



Ethiopia Country Office

CHILD SURVIVAL PROJECT SECOND YEAR ANNUAL REPORT (1st October, 2008— 30 September, 2009)

**Innovation for Scale:
Enhancing Ethiopia's Health Service Extension Program
in the Southern Nations and Nationalities People's Region (SNNPR)
Shebedino and Lanfaro Districts**

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Acronyms

ASO	Awassa Sub Office
AWD	Acute Watery Diarrhea
BC	Behavior Change
CCM	Community Case Management
CCM/P	Community Case Management/Pneumonia
CDD	Control of Diarrheal Diseases
cIMNCI	Community-Integrated Management of Newborn and Childhood Illnesses
CS	Child Survival
CS-23	Child Survival-23
CSHGP	Child Survival and Health Grants Program
CSTF	Child Survival Task Force
DHO	District Health Office
DIP	Detailed Implementation Plan
DPO	District Program Officer
EPI	Expanded Program of Immunization
EtCO	Ethiopia Country Office
FMOH	Federal Ministry of Health
GO-NGOs	Government Organization- Non Government Organization
HC	Health Center
HFA	Health Facility Assessment
HP	Health Post
HEP	Health Extension Package
HEW	Health Extension Worker
HMIS	Health Management Information System
HPC	Health Program Coordinator
HR	Human Resource
IEC	Information Education Communication
IFHP	Integrated Family Health Program
IMNCI	Integrated Management of Newborn and Childhood Illnesses
IR	Intermediate Result
ITN	Insecticide Treated Bednets
M&E	Monitoring and Evaluation
MNCH	Maternal Newborn and Child Health
MOH	Ministry of Health
NGO	Non-Governmental Organization
NS	Neonatal Sepsis
ORS	Oral Rehydration Salt
ORT	Oral Rehydration Therapy
PNC	Prenatal Care
PSI	Population Service International
PTM	Preventive Treatment of Malaria
RHB	Regional Health Bureau
R-HFA	Rapid Health Facility Assessment
SC	Save the Children Federation, Inc.

SNL-II	Saving Newborn Lives-II
SNNPR	Southern Nations Nationalities People's Region
SS	Supportive Supervision
TA	Technical Assistance
TAG	Technical Advisory Group
TBAs	Traditional Birth Attendants
TTBA	Trained Traditional Birth Attendants
UNICEF	United Nations Children's Fund
USAID	United State Agency for International Development
VCHW	Volunteer Community Health Workers
WHO	World Health Organization
ZHD	Zonal Health Desk

Introduction

Although Ethiopia has shown commendable progress in the reduction of under five mortality, it is not on track to reach the MDG 4¹. With the under five mortality rate of 123 per 1000 live births, one child dies every four minutes and 381000 Ethiopian children under five die each year. Save the Children is implementing a five-year Standard USAID/CSHGP Child Survival Project (CS), *Innovation for Scale: Enhancing Ethiopia's Health Service Extension Program in the Southern Nations and Nationalities People's Region (SNNPR)* - to address four main causes of child death: (1) pneumonia, (2) malaria, (3) diarrheal diseases (that together account for 68% of under-five mortality); and (4) neonatal infection, responsible for half of all neonatal mortality. This project is implemented in Shebedino (Sidama Zone) and Lanfaro (Silti Zone) Districts of SNNPR with the potential to scale at the regional level. The project reaches a total population of 366,898 (255,209 in Shebedino and 111,689 in Lanfaro) including 69, 491 children 0-59 months; and 87,496 women of reproductive age.

The selected CSHGP interventions are: Pneumonia Case Management (PCM) 35%; Immunization (5%); Control of Diarrheal Diseases (CDD) 20%; Prevention and Treatment of Malaria (PTM) 20%; and Newborn Care (20%). The project's key implementation strategy is Community Case Management (CCM), supported by behavior change at the household and community level. The project **Goal** is "Under-five mortality reduced" and its **Strategic Objective** is "Use of key child health services and behaviors improved". It has four Intermediate Results (IRs): IR-1: Access and availability of child health services and supplies increased; IR-2: Quality of child health services increased; IR-3: Knowledge and acceptance of key child health services and behaviors increased; IR-4: Child health social and policy environment enabled. **Major strategies are:** CCM and strengthened Expanded Program of Immunization (EPI) at the health post (HP) level (IR1); capacity-building, training and supervision for improved systems and provider performance; Health Extension Program (HEP) "16 packages" for behavior change delivered at the HP and household levels by Health Extension Workers (HEWs) and volunteer community health workers (VCHWs); and Technical communication and advocacy directed at the government, professional associations, civil society, and the Ministry of Health (MOH) for policy change to support the use of antibiotics by HEWs at the HP level. The project period is from 30 September, 2007 to 30 September, 2012 and to implement this project, USAID/CSHGP has awarded \$1.2 million, matched by \$400,000 from Save the Children. This is the second year annual report covering program activities implemented from October 1, 2008 through September 30, 2009.

A. Key Progress and Main Accomplishments

The main accomplishments include: (1) 1,080 VCHW were trained in community integrated management of newborn and childhood illnesses (cIMNCI), (2) 109 HEWs and 13 health workers were trained in Integrated Management of Newborn and Childhood Illness (IMNCI) and initiated IMNCI implementation in all 55 HPs, (3) trained health workers began distributing zinc treatment for acute diarrhea in children, (4) IMNCI was implemented in eight health centers, (5) three joint supportive supervisions at the HC and HP level were conducted, (6) the project provided essential IMNCI drugs, medical supplies, IMNCI reference manuals, charts booklets and registration books to all HPs and HCs, and (7) Information Education Communication (IEC) materials and counseling cards, reporting formats, and supervision checklists which were developed and adopted by our CS team for HCs and HEWs.

¹ Countdown to 2015, 2008 report

A.1. Community IMNCI training

Community and household care practices are being implemented via cIMNCI, through 20 specific behaviors, to address major problems related to child health, nutrition and development, with a special emphasis on behavior change and community concerns relevant to Ethiopia. The District Health Office, the community, and the HEWs carefully selected 1,080 VCHWs (684 male and 396 female) from each kebele, with a ratio of 17 VCHWs per kebele. In coordination with the RHB; SC trained 58 HEW and 8 HEW supervisors as trainers of the VCHWs. We used the national cIMNCI training manual adapted from the WHO Household and Community IMNCI Manual. The behavior change (BC) messages focused on growth promotion and development (key nutrition messages); disease prevention (hygiene and sanitation, malaria prevention); home management (food and fluid during illness, home treatment) and care seeking and compliance (immunization, early care seeking, family planning and antenatal care (ANC)).

Prior to the start of VCHW training activities, SC conducted sensitization activities for 379 community members, including kebele chairpersons, community leaders, women's affairs representatives, HEWs, district health officers, HEW supervisors and a district administrator. Participants discussed major child health problem and developed ways to ensure community participation in message delivery. Following the sensitization activities, SC trained the selected 1,080 VCHWs (1,080 total or 94% of 1,153 targeted) in cIMNCI. Most (980) of the selected VCHWs are literate, have been assigned to their respective villages, and have started delivering messages using the cIMNCI manual and quick reference family health card, during household and community gatherings. Monthly review meetings with the HEWs serve to collect reports, review topics related to key messages, calculate the number of households reached and gaps in key message delivery, assesses VCHW activity, share positive experiences, and identify gaps and solutions.

A.2. IMNCI training for Health Extension Workers (HEWs)

Community case management (CCM) has been identified as a CS strategy. The project aims to implement CCM through the existing HEP implemented at the HP level by training all HEWs in IMNCI. The Project's CCM approach aims to enhance the current HEP by adding: (1) CCM of pneumonia (CCM/P) with antibiotics; (2) zinc treatment for diarrhea; (3) use of a new ORS formula for dehydrating diarrhea; and (4) improved assessment/referral of neonatal sepsis (NS) with the possibility of adding CCM/NS.

Although the strategy is included in the HEP and the RHB has signed and accepted the project strategies and activities, SC had to conduct a series of discussions both at the federal and regional levels to proceed with the existing plan. The main concern of the MOH was that the proposed training content contradicts the current policy of "no antibiotics by HEWs." However an agreement to proceed was provided to SC, reminding the Project to observe this policy. Subsequently, SC, in collaboration with the RHB and Integrated Family Health Program (IFHP/JSI), trained HEWs on IMNCI for six days. SC used the national IMNCI training manual for HEWs and ensured a competency-based focus by conducting the training at the Yirgalem Hospital and at a health centre which has a sufficient number of cases. SC trained 109 (96.4% of the 121 target) HEWs in the assessment and treatment of malaria/fever, diarrhea and malnutrition; in the assessment and referral of newborn infections and pneumonia; in newborn care; and in counseling for immunization, infant feeding, early care seeking and follow up of

sick under five children. Fifteen HEW supervisors and district and zone health officers were also trained in IMNCI for HEWs. All 55 HPs now have trained HEWs managing cases of sick children who are under five. SC has equipped all HPs with IMNCI chart booklets and IMNCI registration books. Counseling cards for HPs are being translated into the local language, which we hope to eventually provide to all HPs. The FMOH provides drugs like Coartum and ORS to HPs. Following the training, we conducted joint follow up supervisions and on-the-job training with HEW supervisors.

Although the MOH policy still does not allow HEWs to treat pneumonia and newborn infection (except in Afar, Somali and Benshangul Regions where the shortage of skilled health workers [nurses and above] and limited number of HCs mandates the policy), SC was able to implement IMNCI at the HP level, as described above. This is a major accomplishment and learning opportunity for the MOH because for the first time in SNNPR, IMNCI is being implemented at HPs, and the lessons learned are informing the roll-out and scale-up of CCM to address common childhood illnesses. (IMNCI had not been allowed at HPs because of the CCM/P issue.)

