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

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**Ethiopia CS-17
Third Annual Report**

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Acronyms and Terms

ACNM	American College of Nurse-Midwives
ANC	Antenatal Care
AIDS	Acquired Immune Deficiency Syndrome
ARSH	Adolescent Reproductive and Sexual Health
BC	Behavior Change
BCC	Behavior Change Communication
BHT	Bridge-to-Health Team
C&S	Care and Support
CBO	Community-Based Organization
CCM	Community Case Management
CDC	US Centers for Disease Control and Prevention
CDD	Control of Diarrheal Disease
CHW	Community Health Worker (BHT and HAC members, TBAs, CMWs, CBDs)
C/H IMCI	Community-Health Integrated Management of Childhood Illness
C-IMCI	Community-Integrated Management of Childhood Illness
CMW	Case Management Worker (CHW trained to do case management)
COP	Chief of Party
CS-13	Child Survival-13, <i>WomanWise</i> , the previous CS project in Liben District, funded through the 13 th cycle of the PVO CS Grants Program.
CS-17	The current child survival project in Liben District, <i>Essential Services for Maternal and Child Survival in Ethiopia: Mobilizing the Traditional and Public Health Sectors and Informing Programming for Pastoralist Populations</i> , funded as a cost-extension of the CS-13 grant, mainly through the 17 th cycle of the PVO CS Grants Program, is referred to as “CS-17” throughout this document to distinguish it from the previous “CS-13” grant, and for the sake of brevity.
CSTS	Child Survival Technical Support Project
DAP	Development Assistance Program (current FFP-funded Liben Title II program)
DHMT	District Health Management Team
DFOD	Deputy Field Office Director of Save the Children
DHO	District Health Office/Officer

DIP	Detailed Implementation Plan
DPT3	Diphtheria/Pertussis/Tetanus Vaccine, 3 rd dose
EFO	Ethiopia Field Office of Save the Children
EMOC	Emergency Obstetric Care
EOC	Essential Obstetric Care
EPI	Expanded Program for Immunization
FGD	Focus Group Discussion
FHI	Family Health International
FOD	Field Office Director of Save the Children
FP	Family Planning
FY	Fiscal Year
GOE	Government of Ethiopia
HAC	Health Action Committee
HACI	Hope for African Children Initiative
HBLSS	Home-Based Life-Saving Skills
HEPP	Health Extension Package Program
HIV	Human Immune Deficiency Virus
HMIS	Health Management Information System
HNP	Healthy Newborn Partnership
HO	Home Office of Save the Children
HRD	Human Resource and Development
IEC	Information, Education and Communication
IMCI	Integrated Management of Childhood Illness
<i>Katenas</i>	Community consisting of several villages, but smaller than a PA
KPC	Knowledge, Practice, and Coverage
LQAs	Lot Quality Assessment Surveys
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MCM	Malaria Case Management
MNTE	Maternal Neonatal Tetanus
MOH	Ministry of Health
MTE	Midterm Evaluation

OCA	Organizational Capacity Assessment
ORS	Oral Rehydration Solution
OVCs	Orphans and Vulnerable Children
PA	Peasant Association (<i>kebele</i>), an administrative division
PCM	Pneumonia Case Management
PEP/FAR	Presidential Emergency Plan For HIV/AIDS
PLG	Program Learning Group, annual SC meeting for senior health staff
PLWHA	People Living With HIV/AIDS
PM	Program Manager
PVO	Private Voluntary Organization
RDF	Revolving Drug Fund
RH	Reproductive Health
RHB	Regional Health Bureau
SC	Save the Children Federation, Inc. (USA)
SPA	Senior Program Assistant (SC staff in Liben District)
SIA	Supplemental Immunization Activity
SNL	Saving Newborn Lives Initiative
STI	Sexually Transmitted Infection
TA	Technical Assistance
TBA	Traditional Birth Attendant
TTBA	Trained Traditional Birth Attendant
TOT	Training of Trainers
TT2	Tetanus Toxoid, 2 nd dose
UNICEF	United Nations Children's Fund
VCT	Voluntary Counseling and Testing
WRA	Women of Reproductive Age
ZHD	Zonal Health Department

Introduction

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

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

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

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

The Midterm Evaluation (MTE) was conducted by an external consultant, the government of Ethiopia and partners at the end of FY 2003. The findings suggest that implementation is progressing according to plan and it made recommendations that the program is addressing.

I. Main Accomplishments

This is the third annual report for CS-17, *Essential Services for Maternal and Child Survival in Ethiopia: Mobilizing the Traditional and Public Health Sectors and Informing Programming for Pastoralist Populations*. It shows the progress of planned health interventions that were accomplished for the period October 1, 2003-September 30, 2004. The major areas of intervention during this time were: HIV/AIDS/STI, Maternal and Newborn Care, Community-Based Case Management, Expanded Program for Immunization (EPI) and Program Supportive Trainings. Almost all of the activities that were planned for the year have been successfully accomplished, including HIV/AIDS activities which were lagging during the first half of the fiscal year (FY). Moreover, some activities which were not planned but were necessary were also accomplished as a result of the supports provided by other projects like Saving Newborn Lives (SNL), the Development Assistance Program (DAP) and Flex Fund. These include an orientation workshop on C-IMCI for health facility staff members, trainings and preparation of materials on Home-Based Life Saving Skills (HBLSS), refresher training for Case Management Workers, and others.

Highlights of program accomplishments include the 11-day training of Bridge-to-Health Teams (BHTs) identified from five peasant associations (PA) on modified IMCI. This intervention was delayed for two years because government policy prohibited non-health workers from handling antibiotics. However, ongoing dialogue at various levels and the recent decision of the government to expand health service coverage through the Health Extension Package Program (HEPP), have made this possible. In addition, the Zonal Health Department (ZHD) acknowledges the project's significant contribution to increased vaccination coverage. This year's EPI review meeting showed that the Zones' coverage for DPT₃ was 78% and was due to the District's good performance. While this data needs to be confirmed by a Knowledge, Practice and Coverage (KPC) Survey, this coverage is almost twice the national coverage.

The effort to strengthen the care support of the HIV/AIDS component has been successful in securing the initial funding from HACI and three years of additional funding from PEP/FAR. The project also obtained medicines to treat sexually transmitted infections (STI) from other sources. It then provided these drugs to the health facilities after training them on the syndromic management of STIs.

The project has also faced some challenges that include a chronic shortage of staff at all levels of the government. For example, the District Health Office (DHO) is supposed to be staffed by 13 people. However for the past two years, there has only been one person, the District Health Officer (DHO), on staff. There were also staff transfers from the District hospital and the ZHD. These people were working closely with SC and had participated in a number of trainings organized by the project, including the CS-13 final evaluation and the CS-17 DIP preparation. This transfer has created an institutional gap as new staff learn their job responsibilities and become engaged with the project.

Summary of Activities Planned vs. Accomplished in the FY'04

Key Process Indicators	Unit	Annual Plan	Achievement	%	Remark
1. HIV/AIDS/STI					
TBA training on universal precautions	Number	150	146	97	
Peer educators training on HIV/AIDS/STI	Number	109	84	77	
Influential community leaders workshop on HIV/AIDS/STI	Number	127	118	93	
CBO training on home based care, support and follow up	Number	10	10	100	
School Anti-HIV/AIDS clubs training on HIV/AIDS/STI	Number	68	64	94	
District HIV/AIDS council training on program design and management	Number	7	0	0	It was planned to be done in the 4 th quarter but participants from Gov't office were not available since they were busy with other assignments
Quarterly edutainment sessions organized by coached facilitators	Number	96	77	80	
Supervision of HIV/AIDS activities and field support developing and distribution of flip chats	Number	20	8	40	
Provision of STI kits for MOH	Number	-	15		Not planned but provided by EFO
Provide CBOs with home based care and support kits	Number	10	10	100	
2. Maternal and Newborn Care					
TOT for MOH staff on HBLSS	Number	7	7	100	
HAC orientation workshop on HBLSS	Number	66	46	70	Some of them were absent
BHT orientation workshop on HBLSS	Number	66	53	80	
TBA refresher training on HBLSS	Number	300	289	96	
Deliveries attended at health facility	Number		181	-	All are accomplished as a result of trainings given to TTBA's.
Deliveries attended by TTBA's	Number		537	-	
ANC at health facility	Number		4627	-	
ANC at outreach	Number		938	-	
3. Community-Based Case Management					
Case management workers training on PCM/MCM/CDD	Number	10	10	100	
HAC refresher training in PAs with community-based case management	Number	60	57	95	
BHT refresher training in PAs with community-based case management	Number	60	44	73	
MOH staff training on IMCI	Number	14	8	57	The number of trainees was fixed by EFO to sent only 8 trainees to Yergalem

