCC	Behavioural Change Communication
BCG	Bacillus Calmete Gurein vaccine
BFHI	Baby Friendly Hospital Initiative
CBRHAs	Community Reproductive Health Agents
CDD	Control of Diarrhoeal Disease.
CHAs	Community Health Agents
CHW	Community Health Worker
C-IMCI	Community – Integrated Management of Childhood Illness
CM	Community Mobilizers
CO	Country Office
COPE	Client Oriented – Provider Efficient
CORE	Collaboration and Resource Group for Child Survival
CRP	Community Resource Person
CS	Child Survival
DAs	Development Agents
DHC	Debre-tabor Health College
DIP	Detail Implementation Plan
DPT	Diphtheria-Pertusis-Tetanus
EAs	Extension Agents
ENA	Essential Nutrition Actions
EOC	Ethiopian Orthodox Church
EPI	Expanded Program on Immunization
ESHE	Essential Service for Health in Ethiopia
ETB	Ethiopian Birr
FWHO	Farta Woreda Health Office
FY	Fiscal Year
GM	Growth Monitoring
IFA	Iron Folic Acid
IMCI	Integrated Management of Childhood Illness
M&E	Monitoring and Evaluation
MoA	Ministry of Agriculture
MoE	Ministry of Education
MoH	Ministry of Health
MTMSGs	Mother-to-Mother Support Groups
OPV	Oral Polio Vaccine
ORT	Oral Rehydration Therapy
PAs	Peasant Associations also Kebele
PDMs	Positive Deviant Mothers
PRA	Participatory Rural Appraisal
RDF	Revolving Drug Fund
SNIDs	Sub National Immunization Days
TBAs	Traditional Birth Attendants
ToT	Training of Trainers
VCHWs	Volunteer Community Health Workers
Woreda	District

Mengistawi Budin = The lowest unit in the government structure. 1/50 households

Kebele = Government structure unit higher than Mengistawi Budin.

Idir = Social guild for funeral support at village level

Project Summary Sheet

Country	Ethiopia
Project title	CHILD-E: Child Health Initiatives for Lasting Development in Ethiopia
Cooperative Agreement No:	HFP-A-00-02-0004600
Total project budget	USD 1,758,080.00
Location of project	Farta Woreda, S/Gondar Administrative Zone, Amhara National Regional State (ANRS)
Target population	Children of <5 yrs and women of reproductive age, especially pregnant and lactating mothers residing in 40 PAs of the Farta Woreda
Thematic area	Children/Women Nutrition Security
Project Objective	Improve the health status of children <5 yrs & women of reproductive age
Project components	<ul style="list-style-type: none"> ▪ Nutrition, ▪ Diarrhea illnesses, ▪ ARI –Acute Respiratory Infection ▪ EPI – Immunization
Strategies:	<ul style="list-style-type: none"> ▪ Skill Development; ▪ Community Mobilization to promote ownership. ▪ BCC - Behaviour Change Communication approaches ▪ Quality Assurance for service delivery. ▪ Improve access and availability of services and supplies
Project duration (approved)	5 years, October 2002 – September 2007
Local implementing agency	CARE International in Ethiopia
Implementing partners	Zonal – Woreda Health Offices, NGOs, CHA/Ws, VHCs, school clubs, women's associations.
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The partners' and other organizations' (e.g. LINKAGES) involvement and collaboration with the project in training and the Essential Service for Health in Ethiopia (ESHE) Amhara in resource sharing, CORE Ethiopia in polio eradication initiative and all other partners involved in project implementation at all levels deserve gratitude and thankfulness for their respective support and input to the project.

The project also would like to express its gratitude to all support staffs of the CO and FO for fulfilling their respective duties and responsibilities, which have significant contribution to strengthen project progress.

The project staffs have also heartfelt appreciation for the Area Coordinator of the Field Office (Ato Amdie) for his genuine and continuous support to move our efforts forward and develop teamwork not only within FCSP staff but also among all FO projects. This has helped our project exploit the opportunity for complementarities among the different projects that ultimately would lead to synergistic effect.

Introduction

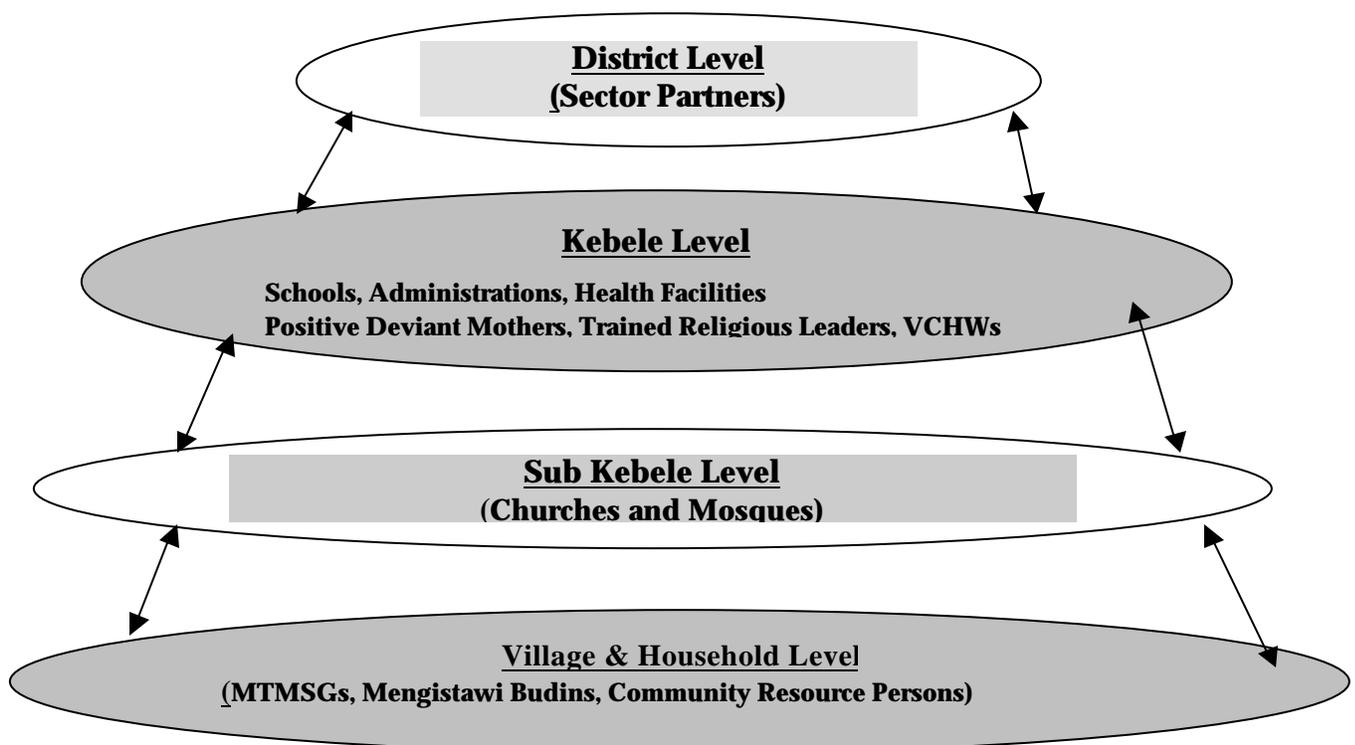
The Farta Child Survival Project (FCSP) is located in Farta Woreda, South Gondar Administrative Zone of the Amhara National Regional State (ANRS). FCSP is one of the four projects operating under the auspices of CARE South Gondar Field Office (FO). FCSP has been operational in Farta since October 2002.

Almost three years have elapsed since the commencement of FCSP's operations. So far, the project has submitted two annual progress reports to relevant stakeholders as part of its commitments. This report is its 3rd annual report applicable for the period July 2004 to June 2005.

In this fiscal year, the project has been engaged in different interventions organized under its lead components in accordance with its annual plan of operation and detail implantation plan (DIP). This report attempts to address the achievements of the relevant activities accomplished during the FY. It is structured and narrated under each major project strategies.

The major aim of the report is to share information about the progress, problems/challenges faced and lessons learnt with the different project stakeholders. Thus, the project management appreciates constructive comments as feedbacks that would help it improve project performance leading to the achievement of project objectives.

Project Implementation Levels and Key Partners



1. Executive Summary

CSP Ethiopia has had serious difficulties in recruiting/retaining a Project Manager meeting the criteria established for this position. During this fiscal year, as the project continued to be unable to recruit a PM, CARE USA Child Health Team (which also had an unfilled technical position) sent an external consultant In January-February 2005 to assess the overall situation of this project, review project status in relation to the DIP, provide technical guidance and make concrete recommendations for short-term strengthening. The consultant, Renee Charleston, provided a thorough and detailed Trip Report. As the project was scheduled for Midterm Evaluation in April 2005, it was decided that an MTE at that point would be an inefficient use of resources. Instead, CARE USA sought approval from USAID CSHGP to develop a Midterm Evaluation Report based on the Trip Report of the consultant plus some additional information from project monitoring systems and other documentation. This was approved and is attached as Annex D. Although an Annual Report is not required when an MTE report is submitted, CSP Ethiopia developed this Annual Report for two reasons -- the MTE report reflects a modified MTE, and in order to be able to highlight forward progress since the consultant visit. It also should be noted that CARE USA filled the Child Health Team position in April 2005 and this Technical Advisor, Khrist Roy, has made two field visits to-date to provide TA to this project (3 weeks in June-July 2005, andweeks in October 2005). See Annex D.

The FCSP has four major interventions: nutrition, acute respiratory infection (ARI), control of diarrhoea disease (CDD) and Expanded Program on Immunization (EPI).

During this third fiscal year (FY), the project has been engaged in various programmatic activities planned under the lead project strategies for the achievement of project objectives. Skill development was one of the key strategies the project intervened during the FY. This intervention particularly concentrated on the achievement of project objectives related to improving the quality of health services. The programs aimed at strengthening the capacity of local partner communities and institutions so as to enhance their effort in implementing maternal and child health promotions and ultimately would be able support child survival initiatives on sustainable basis.

In this connection, the project in collaboration with its partners effectively organized and facilitated different types of training programs for community health promoters, health facility staffs and district partners. The programs covered all four components mentioned above.

The overall accomplishment during the FY covered the following:

- Maternal and child health care training for 423 religious leaders, 145 school members and 81 facilitators of mother-to-mother support groups' (MTMSGs),
- EPI and cold chain maintenance training for 22 health workers.

- With the support of LINKAGES projects in Ethiopia, training of trainers (ToT) on counselling skills and BCC in the context of essential nutrition actions (ENA) was organized for 16 resource persons from district partners and project staff as well as 26 Health workers and district supervisors.
- Nineteen people representing key partners participated in ToT for Community-Integrated Management of Childhood Illness (C-IMCI).
- A workshop on launching, orientation and planning of C-IMCI for 95 participants from community and district.
- Training for 269 community resource persons (CRPs) and 15 health workers on C-IMCI was done.
- Training on management of revolving drug funds (RDF) for 24 health workers and district partners was done
- Health information management training for 56 health workers and district supervisors was done.
- A 1-day workshop aimed at promoting home gardens for micronutrient production conducted for 58 govt. development agents (DAs) and FO's extension agents (EAs) was held.

In addition to the above, Client Oriented Provider Efficient (COPE) training is slated between the 11th and 14th of October. Similarly, LQAS training to help get quantitative data at regular intervals has been fixed from the 18th to the 21st of October.

Behavioural change communication (BCC) is the other core strategy of the project. The BCC strategy has been developed and is under implementation. Simple guidelines have been prepared for MTMSGs discussions, school clubs, religious leaders and home visits. BCC materials like leaflets and pamphlets had been developed and distributed.

The participation of the community in BCC strategy is very impressive. Large group of community members have been involving in BCC activities. MTMSGs, religious leaders, school clubs and volunteer community health workers (VCHWs) are the most important health promoters actively involving in BCC initiatives.

In terms of community mobilization, the project started the approach initially by familiarizing the community about the project and findings of maternal and child health problems in the project area. The maternal and child health promotional activities involved religious leaders from 168 churches and 3 mosques existing in the woreda. MTMSGs are the key target partners who are encouraged to convene, share, interact with health providers and key partners thus educating and supporting themselves. Out of 47 schools, 36 school clubs are actively involved in maternal and child health messages dissemination. The rest are moderately active.

VCHWs have different functions in the community, which include service delivery, community and resource mobilization as the main ones. They have also been involved in organizing and monitoring of activities of community health promoters.

To ensure the quality of health service, refresher training for integrated management of childhood illness (IMCI) was provided to trained health workers; referral systems of health facilities strengthened; supportive supervisions for health facilities held and technical support for health service delivery offered.

The capacity building effort also encompassed ensuring access and availability of supplies. Refrigerators and megaphones have been donated to the health facilities which did not have them to strengthen the EPI activities. The project identified model farmers to distribute seeds of plants rich in micronutrients like, papaya, pepper and tomatoes to improve home based gardening and family micronutrient status. Using the findings of the partners need assessment survey, different capacity building equipments (e.g. refrigerators) have been donated to our the Ministry of Health (MoH) and a typewriter has been purchased and given to the Ethiopian Orthodox Church (EOC). These have helped improve their capacity. And in the case of the DHO has improved health service delivery. The project has exerted ceaseless efforts in establishing revolving drug fund scheme. The RDF scheme is believed to alleviate the problems of shortages of essential drugs prevailing in almost all pertinent health facilities in the Woreda. The project has already released the initial seed money to start the RDF scheme in selected six health facilities and has trained the health staff of these health facilities to manage the drugs and the related finance instruments.

The project has created significant integration, linkage and partnership with partners and other organizations. It was fully involved in four campaigns (Polio vaccine and Vitamin A) held in the Woreda through community mobilization, supervision and technical support. This helped partners to develop a better understanding with each other.

Monitoring and evaluation activities had also been performed during the FY. A workshop to strengthen the planning capacity of the Woreda and micro planning for EPI activities was conducted. Regular review meetings intended to improve performances of stakeholders at different levels have been conducted. Quarterly review meetings of the Core Team of partners¹ and biannual review meeting with Kebele leaders, health facility workers, VCHW and relevant district partners have been carried out.