A.3. Introducing zinc treatment

Experts agree that zinc is one of the CS treatment interventions with sufficient evidence to reduce under-five mortality due to diarrhea² and to prevent diarrhea and pneumonia. Four CS team members participated in a one-day zinc treatment orientation conducted by PSI and GOAL Ethiopia. Subsequently, the SC team conducted a one-day training for 20 health workers (in eight HCs) as well as the staffs from the RHB, and zonal and district health offices to introduce zinc sulphate for the treatment of diarrhea especially in the importance of zinc treatment for diarrhea (i.e., treatment, benefits, dosage, and importance of parallel ORS usage). During the reporting period, SC received zinc tablets from PSI, and started treating all acute diarrhea cases at HCs with zinc and low osmolarity ORS. As a result, the HCs have treated 451 cases of AWD (among children) with zinc sulphate. In addition, HEWs are now trained on how to use zinc in their IMNCI training, and we will supply zinc supply by the end of September 2009.

A.4. IMNCI implementation

The CS project has trained 18 HWs from all HCs in Year 1 and now all sick under five children who visit the HCs, are being treated by the IMNCI protocol. Each HC has a trained health worker, an IMNCI chart booklet, an IMNCI register and all essential IMNCI drugs and supplies. In the seven months between February and August 2009, the eight HCs treated 11,658 sick children (11,366 2-59 months; 292 < 2 months of age). The diagnoses for the older children were: malaria (28.8%), acute diarrhea (22.6%), pneumonia (22%), pneumonia and malaria (13.3%), and dysentery (1.0%). The diagnoses for the young infants were localized bacterial infection (31%), acute diarrhea (23%), possible serious bacterial infection (9.6%), breathing problem/asphyxia (4.8%) and low birth weight/preterm (3.8%).

These health facilities have also checked the immunization status of 6,720 children under five and the vitamin A status of 6,560 children. The low proportion of young infant visits at under-five clinics, indicates the need for enhanced community mobilization efforts targeted at caregivers of young infants, during ANC and prenatal care (PNC).

² How many child deaths can we prevent this year? The Lancet. Vol 362. July 5, 2003.

A.5. Supportive supervision

Following the IMNCI training of HWs and HEWs in both project sites, SC conducted joint supportive supervision using standard supervision check-lists with the zonal health desk HEW coordinator and the HEW supervisor. The objectives of supportive supervision is to provide on-the-job support for HEWs and HWs, to identify skill gaps and to assess the proper use of IMNCI job aids, like IMNCI chart booklets and registration books for sick children who are under five.

The baseline health facility assessment (HFA) in Year 1 indicated that none of the HPs were implementing IMNCI (0%), and none had an integrated registration book (0%) for under five sick child visits. Following the IMNCI training for HEWs, all HPs now have IMNCI chart booklets (100%) and a registration book (100%), and HEWs were properly registering all sick child visits at the 55 HPs (30HPs in Shebedino and 25 in Lanfero). The team also observed that all HEWs (100%) started IMNCI at each HP (2 per HP) and were treating or referring patients for additional care. The HEW Supervisors were providing supervision (a minimum of once per month), and the VCHWs were referring sick children to the HPs. All the HPs had the necessary IMNCI references and guides (100%). Very few reported ORS stock-outs (2 of 55 HPs [4%]). No HP had materials for their ORT corner (0%), and SC has provided ORS and ORT corner supplies to all 55 HPs (100%).

Nearly all sick visits to HPs were for children 2-59 months old. According to HEWs, this is due to the perception that HPs do not perform deliveries (most women deliver at home or at HCs) so mothers do not bring sick young infants to HPs. If deliveries begin to take place at HPs, then newborns would be seen at HPs, and the community may begin to trust the HPs enough to bring sick children under two months old, to the HPs for care. To ensure a greater use of available services for infants at the HP level, more emphasis has to be placed on community mobilization. The formative research provided by Saving Newborn Lives-II, indicated that besides cultural beliefs (such as the belief that birth should take place at home close to family and beliefs for privacy for the woman in labor) an important reason for not seeking care for newborns, was the perception that HCs and HPs do not provide care for infants. All eight HCs (100%) were implementing IMNCI in their under-five clinics, but two in Lanfero experienced transfer of trained health workers (25%). The HCs had IMNCI job aids and essential drugs and supplies, but two (25%) lacked sufficient ORS stocks.

A.6. Drugs and essential IMNCI supplies

The other basic component of IMNCI is improving the health system. In line with this, SC has provided Zinc, ORS, essential IMNCI first and second line drugs, medical supplies (i.e. thermometer, Salter scale, timer for counting respiratory rate, ORT corner supplies and baby scale) to the eight HCs and 55HPs.

A.7. Information Education Communication (IEC) materials (counseling cards on IMNCI), reports and supervision checklists

Using the cIMNCI guideline and the 20 key health messages, we have adopted pictorial counseling cards with local language and costumes for use at the health facilities level during individual counseling. SC developed IMNCI/cIMNCI reporting formats for HCs, HPs and VCHWs and shared these with the RHB, zonal health desk and district Health Offices for harmonization with existing HMIS of MOH. SC developed referral slips for IMNCI that the

HEW can use for referring cases to HCs and pictorial reporting formats for TTBA on deliveries, postpartum follow up, live and still births. SC also drafted supervision checklists for IMNCI at HC and HP and cIMNCI at community and household level. The RHB is reviewing these documented and in the meantime, we are using it.

A.8. Other Accomplishments: National and Regional Child Survival Meetings

The CS team has regularly participated in Regional Child Survival Task Force meetings (fortnightly or weekly). Key agenda items include: emergency health and nutrition updates and trends; partnerships in intervention for emergency response; and technical updates in CS. SC has also joined the regional EPI technical support group led by RHB, which monitors EPI quality and cold chain management. SC participates in the national CS Working Group and in relevant Save the Children Alliance Newborn and Child Survival Campaign workshops and advocacy meetings. SC participated in the joint JSI/Pathfinder, USAID-funded Integrated Family Health Program (IFHP) launching and planning meeting.

Technical assistance for field team

The EtCO SC Health Unit Head provided technical assistance to the CS team on the roll-out of operations research (OR) and supervision of trainings. In a meeting between SC and the RHB, we agreed to include the topic of “Improved Supervision for the Health Extension Worker” in the technical advisory group agenda. The RHB also agreed to collect available HEW supervision tools used by the RHB, and to start the formative phase of OR to evaluate the existing HEW supervision plan and its status, during this project year. We completed the formative phase through key informant interviews of HEP experts and supervisors at regional, zonal, district and health center levels. The key findings included (see Annex 4 for details):

- HEW supervisors do not have uniform and regular supervision plans;
- Only 40-60% of the supervision plans are implemented by the HEW supervisor;
- There is great variation between the existing HEP supervision plans;
- Major resource and logistics limitations exist;
- The content of the HEW supervision is not consistent;
- No standard checklists exist; and there is a need to improve supervisory skills.

The SC Senior Child Survival Advisor, David Marsh, provided technical assistance to the CS team through prompt and frequent email and telephone communications as needed, during the development of the different reporting formats and checklists. He also provided assistance with the development of CCM technical updates, guidelines and publications. He visited the team in Ethiopia for follow-up and support, and to help ensure consistency between the project and operations research.

Health Management Information System

In order to ensure the coordination of the HMIS, supportive supervision and reporting of CS project activities with the RHB, SC organized a five-day training on the new MOH HMIS plan. The objective of the training was to agree on a standard and uniform HMIS at all levels, to plan for integrated program supervision, to build the capacity of both project and MOH staff on the new HMIS system, and to update participants on the different reporting lines and formats.

The event covered topics related to integrated supportive supervision, and monitoring and evaluation (M&E) by the RHB. Twenty-five participants from the CS team, and Zonal and District HEP supervisors, attended.

Refresher training for VCHW on cIMNCI

SC conducted refresher training on cIMNCI for 831 VCHWs and used the opportunity to review performance issues and identify challenges and gaps in the implementation at community and household levels. The refresher training emphasized household and community components of IMNCI. Additional topics included: linkage between VCHWs and HEWs; inconsistency in reports; the importance of follow-up, VCHW linkage with TTBA's at the community level, and strengthening mechanism of zinc treatment follow-up. Positive outcomes include fortnightly meeting at the HC level, monthly reports, and the increased availability of IEC materials.

B. Activities Status

The status of Year 2 activities and intermediate results, are summarized in the table below.