Key Process Indicators	Unit	Annual Plan	Achievement	%	Remark
Health Facility staff orientation workshop on C-IMCI	Number	-	8	-	Not planned but, prioritized for supervision of CMWs.
CMWs (CMWs) refresher training	Number	-	10	-	Not planned in DIP, but given since they stayed longer before they started managing cases with drugs.
4. Expanded Program on Immunization					
Modular EPI training for MOH staff and SPAs	Number	15	10	67	2 health facilities are not functional
Children fully vaccinated	Number	3690	4052	109	
Pregnant women received TT ₂₊	Number	3105	2321	74	
Non Pregnant women received TT ₂₊	Number	4500	4691	104	
5. Program supportive trainings (for all interventions)					
HAC refresher training on all health interventions	Number	444	393	89	
BHT refresher training on all health interventions	Number	444	379	85	

1. HIV/AIDS/STI

1.1. TTBA Training on Universal Precaution

Trained Traditional Birth Attendants (TTBAs) are the primary attendants at almost 95% births in Liben District. They face many challenges including the risk of infection because they lack gloves. In order to minimize the risk of contamination while attending births, a great deal of effort has been made to improve their knowledge and skill about reducing the transmission of HIV/AIDS, for themselves and for the mothers whose births they attend. They have also received training on the prevention of mother-to-child transmission of HIV/AIDS. In this FY, 146 TTBA (97% of the goal) have been trained on universal HIV/AIDS precautions which also enables them to teach mothers how to control and prevent the disease. In response to the need for gloves, they are now included in the Revolving Drug Fund (RDF) kits.

1.2. Peer Educator Training on HIV/AIDS/STIs

Eighty-four peer educators (77% of the goal) were selected from different HIV/AIDS clubs, commercial sex workers and mothers from the community, were trained on HIV/AIDS/STI prevention in order to enable them to educate their friends and neighbors and help reduce the spread of HIV/AIDS within the community. This training has significantly raised community awareness around HIV/AIDS prevention and especially among commercial sex workers.

1.3 Influential Community Leaders Workshop on HIV/AIDS/STI

A workshop for influential community leaders was conducted so that participants could better educate their communities about behavioral factors (Polygamy, sex out of marriage, etc.) that

contribute to the spread of HIV/AIDS. Overall, 118 influential community and religious leaders (93% of the goal) participated. The format of the workshop was participatory and encouraged every participant to share his/her idea on the economical, social and general development impact of HIV/AIDS.

1.4. School Anti-HIV/AIDS Clubs Training on HIV/AIDS/STI

To increase the knowledge of anti-HIV/AIDS club members and to educate school students through them and to use them as a media for community education, training was given on basic HIV/AIDS/STI prevention and control for 64 club members (94% of the goal). To attract the students' attention, media such as poetry, songs and drama were used to raise the awareness of students about the magnitude of the HIV/AIDS problem.

1.5. CBOs Training on Home-based Care Support and Follow Up

In order to build community capacity to address priority health issues affecting mothers and children, training was provided to ten community home-based care providers as planned. The objectives of the training included:

- Provide necessary nursing care and care for people living with HIV/AIDS (PLWHA);
- Provide nutrition education and services for PLWHA;
- Provide care at home for illnesses associated with AIDS;
- Refer cases as needed for medical services; and
- Provide home-based information, education and communication (IEC) and advocacy.

The training was based on a MOH curriculum using participatory approach that included role plays, demonstrations, and actual field practice and the presentation of field results. Ten home-based care kits were provided through the HACI grant in order to assist them to apply the knowledge and skills they have gained from the training and meet the training objectives.

1.6. Edutainment Sessions Organized by Coached Facilitators

School based anti- HIV/AIDS clubs organized 77 “edutainment” sessions (80% of the goal) during the year. “Edutainment” sessions include various components including education by facilitators, question and answer sessions, role plays, songs and poems. The sessions educate while also entertaining the school community. Rural students have been proven to be the most effective mechanism. The information that is communicated during “edutainment” not only enhances the knowledge, attitude and behavior of school children, but also reaches and positively impacts the knowledge base of harder to reach children and families. Therefore, this information also increases maternal knowledge and assists in the promotion of Behavior Change Communication (BCC).

Since the results so far have been encouraging, school-based HIV/AIDS programming should be strengthened in order to further mobilize and motivate these key groups. Partnerships with DHO staffs and teachers will help to improve the performance of these school-based clubs.

1.7. HIV/AIDS Supervision and Field Activity Support

In order to motivate and build the capacity of community-based HIV/AIDS initiatives, regular follow-up and supervision is necessary at all levels. Community and facility-based HIV/AIDS initiatives such as school anti-HIV/AIDS clubs, peer educators, *kebele* HIV/AIDS counsels and health facilities were supported in order to improve their performance so that they can reach the target community and influence behavior at the household level. However, due to unplanned activities such as participating in traditional ceremonies and HIV/AIDS assemblies by project staff, and the shortage of transportation, only eight of the planned 20 visits were made.

As part of the field support for HIV/AIDS, SC participated on four major traditional assemblies (“Gumies”). These were Gubbisa (Borana traditional naming ceremony), Gumi Eldalo, Gumi Gayo and Gumi Boko assemblies. Most of the Gumies are well attended by traditional law makers. In addition to the intensive awareness raising activities that were undertaken during these ceremonies, the assemblies provided a unique opportunity for Gada leaders to make new laws to discontinue harmful traditional practices.

2. Maternal and Newborn Care

2.1. TOT for MOH Staff on HBLSS

HBLSS is a new approach for Ethiopia that contributes to the reduction of maternal and neonatal morbidity and mortality among the rural, underserved communities. In order to familiarize the health workers with this approach and enable them to train and support the TTBAAs, training of trainers (TOT) sessions were provided for seven health workers from Liben District health facilities as per the project workplan.

2.2. TBA Training on Phase II HBLSS

Since Liben is a wide District with scarce health facilities, a lack of skilled health workers and a shortage of life saving supplies, the expansion of life saving skills at the household level is the best strategy to address this need. To this end, with the support of SNL, 289 of the 300 planned TTBAAs were trained on Phase Two of HBLSS. This was a continuation of the first phase that was provided in FY 2003 to train them to save the lives of mothers in their respective PAs. Since most of the TBAs are illiterate, an adult teaching methodology which relies on picture cards was used to ensure their understanding of relevant topics. The training included: child spacing strategies, prevention of neonatal problems during pregnancy, delivery and after birth, birth preparation, immediate newborn care, care of a small baby, and breastfeeding.

TTBAAs in all PAs are increasing the coverage of deliveries attended by trained personnel. The BCC effort carried out by the BHT, attempts to increase the demand for this service. Geographic distance, the scattered nature of settlements, and the TTBAAs’ request to use gloves during delivery, are some of the challenges addressed during this year.

During the discussion on the impact of TTBA, conducted with the BHTs during their refresher training, one woman from Boba PA said:

“The way TTBA is delivering is different from the traditional TBAs. That is to say they care for the infant, they care for the woman and because of their advice mothers are now following the necessary care for early detection of maternal problems which is the indication of big change in the community to save lives of the mothers”.