Similarly, Health promoters of each Kebele have been conducting monthly review meetings at health facility level. This has created the opportunity for community-level monitoring of maternal and child health activities within the respective communities in

¹ - Partners include: DHO, WOE, EOC, DA, DHC, etc.

this meeting the health promoters discuss maternal and child health issues and search for solutions at the local level on their own.

Project staff conducts regular project progress review meetings on monthly, quarterly, bi-annual and annual basis. Though most of the reviews are participatory and involve all key stakeholders, the project also does its own internal review. Reports of the different reviews are shared with all stakeholders.

Field guidelines for use by project staff during field visits to monitor the project activities were developed and are being regularly used. Exhaustive checklists for monitoring community and health facility level interventions of the project have been prepared and are regularly used. Also, an internal project checklist has been extracted from DIP and is being used as means of tracking of project progress.

2. Project Background

The FCSP's goal is to improve the health status of children under five and of women of reproductive age through four major components: Nutrition, ARI, CDD and EPI with 35%, 25%, 20% and 20% level of effort respectively within the framework of community IMCI in all target PAs. The project's specific objectives include:

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

The pre-project studies conducted in relation to the situation of the target groups of the project indicated a prevalence of underweight to be 59.2% in children less than < 5 year of age. In the two weeks preceding the KPC survey, 27.3% of children with symptoms of pneumonia sought health care; the prevalence of diarrhoea was 36.6%. Completed immunization coverage (BCG, DPT3, OPV3 and measles) was 19%. The baseline survey also indicated that MOH health staffing is limited, with only 43 facility staff outside of the one hospital (there are no private health facilities) serving more than a quarter of a million people.

The project's target beneficiaries are estimated at 118,223 individuals, 46,314 <5 children and 71,909 women of reproductive age.

The FCSP implements its programmatic activities in the context of IMCI covering all the three components of the IMCI approach that includes:

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

The project also integrates the three elements of the C-IMCI framework:

1. Improving partnerships between health facilities & the communities they serve.
2. Increasing appropriate and accessible care and info from community-based providers.
3. Integrating promotion of key family planning practices critical for child health & nutrition.

The strategies to carry out this approach are:

1. Skill Development of health and core staff from partner organizations, CHAs, VCHWs, VHCs, community leaders, school clubs, women's associations and other community groups to improve communities' access to info and health care services.
2. Community Mobilization to promote ownership through active involvement and support from religious leaders, women's associations, VHCs and influential community leaders.
3. Behaviour Change Communication (BCC) approaches to promote healthy practices at the community, family and individual level.
4. Quality Assurance for service delivery by use of COPE, supportive supervision and promotion of Village Health Committees (VHCs).
5. Improve access and availability of services and supplies by strengthening formal government and private sector systems.

The project implements its activities in a partnership approach by involving all relevant entities existing from grass root /district to regional levels. It operates with 12 partners (MoH, EOC, MoE, etc) at the Woreda level on the basis of the Memorandum of Understanding (MOU). The partners regularly meet for planning of program activities and reviewing of progress jointly with the project staff. As a result, a number of meetings and planning sessions have been made routine. All of these partners have been playing their respective roles in the implementation of the project activities. In this context, the project served more as a technical support provider/ facilitator, while the responsibility for implementing the activities remains with the partner institutions.

Community-based structures like churches, MTMSGs, VCHWs, health facilities, school clubs, local GOs, etc are very important actors the project works with.

Accordingly, the project is strengthening and providing supportive supervision in maintaining the integrations, linkages and supports among these key stakeholders for the efforts of promoting child health aspects at grass root level.

Table Number 1 : Progress Toward Reaching Objectives

Objective	Key Activities (as outlined in the DIP)	Status of Activities	Comments
<p>1: To promote the practice of healthy behaviors, including seeking of appropriate medical care as needed, by caregivers of children under five years and women of reproductive age, especially pregnant and lactating mothers.</p>	<ol style="list-style-type: none"> 1. Strengthen home visits to educate household members on key intervention messages (nutrition, ARI, CDD and Immunization). 2. Community modelling of positive deviant mothers for resistant mothers & message reinforcement in all PAs. 3. Introduce Baby Friendly Community/Hospital Initiatives. 4. Strengthen/establish community-based support networks for nutrition activities like MTMSGs, EOC, School systems and government. 5. Conduct village level campaigns and nutrition demonstrations. 6. MTMSG and community groups convened regularly for discussion of issues related to child health. 7. Assessment of community perceptions on EPI (to complement PRA). 8. School clubs perform skits. 9. Regular health education by health facility staff about maternal and child health issues. 	<ol style="list-style-type: none"> 1. On target: Health workers, religious leaders and MTMSG facilitators are conducting home visits. 2. On target: Modelling is being done by most MTMSGs of the community. 3. Not performed: 4. On target: 2664 MTMSGs established. Churches, 168 and 3 mosques are participating. 47 schools are involved. 40 Kebeles and 888 Mengistawi Budins are participating. 6 Idirs are involved in supporting treatment seeking behaviour. 5. Initiated, activity not yet on target: Integration with food security project made. The activity is planned for FY 2006. 6. On target: MTMSGs are convening at village level for regular discussion. Guidelines developed and distributed. 7. Not performed: 8. On target: 64% of the schools are actively 	<ol style="list-style-type: none"> 3. The MTE external consultant advised against this activity as the Region has no lead organization (generally UNICEF) for this activity and felt that CARE could not do this alone. 7. As advised by the MTE consultant this activity was dropped.

	<p>10. Develop BCC strategy.</p> <p>11. Develop/adapt BCC materials</p> <p>12. District health desk provides ongoing supportive supervision to community/health facility level BCC activities.</p>	<p>involving in skit performing.</p> <p>9. On target: Regular health educations are being held by all health facilities in the target area as a routine.</p> <p>10. Completed</p> <p>11. Initiated, activity not yet on target: Bulk of activity completed. BCC material for illiterate facilitators of MTMSG remains. It is being published.</p> <p>12. On target: The Wereda Health Office in collaboration with project is providing supportive supervision for activities related with BCC at Kebele and village level.</p>	
<p>2. To increase sustainable access to health education, quality care and essential medicines (from government, private health sectors, private institutions and partner organizations).</p>	<p>1. Strengthen household level health promotion, special targeting of newborn mothers and household members.</p> <p>2. Organize community service delivery: a) <i>Establish community level pharmacies with essential drugs (cotrimoxazole, Vitamin A) for community management of ARI.</i> b) Explore use/modification of community funeral funds to act as emergency funds for access to drugs and treatment in emergencies for children under five.</p> <p>3. Improve linkage with referral facilities by establishing a referral system from the community (CHW's) to near by health facilities.</p>	<p>1. On target: Religious leaders, members of MTMSGs, CRP, VCHWs and health workers are targeting newborn mothers with key messages.</p> <p>2. a) Not performed b) On target: The project has already started working with 6 "Idirs" – social guilds for funeral support to act as loan centre for emergency fund for sick child.</p> <p>3. On target: Referral system from community</p>	<p>2. As the government policy does not allow community pharmacy, MTE consultant advised to drop activity. Instead greater focus for RDF initiated.</p>

	<p>4. Organize and strengthen health service delivery at health facility level: These include: Out reach programs, growth monitoring and promotion, regular health educations and introduction of the essential nutrition actions.</p> <p>5. Improve access and availability: Establish revolving drug fund in each health facility, strengthen ORT corners, ensure the availability of cold chain supplies and vaccines..</p> <p>6. Integration/linkage with other health or development program: Facilitate initiation of linked development programs that have impact on nutrition in Farta district..</p>	<p>to health facility and from health facility to referral health facility has been established.</p> <p>4. On target: All health facilities have been organizing regular out reach programs systematically. There are 111 out reach sites. Refresher training on growth monitoring has been given to health workers. Health education based on ENA is being routinely done by all health facilities. Regular supportive supervision is the norm by the project and Wereda Health Office to strengthen growth monitoring promotion activities.</p> <p>5. On target: RDFs have been established very recently in six health facilities. 16 water filters had been given to health facilities to strengthen ORT corners. 16 new SIBIR refrigerators were donated by partners to help logistic support for vaccination.</p> <p>6. On target: The project had involved in Vitamin A, Deworming and Measles Campaigns – 2 rounds. The project has worked with UNICEF for the Extended Outreach Campaign for Polio, GM and Vitamin A</p>	<p>5. RDF is planned to be extended to all health facilities.</p>
<p>3. To ensure that quality health care is provided in areas of diarrhea, pneumonia, malnutrition and immunization by government health personnel, CHAs, CHWs (including CBRHAs and trained TBAs) and other</p>	<p>1. Training for community members: For religious leaders, MTMSG facilitators, school members and Mengistawi Budins on counselling and communication and C-IMCI for CHWs.</p> <p>2. Training for health workers on communication/ counselling skills-IPCS, IMCI, EPI and RDF.</p>	<p>1. On target: 423 religious leaders, 81 MTMSGs facilitators and 145 school members had been trained on counselling and communication. 269 community resource persons had been trained on C- IMCI in 10 pilot Kebeles.</p> <p>2. On target: Trainings like counselling and</p>	<p>1. Training for Mengistawi Budin members has not been conducted due to trainers workload with the current situation.</p> <p>2. Last year, IMCI training was given for 20 health workers. It was planned to train untrained health workers but it has been postponed due to over occupation of the health workers</p>

<p>service providers.</p>	<p>3 Introduce a community based surveillance system and a system to track drop-outs and encourage complete immunization in collaboration with EOC.</p> <p>4. Refresher trainings on IMCI for health facility staff.</p> <p>5. District health office team is trained on quality improvement techniques to help them support the health facilities respond to problems identified by COPE.</p>	<p>communication on the context of ENA and BCC for 26 health workers, EPI for 22 health workers, RDF management for 24 health workers had been given. But IMCI training has not been given for health workers, which was planned for untrained health workers.</p> <p>3. On target: The project had oriented religious leader on surveillance of measles and Acute Flaccid Paralysis (AFP). Community health promoters identified 4 suspected measles and 3 AFP cases (two confirmed as polio cases). Surveillance of vaccine preventable diseases is done. Health promoters track drop outs. They are highly mobilizing defaulters and monitoring during out reach program days.</p> <p>4. On target: Refresher training has been given for 20 health workers on specific part of IMCI.</p> <p>5. On target: District health office team and partners have been trained on COPE.</p>	<p>5. The training is slated from 11th to 14th October 2005.</p>
<p>4. To strengthen local and community-based institutions and partners and build capacity to support child survival activities on a sustainable basis.</p>	<p>1. Community education to build strong community support to mobilize local resources, as well as demanding quality services from the health facilities through out reach immunization program.</p> <p>2. Capacity/skill to deliver vaccines and manage immunization program is built in the health facilities.</p> <p>3. Plan with health facility management teams for initiating and maintain out reach program.</p>	<p>1. On target: All trained VCHWs, health workers and most health promoters are conducting group health education on importance of immunization. With availability of new EPI refrigerators, both the demand and the supply are matched well.</p> <p>2. On target: Woreda health office and health facilities through regular support and systems in place have been empowered to deliver immunization credibly.</p>	

	<p>4. Discussion at regional and national level with key policy makers on nutrition related policies</p>	<p>3. On target: Yearly planning workshop is being conducting including micro planning and community level out reach programs.</p> <p>4. Initiated, the activity has not been performed but planned for next year. The project familiarized itself and the Woreda health staff on the National Infant and Young Child Feeding Guidelines.</p>	
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3. Project Achievements By Strategies

3.1. Skill Development

As explained earlier, skill development is one of the key strategies in which the project concentrated its effort towards achieving project objectives related to quality of health service and capacity building of local partners and institutions.

The major achievements of the project in skill development areas are trainings offered for partners and community members in order to strengthen their capacity and efficiency in implementing maternal and child health promotions and ultimately support child survival initiatives in their operational areas on a sustainable basis.

In this connection, the project together with its partners and other collaborating organizations effectively organized and facilitated different training programs for community health promoters, health facility staffs and district partners. In all the training programs organized by the project, all four lead project objectives mentioned earlier have been given due attention.

The summary of the trainings offered is shown in the following table:

Table No. 2 Debre Tabor, Ethiopia, CSP: Types of trainings and numbers trained in FY 05

S/N	Training Topic	Participants	Trainee:	Duration	Facilitator (s)
1	Maternal and child health care - BCC	Religious leaders (EOC & Muslim clerics)	423	3 rounds ²	Debre Tabor Health College (DHC)
2	Maternal and child health care - BCC	MTMSGs facilitators \PDMs	81	16 - 17 April 2005	DHC, WOH
3	Maternal and child health care - BCC	School members (students + teachers)	145	5-8 February 2005	DHC
4	EPI & cold chain maintenance	Health workers	22	16 October to 02 Nov'04	Regional BoH
5	ENA & BCC counselling & communication - ToT	District partners and project staffs	16	4-9 April 2005	LINKAGES
6	C-IMCI ToT	District level partners	19	8-10 July 2005	Federal MoH and Regional BoH
7	C-IMCI training	Com. Resource Persons and CHWs	269 + 15	11-14 July 2005	District partners
8	ENA & BCC counselling & communication - Training	Health workers & district supervisors	26	1-5 September 2005	District partners
9	RDF management training	Health workers & district supervisors	24	23 - 26 August 2005	Regional Health Bureau
10	Health information management training	Health workers & district supervisors	56	14-15 August 2005	Woreda Health Office and Project

The details of the trainings offered are narrated below:

² - 3 rounds of training: on 21 November to 04 December'04; 26-29 March'05 and 25-26 June 2005.

3.1.1 Training for Religious Leaders

One of the fundamental strategies of the project is working with religious leaders. More than 94% of the population is a member of the Ethiopian Orthodox Churches (EOC), with very few Muslims. There are 168 (one new) Ethiopian Orthodox Churches evenly distributed in all 40 Kebeles of the Woreda and there are 3 mosques in the Woreda. Most mothers and fathers in the whole project area attend religious congregations. Thus, religious leaders - priests of the EOC and Sheiks of Muslims are assumed to be the most influential persons in bringing the required behavioural changes related to maternal and child health in the target community.