Project Objectives/ Results	Activities Planned for Year 2	Activity Status	Comments
Access and availability of services and supplies increased	Train HEWs in IMNCI	Completed	Started case management
	Provide standard IMNCI algorithms	Completed	Provided for all HC s and HPs
	Train VCHW in c-IMNCI	Completed	
	Facilitate prompt referral of sick children	Ongoing	HPs have started referral
	Strengthen assessment and appropriate treatment of diarrhea and malaria by trained HEWs	Ongoing	HEWs have started case management using IMNCI algorithm
	Strengthen assessment and referral of pneumonia and sick newborns by trained HEWs	Ongoing	HEWs have started assessment and referral of pneumonia
	Provide essential drugs to treat diarrhea and malaria	Completed	All HCs and HPS supplied
	Avail antibiotic to treat pneumonia at HC	Completed	All HCs supplied
	Ensure adequate zinc supply at HC and HP	Ongoing	HCs supplied
	Start zinc treatment for diarrhea at HC and HP	Ongoing	8 HCs started
	Follow up for adequate supply and distribution of ITN at HC and HP	Ongoing	We support MOH, we do not supply
	Follow up for adequate supply and stock of childhood vaccines at HC and HP	Ongoing	We support MOH, we do not supply
	Promote routine and outreach immunization	Ongoing	We support MOH
	Avail a trained HEW and a health professional in essential new born care and assessment of sick new born	Completed	HEWs trained in IMNCI in newborn care & case management
	Strengthen the link between TBAs and HEWs in follow up of deliveries, newborns to provide essential newborn and postnatal care	Ongoing	TBAs have started submitting monthly report to HEWs
	Avail standard Job aids (IMNCI reference materials, wall charts, teaching aids, IEC materials) in child health	Completed	Key messages, reference materials supplied to HC and HP
	Avail standard registers and reporting formats	Completed	Shared with MOH
Follow up for appropriate drug treatment at HP and HC level	Ongoing	Supportive supervisions and on the job training going on	

Project Objectives/ Results	Activities Planned for Year 2	Activity Status	Comments
Quality of services increased	Follow up for proper counseling and follow up at HP and HC	Ongoing	HCs and HPs have started counseling
	Facilitate rehydration therapy with the new ORS formula	Ongoing	We have ORS shortage
	Regular on the job training in IMNCI	Completed	
	Support/build capacity of health workers and District Health Office staff in proper supervision and routine monitoring	Ongoing	Supervisory skills training given and supervision is done with MOH
	Review regional data collection/HMIS	On target	Shared with MOH after review
	Facilitate use/adoption of standard supervision checklists inclusive of curative services and counseling services	Completed	Checklists on use
	Conduct joint review meetings and feed backs on performance on regular bases (recognize best performances)	On going	Monthly and quarter meetings with HEWs and VCHWs
	Ensure use of standard reporting formats and registers	Completed	
	Annual progress review and planning meeting	On target	
	Train HEWs and VCHWs in delivery of 20 key messages in c-IMNCI	Completed	Used c-IMNCI tools
	Adopt/develop IEC materials	Completed	Counseling cards for HCs
	Knowledge & acceptance of key services & behaviors improved	Provide health promotion activities	Ongoing
Promote appropriate hand washing practices		Ongoing	
Promote standard immunization services during health facility visits		Ongoing	
Counsel/advise caretakers on proper feeding and fluid during diarrhea episodes		Ongoing	Part of IMNCI follow up
Counsel caretakers in proper breast feeding, proper feeding for infant and household sanitation and hygiene, young child and feeding during illness		Ongoing	Part of IMNCI follow up
Inform community on ITN availability and proper utilization by children and pregnant women		Ongoing	
Ensure caretakers understanding of importance of referral and follow up of sick child		Ongoing	Part of IMNCI F/up
Collaborate with RHB and other partners on child survival working groups at regional and national level		Ongoing	CSTF and TAG meetings are conducted. The CS team has participated on child survival meetings.
Work with GoE/NGO/UN partners for policy improvement in HSDP-IV particularly in CCM of pneumonia by HEWs		Ongoing	Regular member of both regional and National CS task force , the TAG promotes this, participated on the national HSDP III review meeting and brought into attention CCM/P
Document and disseminate evidence based best practices in CCM using MOH guidelines and documents		Ongoing	Child Survival 17 CCM best practices disseminated

Project Objectives/ Results	Activities Planned for Year 2	Activity Status	Comments
Social and policy environment enabled and sustainability of all activities improved	Lead regular partners coordination, advocacy and policy dialogue in CCM and evidence based newborn & child practice	Ongoing	Actively participated with alliance on newborn and child survival campaign planning and CCM/P is one of the campaign objectives
	Conduct joint and integrated supportive supervisions and TAs	Ongoing	Joint supervisions and trainings with MOH
	Facilitate proper health service delivery by HPs in collaboration with MOH and partners	Ongoing	IMNCI, c-IMNCI and Supervisory skills training given
	Participate and advocate through Save the Children Health and Nutrition (PR3) Program Learning Group	Ongoing	Participated in SCUS Advocacy day for newborn and CS, in 2009 HN PLG
	Participate in periodic regional child survival taskforce meetings	Completed	2 to 4 times per month
	Document and share child survival interventions and updates	Ongoing	Reports are shared to RHB, ZHD and BoFD regularly
	Support and participate in national child survival taskforce to advocate for policy change in CCM	Ongoing	
	Conduct regional TAG meeting	On target	September 2009 for second time
	Establish district level child survival team (MOH, SC, others working on CS)	On target	September 2009

C. Challenges and Factors That Have Impeded Progress (*with interim solutions*)

- The MOH policy still does not allow HEW to provide pneumonia case management. *For policy change in HSDP IV we are advocating both at the regional and national levels through the Technical Advisory Group, the Child Survival Task Force, professional associations (pediatric society) and in collaboration with UN agencies like UNICEF.*
- There is an increased demand on our human resources for implementation and close follow-up of cIMNCI for BC, since we have only one district based officer. *This is being addressed through the use of MOH staff like HEW supervisors by strengthening the link between HEWs and VCHWs.*
- Shortage of ORS and other essential drugs in the health facilities. *We have purchased ORS through other projects and received zinc free of charge from PSI.*
- Quality of IMNCI implementation is compromised by transfer or turnover of trained health workers. *We have planned refresher trainings and we are conducting strong on-the-job competency-based training.*
- HEWs are very busy with different meetings and political commitments. *The close collaboration with the Woreda Health Office and HEW supervisors to prioritize health issues has been successful.*
- Low care seeking behavior by communities for sick young infants at the HP level. *We need to work with VCHWs and TTBA's to reach these mothers.*
- Lack of budget to provide essential supplies like IMNCI drugs and ORS, and to develop IEC materials for VCHWs. *We are looking at other options like sharing with other projects and SC private fund, possibly through the Survive to Five Campaign.*

D. Technical Assistance Needs

The following are the projects current technical assistance (TA) needs: conducting OR on supervision packages (on-going); conducting HEWs performance assessment (on-going); technical updates from the Senior CS Advisor for project staff and implementation partners (on-going); advocacy and policy dialogue to convince the FMOH to authorize the use of antibiotics to treat pneumonia at the HP level (on-going); from Home Office in report writing, and dissemination and documentation (on-going). In addition, TA is needed for the mid-term evaluations in Year 3 (planned). All TA activities are planned and budgeted accordingly.

E. Substantial Changes in Project Intervention

There are no substantial changes in the project intervention from what was stated in the Detailed Implementation Plan (DIP).

F. Progress Made Towards the Sustainability Plan for the Project

- IMNCI implementation by HEWs at 55 Health Posts.
- Delivery of key household practices by MOH and community selected trained VCHWs
- All the trainings targeted MOH staff at the health facility, region, zone and district level
- MOH approved training manuals, chart booklets and registers were used.
- All trainings used MOH staff thereby creating in-house capacity for the MOH.
- Engaging key community members and health workers to address child health issues.
- Joint supervision and annual review meeting conducted to build the capacity of the government in supervision, planning and monitoring the progress of activities.
- The steps taken for advocacy and policy change in the CCM/P.
- The strong link established with the District Health Office, HCs and HPs in implementing CS activities.
- Strong support and interest both at the national and regional levels in IMNCI/cIMNCI, a major vehicle to implement CS interventions.
- Strong partnership in strengthening IMNCI efforts between IFHP, UNICEF and RHB.

G. Specific Information for DIP or Year 1 Report

No specific information was inquired for the year one annual report.

H. Specific Information for Type of Project or Year of Implementation

Not applicable for the 2nd year project report

I. Challenges or Updates to Project's Management System

I.1 Financial management system

All financial management system components are the same as reported in Year 1. No major challenge was encountered in the reporting year except for a lack of budget for the development of IEC materials.

I.2 Human resources

All CS staff members were actively engaged throughout the year and the team was supported by SC's Senior Child Survival Advisor as a backstop and the EtCO health unit head. No major challenge in human resource management occurred, however, the Lanfaro District Officer resigned and a new person has been recruited (with a bachelor degree in public health).

I.3 Communication system and team development

We use broadband and Outlook for all communications, but in recent months an electric power interruption in the country has challenged regular communications. There is sound teamwork at all levels. For capacity building and staff development, the CS team and other program staff have been trained in health service planning, HMIS use, supervisory skills, and M&E organized by SC's Awassa Sub Office in collaboration with RHB. We have provided training of trainers (TOT) on IMNCI for the CS team to train HEWs. A team building and experience sharing visit and workshop was conducted at the sub-office level for better program learning.

I.4 Local partner relationships

SC strengthened local partnerships during the reporting period by participating in the Regional Child Survival Task Force, the TAG meetings and joining the EPI working group which the RHB chairs. SC training activities were facilitated by experts from the MOH and were conducted in an integrated supportive supervision with the MOH. SC provides frequent updates to all key government partners. Through HEWs, community leaders and volunteers, SC also works closely with communities to ensure that their expressed needs are incorporated into program planning and implementation.

I.5 PVO Coordination/Collaboration in country

The Regional Child Survival Task Force, with its regular periodic meetings and TAG meeting has facilitated PVO coordination. There is a strong collaboration with IFHP/JSI in the use of IEC tools, IMNCI training for HEWs and sharing key CS job aids for health facilities. IFHP/JSI provided TOT training for the CS team to build their capacity in the facilitation of IMNCI training for HEWs. SC is collaborating with UNICEF to provide essential medical supplies to health posts and with WHO on the joint effort for policy influence on CCM/P. SC works closely with GOAL Ethiopia to share ideas and organize joint trainings (i.e. zinc treatment).