2.3. HAC and BHT Orientation Workshop on HBLSS

In support of the TTBA's activities and in order to acquaint health action committees (HAC) and BHTs with the revised TTBA reporting format, an orientation workshop was held for 46 HAC and 53 BHT committee members. The goal for the FY was to train 66 members of each, but some did not attend the training. The workshop was participatory in nature and enabled participants to understand the pictorial reporting formats. As a result of this orientation, health activities in all PAs are coordinated and well organized.

3. Community-Based Case Management

3.1. CMWs Training on PCM/MCM/CDD

C-IMCI is intended to contribute to global, national and local efforts to reduce under five morbidity and mortality that result from common childhood diseases. As such, ten, literate BHT members were selected from five pilot PAs and trained how to assess, classify and treat cases based on their knowledge and skill levels. The training was supported by videos, demonstrations, re-demonstration and field visits to nearby PAs and Negelle Hospital throughout the training. During the discussions with HACs and BHTs at the IMCI orientation workshop, they emphasized the need for the provision of health care services closer to home in order to prevent deaths in children under five.

3.2. CMWs Refresher Training

The actual implementation of case management by the case management workers (CMW) was delayed due to drug shortages and difficulties in establishing the RDF using the DHO RDF. This was due to the transfer of key staff to other positions, which made it necessary to provide refresher training. CMWs received refresher training on IMCI drug management in order to enable them to start working in their respective PAs. The pre- and post-tests performed during the training, indicated that CMWs need regular, on-the-job training. The CMWs were actively managing cases, including assessment and referral to the nearest health facility. This demonstrates a high level of motivation. In recognition of their commitment and the challenges of accessing the DHO RDF, SC has identified other sources for the initial supply of drugs to stock the RDF. In this period, the DHO provided the CMWs with anti-malarials, Paracetamol and Cotrimoxazole from the IMCI drug kits for the health facilities. As oral rehydration solution (ORS) is not available, home fluids are recommended. Although these steps address the short-term supply issue, they are unreliable and not sustainable, due to frequent stock-outs and incomplete supplies. Therefore, SC is working hard to establish an RDF.

3.3. MOH/SC Staff Training on IMCI Supervisory Skills

In order to build district capacity, eight health workers (57% of the annual goal) from clinics and health posts, have been trained in IMCI protocol developed by the MOH, in order to enable them to treat cases at the health facility level. This training has increased the knowledge, skills and abilities of front-line health workers to reduce under five morbidity and mortality. Training on IMCI supervisory skills was also provided to MOH and SC staff in order to strengthen the quality of services provided at each district health facility. At the health facility level, health workers are trained in the standard case management, while at the community level, training is provided by BHT cadres. In addition to promoting certain key interventions, the project has taken C-IMCI a step further to include the management of mild diseases and the timely referral of severe cases.

3.4. HAC and BHT Refresher Training in PAs with Community-Based Case Management

Refresher training was provided to 57 HACs and 44 BHTs (95% and 73% of the annual goal, respectively), in PAs with community-based case management, to enable them to support the CMWs. As a result of this training, they are now able to collect data in their respective *katenas* regarding births and deaths, strengthen health education on the prevention of pneumonia, malaria and diarrhea, and also educate the community on environmental concerns and personal hygiene. HAC and BHT members also learned how to teach family members to recognize and seek prompt care for childhood pneumonia, malaria and diarrhea, in order to create an enabling environment for timely care seeking and referral. Through discussion, standards for organizing village committees and managing C-IMCI programs in the PAs were developed and agreed upon.

4. Expanded Program for Immunization

4.1. Modular EPI Training for MOH Staff and SPAs

In order to enhance EPI activities and the quality of services, it is crucial that front-line health workers have current knowledge and skills. As such, modular EPI training was provided to ten (67% of the annual goal) MOH staff members and Senior Program Assistant (SPAs) from health facilities in Liben District, to enable them to educate the community and improve their skills. The EPI program is highly accepted and appreciated by the community members.

4.2. Vaccination of Mothers and Children

The CS-17 project was designed to support DHO and enable them to undertake regular immunization programs on six vaccine-preventable diseases for children under one, pregnant mothers and women of reproductive age (WRA) in the District. To this end during the FY, the project provided logistical support to the DHO in addition to the training that was provided to their staff. The immunization program has been provided at eight health facilities by static delivery, at 27 outreach sites and through services, 4,052 children (109% of the annual goal) were fully vaccinated¹. Moreover, 2,321 (75% of the goal) pregnant women and 4,691 (105% of the goal) non-pregnant WRA received TT₂⁺. As a result, the percentage of fully immunized children increased from 14% to 52% of the target, while the coverage of DPT3 rose to 78%. However, the coverage for TT₂⁺ is still

¹ This could be due to denominator estimation error, neighboring PAs using the services etc.

lagging behind as a result of low social mobilization at the grassroots level. Through the SNL-supported national campaign to eliminate Maternal Neonatal Tetanus (MNTE), formative research-based, multi-channeled communication materials were produced. These materials will be used to reach the different target groups. In addition to SIA, the campaign promotes the routine immunization of WRA and clean delivery.

5. Supportive Program Training on all Health Interventions

5.1. HAC and BHT Refresher Training on all Health Interventions

As most of the BHT and HAC members are illiterate or semi-literate, they rely on their ability to memorize information, which they do very well. However, as the number of topics that they are required to teach increases, including formative research regarding family planning (FP) and nutrition, it was necessary to provide refresher training on all health interventions for 393 HAC (89% of the annual goal) and 379 BHT (85% of the annual goal) members. The goals of the refresher training included; the transfer of new knowledge, skills and attitude on the identified behavior change (BC) messages identified by formative research, to provide updated information, to provide an opportunity to share their experiences implementing activities in their respective areas, and to discuss on how to strengthen future activities. The major topics included during the refresher training were:

- ▶ ☐ Maternal and Newborn Care
- ▶ ☐ Diarrhea , Malaria and Pneumonia control
- ▶ ☐ Expanded Program on Immunization (EPI)
- ▶ ☐ Family Planning
- ▶ ☐ HIV/AIDS/STI, and
- ▶ ☐ Nutrition

During the refresher training, they developed a plan of action to strengthen BCC among the community in collaboration with SPAs who are located at health facilities.

There was a discussion to assess the impact of CHW training, and one BHT member from Hadhessa PA said that:

“The training has great impact because now we are using EPI service, mothers are using family planning, and lactating mothers were not giving colostrums to children and now as soon as the child is born we are giving the first milk to the child, and also workload during pregnancy was not considered as a problem before the training of CHWs. For malaria we were drinking different roots rather than going to the health facility; currently we have enough knowledge on how malaria is transmitted and its prevention method. All these improvements are due to the training of CHWs on all health interventions since they educate the community”.

Another BHT member mother from Malkaguba PA said that:

*“Before we learned about health we were considering pregnant women as any person who does not need any kind of care and they were delivering in the field while they were looking after cattle and fetching water. Now all that are improved, because our friends are teaching us and we teaching our community members with the knowledge we gained from **Shaf** (as they call Save the Children locally)”*

II. Challenges Encountered and Actions Taken

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

1. The main partner for this project is the DHO which has chronic staff shortages. For the past two years, only the head of the DHO has been in place, however the DHMT regularly has 13 positions. Thus it was not possible to conduct any significant capacity building or hold regular meetings or joint supervision visits with the DHMT. Although staff are advocating at higher governmental levels to change this, the problem is widespread and not unique to the district. There are some districts in the Guji Zone that are not staffed at all.
2. The SPAs could not travel to every PA as per the existing workplan due to a lack of motor bikes. The project is waiting for the purchase of four motor bikes to be provided through the SNL project. Procurement was delayed due to a government decision and this activity will be implemented in first quarter of the FY05.
3. Some of the planned activities did not consider the limited capacity of the DHO related to vehicle availability for staff to provide technical assistance for community training in EPI activities. However, the project was able to use some vehicles by diverting them from other activities, and used trainers hired by other projects like SNL, in order to accomplish its annual goal.
4. Negelle Hospital’s voluntary counseling and testing (VCT) center was not selected by the CDC to receive funding and thus these services were not strengthened as planned. The Ethiopia Field Office (EFO) of Save the Children, is continuing its efforts to identify other potential resources.