Accordingly, the project has been exerting lots of efforts to work with these entities. Foremost is capacitating these stakeholders through training (minimum 3 religious leaders /church or mosque) in areas of skill development to enable them efficiently counsel members, disseminate and promote key messages designed to bring healthy behaviours among their followers and strengthen local capacity to support child survival initiatives.

During the FY, 423 religious leaders (see Table 1 below), 3 religious leaders per church/mosque, which makes up the total number of religious leaders in the Woreda to be more than 400 were trained for three rounds by eight trainers (each round) drawn from Debre-tabor Health College (DHC) and Farta Woreda Office of Health (WOH). Including the 43 trained last year, the total number of religious leaders trained in maternal and child health initiatives in the project area has now reached to 466.

The major topics covered by the trainings include:

- ☞ Optimal breastfeeding.
- ☞ Control of diarrhoeal disease (CDD); personal hygiene.
- ☞ Acute respiratory infection (ARI), health care seeking behaviour and recognition of danger signs of childhood illness;
- ☞ Home management on childhood illness.
- ☞ Expanded Program of Immunization.
- ☞ Counselling, communication and how to conduct home visits.

Table A:- Summary for Religious Leaders Training

S/N	Round	# of Trainee:	Duration
1	Round ₁	131	Nov 21- 04 Dec '04
2	Round ₂	149	26-29 March 2005
3	Round ₃	143	25-26 June 2005
	Total	423	



Religious Leaders/priests on Training – Debre Tabor Health College

3.1.2. EPI - Modular Training for Health Workers

The regular joint supervision and monitoring (DHO and CARE) of health service delivery by health facilities, especially outreach level services revealed that there was clear knowledge and practice gap between those HW trained by the project and those not trained.

To narrow down this skill gap and ultimately improving the effectiveness of the EPI service delivery system, the project organized an EPI - modular training with cold chains maintenance component for 22 health workers who had not been trained earlier. The training was held from 16 October to 02 November 2004. The training is believed to have equipped these health workers with the technical capacity required to improve service delivery on EPI and answer sustainability issues at the local level.

3.1.3 Training for Facilitators of Mother-to-Mother Support Groups (MTMSGs)

MTMSGs are the most important community-level structures that play significant role in bringing behavioural changes regarding good practices of maternal and child health care. There are around 2664 voluntarily established MTMSGs in all 40 Kebeles of the Woreda. These groups were initiated by VCHWs, health workers, Kebele leaders and religious leaders. Each MTMSG³ has one positive deviant mother as a group facilitator.

Last year, the project reported that training on maternal and child health related basic skills and potential messages was given to 30 positive deviant mothers (PDMs). Since then, there have been encouraging results while working with MTMSGs to bring the required changes in the behaviours of target beneficiaries concerning maternal and child health initiative.

In this fiscal year, 81 MTMSGs facilitators were trained from 16 – 17 April 2005 using a training material prepared by the project. The training was facilitated by DHC and WOH. On the basis of an earlier recommendation the training was delivered directly to the MTMSGs' facilitators (disregarding cascade training) on the following basic topics:

- ☉ Maternal & child health related skills & messages.
 - Optimal breastfeeding.
 - CDD and personal hygiene.
 - Health care seeking behaviour, ARI and recognizing danger signs of childhood illness
 - Home management of childhood illness.
 - Expanded Program on Immunization.
- ☉ Facilitating & organizing discussions by MTMSGs.
- ☉ Conducting home visit for target mothers (pregnant and lactating mothers) and counselling.



[MTMSGs Facilitators on Training - Debre Tabor Health College.](#)

³- On average a group has 12-15 members (all women), the size depends on the number of HHs in a specific village.

The certificate of participation issued to all trained facilitators/PDMs upon completion of the training has motivated the mothers as they develop a sense of empowerment. As of now, both the trained and untrained facilitators have started facilitating discussions among their group members. Furthermore, all trained health promoters are now supporting untrained facilitators at group discussions, counselling target caretakers, disseminating the required messages.

The external consultant recommended training of one facilitator of MTMSGs per Mengistawi Budin (around 888 in total) directly by the project. However, most of the facilitators of MTMSGs are illiterate and need at least one kind of descriptive behaviour change communication (BCC) material that helps them to facilitate the discussions among MTMSGs' members. The preparation of relevant BCC materials and counselling cards is being finalized. The project will immediately embark upon training of facilitators of MTMSGs following completion of production of the BCC materials.

3.1.4 Training on Counselling and Communication (ENA & BCC)

As per the findings of surveys and observations conducted by the project, counselling and communication skill is one of the major gaps among health workers to implement the key component of maternal and child nutrition at health facility as well as community levels.

To address the gap, the project with the help of two experienced resource persons from LINKAGES project in Ethiopia conducted a ToT on counselling and communication on the context of ENA and BCC to partners and project staff. These trainees are the resource persons to train health workers on the same topics and conduct supportive supervisions for health facilities.



ToT Training on Counseling and Communication on ENA & BCC- Group Work

In order to effectively enhance implementation of ENA and BCC components at health facility level, the project also organized similar training for health workers and Woreda level supervisors that equipped trainees with the necessary skills needed to undertake ENA & BCC at health facility level. As a follow up activity, two of the trained resource persons trained the health workers and district supervisors.

The project procured a manual on '*infant and child feeding strategy/policy*' of the country from Regional Health Bureau and made aware the government health workers of their role and responsibilities *vis a vis* ENA as valid and required standard practices that all government health workers are expected to follow.

3.1.5 Training for School Members

Schools, especially school clubs are among the most important institutions supporting the implementation of the project activities. There are 47 schools in the project target area working with the project to bring improved maternal and child health status. School clubs are greatly involved in dissemination of messages of behavioural change to the community.

A drawback was noted during one of the review meetings which was, activities of the were weakening when trained leaders/teachers/students were transferred to other schools.

Therefore, to make school clubs' effort in promoting maternal and child health initiatives in the community more sustainable, the project reviewed and revised its strategy of capacity building for school clubs. Accordingly, school clubs now days constitute two teachers and two students who have at least two years of stay in a given school before graduating.

To this effect, the project capacitated 35 schools clubs of the Woreda. The capacity building effort included training for two school leaders & two students from each school and 5 Woreda representatives. A total of 145 participants were trained on maternal and child health care and behaviour change messages dissemination through different methods like poems, drama, plays, etc.



School Members Training – Debre Tabor Health College.

As a result, members of the schools clubs have been involved in dissemination of BCC messages in a more sustainable manner within the community especially during community gathering, parents school holiday, etc. Some of the clubs have used their members (students) as one of the means to disseminate maternal and child health messages for their families and neighbours.

3.1.6 Workshop for Government DAs and CARE EAs on Promotion of Home Gardens

To make its impact more sustainable the project partnered with District/Woreda Office of Agriculture for training of model farmers to promote home gardens for planting micronutrient rich plants and consumption of plant produce at the household level.

In this regard, the project organized a workshop at three selected sites of the Woreda from 31 January to 02 February 2005. Fifty eight (58) participants, PA level Development Agents (DAs), Woreda relevant experts and CARE's extension agents (EAs) attended the workshop.

The workshop had two important purposes:

- Integration between sectors to create better access for micronutrient rich agricultural produce.
- As a part of BCC regarding households' production and consumption of micronutrients (for mothers and children).

The workshop addressed:

- Sources of micronutrients (vitamin A, iron and iodine).
- Health problems due to deficiency of micronutrients (vitamin A, iron and iodine).
- Ways of promoting home gardens for production of micronutrients – vegetables and fruits (rich in micronutrients) and sustainable consumption.
- Means and potentials of the Woreda for micronutrients production.
- Action plan for promotion of home gardens for micronutrient production and BCC in regards to micronutrients.

Since the training, productive communication is being held with all workshop participants to strengthen the implementation of the action plan developed at the workshop. The project in collaboration with WOA will use selected model farmers for demonstration purposes. Also, members of the different MTMSGs have been given attention and are already engaged in promoting home gardens for micronutrient production.

3.1.7. Community-Integrated Management of Childhood Illness (C-IMCI) Training

Community - Integrated Management of Childhood Illness (C-IMCI) is the framework on which the project activities are based. The thrust area of the C-IMCI framework is to promote key behaviours of maternal and child health at household level and to link these with available primary health care.

The project exerted lot of efforts and held series of communications and discussions with the Regional Health Bureau (RHB) and National MOH focal persons so as to embark upon implementation of C-IMCI. The project has planned to initially apply C-IMCI interventions in 10 pilot PAs of the Woreda, which was accepted by the National MoH and Regional BOH.

Facilitating training programs on C-IMCI is the responsibility of the Federal MOH (in collaboration with the concerned RHB). Getting the project Farta Woreda recognized as one of the pilot areas of the country for C-IMCI by both Federal and Regional health offices/bodies was the other essential matter that needed prior sanction before launching C-IMCI in the community.

However, the resource persons from the National MOH were busy with C-IMCI works in pilot areas of the country for long. This has been a major delaying factor for the training program, which the project planned months back as per its work plan.

Finally, the project organized the training on C-IMCI, which was facilitated by two/three nodal persons from the National MoH and RHB. In line with the National guidelines on C-IMCI, the training was comprised of three main components:

- Orientation and planning workshop for partners from Kebele, district and Zonal level.
- Training of trainers (ToT) for partners.
- Training for community resource persons (CRP), one resource person /50 households.

Accordingly, 19 participants from partner organizations attended the ToT on C-IMCI. Prior to it, an orientation and planning workshop was held, which was attended by 95 participants from Kebeles, District and Zonal offices. This workshop was aimed at orienting the key partners on C-IMCI and served as a launching event for C-IMCI. Two persons from national C-IMCI pilot Woredas, Dabat and Wukro, had shared their experience in C-IMCI interventions. The resource persons who attended the ToT facilitated the training for CRPs. The orientation workshop, ToT and training were held consecutively.

The CRPs are now operational and linked with the health facility and community health systems of the Woreda. Each of the CRPs has around 50 households to serve. Feedback from community and health promoters is indicating that the trained CRPs have been effectively discharging their responsibilities to their designated households.

3.1.8 Training on Revolving Drug Fund (RDF) Management

The objective of establishing revolving drug fund (RDF) scheme is to improve communities' access to essential drugs for children. RDF schemes are going to be established in 6 pilot health facilities of the Woreda and Debre Tabor health centre to meet the needs of the target communities. Skill development training on RDF scheme management for concerned partners was an essential endeavour as part of this effort of the project. The training was planned to enable them effectively implement the schemes in their respective areas of assignment.

The training on RDF scheme management was given for 24 participants from partners at different levels, who would be involved in RDF implementation. The training aimed at equipping participants in the whole approach and modalities of RDF management, including sustainability issue. Staff members of the Drug Administration Department of the RHB facilitated the training.

3.1.9 Training on Health Information Management Systems

Last year, the project conducted gap analysis on health facilities information management systems (IMS). The exercise revealed that there were problems of lack of skill in managing and using health information at health facility and also at Woreda level.

Aiming at resolving this problem, the project organized a two-day training on health IMS of the Woreda. All health facility workers (56) and 6 district staffs, who are involved in planning & report writing, attended the training.

At this training, all MOH data collection tools were briefed and introduced to participants; health IMS strengthened; in-depth discussions held and critical areas of gaps in health IMS identified; additional use and analysis of health IMS at health facility level addressed.



Health Information Management Training

3.1.10. ToT on Client Oriented Provider Efficient (COPE)

This training is slated between October 11th and 14th of 2005

3.2. Behavioural Change Communication (BCC)

3.2.1. Development & Implementation of the BCC Strategy

In this FY, the project not only finalized the development of, but also started operationalizing the BCC strategy document. In this regard, the project familiarized the BCC strategy document to all relevant partners, the government and non-government organizations via a workshop held on April 23, 2005. 14 participants from partners' organizations (CARE Bahr Dar, Family Guidance Association Bahr Dar branch, ESHE Amhara Region and Regional Food Security and Disaster Prevention Office) actively participated in the familiarization & orientation workshop. The workshop served as a venue to gather important feedbacks / comments that helped us enrich the strategy. All comments and feedbacks obtained from the workshop are incorporated in the strategy paper.

The implementation of the BCC strategy commenced with collection of BCC sample materials for adaptation and production as well as pre-testing of new materials.

Cassettes recorded with key BCC messages are one of the many ways of disseminating BCC messages within the community that proved to be effective. The cassettes are intended primarily for listening groups/audiences targeted for specific child health messages. Materials (10 tapes with dry cell batteries) required for this purpose have been procured and distributed to 10 pilot Kebeles. Local amateur artists have developed scripts of basic child health messages in the form of songs and plays. Such materials recorded on cassettes have been distributed to health facilities to facilitate listening sessions.

Accordingly, the health facilities are organizing the listening sessions taking place at different occasions. Both the health workers and VCHWs are facilitating messages dissemination at outreach sites, during community gathering, at health facilities on immunization days, etc. In some cases the audiences have been seen willingly listening to the sessions even after having completed the main purpose of their gathering.

The project developed cassettes listening guideline for use by facilitators of the listening sessions; oriented the intended users; and circulated the guideline to the all health facilities. The guideline highlights the methods of disseminating messages through cassettes listening and processing the listening sessions by pausing and raising questions for discussion.

Leaflets are also the other materials developed and distributed to the target audiences. More than 3000 leaflets were produced and distributed to the target groups. Each type of leaflet carries key messages of the four interventions of maternal and child health as identified in the BCC strategy and written in local languages. The health promoters in all Kebeles⁴ have also received the leaflets and are using them as teaching/facilitating aid/materials for the promotion of maternal and child health within the community.

Also, production of counselling cards and posters is underway. Samples were collected from ESHE Amhara and LINKAGES project (via internet). Development and pre-testing of these materials completed. Counselling messages to be printed on one side of the counselling cards have been adapted and refined. The production of the materials for the large group of community is on process in consultation with the Regional BOH.

Design of T-shirt, pictures and messages has been completed. The production of the T-shirts with key messages and pictures is on process for printing.