J. Local Partner Organization Collaboration and Capacity Building

The primary and key partners are the RHB, especially the Family Health Department, The Child Health & Nutrition Team, The RHB Health Extension Program and Planning and Programming Department, Sidama Zone Health Department, Silitie Zone Health Department, Lanfaro District Health Office and Shebedino District Health Office. These partners have been involved since project start-up, through briefing meetings, DIP workshop, the baseline survey, a dissemination workshop, district-based planning and capacity building trainings for health professionals, and integrated supportive supervision. We have jointly trained 13 HEWs supervisors in Health Service Planning, HMIS implementation, Supervisory Skills, and Monitoring & Evaluation; 109 HEWs and 15 supervisors in IMNCI case management for HEWs, 1,080 VCHWs in c-IMNCI from both districts. We supply IMNCI antibiotics to eight health centers and basic medical supplies and ORT corner materials to 55 HPs. The CCM key implementers are HEWs and VCHWs, which ensure local partnership and capacity building at the community level.

K. Mission Collaboration

USAID's Mission in Ethiopia was engaged in the CS project since its initial stages through provision of technical advice and revision of the project document. During the reporting period, the EtCO health unit head met with USAID/Ethiopia's CS focal person/HPN's Program Officer at the Mission on the status of existing CS interventions.

ANNEX 1: M&E TABLE/PROGRAM MATRIX

Goal, Objective, Intermediate Result	Indicator	Source/ Method of Measurement	Base-line Value	EOP Target	Associated Activities
Goal: Under-five mortality reduced					
*** Please see Table 7 below for KPC survey results and targets BY DISTRICT ***					
Strategic Objective: Use of key child health services and practices increased					
<i>Appropriate hand washing practices</i>	% of mothers of children 0-23 months who live in a household with soap or a locally appropriate cleanser at the place for hand washing and who washed their hands with soap at least 2 of the appropriate times during the day or night before the interview	KPC	28%	45%	<i>BCI:</i> HEP "16 packages", c-IMNCI (model families, community conversations, one-on-one counseling in household) <i>HEW/VCHW training in IMNCI/c-IMNCI</i>
<i>Increased feeding during diarrheal episode</i>	% of children aged 0-23 months with diarrhea in the last two weeks who were offered the same amount or more food during the illness	KPC, 2011 EDHS	29%	43%	<i>BCI:</i> HEP "16 packages", c-IMNCI (model families, community conversations, one-on-one counseling in household) <i>HEW/VCHW training in IMNCI/c-IMNCI</i>
<i>Increased fluid intake during diarrheal episode</i>	% of children 0-23 months with diarrhea in the last two weeks who were offered more fluids during the illness	KPC, 2011 EDHS	20%	36%	<i>BCI:</i> HEP "16 packages", c-IMNCI (model families, community conversations, one-on-one counseling in household) <i>HEW/VCHW training in IMNCI/c-IMNCI</i>
<i>Appropriate care seeking for pneumonia</i>	% of children age 0-23 months with chest-related cough and fast and/ or difficult breathing in the last two weeks who were taken to an appropriate health provider	KPC, 2011 EDHS	32%	60%	<i>BCI:</i> HEP "16 packages", c-IMNCI (model families, community conversations, one-on-one counseling in household) <i>HEW/VCHW training in IMNCI/c-IMNCI</i>
<i>ORT use</i>	% of children age 0-23 months with diarrhea in the last two weeks who received ORS and/or recommended home fluids.	KPC, 2011 EDHS	57%	72%	<i>BCI:</i> HEP "16 packages", c-IMNCI (model families, community conversations, one-on-one counseling in household) <i>HEW/VCHW training in IMNCI/c-IMNCI</i>
<i>Zinc therapy</i>	% of children 0-23 months with diarrhea in the last two weeks who were treated with zinc supplements	KPC, 2011 EDHS, DHO/RHB service data	7%	25%	<i>BCI:</i> HEP "16 packages", c-IMNCI (model families, community conversations, one-on-one counseling in household) <i>HEW/VCHW training in IMNCI/c-IMNCI</i> <i>Dialogue, monitoring, trouble shooting, facilitation of zinc supply to health posts/health centers</i>
<i>ITN use by child</i>	% of children age 0-23 months who slept under an	KPC, 2011 EDHS	40%	65%	<i>BCI:</i> HEP "16 packages", c-IMNCI (model families,

Goal, Objective, Intermediate Result	Indicator	Source/ Method of Measurement	Base-line Value	EOP Target	Associated Activities
	insecticide-treated bed net (in malaria risk areas, where bed net use is effective) the previous night				community conversations, one-on-one counseling in household HEW/VCHW training in IMNCI/c-IMNCI
<i>Post-natal visit to check on newborn within first 3 days after birth</i>	% of children age 0-23 who received a post-natal visit from an appropriate trained health worker within three days after the birth of the youngest child	KPC, 2011 EDHS	4%	30%	<i>BCI:</i> HEP "16 packages", c-IMNCI (model families, community conversations, one-on-one counseling in household) HEW/VCHW training in IMNCI/c-IMNCI
<i>Immediate and exclusive breastfeeding of newborns)</i>	% of newborns who were put to the breast within one hour of delivery and did not receive prelacteal feeds	KPC, 2011 EDHS	62%	69%	<i>BCI:</i> HEP "16 packages", c-IMNCI (model families, community conversations, one-on-one counseling in household) HEW/VCHW training in IMNCI/c-IMNCI
<i>Exclusive breastfeeding (0-5 months)</i>	% of children age 0-5 months who were exclusively breastfed during the last 24 hours	KPC, 2011 EDHS	3%	25%	<i>BCI:</i> HEP "16 packages", c-IMNCI (model families, community conversations, one-on-one counseling in household) HEW/VCHW training in IMNCI/c-IMNCI
IR-1: Access and availability of child health services and supplies increased					
<i>Access to immunization</i>	% of children age 12-23 months who received a DPT1 vaccination before they reached 12 months	KPC, 2011 EDHS	80%	80%	Routine vaccination at health posts; vaccination campaigns
<i>Clinical IMNCI coverage</i>	% of HEWs trained in IMNCI	RHB/ZHD/DHO documentation, project training records	0%	60%	Training of HEWs in clinical IMNCI. 109 (96.4%) HEWs trained in Yr 2
<i>Community IMNCI coverage</i>	% of VCHWs trained in c-IMNCI	RHB/ZHD/DHO documentation, project training records	0%	60%	Training of VCHWs in c-IMNCI. 1080 (94% of the target) trained in cIMNCI in Yr 2
<i>Availability of zinc</i>	% of health posts that report no stock out of zinc in previous month	RHB/ZHD/DHO documentation, rapid inventories of health posts, stock out reports	0%	75%	Monitoring of stock and supply chain; trouble shooting; facilitation
IR-2: Quality of child health services improved					
<i>Health system performance regarding immunization</i>	% of children age 12-23 months who received a DPT3 vaccination before they reached 12 months	KPC	47%	75%	Routine vaccination at health posts; community vaccination campaigns
<i>Measles vaccination</i>	% of children age 12-23 months who received a measles vaccination <u>regardless of age</u>	KPC, 2011 EDHS	60%	75%	Routine vaccination at health posts; community vaccination campaigns
<i>Child with fever receives appropriate anti-malarial</i>	% of children age 0-23 months with a febrile episode during the last two weeks who were treated with an effective anti-malarial drug within 24 hours	KPC, R-HFA, health facility record review	17%	60%	HEW/VCHW training in IMNCI/c-IMNCI <i>BCI:</i> HEP "16 packages", c-IMNCI (model families, community conversations,

Goal, Objective, Intermediate Result	Indicator	Source/ Method of Measurement	Base-line Value	EOP Target	Associated Activities
	after the fever began				one-on-one counseling in household)
<i>Use of medicine during diarrhea</i>	% of children 0-23 months with diarrhea in the last two weeks who were not treated with anti-diarrheals or antibiotics	KPC, health facility record review	41%	22%	HEW/VCHW training in IMNCI/c-IMNCI <i>BCI:</i> HEP “16 packages”, c-IMNCI (model families, community conversations, one-on-one counseling in household)
<i>HEW performance</i>	% of trained HEWs who followed correct IMNCI steps to assess, classify, treat, refer childhood illness	R-HFA, performance observations, supervisory records	0%	60%	HEW/VCHW training in IMNCI/c-IMNCI Supportive supervision
<i>Functional supervisory system</i>	% of health posts that have received supportive supervision at least once in past quarter (according to MOH criteria)	R-HFA, monthly <i>woreda</i> reports	98%	100%	Accompany, provide transport, ensure check list supply and use, give feedback
<i>Functional health system</i>	% of health posts meeting FMOH “functional” criteria (refer to Annex 18)	RHB/ZHD/DHO records, reports	80%	90%	Provide limited supplies, equipment, support, facilitation
<i>Functional health system</i>	% of health posts that have met all reporting requirements in past quarter (according to MOH criteria) % HEWs whose register records adequate info. (age, dx, Rx)	R-HFA	54%	90%	Remind, review, provide feedback
IR-3: Knowledge and acceptance of key child health services and practices improved					
<i>Maternal danger signs</i>	% of mothers who report knowledge of at least 2 maternal danger signs requiring immediate intervention	KPC	8%	30%	<i>BCI:</i> HEP “16 packages”, c-IMNCI (model families, community conversations, one-on-one counseling in household)
<i>Neonatal danger signs</i>	% of mothers who report knowledge of at least 2 neonatal danger signs needing treatment	KPC	29%	60%	<i>BCI:</i> HEP “16 packages”, c-IMNCI (model families, community conversations, one-on-one counseling in household)
<i>Child danger signs</i>	% of mothers who know at least 2 signs of illness in children needing treatment	KPC, 2011 EDHS	51%	75%	<i>BCI:</i> HEP “16 packages”, c-IMNCI (model families, community conversations, one-on-one counseling in household)
IR-4: Policy and social environment enabled					
<i>Policy change</i>	HSDP-IV includes CCM as HEP strategy at level of health post - including antibiotics for treatment pneumonia, dysentery, neonatal sepsis	FMOH/RHB policy documents and operational guidance	None	Partial	Facilitate policy dialogue, debate, technical updates; provide evidence of feasibility
<i>Joint planning for sustainability</i>	Joint planning takes place on annual basis with RHB/ZHD/DHO, SC, ESHE, and relevant key community stakeholders	RHB/ZHD/DHO records, project documentation	N/A	Yes	Participate in region, zonal, district planning

ANNEX 2: PROJECT WORKPLAN
THIS IS IN EXCEL AND ATTACHED.