III. Technical Assistance

The project has benefited from a range of technical assistance provided from both the home office (HO) and the field office. The RH specialist from the HO provided assistance during the initial planning phase of the Flex Fund. The child survival specialist provided his continued support through regular e-mail communication and during Program Learning Group (PLG) meetings. ACNM provided two TA visits during this FY to develop and implement HBLSS phase II. From the field office, the Health and Nutrition specialist provided five TA trips to review program implementation, CMW training and problem solving, and provide technical materials from the Child Survival Technical Support Project (CSTS). In addition, she provided regular support through

telephone communication. Areas that required TA were maternal/newborn interventions and community case management (CCM).

IV. Change from the Program Description

There is no modification to the program detailed implementation plan in terms of goals, objectives, sites or interventions.

V. Phase-Out Plan and Summary of Findings, Conclusions, Recommendations and Action Plan

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

Summary of Findings, Conclusions, Recommendations and Action Plan

SUMMARY FINDINGS and CONCLUSIONS	RECOMMENDATIONS	INITIAL ACTIONS	PERSON(S) RESPONSIBLE	ACTIONS SO FAR TAKEN
PROJECT OVERVIEW				
<p>1. The SC/Liben CS-17 Project incorporates several promising, interesting and innovative strategies:</p> <ul style="list-style-type: none"> ➤ HB-LSS ➤ District HIV/AIDS Council's Community Capacity Building initiatives. ➤ Integration of DAP and CS program activities through integrated EPI, ANC and FP outreach. ➤ The potential for CCM. 	<p>1. Document project successes and advocate for their adaptation to other project sites in Ethiopia and other Child Survival Projects throughout the world.</p>	<p>1. Collect information on program successes.</p>	<p>1. Health Sector Manager, with the support of the M&E Coordinator, the EFO and SC/HQ.</p>	<p>➤ HBLSS</p> <ul style="list-style-type: none"> • CARE ETHIOPIA has visited our project site to share experiences on HBLSS to adapt activities to their organization. • Our Master trainers on HBLSS sent to CARE ETHIOPIA, West Harar project to share their experiences and give training for TBAs to adapt our activities to other part of the country. • The Ethiopian Mid-wives Association sent their two members from two health centers in Addis Ababa to visit our HBLSS activity that enables them to adapt the activity to the other part of the country. • Our Master trainers on HBLSS sent to an organization called INTRA, ETHIOPIA, to share our experience and to give training on HBLSS to their project site located in Amahara region, Tigray region and Benshangul region to adapt our experience on HBLSS. <p>➤ HIV/AIDS</p> <ul style="list-style-type: none"> A. To strengthen HIV/AIDS activity in the District training has given for District HIV/AIDS council on program designing, planning and management activities. B. HIV/AIDS prevention and control sub-committees have organized in all PAs to mobilize the community on HIV/AIDS prevention and control. C. Awareness raising workshop has been given for community representatives to enable them combat barriers that aggravates the transmission of HIV/AIDS/STI among the community. <p>➤ Activity integration</p>

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				<ul style="list-style-type: none"> • Outreach Family Planning, EPI and ANC activities are implemented in integrated manner for better management of activities, and effective and efficient utilization of resources. The activities are implemented with the involvement of MOH, CHWs and the community as well. ➔ Community Case Management (CCM) • Training has been given for health facility workers to enable them treat IMCI cases in their health facilities and to enable them supervise and control the activities of community based case management workers. • Training has been given for community based case management workers who are selected from pilot PAs to start the actual work. • Orientation workshop on CCM has been given for MOH health workers and SPAs to enable them support, supervise and monitor the activities of community based case management workers. • Training has been given on IMCI supervisory skills for selected health workers who took basic training on IMCI to enable them supervise the activity of health facilities and to support, supervise and monitor the community based case management. • Community based case management workers training manual and reporting formats have been adapted from CARE KENYA, and developed according to the local situation and settings. • Community Based Case management training materials, reference materials and different formats have been translated into Afan oromo and given

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				<p>to community based case management workers for better performance.</p> <ul style="list-style-type: none"> • Refresher training on IMCI drug management has been given for the previously trained community based case management workers and they have started the actual treatment of childhood illnesses in their respective PAs. For this activity IMCI drug has given for 4 pilot PAs from health facilities with the facilitation of DHO.
HIV/AIDS				
2. It is common practice for individuals in Liben with STI/HIV/AIDS symptoms to bypass the health care system, going directly to drug vendors to purchase medicines.	2. Consider incorporating a training component for drug vendors that would educate them on symptoms of HIV/AIDS/STIs and the importance of referral for medical care.	2.a. Discuss the need for this training and program options with the members of the District HIV/AIDS Council. 2.b. Implement FGDs with health workers and drug vendors to assess demand for and feasibility of the training.	2. SC/HIV/AIDS Unit Head and members of the District HIV/AIDS Council	<ul style="list-style-type: none"> • STI drugs have been supplied once for all health facilities. • The training of drug vendors is not implemented because of most drug vendors do not have license. To train them they should have official license from the Government.
3. VCT capacity in Liben District is limited to the sparse services available in Negelle Hospital.	3. Build the capacity of the District in VCT. More staff in Negelle Hospital need to be trained in counseling and referral mechanisms need to be established at the health facility level that will involve orientation and training of MOH staff and the establishment of a monitoring system to track referrals from the outlying health facilities to the hospital.	3.a. Assess the sustainability of the supply of reagents. 3.b. Identify training opportunities for hospital staff in counseling. 3.c. Strategy for increasing demand for VCT services. 3.d. Assess infrastructure needs	3. Medical Director/Negelle Hospital, the Oromia RHB and the Health Sector Manager.	<ul style="list-style-type: none"> • Health staffs are trained by MOH. • With the support obtained from C&S project funded by HACI, SC/US has upgraded the Negelle Hospital VCT center with necessary equipments and supplies. Moreover, SC/Negelle Hospital has developed proposal and submitted to CDC for the purpose of standardizing the VCT center of Negelle Hospital. However this funding is not secured.
4. Mothers living in the towns report that they are learning about health through TV and radio, which are becoming increasingly available.	4. The project should explore opportunities to exploit all types of media (TV and radio) available in the project area for communicating IEC messages on HIV/AIDS.	4. Explore the potential for developing and placing health education ads on TV and radio that would appear in Liben District.	4. SC/HIV/AIDS Unit Head with the support of the CS-17 Training Coordinator and the EFO.	In Negelle town home to home visit and education on coffee ceremony is going on for communicating IEC messages on HIV/AIDS. Locally there are no TV and radio that are used for education purpose.
5. The FHI/UNICEF report found compelling evidence of intolerance	5. The CS-17 Project should advocate with the District HIV/AIDS Council to	5. Advocate with District HIV/AIDS Council	5. SC/HIV/AIDS Unit Head and members of the	<ul style="list-style-type: none"> • SC/US is implementing care and support program for PLWHAs and