⁴ - These include MTMSG facilitators, religious leaders, VCHWs, School clubs, health workers

3.2.2. Production of Guidelines for Health Promoters

The project with the support of external consultants and CARE's TA identified the need for consistent and simple guidelines to be used by health promoters for the implementation of maternal and child health promotion at grass roots level. To this effect, the project developed guidelines for: facilitation of MTMSGs' discussions; school clubs; religious leaders; home visits by health promoters.

These guidelines were oriented during training sessions to and distributed for application by the relevant health promoters. The latter have now started using the guidelines for messages dissemination process at community level. The project is closely following up the use and effectiveness of these guidelines. The results so far are encouraging.

3.2.3. Community Participation in BCC Initiatives – Support Networks (a) Mother-to-Mother Support Groups (MTMSGs)

The community level activities that initially started in selected 10 pilot PAs in general and the community based support networks in particular have now expanded to the remaining 30 PAs of the Woreda. The lessons learnt from the initial 10 PAs in facilitating community-based activities are being systematically incorporated.

From the date of establishment, the members of the MTMSGs have selected their respective group facilitators and fixed date of convention at their village (1-2 times per month). Most of MTMSGs have been conducting regular conventions among the group members at village level to discuss about maternal and child health care. The members of the MTMSGs have also been supporting each other using different opportunities like by visiting homes of members (important especially for pregnant and newly delivered mothers), during coffee ceremony, "mahiber" – religious social guild, fetching water, market days, congregations at churches, etc. They also disseminate key messages discussed during convention to non-members of the MTMSGs i.e. for relatives and other family members.

The facilitators of MTMSGs are participating in monthly meetings regularly held at Kebele level with all health promoters of the Kebele. This creates the opportunity to exchange ideas; identify problems and find solutions; present achievement reports and are seek support from different community level health promoters. The most important sources of support for MTMSGs are the respective health workers, VCHWs, religious leaders.



MTMSGs Convention. Village -
“Kesimender” at “Meskeltsion PA”.

The project has been strengthening the support to mothers through MTMSGs through regular supervision and by involving them regularly in monthly meeting. Group discussions with MTMSGs imply that mothers exchange behaviours mainly on optimal breastfeeding, home based care for sick child, health care seeking and immunization.

(b) Religious Leaders

Religious leaders are key to bring behaviour change in the community (by persuading/ counselling and negotiating with their followers) and disseminating maternal and child health messages using their beautiful languages and approaches.

More than 400 CARE’s trained religious leaders have been involving in disseminating key maternal and child health messages for large the target community members, mothers and fathers. They use churches/ mosques as the major centre to disseminate messages during specific holidays, Sundays and/or Saints’ congregations.

The religious leaders also visit confessors home to disseminate and persuade caretakers of children and mothers on maternal and child health messages. On average a priest has 24 confessors to visit regularly and pray for. The priests use such communications as opportunity for talking about the given health messages role in the community. Some are using various occasions like, community gatherings for messages dissemination and persuading mothers for faulty practices, which negatively influence maternal and child health at household level. Caretakers have started seeking care from trained health personnel and taking their infants for vaccination at the right age and keeping immunization schedule.

The role of religious leaders in promoting maternal and child health behaviours, including practising vaccination, optimal breastfeeding, etc. is remarkable. They also now authoritatively talk on ARI diagnosis and referral and CDD. Besides this, the priests are also supporting MTMSGs in their initiative for same effective team work and behaviour change. Some Kebeles had already linked the religious leaders with MTMSGs for support. Community mobilization for EPI and surveillance for AFP and measles are also the other important activities in which the religious leaders have been engaged.



Two Trained Priests – At Sunday Congregation at “Simina Mariam”

(c) School Systems

Trained school club members and leaders have been involving in messages dissemination for the community using the scripts of poems and dramas and exercising for long time. They use different events including year-end parents days, holidays, community gatherings, etc. More than 64% of the schools have actively been involved in maternal and child health messages dissemination in the community.

Students are also disseminating maternal and child health messages for their families and neighbours and also supporting their families by reading of leaflets.

The project staffs have been regularly supporting the schools in updating their works and monitoring the relevant messages are disseminating according to project indicators toward achieving the objectives.



Students Drama Show at Year End School Holiday - ‘Aringo’ School.



A Priest Reading Poem at ‘Ayide’ School During Parents Holiday.

(d) Volunteer Community Health Workers (VCHWs)

CARE’s trained VCHWs and existing CHWs are involved in behaviour change initiatives. This is done through: conducting home visits to target groups, group education etc. In addition to these efforts in the community they have also been active in resource mobilization for EPI activities, health service delivery with health workers at out reach sites, organizing the community level maternal, child and primary health care promotion.

3.3. Community Mobilization

Community mobilization is one of the lead project strategies for implementing its activities. Accordingly, the project has been facilitating community mobilization to actively involve the community in the implementation process. In addition, the project's partners also are involving community mobilization initiatives.

The 400 project trained religious leaders are involved in mobilization of the community for promotion of maternal and child health. They are engaged mainly in: BCC messages dissemination at churches; supporting MTMSGs in their vicinity; community mobilization for EPI (especially defaulters) and other health development activities like campaigns, epidemic prevention, etc; Surveillance of AFP and measles; etc. The religious leaders from the Muslims community (3 trained Shiekas/mosque) also are disseminating BCC messages and equally mobilizing the community for maternal and child health care initiatives. This is a demonstration of CARE's principle of equity and avoidance of discrimination.

CARE's initiated MTMSGs are also the most significant groups in the community who have been mobilizing large groups of the target community (pregnant and lactating women in particular). The majority among the 2664 MTMSGs trained by the project involve in behaviour change activities and support mothers with positively deviant attitude (early adapter). They conduct village level convention for maternal and child health promotion. The PDMs too share experiences of child health care for group members during regular village level conventions.

The school clubs in all 47 schools in the project target area are working with the project to bring improved maternal and child health status and mobilize the community for the promotion of key maternal and child health messages. The community has high respect for schools and considers them as change agent for modernization. Hence, their influence in disseminating key maternal and child health messages through the various means mentioned earlier in the community is highly appreciated and accepted.

All 40 project trained VCHWs and more than 200 existing CHWs (TBAs, CBRHAs, CHAs) in all Kebeles of the target Woreda who work with health facilities also have been engaging in community mobilization activities of the project. The trained VCHWs are also acting as bridges in linking the different health promoters in the community with health facilities. Their participation in maternal and child health promotions is considerable. They are involving in the following major activities at grass root level. CARE's trained VCHWs have been

- Organizing and supervising activities of health promoters in the community (MTMSGs, religious leaders, schools, etc).
- Directly involving in community and resource mobilization activities for maternal and child development.

- Involving in outreach level health delivery jointly with the health workers, EPI, Growth monitoring, health education, etc.

Local level Kebele administrations have been participating in community mobilization jointly with the project and health facility of the Kebele. There are 40 Kebele (PA) administrations, 24 Mengistawi Budins and 5 sub Kebeles under each PA (on average). The followings are the major areas of engagement of these entities at all levels down to Mengistawi Budins.

- Involve in organizing and monitoring of health promoters of the Kebele for maternal and child health promotion.
- Participate in community mobilization for EPI & related health development programs.
- Search for and advise defaulters to complete EPI by working with health workers.

3.4. Quality Assurance

The project has done a lot of activities that contribute for improvement of quality of health service delivery systems for the community. The training on IMCI conducted by the project last year for lower level health workers from health posts enabled the WOH staffs fulfil their duties better than they regularly used to do.

The following, among others are the major project efforts exerted towards quality assurance:

- (1) WHO and project staff jointly conduct supervision and monitoring of the health workers' achievements, especially in referring sick children to referral facilities according to IMCI protocol. Health facility staffs hardly practiced these skills prior to the training.
- (2) In support of the effort of strengthening the referral systems of the health facilities, the project in collaboration with WOH had developed two types of referral formats – one from community to health facility and the other from health facilities to referral facility. Orientations on the referral formats were given for those involved in the system; the formats have been distributed to health facilities and are being used.
- (3) The project also supported health facilities to improve the quality of their health service delivery for their clients. The WOH jointly with project staffs conducted supportive supervision for all health facilities in the Woreda (now 33). This involved observations; in-depth discussions with all health workers on findings of observations for improvement of health services. Written on spot feedbacks are also displayed at all health facilities as feedbacks. As a result, most of the health workers support to continue such kind of supportive supervision. The project and WOH staffs regularly supervise and provide support to health facilities on different technical aspects of health service delivery like GM, counselling, immunization, IMCI, etc. At the beginning of the year, refresher training on IMCI was also given for health workers trained by the project in the previous year.

- (4) Rapid assessment of the health service delivery systems that focused on effects of trainings conducted by the project by the end of the FY and major bottlenecks in improving the health service delivery systems was conducted by the project as part of supportive supervision. Findings shared with WOH for due attention by decision makers.
- (5) The resources for maintenance of cold chain systems provided by the project have enabled the WOH to timely maintain different non-functional refrigerators & other equipments.
- (6) Oral rehydration therapy (ORT) corners strengthened with the provision of ORT equipments. Some health facilities did not have access to potable water in order to facilitate ORT demonstration for caretakers of sick child with diarrhoea. The regular supervision and partners' capacity need assessment identified the need for water filters. Thus, the project procured and distributed to WOH 16 water filters to strengthen the functioning of the ORT corners.
- (7) Improving the quality of health service at health facility level through Client Oriented Provider Efficient (COPE) methodology and tools was another area of engagement of the project. However, the training dates have now been finalized to be from the 11th to 14th of October 2005.

3.5. Improve Access and Availability of Supplies

Vaccination Access

The findings of the health facility survey and partners need assessment show that many (47%) health facilities of the Woreda had no refrigerators to keep intact the cold chain system of vaccines for use for outreach and static sites immunization activities. The health workers and VCHWs of these health facilities had to travel long distances on immunization days to bring vaccines from suppliers (i.e. other health facilities that have refrigerators or the WHO).

These health workers often had to spend significant period of time away from their station in search of vaccines or return empty handed due to poor communication between the two parties. The outreach programs suffer most if they are scheduled on weekends. Outreach sites were also closed during static immunization days for lack of vaccines. Furthermore, provision of immunization at the health facilities (static sites) on daily basis was not possible due to absence of refrigerators. This coupled with other factors contributed to increased dropout rates (defaulters) and low EPI coverage.

Amidst all these constraints, the project purchased and distributed 16 refrigerators to the WOH for distribution to needy health facilities. This is expected to resolve the aforementioned problems of the EPI program and improve the immunization coverage of the target area/woreda. The WOH distributed the refrigerators to the respective health facilities. Including the newly constructed health facilities (not considered during planning), project donation of refrigerators reaches and ensures access to 44% of the

health facilities. The effort will result /make EPI service for 80,000 segment of the population.



**Donation of Refrigerators – Ceremony
(WOH receiving)**

In addition to these, the project also donated 36 megaphones (one per PA, 4 PAs delineated to Debre Tabor town), to support the community mobilization efforts for EPI. Four motorbikes were also maintained to strengthen the supervision activities of the WOH to health facilities.

VCHWs and health EAs (newly assigned at the Woreda) were provided with basic materials including field bags and umbrellas printed with child health message (to protect them from rain and heat while mobilizing the community for health service) to strengthen the outreach level health service delivery effort being exerted by these groups at the grass root level.

Micronutrient Access

Integration strengthened the other FO sister projects and WOA to promote home gardens for micronutrient production. The project had complemented the other projects initiatives with the provision of micronutrient-rich plant seeds for distribution to target farmers. Currently, CARE's EAs and WOA DAs are promoting consumption of micronutrient-rich vegetables at household level. In the future, Home Agents of the WOA will be fully engaged in this initiative.

Strengthening HMIS

The findings of the partners need assessment indicate that most of the partners lack the capacity in planning and management. They need training in this field. The project also equipped the WOH with computer, photocopier and projectors so as to strengthen the health info management system (also training). The materials also support training programs for health workers, and improve the linkages between the district office and health facilities. The project had also donated a typewriter to the district EOC office. The EOC representatives believe that the donation improves and makes easy their work with the churches in their communication.

Access to medicine and timely treatment

The establishment of the RDF scheme that took almost a year is another effort of the project that is believed to strengthen the capacity in the supply of drugs and other essential materials.

Overall project achievements along the RDF include:

- Establishment of all aspects of RDF scheme is completed. The project already released initial capital/seed money to start the scheme in 6 selected health facilities.
- Memorandum of understanding was signed between the project and key partners (Woreda Admin, Zonal Health Desk, WOH, DHC) on the RDF scheme management.
- Agreement among/with the Regional BOH to deliver capacity building training on RDF to WOH and DHC Staffs. Accordingly, staff from the Regional BOH drug administrations department trained staff on drug and finance management.

Access to Sanitation

To support and strengthen the WOH in promoting latrine construction in the community, FCSP has produced 200 slabs for distribution to model MTMSG members, religious leaders, VCHW and other influential members of the community so that they could demonstrate and promote hygiene, construction and usage latrine in the rural community.

4. Challenges impeding progress:

The following were some of the constraints and challenges to project implementation during the reporting period.

- The District Health Officer for Farta has been changed. Though the position has been given to one of his juniors, the project has lost some valuable time in bringing up the incumbent in the understanding of the project.
- The Project Manager position is still not filled and the country office is finding it difficult to get a doctor with masters in public health to work in a remote area.
- The project is still handicapped by relative lack of transport. There have been efforts made to purchase motorcycles which are expected to fill in the gap the next fiscal year.
- The government policies preclude the establishment of community pharmacies, establishment of an RDF etc

- The MOH has made change in the first line malaria treatment, but those drugs are not freely available. Similarly, the government does have the ITNs, but has no funds to transport them to the people.