ANNEX 2: CHILD SURVIVAL - YEAR 3 WORK PLAN (Sept 30, 2009 to Sept 30, 2010)

RESULTS	MAJOR ACTIVITIES	Year 3				
		Q1	Q2	Q3	Q4	
Intermediate result 1: Access and availability of services and supplies increased	Community case management of diarrhea, malaria and pneumonia at health centers and health posts					
	Train health workers including health extension workers in IMNCI	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
	Provide Standard IMNCI algorithms to assess, classify and treat symptoms of diarrhea, malaria and pneumonia for health centers and health posts	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
	Facilitate prompt referral of sick children from community to Health post & severe cases from HP to health center	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
	Strengthen prompt & effective assessment and appropriate treatment of diarrhea and malaria by trained HEWs	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
	Strengthen prompt & effective assessment and referral of pneumonia by trained HEWs	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Provide/facilitate for health centers and health posts with essential IMNCI drugs to treat diarrhea and malaria	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Provide/facilitate availability of first line antibiotic to treat pneumonia at health centers	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Ensure adequate supply of antimalarial and new formula ORS at health center and health post level	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Ensure adequate zinc supply/stock at health post(HP) & health center (HC)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
	Advocate at Regional & National level through established child survival groups and UN organization to start CCM/pneumonia by trained HEWs	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Ensure adequate supply/stock of first line antibiotic for pneumonia at health posts	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
	Start community case management of pneumonia at health posts by trained HEWs	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
	Follow up for adequate supply and distribution of ITN at HC & HP	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
	Follow up for adequate supply and stock of childhood vaccines at HC & HP	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
	Promote on routine and outreach immunization	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
	Maternal & Newborn Care					
	Avail a trained HEW and a health professional in essential newborn care and assessment of sick newborn	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
	Avail a trained HEW & health professional in safe Delivery, newborn care, assessment, resuscitation & postnatal care	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
	Strengthen the link between TBAs & HEWs in follow up of deliveries, newborns to provide essential newborn care & postnatal care	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
	Strengthen the referral link of sick newborns to health centers for early & prompt management	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
	Follow up for availability of safe delivery kit and newborn resuscitation equipment at health post & health Centers	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
	Support TT immunization and availability at health post	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
	Avail standard Job aids (IMNCI reference materials, wall charts, teaching aids, IEC materials) in child health	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
	Avail standard registers and reporting formats	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
	Monitor and follow up for essential drugs & supply & facilitate corrective actions	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	

	Intermediate Result 2: Quality of services increased	Facilitate/provide with IMNCI essential drugs & supplies for health centers and health posts.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Follow up for appropriate drug treatment at HP & HC level	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
		Follow up for proper counseling and follow up at health post & HC	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Facilitate rehydration therapy with the new ORS formula		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Facilitate Zinc treatment for diarrhea		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Give regular on the job trainings and technical assistance in IMNCI implementation at health post & health centers		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Support/Build capacity of health workers and District Health Office staff in proper supervision and routine monitoring, in sustaining facility & community level activities		<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Review quality improvement options with partners in delivery of MCH services (Conduct an operational research)		<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Review Regional data collection/HMIS in standard documentation, reporting to make them user friendly toolkits		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Strengthen existing supportive supervision for HEWs jointly with district health office health center staff		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Facilitate Use/adoption of standard supervision checklists inclusive of curative services and counseling services		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Avail Standard job aids for reference and documentation (registers, reference job aids for key messages delivery, IMNCI reference materials/algorithm)		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Conduct joint Review meetings and feed backs on performance on regular bases (Recognize best performances)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Strengthen the link between HEWs & TBAs/TTBAs in essential newborn care and post natal care		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Promote on Early treatment of sick child for fever, diarrhea & pneumonia		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Monitoring and evaluation for program quality						
Annual Progress Review & Planning meeting		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Mid term Evaluation Survey		<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Review midterm assessment and MTE findings & recommendations with MOH and partners, prioritize & schedule actions to address recommendations, & plan for required actions		<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	

	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intermediate Result 3: Knowledge and acceptance of key services and behaviours increased	Adopt/Develop education materials/teaching aids for key messages in child health, in appropriate behaviors & practices	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Provide health promotion activities in health facilities in child health, nutrition, care seeking, hygiene and sanitation during one to one sessions or during health education	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
	Deliver key behaviors & practices in appropriate care seeking for ill child, in recognition of signs needing proper treatment, in recognition of danger signs through trained CRPs/CVs/HEWs at household level	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
	Promote on Appropriate hand washing practices	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
	Promote standard immunization services during health facility visits	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
	Promote on proper oral rehydration at health facilities and home during diarrhea	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
	Counsel/advise caretakers on proper feeding and fluid during diarrhea episodes	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
	Counsel Caretakers in proper breast feeding, proper feeding for infant & young child and feeding during illness	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
	Counsel caretakers in one to one and in groups about household sanitation & hygiene (Proper hand washing, safe waste disposal & safe water storage/ treatment) using trained HEWs &CHPs/CRPs	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
	Inform community on ITN availability and proper utilization by children & pregnant women	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
	Ensure caretakers understanding of importance of referral and follow up of sick child	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intermediate Result 4: Social and policy environment enabled and sustainability of all activities improved	Collaborate with RHB and other partners on child survival working groups at Regional and National level	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
	Work with Go/NGO/UN partners for policy improvement in HSDP-IV particularly in CCM of pneumonia by HEWs	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Document and disseminate evidence based best practices in CCM using MoH guidelines and documents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
	Lead Regular partners coordination,advocacy and policy dialogue in CCM and evidence based new born & child practice	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
	Conduct joint and integrated supportive supervisions andTAs	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
	Follow up of health facilities functionality in IMNCI implementation and reporting	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
	Facilitate proper health service delivery by health posts in collaboration with MoH and partners	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
	Support and facilitate standard documentation and regular reporting by health posts & health centers	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
	Standardize the referral link between HEWs and TBAs/CHPs in safe & clean delivery & postnatal visit	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
	Participate and advocate through Save the Children Office of Health/SNL Program Learning Group	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
	Participate in periodic Regional child survival taskforce meetings	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
	Document and share child survival interventions & updates in regional review meetings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
	Support and participate in national child survival taskforce to advocate for policy change in CCM	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
	Conduct regional TAG meeting	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

ANNEX 3: BUDGET
THIS IS IN EXCEL AND ATTACHED.

ANNEX 4: PAPER ABOUT PROJECT

SUPERVISING HEALTH EXTENSION WORKERS IN SHEBEDINO DISTRICT IN ETHIOPIA'S SOUTHERN NATIONS AND NATIONALITIES PEOPLE'S REGION:

A FIRM FOUNDATION TO BUILD UPON

Hailu Tesfaye, Tedbabe Degefie, David Marsh

(draft September 17, 2009)

Background: The Health Extension Program (HEP) is a pro-poor strategy in which trained, supervised Health Extension Workers (HEW) deliver mainly preventive interventions to communities and households. HEWs are women who are well-educated (\geq grade 10) and well-trained (one year of theoretical and practical training).

A successful HEP requires strong training and strong supervision. Assuring the quality of HEW performance, inseparably linked to supervision, remains a challenge.

The Ministry of Health (MoH) assigns one HEW Supervisor to work full-time to supervise five HEWs at their respective Health Posts. The HEW Supervisors, based at Health Centers (HC), report to District Health Office (DHO). They are supposed to track HEP implementation and HEW performance, providing technical support to HEW and identifying areas for improvement. HEW supervisors are either Environmental Health professionals or Public Nurses trained for one month in the HEP package and in supportive supervision. Supervisor training is competency based with 60% practical session and field practice. MoH plans to train 3200 HEW supervisors in one year; SNNPR has trained its allotted 638 HEW supervisors.

There are currently two supervision systems: the Integrated Supportive Supervision (ISS) introduced in 2006 and HEP Supervision introduced in 2007/8. The ISS Tool was developed before the supervision system for the HEP and lacks a section for HEP. The RHB, SZHD and Shebedino DHO use the ISS Tool and methods (frequency, sampling, etc); the HEP teams in the RHB and DHO use HP Supervision Checklist.