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directed at PLWHAs and demand for services for OVCs.	focus Phase II of the World Bank funding for care and support of PLWHAs and OVCs.	members to prioritize funding in support of PVLHAs and OVCs in the Phase II funding guidelines.	District HIV/AIDS Council.	OVCs in Negelle town which is funded by HACI project, and also secured three years OVCs focused care and support fund from PEPFAR which is dominantly used for care and support. <ul style="list-style-type: none"> The District HIV/AIDS council is also funded by World Bank to strengthen care and support activities.
MATERNAL/NEWBORN CARE				
6. The District is unable to respond to obstetric emergencies and therefore, women are put at unnecessary risk of maternal death.	6. The EFO, along with other NGOs, multilaterals and government agencies involved in maternal health, should advocate for a change in the GOE policy that restricts the use of c-sections and other EOC surgical procedures to obstetricians, so that general practitioners can be permitted to do these procedures upon completing an appropriate training program.	6.a. Advocate for change in GOE policy restricting care for comprehensive obstetric emergencies to obstetricians. 6.b. Solicit funding to cover costs of training a team from Negelle Hospital (1-2 general practitioners, one scrub nurse and one anesthesiology nurse) and address related infrastructure needs. 6.c. Pursue development of emergency transportation plans at the community level once EOC services are available at Negelle Hospital.	6.a. EFO 6.b. EFO and SC/HQ 6.c. SC/Liben MCH Unit Head and the SPAs.	6b. The EFO developed concept paper to solicit funding form UNFPA to develop the capacity for EMOC which has not been successful. Effort is continued 6.c. Because of emergency obstetric care service is not implemented with trained physicians, emergency transportation plan is not implemented at the community level.
7. There is no regular mechanism for assessing and reviewing complicated deliveries and maternal mortality in Liben District, the information from which could be used to improve practices and the quality of care.	7. The Project should assist Negelle Hospital in establishing a regular system for reviewing complicated deliveries within the District, interviewing the involved TBA, health workers and women to assess whether all the necessary steps were followed and identify areas needing improvement.	7. Establish protocols and regular meeting times to review cases.	7. Medical Director/Negelle Hospital and the SC/Liben MCH Unit Head	Depending on TTBA's monthly report; if there are complicated cases, complication Audit is done on monthly basis to assess complicated deliveries and maternal mortality to improve practices and quality of care at the community level.
8. The TBAs report lack of access to gloves and gowns for deliveries, which is a growing concern with the increasing presence and awareness of HIV/AIDS.	8. The project needs to develop sustainable mechanisms for ensuring a consistent supply of delivery supplies for TBAs, including gloves and gowns.	8. Identify internal Save the Children expertise on RDFs and assess feasibility within Liben context and explore other supply sources.	8. MCH Unit Head and Health Sector Manager	The RDF system that will be in place for the CCM has clean gloves. We will promote it among pregnant mothers as birth preparedness. Alternatively we are teaching TTBA's to use locally made plastic apron and plastic hand cover that is easily accessible and cheap to buy.

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IMMUNIZATIONS				
9. Two health facilities lack functioning refrigerators and some lack EPI cards, both of which were promised by the project.	9. Providing the promised cold chain equipment and EPI cards as soon as possible needs to be a priority as further delays will directly limit the intervention's impact and can undermine the project's credibility.	9.a. Supply frigs as required in the DIP. 9.b. Reassess need for EPI cards as needed.	9. EPI Unit Head	9.a. The two refrigerators are replaced by DHO. 9.b. EPI cards are already printed and distributed.
10. Some mothers expressed concerns about having their children immunized due to perceived side-effects.	10. The project needs to work closely with the HACs, BHTs and TBAs through the SATs to further assess the nature and underlying causes for any community misconceptions about the safety and efficacy of childhood vaccines and develop responsive IEC strategies.	10. Implement FGDs with mothers to identify extent of the belief and if necessary develop IEC messages to counteract false perceptions.	10. EPI Unit Head, the SPAs and the Training Coordinator.	FGDs conducted in sample PAs and discussion made with MOH to minimize the side effects that may occur due to lack of care by health workers. To develop IEC materials formative research is under process to be completed, though major messages that were identified by formative research have incorporated in training materials and implemented during refresher trainings.
MOBILIZATION OF COMMUNITY LEADERS AND TRADITIONAL PRACTITIONERS				
11. The MTE Team found that the project has achieved solid community involvement through its participation as CHWS and in project activities, which needs to be sustained beyond the life of CS-17.	11. The project needs to identify and institutionalize rewards the communities are willing and able to provide as incentives to the CHWs to ensure their continued volunteering with the project and the ability to recruit new CHWs as others move on.	11. Bring the Project staff and partners together to design a system of incentives for community volunteers, which is sustainable by the community itself.	11. Health Sector Manager, Area Manager, senior Liben staff and program partners.	<ul style="list-style-type: none"> The community health service is part of community development activity and the government has given due attention on program sustainability to continue the activities of CHWs even after the project is phase out. There is no tangible incentive that is given for CHWs by their respective PAs. Planning workshop has given for PA chairman and <i>katena</i> leaders on how to support control and monitor the activities of CHWs at PA level for program sustainability.
12. While the project has trained 440 BHTs in CS-13 and CS-17, the number of <u>active</u> BHTs needs to be counted so replacements can be recruited and trained by the end of CS-17 if necessary.	12. The project needs to assess the number of active BHTs throughout the project area and recruit and train replacements as needed.	12. Survey the active BHTs throughout Liben District and if necessary, recruit and train replacements.	12. Training Coordinator and the SPAs.	<ul style="list-style-type: none"> To replace some HAC members who are non-functional due to old age training has been given for newly recruited HACs from PAs that needs replacement. BHTs are traditional practitioners (wise

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				man and wise woman) which can not be replaced by selection, so that we are encouraging the existing BHTs to have apprentices that will replace the elder BHTs for future activities.
COMMUNITY CASE MANAGEMENT OF CHILDHOOD ILLNESS				
13. SC/Liben will need technical support in designing and implementing the CCM strategy.	13. The direct and concentrated involvement of the EFO technical backstopping staff will be required for the adaptation of the CCM training materials and related IEC strategies as well as the overall planning and implementation of CCM.	13. Hold a training meeting to develop an action plan for the design and implementation of CCM	13. EFO backstopping staff, the Health Sector Manager, the MCH Unit Head, the Training Coordinator and representatives from the MOH.	<ul style="list-style-type: none"> In all the health facilities in the District at least one of the two staffs were trained on trained on IMCI with the organization and involvement of EFO Health/Nutrition specialist. Case Management workers training manual and reporting formats are developed by full support of the EFO Health/Nutrition specialist, and here locally translated into Afan oromo for better understanding by the trainees for better program implementation. Community Based Case Management Workers training has been conducted with full involvement and technical assistance of EFO Health/Nutrition specialist.
14. A system that can provide a consistent supply of antibiotics and antimalarials for the CMWs needs to be developed.	14. Technical and administrative support is going to be required throughout the planning and early implementation of the RDF.	14. Identify and access individual(s) with both practical experience and expertise in the design and development of Revolving Drug Funds.	14. The Health Sector Manager, the EFO and SC/HQ.	The EFO has secured other sources of funding to start the RDFs. The initial supply for the community based case management, first round IMCI drug has been given out from Oromia Regional Health Bureau, and CMWs have started treating cases in their respective PAs.
CAPACITY BUILDING OF THE MOH				
15. The GOE policy of 'decentralization' has limited the technical and administrative capacity of the DHO and the DHMT.	15. The project needs to reassess the current and projected capacity building needs of the new DHO within the context of the remaining CS-17 project and the long-term needs related to its sustainability plans. This could require significant restructuring of the project, especially if a majority of these needs	15.a. The potential for growth within the DHO needs to be assessed, which will involve review of any financial and technical resources that it can access through the Zonal, Regional and National Governments	15. The Health Sector Manager, the EFO and the members of the DHMT and DHO.	15. a. • The DHO is now strengthening with human power and budget allocation to manage the health services of the District. For the time being including the DHO head they are 2 in number, and the DHO head mentioned that for FY 05 they will hire additional health workers to strengthen the management of the health services and