Project actions or plans to overcome constraints:

- The project is actively working with the new District Health Officer and getting the DHO team involved in the project.
- Given the difficulty in getting a doctor with a public health background to work in Debre Tabor, the CARE Country Office and CARE Atlanta are working with USAID to accept the current acting Project Manager as the Project Manager, because he has performed satisfactorily as an acting PM.
- Motorcycles have been purchased and the project staff is in the process of getting trained and getting their licences.
- Though the government polices do not allow community pharmacies, we are working with the local CBOs (Idirs) to make money available to the sick child's caretakers for treatment. The RDF have been established through alternative route of using the community cooperative banks rather than the commercial banks.
- CARE Ethiopia Country Office is working with UNICEF to collaborate and see how the new changed policies on malaria can be made effective at the grass-root. The RDF at the District level might also help the health services providers to procure the changed first line of anti-malarials.

5. Technical Assistance

This year a mid-term evaluation was done by an external consultant. CARE's technical advisor for children's health also did a follow up visit to see the progress since the consultants visit and also add to mid-term report. Through inputs from both of the visitors, changes were made to the project as was recommended by them. The important areas where these consultants provided inputs were:

- a) Identifying key areas of project activities that the project was lacking in and providing links or information as to how these could be achieved. For example, the LINKAGES training for ENA.
- b) Working and expanding the relationship with Ethiopian Orthodox Church and Idirs.
- c) How to improve the projects interactions with the MTMSG.
- d) Utilizing existing data systems to closely monitor the field activities and how to spot early the areas that are being neglected and need closer supervision. One of the outputs of technical assistance was developing a wall chart for monitoring visits to the various institutions, groups and people active in the project based on the Community Mobilizers daily visit reports.
- e) Local review of the BCC material was done.

6. Substantial Changes in the Project:

There are no substantial changes in the project.

7. Sustainability

The project has consistently striven to incorporate sustainability into its each and every activity. The important areas of increased emphasis that was laid in this year for sustainability were:

- a) Identifying and strengthening structures/institutions in the community that have a historically important role in the life and culture of the people. These were identified as: (1) The government with its different departments. For example, the school drama clubs were strengthened to help sustain the effort of bringing child survival messages through school children to their homes. The agriculture department, to help propagate the key messages of ENA and greater consumption of fruits and vegetables by the community. The district health office, skills and infrastructure capabilities were built so that beyond the life of the project the skills and infrastructure would help sustain the important child survival interventions. (2) Strengthening of CBOs like Idirs, who have a role in funeral arrangements of its members. The project has included this ancient institution to help advance credit to parents of sick children, exactly in the same way as they help the funeral arrangements.
- b) A lot of impetus has been brought to bear in the area to build a 'community of trainers' within the district. The health college, the clinic and the hospital academic staff has participated and now are trainers for most 'skill building' activities that a child survival project needs, for example, as C-IMCI trainers, as ENA trainers etc.
- c) The MTMSG are the largest participant group in the community. They meet in groups ranging between 12-35 mothers regularly once or twice a month and exchange experiences and knowledge on the best practices for child rearing.
- d) The health facilities are being enriched through RDFs and they have been mandated to purchase essential life saving drugs only for the paediatric age group. This strengthening will go a long way in saving lives in a timely manner, especially coupled with the Idirs loans to a sick child's' caretakers.
- e) The Ethiopian Orthodox church is influential and commands membership from nearly the entire population. The training of the priests has been taken as an important sustainability activity for the district. The priests have been trained in the ENA and also counselling skills. The priests are aware of the project interventions and are exhorting the churchgoers to higher levels of knowledge and behaviour change.
- f) Building capacities of the DHO for joint supportive supervision. These frequent supervisory visits help improve the government health system to be sensitive to the need of the health workers and health facilities on one hand and on the other helps fill in knowledge and skill gaps of the health workers.

Partnerships and Integration

First and foremost partnership has been established with grass root level communities and institutions they have been empowered. They actively participate and are involved in different grass root level maternal and child health promotions. For example, the members of the MTMSGs are encouraged to elect their group facilitators. Similarly, all members of the churches also elected their own religious leaders to facilitate program activities for CSP.

The project has also been working with 12 partners from government sectors very closely. District Administration, MoH, EOC, MoE, are the key partners that have created partnership down to their community level structures (schools, churches, health facilities, administration office). Currently, the project jointly with WOH closely works with 36 (3 on process of completion) health posts, 34 health workers and 22 health extension agents (HEA).

The project also participated in different maternal and child health development programs initiatives of the WOH. The major events included:

- Sub National immunization Days (SNIDs) – First round polio campaign, held from 08 April to 12 April 2005. By this campaign, two polio cases had been identified and confirmed.
- Sub National immunization Days (SNIDs) – Second round polio campaign, held from May 23, 2005 to May 27, 2005.
- Sub National immunization Days (SNIDs) – Third round polio campaign, July 29 to August 6 2005.
- Vitamin A, Deworming and Measles Campaign – First round, held from April 13, 2005 to April 20, 2005; second round, held from May 13, 2005 to May 19, 2005.

The contribution of the project to the success and achievements of all aforementioned campaigns was very high. It took part in supervision, giving training to campaigners, resources (human and materials) mobilization at the grass root level.

During the second round polio campaign, the project in collaboration with CORE Ethiopia (the sponsor) and Farta WOH played active role in the following areas: -

- Community mobilization.
- Logistic mobilization.

➤ Technical support and supervisions.

This program was made possible through a joint effort of the project and CORE Ethiopia. It was effected with the funding obtained from CORE Ethiopia in response to our mini proposal for supporting community mobilization for polio campaign in Farta Woreda through the existing health promoters (Priests\Sheiks and Positive Deviant Mothers), strengthen routine EPI activities and active surveillance (AFP and measles).



**Religious Leaders and Positive Deviant Mothers
on Orientation Session – May 18, 2005,
D/Tabor.**

The key health promoters of the project in general and the 244 positive deviant mothers and 124 religious leaders in particular actively participated in the effort.

They mobilized caretakers of the target under five children for two days to get the children immunized.

Prior to the campaign, they were given a one-day orientation on the importance of immunization and polio vaccination, surveillance of acute flaccid paralysis (AFP) and measles, community mobilization for polio campaign and routine EPI. The trained VCHWs and existing community health workers were also involved in the community mobilization activities, like selection of health promoters, monitoring and supervision.

The coverage for polio eradication initiatives campaign are the following:-

- First round polio campaign is 100%.
- Second round polio campaign is 95.7% (post polio campaign assessment and found out that acceptable coverage).
- Third round polio campaign is 100%.

The resultant outcomes of the polio eradication campaigns, among others are:

- Health promoters were able to identify four suspected measles and the specimens were sent to National level Central Laboratory for confirmation.
- Community had identified one AFP case and the specimen has been sent to National level Central Laboratory for confirmation.
- Health workers identified two AFP cases and the cases had been confirmed for polio.
- Routine EPI program strengthened.

Joint Supportive Supervision

Through its regular and monthly supportive supervisions, the project also facilitated community level major activities (following the training of VCHWs) that helped in making timely corrective actions and supports for ensuring functioning and organizing of community-based activities like: -

- Facilitating the establishment of mother-to-mother support groups.
- Strengthening out reach level health educations by health promoters.
- Reviewing monthly performances of MTMSG, VCHW and religious leaders. And
- Strengthening the networks of partners at grass root level.

Through the supportive-supervision mechanisms, health facilities have been supported in areas of facilitating outreach health educations, EPI service at outreach level, growth monitoring, counselling of caretakers of children and mothers (especially pregnant and lactating mothers) and referrals. The project staffs were also involved in the campaign against malaria epidemic, which was seen during second round polio campaign.

The project support for EPI activities has been one of the most important achievements. Efforts were also made in keeping the outreach programs more demand-driven. This involved organizing a micro planning; establishing new outreach sites and conducting supportive supervisions to facilitate their EPI service coverage. Based on findings of the latter, the plan for EPI activities at health facility level revised; info related to EPI service delivery updated; enhanced health facility workers response to community demands for EPI service delivery.

As a result, much of the community's demand for EPI service has been met. This FY, DPT₃, BCG and measles coverage of the Woreda are **69%**, **69%** and **44%** respectively from the annual eligible <1year children (see the table and graphical presentations below):

Table C: Immunization Indicators Comparison:

Immunization	KPC Survey % (2002)	EPI Survey % (2003)	M&E Plan (Indicators) %	FY'05 Performance % (2005)
DPT3	19	39	60	69
OPV3	19	40	60	67
BCG	19	59	60	69
Measles	25	49	70	44

Source: DIP, EPI Survey Reports and Farta WOH Records.

The project also shared the results of the community participation initiative in EPI intervention of the project with CORE Ethiopia field staffs and participants of the Partners Forum held from 15-17 September 2005.

The project received important technical assistance from CARE Head Quarter, CO and FO, which have significant contributions for the effective implementation planned project activities during the year.

8. Programs and Management Systems

8.1 Monitoring and Evaluation (M&E) Activities

8.1.1 Planning Workshop

The annual plan for the up-coming FY'06 was prepared at a participatory activity planning workshop held from 16 – 17 **August 2005** with all partners and health facility staffs of the Woreda. 67 participants from health facility, district and zone offices attended the workshop.



Health Workers on Annual Planning
Workshop

The workshop helped develop key project interventions at household, community and health facility level. The following key activities constitute the project plan for next FY: -

- Outreach level programs for health education, EPI, etc.
- Maternal and child health promotion at health facility, community and household level.
- Regular monitoring, reviewing and supervising of health promoters by health facilities.

8.1.2. Review Meetings

The regular project monitoring system includes monthly, quarterly, biannually (mid-year) and annual review meetings held in a participatory manner among core team members of the project, health workers and community level health promoters at different levels. The reviews assess the performances (plans versus accomplishments) of both the project and the health service programs of the district; key constraints encountered the implementation of maternal and child health promotion at all levels, and their causes; mechanisms for mitigating/resolving constraints; and make appropriate comments for action.

The major objectives and focus areas of the reviews, among others are the following:-

- To cross check whether or not application of planned project activities are on the right track or not, in terms of quantity, quality, timeliness, etc and devise mechanisms for ensuring achievement of anticipated results.
- To identify major problems and barriers, to promote learning from past and make adjustments and corrections for improvement in the next implementation period.
- To increase\improve the relationship and integration among community level health promoters, health workers and Kebele administrators in terms of joint planning, implementation, reviewing and monitoring of health programs.
- To promote community based maternal and child health promotion and disease prevention at grass root level.
- To share experiences and lessons among the different health promoters.

The biannual review of the two-day workshop held in mid December 2004 in particular helped strengthen the linkage, support and integration among main actors at grass root level, the health workers, VCHWs and Kebele administrators with their Mengistawi Budin.

The following table summarizes the different review meetings held in the target Woreda during the year:-

Type of Reviews/Meetings	Participants	Time
Project core team review / meeting.	One participant per partner organization.	Quarterly
Planning workshop.	All health facility and Woreda staffs.	Annual
Review meeting at district level.	All health facility and Woreda staffs.	Quarterly
Reviews at health facility\ Kebele level.	All health promoters of the Kebele.	Monthly
Biannual review meeting.	Administrators, VCHWs and health workers	Biannual

Suggestions from the different periodical reviews have been used as appropriate: plans were revised on timely basis; recommendations of the past reviews were incorporated in the plan of the following period.



WHO staffs, VCHWs and Kebele Leaders on the Review Meeting at DHC



Core Team Members of the Project on the Review Meeting at CARE S\Gondar FO

The project also conducts regular internal reviews on its annual work plan and DIP both at office and field levels. Different guidelines and checklists for use by the project for community and health facility level during field visits to monitor the project activities being undertaken in the community are developed and applied.

Using these regular reviews, the project assesses the progress of its activities, prepares and shares periodical reports with stakeholders. The reviews also serve as forums for sharing experience among participants. Lessons learnt as a result of periodical reviews and during field works are regularly compiled and shared among project staffs and partners. The lessons focus mainly on ways and opportunities of solving specific problems in the community and encourage community level maternal and child health promotion.

8.1.3 Annual Work Plan

Annual Work Plan - FY'06
(July'05 to June'06) - (For program activities only)

S/N	Major Planned Activities By Strategy	Annual Plan		Budget	Plan By Quarter			
		Unit	Quantity	In ETB	1 st	2 nd	3 rd	4 th
1	Skill Development							
1.1	Training on counselling and communication skills (BCC on ENA) for all interventions of the project.							
	<i>For MTMSGs facilitators.</i>	No	2664	280980.00	2664			
	<i>For religious leaders</i>	No	168	33142.00	168			
	<i>For school members</i>	No	48	12812.00		48		
	<i>For PA administrators</i>	No	280	46080.00		280		
	<i>For CHWs (CHAs, TBAs, CBRHAs,)</i>	No	200	39500.00	200			
	<i>For health workers.</i>	No	30	15630.00	30			
	<i>For health extension agents.</i>	No	23	12333.00		23		
1.2	Training on community- IMCI for community resource persons.	No		299133.00		0		
1.3	Training on IMCI for health workers.	No	26	15996.00		26		
1.4	Training for RDF management committee on RDF.	No	52	25942.00	52			
1.5	Training on EPI modules for health extension agents.	No	23	24373.00		23		
1.6	Train & implement COPE to improve relative quality of health service and comfort of facilities.	No	26	15936.00		26		
1.6	Training of staff at managerial/supervisory position on health service management to implement COPE.	No	16	28180.00	16			
1.7	Training on supervisory skills for staffs on supervisory.	No	18	26698.00		18		
1.8	Training on improvement of planning and managerial capacity at district level.	No	8	16480.00			8	
1.9	Staff development training							
	<i>Nutrition policy workshop</i>	N	7	5873.00			7	
	<i>Motorbike driving training for project staffs</i>	No	5	7200.00	5			
	<i>Computer training for project staffs.</i>	No	7	2450	7			
	<i>COPE training</i>	No	11	14938	11			
	<i>Supervisory training</i>	No	11	13178		11		
	<i>Video camera training for one staff.</i>	No	1	4880.00	1			
	<i>Other</i>	Bulk		20000.00	0	0	0	0