Save the Children, USA (SC) commenced a five-year (2008-2012) health project in two districts in Southern Nations Nationalities People's Region (SNNPR) to strengthen delivery of child survival interventions through HEWs. During program design and planning the SC team was reminded that HEW supervision remained a challenge. MoH partners prioritized it as the most important area for operations research. We aimed to describe and understand the current HEW supervision processes in SNNPR, thereby to inform the design of a feasible supervision tool and methodology.

Methods: Shebedino District has 35 rural kebeles, 30 Health Posts (HPs) and five HCs. The planned HEP supervision structure has: two experts at the Regional Health Bureau (RHB), one HEP Coordinator at both the Sidama Zone Health Department (SZHD) and at Shebedino District Health Office (DHO), and one HEW Supervisor for each five HP at each HC. We intended to interview all the supervisors at each level. We conducted in-depth interviews over

two weeks (June 1-15, 2009) in two sessions at each level with eight key informants: two HEP experts at RHB, one HEP coordinator at the SZHD, two HEP coordinators at Shebedino DHO, and three HEW supervisors from three Shebedino HCs. Though Shebedino has five HCs, only three had HEW supervisors in place. We used semi-structured question guides to characterize: (1) the current supervision plan; (2) its implementation; (3) explanations for variance, if any; (4) supervision content; (5) job aids; (6) use of findings; (7) supervisor's training; and (8) supervision of supervisors. After obtaining respondents' oral consent, we wrote detailed notes. We tabulated the responses thematically and categorized variables as high, medium and low, as follows:

Frequency – the proportion of planned supervisions that actually occurred at each level in a given period (high: >75% planned supervision occurred; medium: 50-75%; low: only <50% planned supervision occurred)

Coverage – the proportion of HPs actually supervised in a given period (high: >75%; medium: 50-75%; low: <50%)

Checklist availability – High: checklist available, used and seen; medium: available but not used; low: no checklist

Use of Data – reported use of supervision findings for: (a) immediate feed back, (b) written feed back, (c) action planning based on the gaps, (d) informing the responsible actors and next level supervisors, and (e) rewarding the best performances (high: 5/5; medium: 4/5; low: 3/5 or less)

Training in HEP Supervision – High: Master TOT; medium: 1 month; low: not trained or incomplete)

Supervision of Supervisors – High: Supervisor was supervised every month and given feed back, documented; medium: Supervised every quarter and given feed back and documented; low: Supervision < quarterly.

Results The **RHB** planned quarterly supervision of a sample of HPs (4HPs per district) using either the ISS Tool or the HEP Supervision Checklist. The ISS tool was used once, while the RHB HEP team completed the four scheduled supervision visits using the HEP Supervision Checklist. The HEP team visited all sampled HPs per plan. The planned content of the supervision addressed the HEP package (disease prevention and control, family and child health, hygiene and environmental health, health education and communication) and other health interventions. Actual supervision included reviewing the plan and performance for the HEP package, record review, on-site problem-solving, inquiring about but not inspecting supplies, reviewing monthly reports and occasionally liaising with community (by one supervisor). Some RHB supervisors were trained in supervision – or even as master trainers – while others had no training. RHB supervisors were not supervised.

The **ZHD** planned quarterly supervision of the DHO and HPs, but accomplished only three of the four visits (75%) due to transport, workload, and time constraints. The focus of the supervision was the HEP package, as assessed with the ISS Tool. ZHD used the findings to track activity and guide discussions with the decision-making ZHD management team. The HEP supervisor had not been trained in supervision, nor had the RHB supervised the ZHD in last year.

The **DHO** planned quarterly supervision and accomplished 75%-100% of its plan, less than complete due to shortages of transport, manpower and time. The focus of supervision was the HEP package and other health services, using the ISS Tool. Supervisors used findings for on-the-spot feedback, and the district's HMIS Committee used findings to revise plans in the case of low performance. This committee (composed of DHO, administration and other sector offices) also reviewed the content, completeness and use of the HMIS at district level. The DHO Head and Deputy Head supervised the HEP supervisors during the ISS of other health services. Neither district supervisor was trained in ISS or HEP supervision, but they were supervised twice by the ZHD in last year at the DHO.

The three HEW Supervisors³ at the **Health Center level** had different supervision plans. Some planned to supervise one HP per day while others planned two supervisions per week or even quarterly supervision. They accomplished only 40-60% of the plan due to lack of transport, budget for per diem, fuel, and supplies like stationery and due to the demands of work and meetings. The content of supervision included the HEP package, community sensitization, meeting volunteers and tracking achievements versus plan. They visited all planned HPs at each visit. They were not able to produce the HEP Supervision Checklist. The findings informed feedback, reporting and re-planning. Training in supervision varied: one received the full one month; one did not complete it; the third had had none. They were supervised by DHO Supervisors two to three times in a quarter at the HC.

“If I had all the necessary transport means and regular supply of job aids like stationery materials and checklists AND on top of this I get my per diem as is the case for EPI outreach work, I would have done a wonderful job and I am sure I and the HEWs would have implemented all the 6 packages and I would have reached all the HPs I planned to reach and fulfilled all the supervision objectives for which I am trained.” WBD, HC, HEW Supervisor.

HEP supervision varied by the level of supervision (Table 4). The frequency of supervision was high at regional level, medium at zonal and district levels, and low at some HCs. Coverage of supervision was high at all levels. Checklist availability was low at most levels, and the use of data was medium at all levels. Both training and supervision of supervisors were medium to low, with low levels of training at zonal and district levels and low level of supervision of supervisors at regional and zonal levels.

Conclusion

The beginnings of supportive supervision for the HEP were in place in Shebedino District. The DHO assigned supervisors to three of the five HCs. These supervisors reported to the DHO, tracked HEP implementation and HEW performance, provided technical support to HEW and identified areas of improvement. Even supervision of supervisors was occurring. There were training manuals and supervision checklists were included in the training. Supervision training was competency-based and was sometimes used.

³ Two of the five (40%) HCs had no HEW Supervisor (one had resigned and had not been replaced; the other had never been deployed).

There were also several areas for improvement. (1) Most supervisors (from HC) were under-trained. (2) While supervision training was competency-based, supervision itself was not fully competency-based because it was limited to DHO and HC levels, which precluded direct observation at HPs. (3) Supervision was not systematic, lacking checklists at all levels except for the HEP team at RHB level. (4) Supervision was under-implemented. (5) Supervision coverage was not readily obtainable or deemed important – i.e., it was not apparent if remote HPs were ever supervised. Only three of the five HCs had HEW supervisors leaving 50% of the HPs without supervision. (5) HEW Supervisors lacked a uniform supervision plan. (6) HEW Supervisors at HCs were regularly supervised unlike supervisors at regional and zonal levels. (7) Documentation of supervisory findings was poor at all levels. (8) Alternative supervisory methods were lacking, i.e., HEWs never came to the HC Supervisors. (9) Community feedback was not part of supervision. (10) Transport challenges were real, but should have only constrained supervision to remote HPs. (11) No system identified, documented or rewarded good performances or exemplary supervision. (12) Typical with new programs, integration of pre- and post-HEP supervision was lacking.

Comment [S1]: Is this true? I thought coverage was good – where HEW Supervisors in place at HCs. It is good but as you said last time the remote ones may not be reached and HCs had the supervisors in place except for the 2.

In conclusion, supervision is valued and in place and would benefit from fine-tuning. We recommend:

1. Supervision check-lists and job aids to:
 - a. remind supervisor of his/her competencies
 - b. assess his/her supervisees' competencies.
2. Feasible supervision schedules.
3. Testing alternative supervision methods.
4. Competency-based supervision of supervisors.
5. Continued competency based training for supervisors
6. Transport/logistics support to HEW supervisors
7. Recognition of exemplary supervisory behavior.

Table I: Level, plan and performance of supervision for HEP at RHB, SZHD, Shebedino DHO and HCs, June 2009.

Level	ISS				HEP			
	Frequency Per Year		Sample Size		Frequency Per Year		Sample Size	
	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual
RHB#	1	1	1-2HP per district	1-2HP per district**	4	4	2 HC and 4 HP per District	2 HC and 3-4 HP per district**
ZHD					4	3	3 HP per district	3 HP per district
DHO*					4	4	32 HP per month	32 HP per month by 2 supervisors
HC					4-52	4-24	5 HP per week	1-2 HP per week

Comment [S2]: Overall, there is a TREMENDOUS HEW supervision effort envisaged. It seems too much in my opinion. Not a good use of resources to have such an ambitious plan. It could be so much better if there were fewer, but better, contacts.

Comment [S3]: Are these visits mainly to supervise the supervisors or to actually supervise the HEWs? It is to supervise the HEWs and their accomplishment

Comment [S4]: This is incredible to me that the DHO would spend so much resources on supervising when there is a fully dedicated cadre of HEW supervisors at the HC level. Am I missing something? The DHO based HEP Coordinator has to visit all HPs in even in a month time with the HEW supervisor, what they usually have is 2DHO supervisors to share the HPs.