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	cannot be resolved through locally available sources.	and other sources. 15.b. All means for accessing technical and financial resources from outside the DHO need to be assessed and if feasible, pursued, including the possibility of contracting with Negelle Hospital for technical support using DHO budget funds.		DHMT as well. • To build the DHO capacity one MOH owned vehicle is maintained by Liben Impact Area office (from DAP budget) for the facilitation of EPI, FP and ANC services in the District. 15. b. They are getting the support from Oromia Regional Health Bureau.
STRENGTHENING HEALTH FACILITIES AND WORKERS				
16. There is an absence of well-written meeting minutes, necessary to track progress on some of the project indicators.	16. Training on recording meeting minutes is required for the SATs and through them, the HACs.	16.a. Design and implement training. 16.b. Follow-up supervision and review of minutes.	16. Training Coordinator and the SPAs.	16. a. Orientation has been given for SPAs on how to take minutes, and Service Area Team (SAT) has started to document meeting minutes where there are SPAs. 16. b. Individual supervision, by CS-17 training coordinator, has done to strengthen the activity of CHWs and to review meeting minutes at SAT and HAC level.
TRAINING				
17. CS-17 staff report not having received technical support in the design, implementation, monitoring and evaluation of training plans and curricula. This is especially timely with the start of CCM approaching.	17. Increase the capacity of the CS-17 staff in the design, implementation, monitoring and evaluation of training materials and programs through the provision of TA, support and resources from the EFO that can be made available for staff in Negelle.	17.a. Complete a more in-depth assessment of the capacity building needs. 17.b. Collect and share materials on training with the SC/Liben staff.	17. EFO and Training Coordinator	17. b. There is technical support from EFO Health/Nutrition specialist in designing and refining training curriculum, and overall technical support on monitoring the progress of health services, especially, on the implementation of community based case management.
18. In FGDs with the SPAs, they relayed frustrations expressed by the CHWs that they do not receive per diems for the HAC meetings they attend, which is different from their experience during the project trainings when they did receive per diem for attending.	18. The extent of the frustrations expressed about per diems needs to be assessed further and, if necessary, senior project staff (i.e., the Health Sector Manager and/or the Impact Area Manager) need to meet with the CHWs to address the issue.	18. FGDs with CHWs to assess the extent of the frustration and to determine next steps.	18. FGDs can be done by the SPAs and then based on results, involve the Health Sector Manager and/or the Impact Area Manager in meetings with the CHWs.	Consensus was made with CHWs and SPAs as we can not afford to pay per diem when they have review meetings in their catchments areas except when they called for refresher trainings outside their catchments areas.

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SUSTAINABILITY STRATEGY				
19. It is apparent from the DIP and verified in this MTE that the DHO will not be able to adequately support this program beyond the life of CS-17 without continued outside support.	19. The project needs to identify and access all currently and potentially available sources of support for project activities to continue beyond CS-17.	19. See the Initial Actions proposed for the MOH Strengthening Recommendation above.	19. Health Sector Manager, the EFO and SC/HQ.	<ul style="list-style-type: none"> Capacity building trainings have given for DHO head and Negelle Hospital staffs to sustain the ongoing program. Fulfilling of human power and budget allocation is underway by Oromia Regional Health Bureau to enable the DHO to continue with community health services even after CS-17 has phased out.
20. "Sustained increase in the use of key health services and improved MCH practices at the community level" are crucial to the sustainability of project services. However, due to the lack of a population-based survey during this MTE, the project will not know its progress on the KPC indicators until the FE, when it will be too late to make adjustments.	20. The project should consider implementing an abbreviated KPC using LQAS in the summer of 2004 to assess progress on household knowledge/practices and identify any areas in need of improvement.	20.a. Assess the budgetary implications of doing the survey. 20.b. Identify and access expertise to design and implement the survey.	20. Health Sector Manager, the EFO, SC/HQ and the local partners.	<p>20. a. LQAS training has been given for MHO/SC staffs on July 2004 to enable them assess progress on household knowledge/practices to identify areas that needs improvement.</p> <p>20. b. The survey will be done by the program staffs using LQAS method.</p>
21. The GOE policy of 'decentralization' has limited the technical and administrative capacity of the DHO and the DHMT.	21. The project needs to reassess its sustainability plan, based on the changes in the DHO.	21. This needs to be done in tandem with the MOH Capacity Building recommendation noted above.	21. The Health Sector Manager, the EFO and the members of the DHMT and DHO.	Because of the decentralization there was great impact on DHO and DHMT as well, but now they are improving in man power and budget through the support of Oromia Regional Health Bureau to manage the health services of the District.
STAFF TRAINING				
22. CS-17/Liben staff were consistent in expressing the need for further training that would improve their work on the project and their own professional standing.	22. Implement a training needs assessment and plan for the staff with the goal of improving their work with the CS-17 project and also enhancing their employability upon its completion. This plan should include the SPAs as well as the senior health staff.	22. Develop a detailed list by individual staff person on training topics.	22. Training Coordinator and the other Liben CS staff and partners.	Training need assessment has been done by EFO, HRD and started to support staffs in further studies as regular student and distance learning. One SPA has been sent to college to up grade herself to the nursing level to improve her work on the project and her own professional standing. On job training has been also given for health program staffs to improve their knowledge, skills and attitudes, such as LQAS that helps to monitor the progress of health services.

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				In general, it is good start to retain experienced staffs and also to build their professional standing.
SUPERVISION OF PROGRAM STAFF				
The Liben CS-17's greatest assets are its staff and the relationships it has developed with the program partners and communities.	N/A	N/A	N/A	N/A
23. The senior Liben CS-17 staff have not been meeting regularly, primarily due to the frequent changes in the Health Sector Manager position since the beginning of CS-17. This has probably contributed to the number of delays the project has experienced.	23. Regular staff meetings, involving the Health Sector Manager, the Unit Heads and the M&E and Training Coordinators, need to be restarted as soon as possible. It is suggested that initially they occur on a weekly basis at the same time and place. They can then be scaled back as seems prudent.	23. Reestablish regular meetings of the senior health and M&E staff.	23. Health Sector Manager, with the Health Unit Heads and the Training and M&E Coordinators.	Although some meetings were done it was not on regular basis. As to frequent changing of health sector managers, it should not be considered as special to the project only. It is an overall problem of the location.
24. The new Health Sector Manager's orientation to his job did not include a review of the CS-17 DIP.	24. The EFO staff responsible for backstopping CS-17 need to review the DIP in person with the Health Sector Manager and then he needs to do the same with each of his senior staff.	24. Schedule meetings.	24.a. EFO and the Health Sector Manager. 24.b. Health Sector Manager, Training and M&E Coordinators and Health Unit Heads.	The Health Sector Manager has oriented and also read CS-17 DIP and DAP II as well as all the technical documents for CSTS+to enable him manage the health activities. He also had regular telephone communication EFO Health/Nutrition specialist which is part of induction to acquaint him with the activities of health sector. In addition he was sent abroad for a training workshop and exposure to share experience on maternal health service. The EFO also made five TA trips in this reporting year to provide the required assistance.
25. Responsibility for both MNC and the CCM interventions (CDD, ARI and malaria) rests entirely with the MCH Unit Head. Together these interventions are 55% of the total planned intervention-specific effort, which might be too much for one person.	25. The workload for the MCH Unit Head needs to be closely reviewed and probably adjusted prior to the startup of the CCM intervention.	25.a. Review the MCH Unit Head Position Description 25.b. Consider the addition of staff, sharing responsibilities with other current staff, or some other arrangement.	25. The Impact Area Manager and Health Sector Manager with the MCH Unit Head.	<ul style="list-style-type: none"> Two TBA trainers have been hired by short term project (SNL) to do TBA training and also to share some activities of the MCH unit head that can be managed at their level. To manage monthly reports of TTBA and to enable her do the analysis, training has been given for MCH unit head by American College of Nurse Midwives (ACNM) on how to enter and analyze data on Excel.