S/N	Major Planned Activities By Strategy	Annual Plan		Budget	Plan By Quarter			
		Unit	Quantity	In ETB	1 st	2 nd	3 rd	4 th
1.10	Adapt training curriculum for outreach level health workers and CHAs	No	6	3840.00			6	
2	Community Mobilization							
2.1	Strengthen home visits ⁵ to educate and counsel household members on key maternal and child health promotion activities of the project interventions by health promoters and workers.	HH	25% of HH	0.00	5%	7%	8%	5%
2.2	Facilitate and strengthen identification of PDMs within MTMSGs (in addition to the facilitators) and community modelling of positive deviant mothers for resistant mothers & message reinforcement in the houses, villages, groups as well as in the community.	HH	25% of resistant household.	0.00	5%	7%	8%	5%
2.3	Strengthen special targeting of pregnant women and new mothers for colostrums and pre lacteal feeding related information.	Pregnant women	all target	0.00	20%	30%	30%	20%
2.4	Strengthen community-based support networks for the project interventions.							
2.5	Work with MTMSGs - follow up and supportive supervision.	MTMSGs	2664	0.00	666	666	666	666
2.6	Work with religious leaders - follow up and supervision ⁶ .	Churches	168	0.00	42	42	42	42
2.7	Work with schools - follow up and supervision.	schls	47	0.00		16	16	15
2.8	Work with Kebele administrators - follow up and supportive supervision.	PAs	40	0.00	10	10	10	10
2.9	Facilitate and strengthen regular MTMSGs convention for discussions and consultation of child health issues and support of mothers among themselves.	MTMSGs	2664	0.00	666	666	666	666
2.10	Facilitate and strengthen regular community groups' convention for recorded drama and plays listening \discussions.	groups	160	0.00	40	40	40	40
2.11	Facilitate village level nutrition demonstration integrating with home gardens promotion activities.	Villages	20	0.00		10		10
2.12	Strengthen group health education sessions (health promoters) to build strong community support to mobilize local resources, as well as demanding quality services from the health facilities through out reach immunization program, etc.	Bulk		0.00	0	0	0	0
2.13	Strengthen schools to perform skits related to ARI and EPI interventions.	schls	47	0.00		5	15	27
2.14	Support for the organization of community service delivery like:-							
	<i>Out reach programs of EPI and formation of strong linkage with health facilities.</i>	PAs	40	0.00	10	10	10	10
	<i>Growth monitoring and promotion.</i>	PAs	40	0.00	10	10	10	10
	<i>Explore use/modification of community funeral funds to act as emergency funds for access to drugs and treatment in emergencies for children under five.</i>	PAs	40	40000.00		10	20	10
3	Behaviour Change Communication							
3.1	Develop message and means of communication (individual/group education, public campaigns/events, and local cassette listening groups –EPI out reach, MTMSGs convention, community gatherings, etc.)	Bulk		81080.00	0	0		
3.1	Develop BCC\IEC materials according to the BCC strategy, leaflets, posters, cassettes for listening, counselling cards, etc.	Bulk		50760.00	0	0		
4	Quality Assurance							

⁵ - house to house visit

⁶ - one new church

S/N	Major Planned Activities By Strategy	Annual Plan		Budget	Plan By Quarter			
		Unit	Quantity	In ETB	1 st	2 nd	3 rd	4 th
4.1	Establish and improve referral system from community to the near by health facility and from health facility to referral health facility,	PAs	40	0.00	10	10	10	10
4.2	Facilitate the linkage between health facility and community health promoters, supportive supervision, etc,	HF	26	0.00	0	0	0	0
4.3	Strengthen the introduction of community based surveillance systems by designing system.	PAs	40	0.00	0	0	0	0
4.4	Strengthen the introduction of a system to track drop-outs and encourage complete immunization in collaboration with EOC.	Churches	168	0.00	0	0	0	0
4.5	Establish a continuous process of monitoring the quality of health service:							
	<i>Establish a QA team</i>	Team	1	0.00	1			
	<i>Training of committee members in the basic concepts of quality and on specific quality improvements that ensure a self assessment and problem solving process, like COPE</i>	HF	26	0.00	0	0	0	0
	<i>Assist staff on introduction of the specific quality improvement tools and follow up support.</i>	HF	26	0.00	0	0	0	0
	<i>Strengthening the management system and facilitative supervision using COPE methodology</i>	HF	26	0.00	0	0	0	0
4.6	Facilitate supportive supervision for community level maternal and child health promotion, health services by health facilities, BCC activities, etc. to be conducted by district health staffs.	round	4	12800.00	1	1	1	1
5	Improve Access and Availability							
5.1	Strengthen regular health education to be facilitated by health facility staffs on maternal and child health issues.	HF	26	0.00	0	0	0	0
5.2	Strengthen health facilities' activities mainly on maternal and child health promotions like growth monitoring and promotion, counselling on ENA, ORT corner functioning, ensuring essential drugs, joint planning of out reach activities, micro planning, etc.	HF	26	0.00	0	0	0	0
5.3	Establish revolving drug fund in each health facility.	HF	26	200000.00		0	0	
5.4	Establishment of essential drug list and standard guidelines for management, inventory, monitoring, etc. of revolving drug fund at health facility level	HF	26	0.00		0		
5.5	Coordinate the supply of essential drugs for health facility revolving drug fund.	HF	26	0.00	0	0	0	0
5.6	Establish mechanisms and improve logistic management systems:							
	<i>For availability of cold chain supplies and vaccines and avoidance of vaccines wastage - spare parts</i>	No	6	50000.00	0	0	0	0
5.7	Coordinate & facilitate promotion of home gardens with Development Agents of Ministry of Agriculture and CARE extension agents.	PAs	40	43000.00	0	0		
5.8	Capacitate partners to support the project sustainability.	Partners	12	100800.00	0			0
6	Integration and Linkage							
6.1	Integration/linkage with other health or development program							
	<i>- Facilitate provision of Malaria service in pocket areas.</i>	Pocket areas	6	40000.00		0	0	
	<i>- Facilitate initiation of linked development programs that have impact on nutrition in Farta district.</i>	PAs	40	10000.00	0	0	0	0
	<i>- Network with all relevant agencies supporting in immunization program</i>	PAs	40	0.00	0	0	0	0
6.2	Cross visit for partners and staffs	No	10	16000.00				
7	Monitoring and Evaluation							

S/N	Major Planned Activities By Strategy	Annual Plan		Budget	Plan By Quarter			
		Unit	Quantity	In ETB	1 st	2 nd	3 rd	4 th
7.1	Facilitate micro planning workshop.	Event	1	16820.00	1			
7.2	Joint planning and reviewing with partners at district level.	round	4	4400.00	1	1	1	1
7.3	Review meeting with health workers and chws	round	4	50400.00	1	1	1	1
7.4	Joint supportive supervision for health facilities.	Event	5	8000.00	1	1	2	1
7.5	Strengthening community level reviewing process.	PAs	40	0.00				
7.6	Strengthen community health information system.	PAs	40	0.00	0	0	0	0
7.7	Facilitate and strengthen data boards	Churches	40	12150.00	0	0	0	0
7.8	Review and strengthen existing health management information system.	HF	26	4000.00	0			
7.9	Strengthen data\information for decision and lessons at different levels.	PAs	40	0.00	0	0	0	0
7.10	Regular assessment of information retention in the trained community members for training activities.	round	4	0.00	1	1	1	1
7.11	Regular reviewing and monitoring the project activities.	round	4	0.00	0	0	0	0
7.12	Regular progress review and report writing.	round	4	0.00	1	1	1	1
8	POLICY AND ADVOCACY ACTIVITES							
8.1	Strengthen the advocacy of adoption of standard policies for infant and young child feeding practices to be promoted by health facility staffs.	Event	1	0.00	1		1	
8.2	Policy analysis, development of advocacy strategy and advocate for creation of policy/guideline for the provision of Vitamin A, Iron and anthelmithics by CHAs\HEAs.	Event	1	0.00	1		1	
8.3	Advocate to increase facility budget for drugs and supplies.	Event	2	0.00	1			1
8.4	Policy advocacy in areas of allocating local resources/ government budget for immunization activities.	Event	2	0.00		1	1	
8.5	Discussion at regional and national level with key policy makers on nutrition related policies.	Event	1	35484.00				1
	Total			1741268.00				

8.2 PVO coordination/collaboration: The Country Office (CO) is lead by a Country Director (CD), the see organo-gram). The Program Department lead by an Assistant Country Director/ Program (A/CD) has a few Divisions / Units and a number of Field Offices (FO). CARE S/Gondar FO, where FCSP is located constitutes one of the many FOs. The CO-based relevant sections provide TA in their respective areas of expertise and supervision to FOs and projects as appropriate. Accordingly, our FO reports to the Rural Livelihood Programs Coordinator. The FCSP gets TA from the Heath Unit Team Leader.

8.3 Program Integration: The FO coordinates four projects: Farta Food Security and Support (FFSSP), Farta Institutional Capacity Building (FICBP), the Farta Water and Sanitation Promotion, Millennium Water (FWSP) and Farta Child Survival (FCSP) projects.

The integration of all the four projects particularly focuses at complementing each other. Despite the repeated attempts made by the FO program staff for consideration of critical means of access (e.g. water supply schemes) for ensuring the required

behavioural changes (e.g. CDD), no positive response so far, from all directions. Thus, the FO projects are now developing mechanism for integration of activities using existing opportunities. To this effect, the FFSSP's promotion of vegetable production; the FWSP's & FICBP's protected water sources; the FWSP hygiene and sanitation education; etc is now trying to incorporate FCSP's initiatives. The EAs of FFSSP & FICBP are also now sharing the role of FCSP's Community Mobilizers'.

8.4 Human resources: The Program Area Coordinator, who leads the FO is responsible for the overall FO management and overseeing of all FO projects' activities. He is also responsible to ensure project/program integration (see program integration above).

Based on the understanding reached between the CO and FO concerned people, reviewed and identified the project staffing composition; recruited/hired additional staff. These include three Officers (Nutrition, Immunization and Project officers) and three more Community Mobilizers (reclassifying the former 'Partnership Officers position). Accordingly, in terms of HR, the project is now in a much better situation, though the placement of the PM still remains unresolved.

8.5 Logistics: Like the previous year, field activities of the different projects undergoing within one operational area are coordinated. Though equal emphasis is given to all projects, vehicles are scheduled on need bases. When the need arises (during campaigns), we rent vehicles from private vendors. Procurement and other related administrative works are also coordinated.

8.6 Financial management system: It operates in a semi-centralized manner. Annual budgets are prepared by individual PMs and in consultation with ACs and approved by the HO management figures. The CO Finance Department/staff using CARE financial system, Scala. To this effect, the Finance Dep't at the HO organizes annual orientations events to all projects and FO representatives. Also, budget revisions are practised on quarterly basis. At the FO level, each PM has full responsibility for managing her/his project resources. The role of the AC is limited to authorization of payments beyond the signatory limits of the respective PMs. Depending on the nature of a given expense/service provided, we employ a cost-sharing approach. Shared costs are charged based on criteria agreed upon among the PMs and AC. Office rent, utility and staff costs including the AC and program support staff who provide input to all projects in one way or the other, etc fall under the latter category.

8.7 Communication system and team development: The various program management mechanisms [Core Program Team (CPT), Program Management Team (PMT), all Staff quarterly progress review (QPR) meeting, Year-end Program Progress Review (YPR) meeting, etc introduced by the FO so as to improve communication and team work are operational. These forums enable the FO to ensure smooth program implementation through sharing of information and expertise, joint discussion, planning, reviewing and

learning from our endeavours. The mechanisms served as exemplary to other FOs as well.

9. Conclusions and Recommendations

During the FY, most of the core projects activities have been accomplished as per the plan, in terms of schedule, quantity and quality. The project staffs have exerted ceaseless effort with good team spirit to take forward the project interventions. Some activities from the DIP had been adjusted based on the TA both from CARE Atlanta and the CO.

There have been some activities, which have not been accomplished due to overloads of partners' organizations as well as external factors. Nevertheless, these activities, as compared to the activities in the work plan of the DIP do not lag the project in general. Even though there is no qualitative survey, from the perspectives of the regular visits, reviews, supervisions and discussions held with the beneficiaries at grass root level, the project believes that the progress toward achieving the set objectives is on the right track. All pending activities of the DIP are included in the plan for next implementation year.

Strengthening of the RDF scheme, extending working with 'Idirs', finalization of production of BCC materials, capacitating and strengthening partners and community health promoters to effectively implement the project activities would be the priority areas needing due attention in the next implementation year.

Most of the projects vacant positions with the exception of the PM have been filled after a lot of attritions. We expect better and efficient performance in the next FY.

The support from CARE Atlanta and CARE Addis needs to continue. The effort being made by CARE Addis in facilitating some activities of the project like COPE training and exposure visit for FCSP staff will be beneficial to the project.

Annexes

Annex A. Ethiopia Project Data Form

Annex A. Ethiopia Project Data Form

Project: CARE - Ethiopia (2002 - 2007) -
Standard Project

General Project Information:

Cooperative Agreement Number:	HFA-A-00-02-00046-00
CARE HQ Backstop Person:	Khrist Roy
Project Grant Cycle #:	18
Project Start Date:	9/30/2002
Project End Date:	9/29/2007

USAID Mission Contact Person:	Kassahun Belay
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First Name:	<input type="text"/>	Last Name:	<input type="text"/>
Title:	<input type="text"/>	Email:	<input type="text"/>
Address1:	<input type="text"/>	Address2:	<input type="text"/>
City:	<input type="text"/>	State:	<input type="text"/>
Zip Code:	<input type="text"/>	Country:	<input type="text" value="Ethiopia"/>
Telephone:	<input type="text"/>	Fax:	<input type="text"/>
Project Web Site:	<input type="text"/>		

Grant Funding Information:

USAID Funding: (US \$)	<input type="text" value="\$1,300,000"/>	PVO Match: (US \$)	<input type="text" value="\$458,080"/>
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Project Description:
 This new Child Survival project works in the Farta Woreda, Amhara Region, Ethiopia.

The goal of the CS program is to improve the health status of children under five and of women of reproductive age through four targeted interventions: Nutrition, Acute Respiratory Infection, Control of Diarrheal Diseases, and Immunization within the framework of community IMCI.