*Shebedino has 66 HEWs and 32 HPs ** Mostly achieve to visit planned HPs but in few occasions they may not visit a HP if the HEW is in a meeting, workshop or HP is inaccessible # The SNNPR has 133 Districts (8 are Special Districts) and Sidama Zone has 19 Districts

Table 2: Key Informants educational back ground, knowledge and experience in supervision

SN	Name	Age	Sex	Educational Status	Current Position at Interview	Trained in supervision (Y/N, for how long)	Experience in Supervision (Yrs)
1	Dr Sahile Sita, RHB	52	M	MD, MPH	Family Health Department Head	Yes in ISS for 5 days	Supervisory position for 15 years
2	Getachew Assefa, RHB	57	M	BSc in Health care management	HEP expert	Yes, 3 weeks, master trainer in HEP supervision	5 years in supervision and 30 yrs with MoH
3	Adanech Tadele, SZHD	39	F	Senior clinical Nurse, Diploma in Development Studies	SZHD HEP Coordinator	No	7 years in supervision and >20 yrs with MoH
4	Tadesse Demisse	47	M	Senior Clinical Nurse	DHO, HEP Coordinator	No	28 years MoH service and 1 year supervision experience
5	Yonas Henchera		M	Senior Clinical Nurse	DHO, HEP Coordinator	No	13 yr in MoH and 7 yrs in supervision
6	Wudeneh Beza		M	Senior Clinical Nurse	Dulecha HC, HEW Supervisor	Yes	2 years MoH experience and 1 year supervision
7	Kedilmeles Asfaw		M	Environmental Health	Leku HC, HEW Supervisor	Yes but incomplete	6yeras MoH and 2 years supervision
8	Alemu Bokolla		M	Senior Clinical Nurse	TelamoHC, HEW Supervisor	No	5 years MoH and 1 year supervision

Table 3: Summary result of key informant in depth interview for HEP supervisors

Questions	RHB HEP Expert RE1. Getachew Assefa RE2. Dr. Sahile Sita	ZHD HEP Co ZE1. Sr. Adanech Tadele	Woreda HEP Supervisor (2) WS1. Tadesse Demisse WS2. Yona Hechera	HEW supervisor HS1. Wudeneh Beza-Dulecha HC HS2. Kedilmeles Asfaw-Leku HC HS3. Alemu Bokolla-Telamo HC
1. What is the current supervision plan?	RE1. Quarterly for sample HEP/Regional Q6mo RE2. Annually	ZE1. The plan is on quarter basis to WHO	WS1. Quarterly WS2. Same	HS1. 1HP per day HS2. Two times per week for each kebele HS3. On quarterly basis
2. How Much of the plan is implemented?	RE1. 4x at RHB level in 2000EC, we have monthly meeting as a team RE2. All the planned activities are implemented	ZE1. Three times (75%)	WS1. 3x (75%) WS2. 4x (100%)	HS1. 2HP per week (40%) HS2. Six kebeles seen regularly out of ten (60%) HS3. implemented three times
3. What explains the Variance?	RE1. No Variance RE2. No variance	ZE1. Transport problem, workload and time constraint	WS1. 1. Shortage of transport. 2. Shortage of manpower in the office. 3. Shortage of time due to different activity	HS1. 1. No Transport 2. No Incentive/per diem 3. Supplies shortage: stationary HS2. 1. Shortage of transport 2. Fuel shortage for motor bike HS3. Transport problem, workload and overlapping with meetings
4 What is the content of supervision?	RE1. I6 package of HEP, Kebele plan RE2. All health interventions	ZE1. Health Extension packages (Intervention)	WS1. All health extension packages and integrated health activities at health center and health post level WS2. All HEP package and Health programs including	HS1. HEP I6 package, community support/sensitization/meet leaders and VCHW HS2. Activities mainly focused on Community compulsion. HS3. Documentation of plan and

			environmental health, Surveillance, HIV etc.	achievements
5 What job aids do supervisors use?	RE1. RHB HEP team checklist, ISS tool RE2. Integrated supportive supervision checklist	ZE1. Integrated supervision checklist having all activities	WS1. Check list WS2. Same	HS1. Checklist (from training, Not seen & was not available on interview) HS2. No check list used during supervision HS3. There is no job aid
6 How are data from supervision used?	RE1. Spot feed back and support, Written feed back and action plan RE2. For re-planning, for discussion and monitoring the progress of activities	ZE1. For analyzing activity progress and for discussing the progress with decision making body	WS1. For feed back and for HMIS Committee meeting discussion and to re plan the low performance activities WS2. Same	HS1. Feed back to HEWs HS2. For report and no written feed back given. HS3. For discussion, decision making and re-planning
7 What training do supervisors received?	RE1. Master TOT and HC & Woreda person trained for 3 months RE2. Some supervisors took supervisory skill training while others not.	ZE1. No specific training was given	WS1. No formal training WS2. No Training	HS1. 3 months HEW supervisory training HS2. Health extension supervision training but not completed HS3. No training was given
8 How are supervisors supervised?	RE1. RHB supervises DHO and DHO need to do monthly supervision to HC RE2. There was no integrated supervision from FMoH, but each department was supervising (separately) depending on the area of his/her responsibility.	ZE1. There is no integrated supervision from RHB	WS1. By District health office Head/Deputy Head and ZHD 2x in 2001 EC FY ZHD gave feed back only once WS2. Same	HS1. By DHO HEP supervisors, had ISS in 2 months, has not used checklist and no written feed back but verbal HS2. By Woreda Supervisor quarterly HS3. On quarterly basis by DHO using supportive supervision checklist

NB: RE=Regional Expert, ZE=Zonal Expert, WS=Woreda Supervisor/HEP Co, HS=HEW supervisor, DHO=District Health Office, RHB=Regional Health Bureau, ZHD=Zonal Health Department, ISS=Integrated Supportive Supervision, HEP=Health Extension Program, HEW=Health Extension Worker.

Table 4: Supervision of HEP/HEWs: Key characteristics by Supervision level*

Characteristics	RHB	ZHD	DHO	HC
Frequency	High	Medium	Medium-High	Low-Medium
Coverage (HP)	High	High	High	High
Checklist	High	Low	Low	Low
Use of Data	Medium	Medium	Medium	Medium
Training	Medium	Low	Low	Medium
Supervision of supervisors	Low	Low	Medium	Medium

*See text for definitions of high, medium, low

Comment [S5]: Is this "high" score consistent with conclusion #5? Yes it is the proportion of HPs actually supervised in a given period, it high may be the selected HPs were not inaccessible or remote.

ANNEX 5: RESULTS HIGHLIGHT-PROMISING PRACTICE

The first time implementation of Integrated Management of Newborn and Childhood Illness (IMNCI) strategy at all 55 health posts by Health Extension Workers in Shebedino and Lanfero Districts of SNNPR, Ethiopia.

Our baseline health facility assessment found that not one Health Extension Worker (HEW) in the health posts of the two project districts (Lanfero and Shebedino) was trained in *integrated management of newborn and childhood illness (IMNCI)* to manage sick children at their health posts. All the HEWs did not have the skills to treat a child using the IMNCI strategy, a holistic and integrated approach for front-line health workers to address common child killers. The sick under five children registers were generally not available or were incomplete. Sick children were occasionally registered with all cases who visited their health post, so the numbers of cases reported to the district health office did not match the registered cases. The sick child registration, documentation and reporting were poor.

Save the Children, in close collaboration with the Regional Health Bureau and John Snow International (JSI), conducted a six-day, competency-based IMNCI training for 109 HEWs (96% of the 121 HEWs targeted for training) working in the 55 health posts in the two districts. All health posts and HEWs were also supplied with the IMNCI chart, reference guide, and registration books to manage sick children. Health posts were also supplied with allowable first line drugs like ORS and antimalarials. Following training, the HEWs were supervised regarding implementation of IMNCI for the first time ever in their health posts. When skill gaps were identified, on-the-job training was provided.

All 55 health posts now use IMNCI strategy to treat sick children under age five years, as of July 2009. The IMNCI implementation, which formerly was only at the 8 health centers (covering 33,400 children under five [25,000 population per HC and 16.7% are under five children], now reaches an additional 45,925 under five children under the 55 health posts [5000 population per HP and 16.7% are under five children]).

The 109 HEWs can now assess, classify and treat cases presenting with fever and diarrhea; they can assess and treat children with malnutrition and assess, classify cough or difficult breathing and refer children with pneumonia. All 55 health posts now use a standard IMNCI register to document all sick child visits to their health posts. The joint supervisions conducted with Ministry of Health has found out that the HEWs implement IMNCI in their respective health posts, all sick child visits are documented, and the number of sick child visits to the health posts has increased.

This IMNCI training for HEWs and its implementation at all 55 health posts by HEWs was of its first kind in the region, which was recognized by the Regional Health Bureau and in National IMNCI review meeting as a model for scale up.

ANNEX 6: UPDATED CSHGP PROJECT DATA FORM

**Child Survival and Health Grants Program Project Summary
October 2009
Save the Children (Ethiopia)**

General Project Information:

Cooperative Agreement Number: GHS-A-00-07-00023
Project Grant Cycle: 23
Project Dates: (10/1/2007 - 9/30/2012)
Project Type: Standard
SC Headquarters Technical Backstop: David Marsh
Field Program Manager: Hailu Tesfaye
Midterm Evaluator: External
Final Evaluator: External
USAID Mission Contact: Mequanent Fentie

Field Program Manager Information:

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Funding Information:

USAID Funding: (US \$): \$1,500,000 **PVO match: (US \$)** \$400,000

Project Information:

Description:

Nearly half a million Ethiopian children die each year before their fifth birthday. Save the Children was awarded a five-year Standard USAID/CSHGP Child Survival Project (CS-23) - Innovation for Scale: Enhancing Ethiopia's Health Extension Package in the Southern Nations and Nationalities People's Region (SNNPR) - to address four main causes of child death: (1) pneumonia, (2) malaria, (3) diarrheal diseases (that together account for 68% of under-five mortality); and (4) neonatal infection, responsible for half of all neonatal mortality. This project is being implemented in the two SNNPR woredas of Shebedino (Sidama Zone) and Lanfero (Silti Zone) with the potential of taking the interventions to scale at the regional level in SNNPR.