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26. One third of the project health facilities in Liben and the communities they serve have yet to be served by SPAs due to the delay in hiring.	26. The three remaining SPAs need to be hired, oriented and placed in the field as soon as possible.	26. Complete the hiring process as soon as possible.	26. Health Sector Manager and Training Coordinator.	Two SPAs have are hired for two health facilities, but still three more are needed to replace one SPA who resigned, one SPA who sent for education and one SPA for one health facility. It is under process by Liben Impact Area administration to announce for the three remaining positions.
LOGISTICS				
27. Only two of the six (and soon to be nine) SPAs have a motorcycle, which greatly restricts their ability to work at the community level, a critical factor especially with the proposed start of the CCM activities and the establishment and support of the Revolving Drug Fund pharmacies at the community and/or clinic levels.	27. With the delays experienced to date and the amount of work that needs to be accomplished in the most rural, underdeveloped PAs in Liben District by the end of CS-17, SC needs to provide one motorcycle for each SPA.	27. Negotiate borrowing DAP motorbikes (originally purchased for EPI) or seek authorization to purchase them.	27. Impact Area Manager, Liben Impact Area Administration and the Health Sector Manager.	There are no extra motorcycles to be borrowed from DAP and additional motorcycles are not purchased for the remaining SPAs. But some four motor bikes are expected to be purchased by SNL project fund.
INFORMATION MANAGEMENT				
28. Community level data is not being collected, recorded and reported consistently or accurately, due to CHW and HAC confusion about the forms and the process.	28. The project needs to reassess its information needs starting at the community level, focusing initially on the information the CHWs will use to improve their work and involving them in the process.	28.a. Practical TA is needed on the design and development of community-based health information systems. 28.b. FGDs need to be held with the CHWs to identify their information needs and secure their support for collecting the data.	28. M&E Coordinator, the SPAs and a community-based HIS expert.	Monthly reports are collected, recorded and reported consistently to the health facilities by HACs and the copy of the report is tracked on their registration book to be available at PA level that enables them to monitor the progress of activities.

<p>29. The project has experienced several delays and difficulties in developing and adapting the software database for the DHO – the primary challenge being its complexity and the question of whether the DHO can effectively use a computerized system.</p>	<p>29. The capacity of the DHO to effectively use a computerized HMIS needs to be reevaluated and appropriate action taken.</p>	<p>29. The M&E Coordinator, Health Sector Manager and members of the DHMT need to review the strategy for developing this software, determine whether it remains viable, and identify next steps.</p>	<p>29. M&E Coordinator, the Health Sector Manager and the members of the DHMT.</p>	<p>Because of man power shortage that the DHO had, they were not in a position to exercise on the developed software at that time, but our M & E coordinator attempt to enter one year data and identified that there are some errors, and also he said that the software is not friendly to be used by DHO. Further action was not taken due to lack of budget to up grade it and as a result, DHO is not using it.</p>
TECHNICAL AND ADMINISTRATIVE SUPPORT				
<p>30. The Liben CS staff identified the following areas requiring technical assistance and suggested strategies: <u>TOPICS:</u></p> <ul style="list-style-type: none"> ➤ NGO and project planning, management and supervision ➤ Budgeting and financial management ➤ Production of IEC materials and documenting program successes. ➤ Development of training materials. ➤ M&E <p><u>STRATEGIES:</u></p> <ul style="list-style-type: none"> ➤ Regularly scheduled site visits by the EFO. ➤ Updating the established health and training library. ➤ Exposure visits to other project sites and between SPA sites. ➤ Attending relevant training workshops and activities. 	<p>30. The EFO needs to commit to making regular site visits at least once every eight weeks and more frequently during key points in the life of the project, such as during the design of program activities, the testing of training curricula, the startup of new project initiatives and all major evaluations and assessments.</p>	<p>30.a. Establish a schedule and agenda items for EFO site visits.</p> <p>30.b Plan exposure visits for SPAs.</p> <p>30.c. Identify appropriate training opportunities.</p>	<p>30.a. Health Sector Manager, Liben CS staff and EFO</p> <p>30.b. Training Coordinator and SPAs</p> <p>30.c. Training Coordinator, EFO and SC/HQ.</p>	<ul style="list-style-type: none"> • Documentation person has been hired by the Liben Impact Area to document program success of the Impact Area in general. • To produce relevant IEC materials there is technical assistant from EFO, BCC specialist. She did Formative Research to identify relevant messages that leads to the development of locally acceptable IEC materials. So far, the materials are pre-tested in the community to be finalized. • To develop training manuals there is technical assistant from EFO, Health/Nutrition specialist and American College of Nurses Midwives (ACNM) on CCM and HBLSS respectively. • The EFO, Health/Nutrition specialist and other health staffs based at the field office are doing field visits to give technical assistant on the progress of health activities and on the implementation of newly arrived short term projects. In addition to the field visits, if need arises it is possible to directly call the EFO based health staffs to get technical advice as soon as possible.

VI. Program Management System

1. Financial Management System

The EFO is responsible for all financial transactions and budget control, and has a strong financial management system in place that utilizes Sun Systems software. Initially the Sun System was operating in a single location. This system is now expanded to include the department through a network connection. The department revised its structure to make services more efficient. Please clarify. In this line, a grant officer ensures that projects follow the grant agreements, report officers provide internal and external financial reports in a timely manner, while a discernments officer handles all financial requests from the impact area and ensures timely discernments. The HO conducts monthly financial reviews and monitoring in collaboration with the EFO finance unit. The EFO has clear written procedures for disbursement and accounting of financial transactions. There is also a clear line of authority for financial payments. The CS-17 program coordinator can only authorize payments up to \$250 and the program manager up to \$6,250. Amounts above \$6,250 need to be authorized by the field office director (FOD).

Project staff submits monthly budget requests based on planned activities and receive advances from the EFO to support implementation. The Liben impact area has a computerized system for tracking all expenditures on a monthly basis. All requests for funds are based on activity registration, which must be completed at least one month before the advance request is submitted. Monthly financial reports are submitted to the EFO finance unit, where reports from all impact areas are finalized and sent to Westport. The EFO's finance unit in Addis Ababa conducts budget monitoring monthly. Copies of the monthly budget summaries are provided to the impact area program manger. The M&E Unit has the responsibility of crosschecking that the registered activity is completed before more money is disbursed for a similar or subsequent activity by the sector.

2. Human Resources

The Chief of Party (COP) for food security programs will provide oversight for program implementation. The field based impact area manger will report to the COP and provides management oversight. The COP reports to the expatriate Deputy Field Office Director for Programs (DFOD). The COP and DFOD ensure that project activities are carried out per the project agreement, and that timely and accurate reporting is conducted. Both the COP and the DFOD travel periodically to Liben to meet with project staff, discuss concerns and constraints, and to find solutions to these problems. Regular staff meetings including the program manager (PM) and project technical staff are conducted in Liben. The Addis Ababa-based Health and Nutrition specialist also provides technical support and oversight for all health activities.

3. Communication System and Team Development

The SC office in Addis Ababa provides procurement and human resource management support and ensures that all SC polices and procedures are observed at all levels of field office operations. The communication between the EFO in Addis Ababa and the Liben office has been improved by e-mail access. However at this time, this access is limited to one line and is expected to improve in the

near future when the telecommunication service for the District is upgraded. The EFO has connected all impact areas, including the CS impact area, by radio to improve communication.

4. Local Partner Relationships

SC works closely with the DHO in all CS-17 activities. Joint coordination meetings are held quarterly, and a joint supervision exercise is conducted biannually of all health facilities in the district. However, in the last two years the coordination and involvement of the DHO has been critically limited, mainly due to a lack of DHO personnel. In the coming year, this is expected to improve though the addition of two more staff, which is still far below the 13-person staffing plan. SC maintains a very strong and positive working relationship with the DHO and with the zonal Health Bureau, also located in Negelle. Through BHTs and HACs, SC also works closely with communities to ensure that their expressed needs are incorporated into program planning and implementation.

5. PVO Coordination and Collaboration

SC has a close relationship with other PVOs implementing Child Survival programs in Ethiopia. CARE has started a CS program in the north of the country and SC shared its experience at the start of implementation. The program will use workshops and meetings to share CS experiences. Project staff have provided HBLSS training to CARE program sites in the eastern part of the country. SC project staff, along with MOH staff visited the Northern Kenya CARE Siaya project site to learn from the program. The visit was useful in how to start a RDF, and in the training and supervision of CMWs. CARE's training plan for their Siaya program was modified for the Ethiopian context and is being used. SC is recognized as the lead agency in newborn health and child survival programs. SC staff are members of the national Reproductive and Child Survival Task Force and participate in important national and global meetings and conferences, and also hosted the Healthy Newborn Partnership Meeting.