The program employs the strategies of skill development, community mobilization, behavior change communication, quality assurance and improved access and availability.

The Child Survival project works in partnership with the Ministry of Health (MOH) to train staff, improve services, and promote behavior change. Perhaps even more exciting is CARE's strategy to work with the MOH and a Core Health Unit within the Ethiopian Orthodox Church to train and support religious leaders to provide information and profoundly influence the health behaviors of its members.

Project Location:

Partner Information:	
Partner Name: 1. <input type="text" value="Ministry of Health"/>	Partner Type: <input type="text" value="Collaborating Partner"/>

Project: CARE - Ethiopia (2002 - 2007) - Standard Project

Project Location/ Subareas:

Does this project collect, monitor and report on Rapid CATCH data for different *geographic* project subareas ?

Yes No

If this is true, click **Yes** and enter each distinct subarea name:
 If this is false, click **No**.

Project: CARE - Ethiopia (2002 - 2007) - Standard Project

Strategies:
<p><i>The following 3 boxes list different kinds of general strategies, assessment tools and BCC strategies that could be implemented during the life of this CSHGP project.</i></p> <p><i>Please check those boxes that are planned for this project.</i></p>

General Strategies:	
Microenterprise <input type="checkbox"/>	Social Marketing <input type="checkbox"/>
Private Sector Involvement <input type="checkbox"/>	Advocacy on Health Policy <input checked="" type="checkbox"/>

Strengthen Decentralized Health System <input checked="" type="checkbox"/>	Information System Technologies <input type="checkbox"/>
Use Sustainability Framework (CSSA) <input type="checkbox"/>	

M&E Assessment Strategies:	
KPC survey <input checked="" type="checkbox"/>	Health Facility Assessment <input checked="" type="checkbox"/>
Organizational Capacity Assessment with Local partners <input checked="" type="checkbox"/>	Organizational Capacity Assessment for your own PVO <input type="checkbox"/>
Participatory Rapid Appraisal <input checked="" type="checkbox"/>	Participatory Learning in Action <input type="checkbox"/>
Lot Quality Assurance Sampling <input type="checkbox"/>	Appreciative Inquiry-based strategy <input type="checkbox"/>
Community-based Monitoring Techniques <input checked="" type="checkbox"/>	Participatory Evaluation Techniques (for mid-term or final evaluation) <input type="checkbox"/>
Use of Pocket PCs or Palm PDA Devices <input type="checkbox"/>	TB Cohort Analysis <input type="checkbox"/>

Behavior Change & Communication (BCC) Strategies:	
Social Marketing <input type="checkbox"/>	Mass Media <input checked="" type="checkbox"/>
Interpersonal Communication <input checked="" type="checkbox"/>	Peer Communication <input type="checkbox"/>
Support Groups <input checked="" type="checkbox"/>	Use of BEHAVE Framework <input type="checkbox"/>

Capacity Building:

Please check the box next to each capacity building area or group that is targeted for institutional strengthening during the life of this CSHGP project:

PVO	Non-Govt Partners	Private Sector	Govt	Community
US HQ (General) <input type="checkbox"/> US HQ (CS Unit) <input type="checkbox"/> Field Office HQ <input type="checkbox"/> CS Project Team <input checked="" type="checkbox"/>	PVOs (Int'l./US) <input type="checkbox"/> Local NGO <input type="checkbox"/> Networked Group <input checked="" type="checkbox"/> Multilateral <input type="checkbox"/>	Pharmacists or Drug Vendors <input type="checkbox"/> Business <input type="checkbox"/> Traditional Healers <input checked="" type="checkbox"/> Private Providers <input type="checkbox"/>	National MOH <input checked="" type="checkbox"/> Dist. Health System <input checked="" type="checkbox"/> Health Facility <input checked="" type="checkbox"/> Staff <input checked="" type="checkbox"/> Other National Ministry <input checked="" type="checkbox"/>	Health CBOs <input type="checkbox"/> Other CBOs <input type="checkbox"/> CHWs <input checked="" type="checkbox"/> FBOs <input type="checkbox"/>

Project Interventions & Components:

Enter a percentage representing the amount of funds your project is targeting towards each intervention. If you are not implementing a particular intervention then leave the box blank. On the same line as the intervention percentage, check the boxes indicating whether or not this intervention is part of an overall IMCI strategy and also check the kinds of training (CHW or HF) envisioned for this particular intervention. For each intervention implemented, check the specific intervention components that are planned.

Immunizations <input type="text" value="20"/> %	IMCI Integration <input checked="" type="checkbox"/>	CHW Training <input checked="" type="checkbox"/>	HF Training <input checked="" type="checkbox"/>
Polio <input type="checkbox"/>	Classic 6 Vaccines <input type="checkbox"/>	Vitamin A <input type="checkbox"/>	Surveillance <input type="checkbox"/>
Cold Chain Strengthening <input checked="" type="checkbox"/>	New Vaccines <input type="checkbox"/>	Injection Safety <input type="checkbox"/>	Mobilization <input type="checkbox"/>
Measles Campaigns <input type="checkbox"/>	Community Registers		

Nutrition <input type="text" value="35"/> %	IMCI Intearation	CHW	HF Training <input checked="" type="checkbox"/>
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	<input checked="" type="checkbox"/>	Training <input checked="" type="checkbox"/>	
ENA <input checked="" type="checkbox"/>	Gardens <input checked="" type="checkbox"/>	Comp. Feed. from 6 mos. <input type="checkbox"/>	Hearth <input type="checkbox"/>
Cont. BF up to 24 mos. <input type="checkbox"/>	Growth Monitoring <input type="checkbox"/>	Maternal Nutrition <input type="checkbox"/>	
Vitamin A <input type="checkbox"/> %	IMCI Integration <input type="checkbox"/>	CHW Training <input type="checkbox"/>	HF Training <input type="checkbox"/>
Supplementation <input type="checkbox"/>	Post Partum <input type="checkbox"/>	Integrated with EPI <input type="checkbox"/>	Gardens <input type="checkbox"/>
Micronutrients <input type="checkbox"/> %		CHW Training <input type="checkbox"/>	HF Training <input type="checkbox"/>
Iodized Salt <input type="checkbox"/>	Iron Folate in Pregnancy <input type="checkbox"/>	Zinc (Preventive) <input type="checkbox"/>	Food Fortification
Malaria <input type="checkbox"/> %	IMCI Integration <input type="checkbox"/>	CHW Training <input type="checkbox"/>	HF Training <input type="checkbox"/>
Training in Malaria CM <input type="checkbox"/>	Adequate Supply of Malarial Drug <input type="checkbox"/>	Access to providers and drugs <input type="checkbox"/>	Antenatal Prevention Treatment <input type="checkbox"/>
ITN (Bednets) <input type="checkbox"/>	ITN (Curtains and Other) <input type="checkbox"/>	Care Seeking, Recog., Compliance <input type="checkbox"/>	IPT <input type="checkbox"/>
Community Treatment of Malaria <input type="checkbox"/>	ACT <input type="checkbox"/>	Drug Resistance <input type="checkbox"/>	Environmental Control <input type="checkbox"/>
Maternal & Newborn Care <input type="checkbox"/> %	IMCI Integration <input type="checkbox"/>	CHW Training <input type="checkbox"/>	HF Training <input type="checkbox"/>

Emerg. Obstet. Care <input type="checkbox"/>	Neonatal Tetanus <input type="checkbox"/>	Recog. of Danger signs <input type="checkbox"/>	Newborn Care <input type="checkbox"/>
Post partum Care <input type="checkbox"/>	Delay 1st preg Child Spacing <input type="checkbox"/>	Integr. with Iron & Folate <input type="checkbox"/>	Normal Delivery Care <input type="checkbox"/>
Birth Plans <input type="checkbox"/>	STI Treat. with Antenat. Visit <input type="checkbox"/>	Home Based LSS <input type="checkbox"/>	Control of post-partum bleeding <input type="checkbox"/>
PMTCT of HIV <input type="checkbox"/>	Emergency Transport <input type="checkbox"/>		

Child Spacing <input type="checkbox"/> %	IMCI Integration <input type="checkbox"/>	CHW Training <input type="checkbox"/>	HF Training <input type="checkbox"/>
Child Spacing Promotion <input type="checkbox"/>	Pre/Post Natal Serv. Integration <input type="checkbox"/>		
Breastfeeding <input type="checkbox"/> %	IMCI Integration <input type="checkbox"/>	CHW Training <input type="checkbox"/>	HF Training <input type="checkbox"/>
Promote Excl. BF to 6 Months <input type="checkbox"/>	Intro. or promotion of LAM <input type="checkbox"/>	Support baby friendly hospital <input type="checkbox"/>	PMTCT of HIV <input type="checkbox"/>
HIV/AIDS <input type="checkbox"/> %		CHW Training <input type="checkbox"/>	HF Training <input type="checkbox"/>
OVC <input type="checkbox"/>	Treatment of STIs <input type="checkbox"/>	Behavior Change Strategy <input type="checkbox"/>	Access/Use of Condoms <input type="checkbox"/>
STI Treat. with Antenat. Visit <input type="checkbox"/>	ABC <input type="checkbox"/>	PMTCT <input type="checkbox"/>	Nutrition <input type="checkbox"/>

<input type="checkbox"/>			
Home based care <input type="checkbox"/>	PLWHA <input type="checkbox"/>	ARVs <input type="checkbox"/>	HIV Testing <input type="checkbox"/>
Family Planning & Reproductive Health <input type="checkbox"/> %	IMCI Integration <input type="checkbox"/>	CHW Training <input type="checkbox"/>	HF Training <input type="checkbox"/>
Knowledge/Interest <input type="checkbox"/>	FP Logistics <input type="checkbox"/>	Community-Based Distribtuion <input type="checkbox"/>	Social Marketing <input type="checkbox"/>
Male Reproductive Health <input type="checkbox"/>	Youth FP Promotion <input type="checkbox"/>	Quality Care <input type="checkbox"/>	Human Capacity Development <input type="checkbox"/>
FP/HIV integration <input type="checkbox"/>	Maternal/Neonatal Integration <input type="checkbox"/>	Cost Recovery Schemes <input type="checkbox"/>	Community Involvmnt <input type="checkbox"/>
Access to Methods <input type="checkbox"/>	Policy <input type="checkbox"/>		
Tuberculosis <input type="checkbox"/> %	IMCI Integration <input type="checkbox"/>	CHW Training <input type="checkbox"/>	HF Training <input type="checkbox"/>
Facility based treatment/DOT <input type="checkbox"/>	Microscopy <input type="checkbox"/>	Monitoring/Supervision Surveillance <input type="checkbox"/>	Community IEC <input type="checkbox"/>
Drug managment <input type="checkbox"/>	Advocacy/Policy <input type="checkbox"/>	Linkages with HIV services <input type="checkbox"/>	Community based care/DOT <input type="checkbox"/>
Pediatric TB <input type="checkbox"/>			

Project: CARE - Ethiopia (2002 - 2007) - Standard Project

Target Beneficiaries:	
Infants < 12 months:	7,311
Children 12-23 months:	7,062
Children 0-23 months:	14,373
Children 24-59 months:	21,620
Women 15-49 years:	71,909
Population of Target Area:	304,701

Project: CARE - Ethiopia (2002 - 2007) - Standard Project

Rapid CATCH Data:		
<p>Click on the Red link (under the 'Stage' column) to view/access/update Rapid Catch data for that phase of the project.</p> <p>If data has already been entered for a particular phase, the date of first entry will appear under the 'Date' column and an 'X' will appear under the 'Entered' column.</p>		
Date	Stage	Entered
30-Apr-03	DIP	X
	Mid Term	
	Final Evaluation	

Annex B. Ethiopia Midterm Evaluation Report



CHILD-E

Child Health Initiatives for Lasting Development – in Ethiopia

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

Cooperative Agreement No: HFP-A-00-02-00046-00
October 1, 2002-September 30, 2007

Mid Term Evaluation August 2005

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ACRONYMS

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

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A. Summary

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

The FCSP objectives include:

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

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

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

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

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

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

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

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

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

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

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

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

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

B. Assessment of progress made in achievement of program objectives

1. Technical Approach

a. General Overview

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

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

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

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

Population

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

Political Structure

The political structure of the target area is somewhat confusing and can be summarized as:

Country Ethiopia

Region Amhara

Zone South Gondar

Woreda Farta

40 PAs (also called kebeles)

200 Sub-kebeles (average 5 per PA)

883 Megestawi-budens (MB) (15-50 households) (average 4-5 per Sub-kebele or 22 per PA),

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

Rapid CATCH Indicator	KPC¹ (Woreda)	DHS (Regional)
1. Percentage of children age 0-23 months who are underweight (-2 SD from the median weight-for-age, according to the WHO/NCHS reference population)	59.2%	51.8%
2. Percentage of children age 0-23 months who were born at least 24 months after the previous surviving child	25.9%	--

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

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

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

Key Program Activities Completed

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

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

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

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

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

This adaptation of the traditional methodology for conducting MTEs was discussed, and agreed upon, with USAID. Specific information concerning the MTE methodology can be found in Annex C, a list of persons interviewed and contacted during the two MTE visits can be found in Annex D, and a list of CARE staff and partners who participated in a workshop facilitated by the external evaluator is included in Annex B. Through out this document additional suggestions for improving the project during the next two years are included and written in **bold**.

Recommendations are summarized in Section D Conclusions and Recommendations An Action Plan based on the preliminary recommendations made during the first MTE visit was prepared by CARE Ethiopia staff and updated based on the present status following the second MTE visit. The Action Plan is included in the final section of this report.

b. Progress report by intervention area.