Program location and population The project reaches a total population of 366,898 in Shebedino (255,209) and Lanfero (111,689) districts, including 16, 645 infants 0-11; 13, 948 children 12-23 months; 40,815 children 24-59 months; 69, 491 children 0-59 months; and 87,496 women of reproductive age.

Estimated level of effort: Selected CSHGP interventions are:

- Pneumonia Case Management 35%;
- Immunization (5%);
- Control of Diarrheal Diseases 20%;
- Prevention and Treatment of Malaria (PTM) 20%; and
- Newborn Care 20%.

The project's key implementation strategy is Community Case Management (CCM), supported by behavior change at the household and community level.

Problem statement: Ethiopia's most recent Demographic and Health Survey (2005 EDHS) reports an under-five mortality rate (U5MR) of 123/1,000 live births, a third (32%) of which is neonatal mortality (39/1,000). While reflecting a welcome 15-year decline in under-five mortality, the rate of decline is attenuated by entrenched environmental and socio-economic conditions: low access and availability of quality health care; poor illness recognition, child health practices, and care seeking behaviors at the household-level; and a weak social and policy enabling environment. Like most high mortality countries, Ethiopia is not on track to achieve Millennium Development Goal (MDG) 4 by 2015.

SNNPR is a USAID priority geographic area with significant Save the Children history and presence. Our principle partner is the MOH, comprised of the SNNPR Regional Health Bureau (RHB), Sidama and Silti Zonal Health Desks (ZHD), and District (woreda) Health Offices (DHO). Save the Children collaborates closely with the USAID Mission-funded health sector bil-lateral - currently IFHP (Integrated Family Health Program) - being carried out by John Snow International and partners. IFHP will be followed by a new bi-lateral cooperative agreement integrating family planning and maternal, newborn, and child health to begin in FY09 or earlier. In this child survival project, Save the Children is enhancing an existing government package already operating at national scale. The HEP is the government's pro-poor strategy that ensures increased efficiency, expanded coverage, and equitable access. Through the HEP, the Ministry of Health (MOH) strives to bring a set of evidence-based promotive, preventive, and limited curative interventions closer to the household level. Under the current Ethiopian government HSDP-III, the HEP is being taken to scale nationally.

Delivered by trained community-based government-salaried HEWs – who assisted with behavior change interventions by Volunteer Community Health Workers (VCHWs) – the HEP comprises “16 packages” comprising HIV/AIDS prevention, water and sanitation, hygiene, immunization, and best practices for maternal, newborn, and child health at the household level. A limited set of curative interventions includes use of oral rehydration solution (new formula ORS) and zinc therapy (as yet not operationalized) for diarrhea; Rapid Diagnostic Testing (RDT) for malaria with Coartem® for falsiparum and chloroquine for vivax; and assessment and referral of

pneumonia, dysentery, and neonatal infection. Government policy does not yet authorize use of antibiotics at the health post level; so HEWs are currently unable to treat pneumonia, dysentery, or neonatal infection.

Advocacy for policy change and evidence of feasibility are necessary to complete a basic but full package of life-saving community case management interventions to the health post level. Relatively high SNNPR population density means that high coverage for targeted interventions is achievable for this project. Long-term sustainability and cost-effectiveness are ensured by planning jointly with MOH partners, drawing upon local resources, reinforcing in-country capacity, and using available community assets (e.g., TBAs, volunteers). The project’s targeted communication and advocacy strategy, as well as linkage to a national-level newborn health evidence-generating initiative, strengthens the social and enabling policy environment. Proposed operations research The following two questions have emerged as particularly critical to project success potential to inform scale up: (1) With optimal information, education, and communication - how much can we increase care-seeking at the health center level for cough and fast or difficult breathing? and (2) What are some feasible Supervision Packages, in terms of content, process, and schedule? Concept papers have been developed for these two questions and reviewed at the first meeting of the project’s Technical Advisory Group (TAG) and decided to do the Operations Research on the 2nd question.

Program goals, objectives, results:

Goal: Under-five mortality reduced;

Strategic Objective: Use of key child health services and behaviors improved;

Intermediate Result (IR)-1: Access and availability of child health services and supplies increased;

IR-2: Quality of child health services increased;

IR-3: Knowledge and acceptance of key child health services and behaviors increased;

IR-4: Child health social and policy environment enabled.

Major strategies per IR IR-1: Community case management and strengthened Expanded Program of Immunization (EPI) at the health post level; IR-2: Capacity-building, training, and supervision for improved systems and provider performance; IR-3: HEP “16 packages” for behavior change delivered at health post and household levels by HEWs and VCHWs; IR-4: Technical communication and advocacy directed at government, professional associations, civil society, and MOH for policy change to support use of antibiotics by HEWs at the level of the health post.

Location:

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

Project Partners	Partner Type	Subgrant Amount
N/A	Subgrantee	

General Strategies Planned:

Advocacy on Health Policy

Strengthen Decentralized Health System

M&E Assessment Strategies:

- KPC Survey
- Health Facility Assessment
- Lot Quality Assurance Sampling
- Participatory Evaluation Techniques (for mid-term or final evaluation)

Behavior Change & Communication (BCC) Strategies:

Interpersonal Communication

PVO	Non-Govt Partners	Other Private Sector	Govt	Community
US HQ (General) US HQ (CS unit) CS Project Team	(None Selected)	(None Selected)	National MOH Dist. Health System Health Facility Staff	VCHWs

Interventions/Program Components:**Immunizations (5 %)**

(IMNCI Integration)

(VCHW Training)

- Classic 6 Vaccines
- Mobilization
- Measles Campaigns
- Community Registers

Pneumonia Case Management (35 %)

(IMNCI Integration)

(VCHW Training)

(HF Training)

- Pneum. Case Mngmnt.
- Case Mngmnt. Counseling
- Access to Providers Antibiotics
- Recognition of Pneumonia Danger Signs
- Zinc
- Community based treatment with antibiotics

Control of Diarrheal Diseases (20 %)

(IMNCI Integration)

(VCHW Training)

(HF Training)

- Hand Washing
- ORS/Home Fluids
- Feeding/Breastfeeding
- Care Seeking

- Case Mngmnt./Counseling
- POU Treatment of water
- Zinc

Malaria (20 %)

(IMNCI Integration)

(VCHW Training)

(HF Training)

- Training in Malaria CM
- Access to providers and drugs
- Care Seeking, Recog., Compliance
- Community Treatment of Malaria
- ACT

Maternal & Newborn Care (20 %)

(VCHW Training)

(HF Training)

- Recog. of Danger signs
- Newborn Care

Target Beneficiaries:

Infants 0-11 months:	16,645
Children 12-23 months:	13,948
Children 24-59 months:	40,815
Children 0-59 months:	69,491
Women 15-49 years:	87,496
Population of Target Area:	366,898

Rapid CATCH Indicators:

	Numerator	Denominator	Percentage	Confidence Interval
Percentage of children age 0-23 months who were born at least 24 months after the previous surviving child.	0	0	0.0%	0
Percentage of mothers with children age 0-23 months who received at least two Tetanus toxoid vaccinations before the birth of their youngest child.	558	600	91.7%	0
Percentage of children age 0-23 months whose births were attended by skilled personnel.	10	599	1.4%	0
Percentage of children age 0-23 months who received a post-natal visit from an appropriately trained health worker within 3 days after the birth of the youngest child.	19	599	3.5%	0
Percentage of children age 0-5 months who were exclusively breastfed during the last 24 hours.	5	155	2.5%	0
Percentage of children age 6-23 months who received a dose of Vitamin A in the last 6 months (Mother's recall).	251	444	60.1%	0
Percentage of children age 12-23 months who received a measles vaccination.	152	248	59.7%	0

	Numerator	Denominator	Percentage	Confidence Interval
Percentage of children age 12-23 months who received a DPT1 vaccination before they reached 12 months.	204	248	79.9%	0
Percentage of children age 12-23 months who received a DPT3 vaccination before they reached 12 months.	112	248	46.7%	0
Percentage of children age 0-23 months with a febrile episode during the last two weeks who were treated with an effective anti-malarial drug within 24 hours after the fever began.	41	196	17.4%	0
Percentage of children age 0-23 months with diarrhea in the last two weeks who received oral rehydration solution (ORS) and/or recommended home fluids.	87	159	56.5%	0
Percentage of children age 0-23 months with chest-related cough and fast and/or difficult breathing in the last two weeks who were taken to an appropriate health provider.	43	135	31.9%	0
Percentage of households of children age 0-23 months that treat water effectively.	65	600	13.0%	0
Percentage of mothers of children 0-23 months who live in a household with soap or a locally appropriate cleanser at the place for hand washing that and who washed their hands with soap at least 2 of the appropriate times during the day or night before the interview.	150	600	28.2%	0
Percentage of children age 0-23 months who slept under an insecticide-treated bed net (in malaria risk areas, where bed net use is effective) the previous night. This indicator should be used for programs in Africa. In Asia, this indicator should be used in specific geographic areas where bed net use is recommended.	253	600	39.9%	0
Percentage of children 0-23 months who are underweight (-2 SD for the median weight for age, according to WHO/NCHS reference population).	111	548	18.8%	0
Percent of infants and young children age 6-23 months fed according to a minimum of appropriate feeding practices.	202	444	36.1%	0

Comments for Rapid Catch Indicators

1. Child spacing was not collected. This was an oversight.