6. Response to Audit and OCA

SC has contracted PACT to conduct the organizational capacity assessment. The assessment includes the FO, the ARSH program, the Child Survival impact area, the district health office, and SC refugee programs in Jigjiga. The findings showed that “the organization is in the expanding stage and track record of achievements and its work is recognized by its constituency, the government and other NGOs active in promoting the well being of disadvantaged children and women.”² Following the recommendations set forth, improvements in the areas of management and documentation are in place. There is a communication officer to ensure internal and external communication, two internal auditors were hired full-time, to conduct regular field visits, review the financial system, help safeguard assets and ensure that resources are used appropriately.

² Organizational Capacity Assessment of Save the Children/USA, Ethiopia Field Office, Pact, March 2003, Addis Ababa, pp 25.

The organizational capacity assessment (OCA) made recommendations to broaden the donor base. SC has worked hard to increase private and corporate sponsorship and has managed to increase this resource. In order to attract and maintain qualified staff, a staff satisfaction survey was conducted and based on the results, revisions are being made to salary and benefit levels.

Three different groups have conducted three different audits. Price Waterhouse conducted an audit to look into SC's compliance with grant management rules and rules of the US government. The results showed a clear system. A certified local auditor, AW Tomas, audited SC for compliance to Ethiopian law, regulations, and financial records, and reported a good system. The third audit was an internal one conducted by the HO director of capacity building and audit, and looked into the management system. The CS program sites were included in all three audits.

VII. Timeline of Activities for the Coming Year

CS-17 Work Plan for Year 3, FY 05

Activity	Project Year				Remark
	Year 3				
	Q1	Q2	Q3	Q4	
1. Immunization (EPI)					
1.1. Ongoing support DHO EPI activities	v	v	v	v	
1.2. Supply cold chain equipment for 2 health facilities			v		
1.3. Print EPI cards		v		v	
2. HIV/AIDS/STI					
2.1. Awareness raising					
2.1.1. Health education at HF's, outreach sites, and community gatherings in integrated manner with other activities	v	v	v	v	
2.1.2. Incorporate HIV/AIDS/STI topics in all training curricula and introduce HIV/AIDS/STI topics in all SC/DAP staff training	v	v	v	v	
2.2. HIV/AIDS/STI vulnerability reduction					
2.2.1. Promote condom utilization through BCC	v	v	v	v	
2.2.2. Enhance safe obstetric practice by teaching TBAs and mothers re. birth planning and providing gloves to TBAs through FP intervention	v	v	v	v	
2.3. Capacity Building					
2.3.1. Build SC HIV BCC capacity	v				
2.3.2. Build capacity of District HIV/AIDS Council	v		v		
2.3.2. Facilitate STI drugs, VCT, condom and glove supply	v	v	v	v	
2.3.3. Support CBOs and Anti-AIDS clubs, including training	v			v	
2.3.4. IEC materials production/adaptation	v		v		
3. Maternal and Newborn Care					
3.1 Support MOH ANC activities at static and outreach sites, support and supervision of TBAs	v	v	v	v	
3.2 IEC materials production/adaptation	v				
4. Training					
4.1 HIV/AIDS/STI					
4.1.1 District HIV/AIDS Council training on program design and seeking grants		v			
4.1.2 CBO training on home-based care and support			v		
4.1.3 BHTs and HACs training on HIV/AIDS/STI		v	v		

CS-17 Work Plan for the Five Year Life of the Project (cont.)

Activity	Project Year			
	Year 3		Year 5	
4.1.4 Peer educators training		v	v	
4.1.5 Facilitate start up of VCT service	v	v	v	v
4.1.6 Facilitate STI training of MOH staff	v	v	v	v
4.1.7 Facilitate non-formal basic education in collaboration with MOH on HIV/AIDS	v	v	v	v
4.2 Maternal and Newborn Care				
4.2.2 HB-LSS training for HACs/BHTs	v	v	v	v
4.2.3 HB-LSS training for TBAs	v	v	v	v
4.2.4 Community Midwives training				At the time of the DIP it was government policy to train and post CMWs at health posts after six month training, and we said we will sponsor that training. The government has changed this policy. Thus we can not train CMWs.
4.3 Community-Based Case Management				
4.3.1 Training of health facility staff on CB-CM	v			
4.3.2 CHW case management training	v			
4.5 HACs and BHTs				
4.5.1 HAC and BHT refresher training in PAs selected for Community-Based Case Management	v			
4.6 Other				
4.6.1 District health planning and management training				As the DHMT does not exist this activity will remain pending until the DHO status improves
5. Community-Based Case Management				
5.1 Select CMWs with DHO	v			
5.2 Drug supply/RDF	v			
5.3 Train SC/MOH staff as CMW trainers and supervisors	v			
5.4 Drug supply/RDF	v			
5.5 Train SC/MOH staff as CMWs trainers and supervisors	v			
5.7 Train CMWs in case management	v	v		
5.8 Refresher training for HACs and BHTs to support CMWs and do health education on recognition/care seeking	v			
5.9 Follow-up supervision, reporting	v	v	v	v

VII. Highlights

Please see “Section I. Main Accomplishments”.

Annex 1

Child Survival Grants Program Project Summary

**Third Annual Submission: Oct-27-2004
SC Ethiopia**

Field Contact Information:

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Project Information:

Project Description:	SC and the MOH Liben District Health Office will continue implementation through CS-17 of all four CS-13 interventions: ARI (at 15% of planned intervention-specific CS-17 effort), Malaria (10%), CDD (10%), and Maternal and Newborn Care (20%); and continue important support to the DHO in EPI (15%), previously funded through the DAP. CS-17 will devote 30% of intervention effort to introducing an HIV/AIDS intervention, in order to build SC and DHO capacity in Liben to begin addressing the district's HIV epidemic. These CS-17 interventions will be implemented through the following major strategies: · Joint DHO/SC design, implementation, and evaluation of approaches to maternal and child health in Liben that inform development of strategies to address the needs of pastoralist populations in other districts of Borana Zone and Ethiopia. · Introduction and evaluation of community-based case management of childhood illness, to improve access to and use of these services in Liben District, and to inform the present development of Community IMCI in
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	Ethiopia. · Establishment of a multi-sectoral district HIV/AIDS support system to provide leadership, coordination, and technical advice for integration of effective HIV prevention efforts into ongoing community, government, and NGO activities in Liben District. · Continued mobilization of community leaders and traditional practitioners through Bridge-to-Health Teams and Health Action Committees, to support selected MCH services, and to conduct focused education to improve key emphasis behaviors at the household level.
Partners:	MOH Liben District Health Office
Project Location:	The CS-17 site includes all of Liben District in Borana Zone of Oromiya Regional State in southern Ethiopia.

Grant Funding Information:

USAID Funding:(US \$)	\$1,250,000	PVO match:(US \$)	\$416,750
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Target Beneficiaries:

Type	Number
infants (0-11 months):	6,100
0-59 month old children:	25,800
Women 15-49:	31,700
Estimated Number of Births:	6,400

Beneficiary Residence:

Urban/Peri-Urban %	Rural %
25%	75%

General Strategies Planned:

Advocacy on Health Policy
 Strengthen Decentralized Health System
 Information System Technologies

M&E Assessment Strategies:

KPC Survey
 Organizational Capacity Assessment with Local Partners
 Organizational Capacity Assessment for your own PVO
 Community-based Monitoring Techniques
 Participatory Evaluation Techniques (for mid-term or final evaluation)

Behavior Change & Communication (BCC) Strategies:

Interpersonal Communication

Peer Communication

Capacity Building Targets Planned:

PVO	Non-Govt Partners	Other Private Sector	Govt	Community
Field Office HQ CS Project Team	(None Selected)	Traditional Healers	Dist. Health System Health Facility Staff	Health CBOs CHWs

Interventions:

Immunizations 15 %
** CHW Training
** HF Training
Acute Respiratory Infection 15 %
** IMCI Integration
** CHW Training
** HF Training
Control of Diarrheal Diseases 10 %
** IMCI Integration
** CHW Training
** HF Training
Malaria 10 %
** IMCI Integration
** CHW Training
** HF Training
Maternal & Newborn Care 20 %
** CHW Training
** HF Training
HIV/AIDS 30 %
** CHW Training
** HF Training