IMCI

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

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

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

The strategies to carry out this approach are:

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

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

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

Planned Future Activities

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

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

IMCI Supplies

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

Inventory of Supplies February 2005

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

ORS packets are normally sold

* Drug of choice- chloroquine and Fansidar

** Doctor said not using Fansidar or chloroquine, but new drugs, which they don't have

Some outages reported for antibiotics(cotrimoxazole and amoxiciline)

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

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

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

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

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

Future Activities

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

Nutrition (35%)

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

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

PD Hearth/ Positive Deviance

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

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

Home Gardens

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

Baby Friendly Hospital/Community Initiatives

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

Growth Monitoring

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

Introduction of Complementary Foods

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

Establishment of Nutrition Demonstration "Rooms"

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

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

Breastfeeding

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

Pneumonia Case Management (PCM) (25%)

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

Advocacy for allowing CHWs to distribute antibiotics for treatment of pneumonia

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

Mother's Recognition of Danger Signs

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

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

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

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

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

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

Control of Diarrheal Diseases (20%)

In addition to the activities related to IMCI which were previously mentioned, additional activities specific to CDD are included. Activities within the CDD intervention are being carried out as outlined in the DIP.

Recommended home fluids

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

Immunization (20%)

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

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

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

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

EPI Coverage

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

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

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

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

Percentage of children age 12-23 months who are fully vaccinated (against the five vaccine-preventable diseases) before their first birthday	29.8%
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This may be a typographical error given the similarity with the result of children with DPT3. This figure should be verified by the FCSP. It is unclear exactly how this Rapid CATCH indicator was calculated, but it appears that it does not take into consideration the age of the child when all vaccines were received.

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

Training

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

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

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

c. New tools or approaches

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

Ethiopian Orthodox Church

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

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

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

Question: "Are health messages talked on each and every Sunday meeting?"

Answer: "Most priests bring the topic maybe twice a month,

Mulualem said: "The priests favorite topic is HIV/AIDS ."

Yetemegen said: "They talk mostly on immunization."

Yeshareg said: "They talk often on cleanliness and exclusive breastfeeding. They spend a lot of time on these topics, maybe up to an hour on the topics. They refer and quote the Bible, point to individual verses frequently during their teachings, as and when applicable."

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

Idir/funeral funds

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

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

2. Cross-cutting approaches

a. Community Mobilization

Community mobilization activities include:

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

Use of CHWs for the implementation of health activities

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

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

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

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

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

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

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

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

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

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

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

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

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

FCSP staff estimate there are 2,200 organized MTMSGs in the project area.

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

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

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

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

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

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

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

Training of School Clubs for the dissemination of health messages

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

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

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

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

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

Mobilization of EOC priests to deliver health messages

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

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

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

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

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

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

Strengthening of community leaders and formation of community committees

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

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

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

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

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

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

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

b. Communication for Behavior Change

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

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

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

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

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

BCC Strategy

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

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

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

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

Radio Drama

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

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

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

Educational Materials

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

Home Visits

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

Counseling

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

c. Capacity Building Approach

i. Strengthening the PVO Organization

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

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

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

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

ii. Strengthening Local Partner Organizations

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

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

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

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

Institutional Assessment

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

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

The main finding of the assessment were:

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

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

Among the recommendations from the assessment were:

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

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

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

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

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

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

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

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

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

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

Future Steps

The main challenges facing the project are:

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

Needed steps include:

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

iii. Health Facilities/Health Worker Strengthening

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

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

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

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

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

Training

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

Quality Improvement

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

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

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

Supportive Supervision

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

Establishing Links with the Communities

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

Materials/Equipment

The following have been distributed:

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

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

Strengthening of Meetings

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

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

iv. Training

The project employs a cascade training approach for MTMSG leaders. This approach needs to be carefully monitored to ensure quality in the replication of information. Clarity is also required in defining what additional training the project will carry out for the remainder of the funding cycle.

A training plan specifying *who* will be trained, *how many* will be trained, *what* will they be trained in, *who will provide* the training should be developed for the remaining two year of the project.

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

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

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

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

d. Sustainability Strategy

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

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

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

Future activities which will enhance sustainability include:

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

C. Program Management

1. Planning

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

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

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

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

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

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

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

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

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

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

2. Staff Training

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

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

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

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

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

3. Supervision of Program Staff

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

4. Human Resources and Staff Management

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

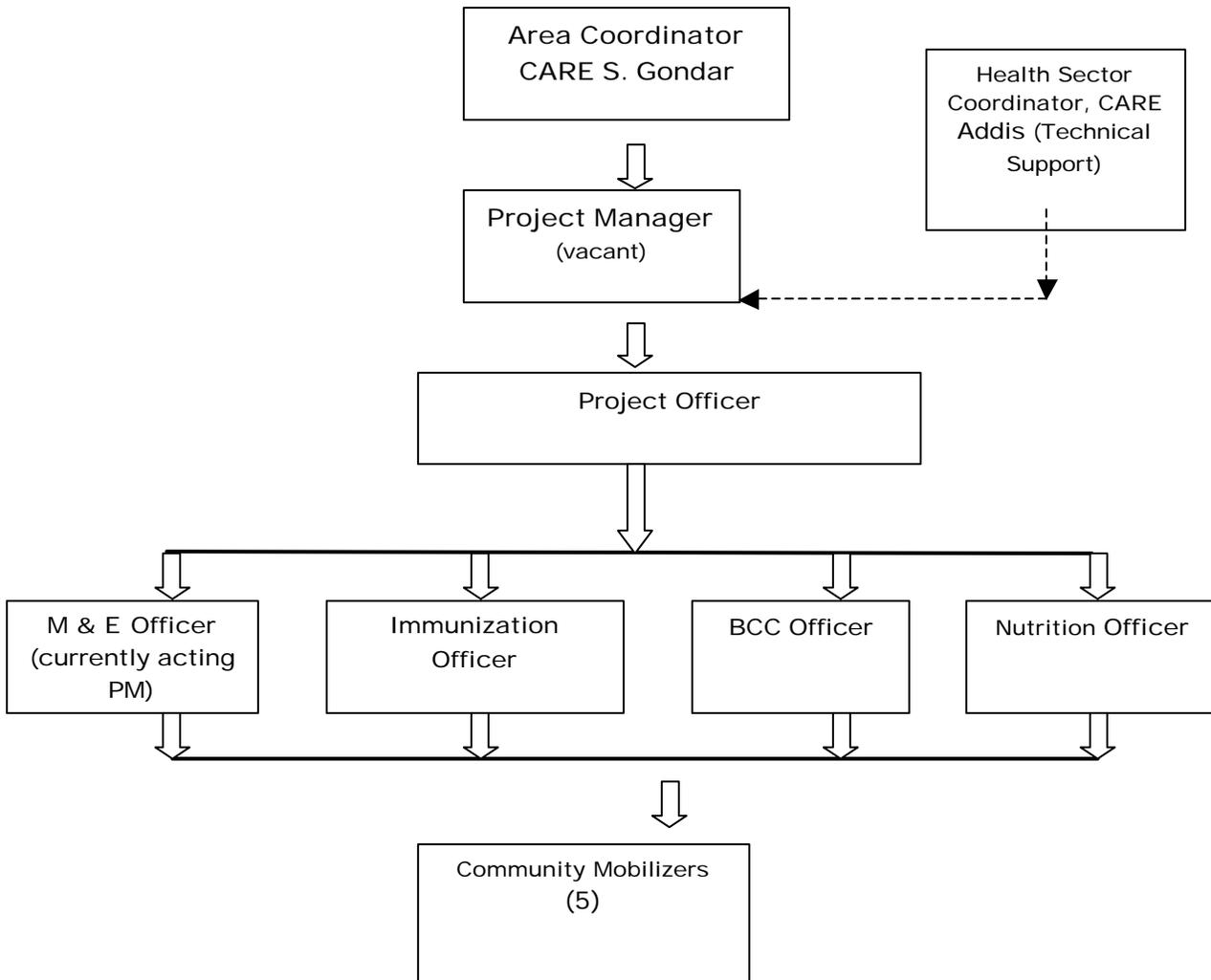
The Debra Tabor regional field office is led by an Area Coordinator responsible for the overall coordination of the field office and the projects operating under its auspices. The newly hired CARE Ethiopia Health Sector Coordinator (HSC) located in Addis Ababa provides technical assistance to the project.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

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

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

The current organizational chart is included on the following page.

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



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

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

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

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

5. Financial Management

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

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

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

6. Logistics

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

7. Information Management

The main activities completed so far in information management are:

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

Baseline KPC, HFA, and PRA Surveys

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

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

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

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

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

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

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

- o Increase the proportion of households disposing children's stool properly from 6% to 25%.
 - o Increase the % of children 12-23 months who consume vegetables, fruits and foods rich in Vitamin A in previous 7 days from survey from 18.9% to 45%
- ♦ **An indicator table should be included in the KPC Survey report which clearly indicates what the numerator and the denominator is for calculating the indicator.** Without this information it is impossible to tell if the indicator has been correctly calculated.
 - ♦ Some of the Rapid CATCH indicators may have been incorrectly calculated in the baseline KPC Survey:
 - o Danger signs refers to IMCI danger signs, not the recognition of danger signs for diarrhea
 - o Complete immunization should be calculated as those children receiving all vaccinations by their first birthday, it is unclear if this was done
 - ♦ Locally available foods should be defined before beginning the KPC based on formative research and general knowledge of the core team. The names of these foods should be included in the questionnaire and all interviewers should be trained based on the locally available foods. For example in the project area sorghum is not commonly eaten, but teff is. The question: *Any food made from grains [e.g. millet, sorghum, maize, rice, wheat, porridge, or other local grains]?* should be changed to reflect locally available foods.

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

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

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

Completed Census /Survey on EPI Coverage in all 40 PAs

In an effort to improve the low coverage of EPI, FWHO proposed a survey be conducted to find out what actual coverage has been reached and to develop a data base for tracing information for further interventions and decision making. The project supported the survey technically and financially. As a joint effort between the FWHO and FCSP staff, the registration of the target groups of the Woreda for EPI was conducted.

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

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

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

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

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

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

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

Improvement of MOH HIS

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

Community HIS strategy

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

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

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

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

Use of Information

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

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

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

8. Technical and Administrative Support

Technical Assistance Visits by CARE HQ

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

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

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

Technical Assistance Needs

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

D. Conclusions and Recommendations

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

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

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

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

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

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

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

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

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

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

Training/Education

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

Community Mobilization

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

Information sharing and use

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

Logistics

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

Staffing

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

Logistics

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

Additional Suggestions:

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

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

E. Results Highlights

There was no results highlight developed at this time.

F. Action Plan

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

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

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

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

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

Annex A.

Baseline information from the DIP

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

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

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

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

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

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

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

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

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

Adjustments to the DIP

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

Annex B.
Evaluation Team Members and their titles

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

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

Annex C.

Evaluation Assessment methodology

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

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

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

The specific objectives for the consultancy in February were to:

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

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

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

Since the consultant's visit, CARE Ethiopia has continued to seek to fill the Project Manager position, but hired a Project Officer as a temporary solution to ensure that management issues would not be a limitation for project activities. CARE Ethiopia has also contracted a new Health Sector Coordinator, who is providing significant support to the CS Project.

Considering the depth of the assessment in February, and the overall best use of project resources, a request was made to the donor to accept the field visit and Trip Report in lieu of a Midterm Evaluation. This request was approved with the stipulation that the Trip Report be rewritten to follow CSHGP Midterm Evaluation Guidelines.

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

MTE visits by consultant in February 2005:

Feb 9 Kanat PA

Participants: Front-line HF worker, CHA, VCHW, 7 MTMSG, PA leader, 5 Priests

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

Feb 10 Buro Teraroch PA

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

Feb 11 Kimir Dingay PA

Participants: HF staff (Health Assistant and front-line), VCHW, PA leader, 2 MTMSG, Priest.

Comments: New PA. Just beginning to organized MTMSG, have monthly meeting, mainly mobilizing community, some home visits and priest conducting Sunday service. Coordinating with Women's Association. Requested educational materials. Need to recruit and train another VCHW.

Feb 9 School Clubs

Participants: 41 total; average 2 teachers and 2 students each from 9 different rural schools.

Comments: Only 9 were females. Students range in age from 10-17. Group discussion included but information conveyed by lecture with no educational materials.

Feb 11 Debretabor Hospital:

Therapeutic Feeding Center: Comments: 14 beds for malnourished children, average stay 1 month with a parent

Use therapeutic formula mix supplied by UNICEF; Provide some education to parents- improving this could be a minor role for CSP

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

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

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

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

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

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

Annex D.
List of persons interviewed and contacted

Partners

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

CARE Ethiopia

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

Coordination Meetings

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

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

CARE Ethiopia

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

Other Contacts

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

Annex E.
Project Data Sheet

<i>Country</i>	Ethiopia
<i>Project title</i>	CHILD-E: Child Health Initiatives for Lasting Development in Ethiopia
<i>Cooperative Agreement No:</i>	HFP-A-00-02-0004600
<i>Total project budget</i>	USD 1,758,080.00
<i>Location of project</i>	Farta Woreda, S/Gondar Administrative Zone, Amhara National Regional State (ANRS)
<i>Target population</i>	Children of <5 yrs and women of reproductive age, especially pregnant and lactating mothers residing in 40 PAs of the Farta Woreda
<i>Thematic area</i>	C-IMCI: 20% IMM, 35% Nutrition, 25% PCM, 20% CDD
<i>Project Objective</i>	Improve the health status of children <5 yrs & women of reproductive age
<i>Project components</i>	<ul style="list-style-type: none"> ▪ Nutrition, ▪ Diarrheal illnesses, ▪ ARI – Acute Respiratory Infection ▪ EPI – Immunization
<i>Strategies:</i>	<ul style="list-style-type: none"> ▪ Skill Development; ▪ Community Mobilization to promote ownership. ▪ BCC-Behavior Change Communication approaches ▪ Quality Assurance for service delivery. ▪ Improve access and availability of services and supplies
<i>Project duration (approved)</i>	5 years, October 2002 – September 2007
<i>Local implementing agency</i>	CARE International in Ethiopia
<i>Implementing partners</i>	Zonal – Woreda Health Offices, NGOs, CHA/Ws, VHCs, school clubs, women’s associations.
<i>Contact Person(s) of the local implementing agency</i>	<p><u>CARE Ethiopia</u> P.O. Box 4710, Addis Ababa, Ethiopia Phone: ++251 1 538040; Fax ++251 1 538040 E-mail: care.eth@telecom.net.et Marcy Vigoda, Country Director Dawn Wadlow, Program Director</p>