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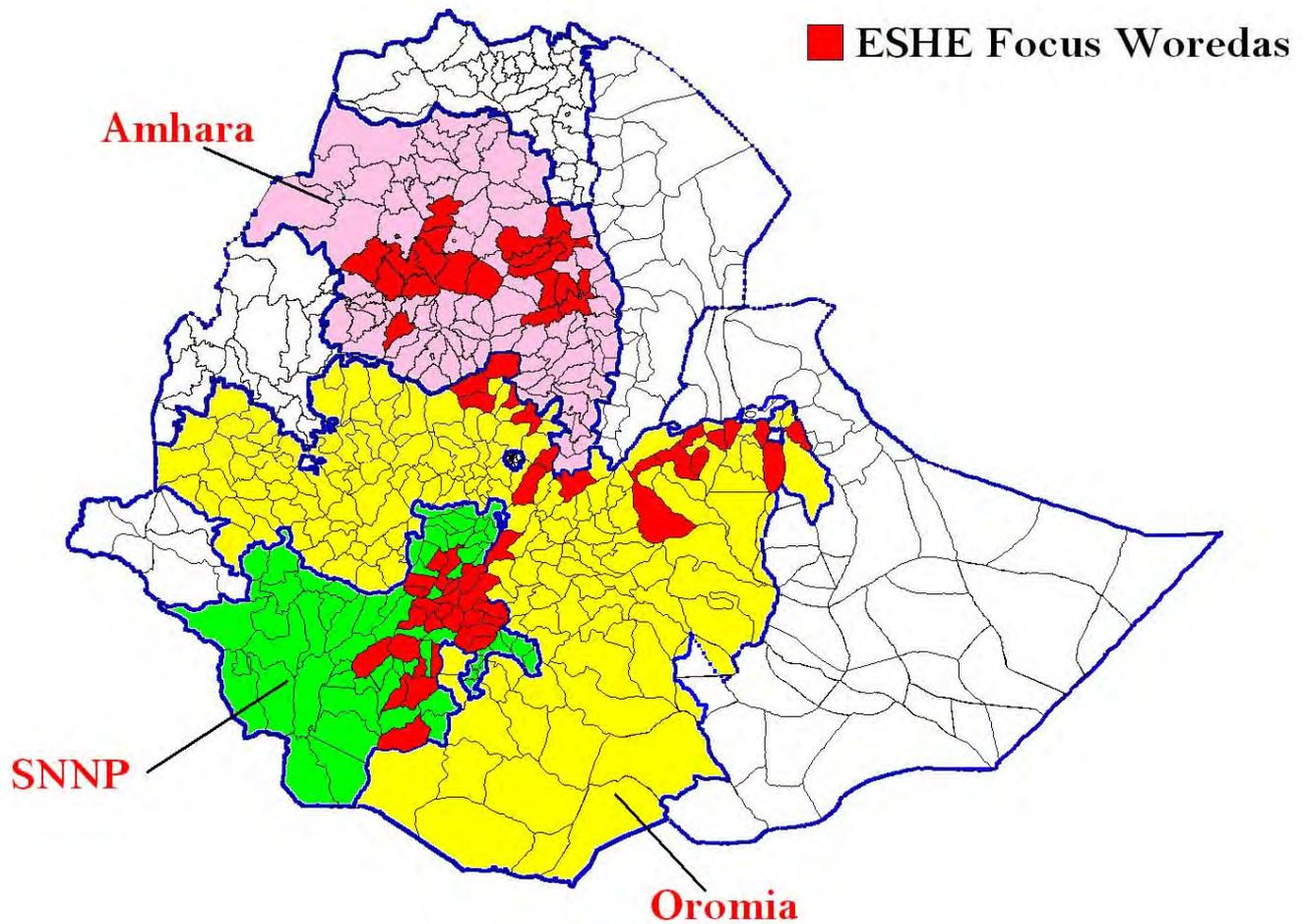


Essential Services for Health In Ethiopia

ANNUAL REPORT

Project Year 3

July 1, 2005 - June 30, 2006



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Essential Services for Health in Ethiopia is implemented by John Snow, Inc. in collaboration with Abt Associates Inc., Academy for Educational Development, and Initiatives, Inc.



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ACRONYMS and ABBREVIATIONS

Ato	equivalent to Mr.
BOFED	Bureau of Finance and Economic Development
CHP	community health promoter
CHPI	Community Health Promotion Initiative
CNP	community nutrition promoter
CTC	Community Therapeutic Care
DHS	Demographic and Health Survey
DPT	diphtheria, pertussis, tetanus
EFY	Ethiopian Fiscal Year
Edir	traditional social institution for supporting funeral expenses
ENA	essential nutrition actions
EPI	Expanded Program on Immunization
ESHE	Essential Services for Health in Ethiopia
FHC	Family Health Card
FMoH	Federal Ministry of Health
HCF	Health Care Financing
HCP	Health Communication Partnership
HEW	health extension worker
HMIS	Health Management Information System
HSDAMP	Health Service Delivery, Administration and Management Proclamation
HSEP	Health Service Extension Program
IEC	information, education and communication
ID	Immunization Diploma
IMCI	integrated management of childhood illness
IMNCI	integrated management of newborn and childhood illness
IRT	integrated refresher training
M&E	monitoring and evaluation
MDG-4	Millennium Development Goal-4
NDA	no data available
MOFED	Ministry of Finance and Economic Development
NGO	non-governmental organization
NHA	National Health Accounts
NPW	non-pregnant women
OPV	oral polio vaccine
ORS	oral rehydration solution
PASS	Pharmaceutical Administration and Supply Services
RHB	regional health bureau
PW	pregnant women
SNNP	Southern Nations, Nationalities, and Peoples
TOT	training of trainers
TT	tetanus toxoid
TVETI	technical vocational education and training institutes
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
W/ro	equivalent to Mrs.
WHO	World Health Organization
WorHO	woreda health office
ZHD	zone health desk

LETTER FROM THE PROJECT DIRECTOR

Year 3 of the USAID Essential Services for Health in Ethiopia Project was a productive year of full-scale implementation in all 64 woredas of the three focus regions, Amhara, Oromia and Southern Nations, Nationalities and Peoples. Project teams in 12 zones, three regions, and at national level worked intensively with their government and other health partners to achieve much more than could ever have been anticipated if they had worked in isolation.

The Three Pillars Strategic Framework-strengthening health worker skills, strengthening health systems, and strengthening positive health behaviors at household and community levels- remains the guiding paradigm for all ESHE work. Working in a balanced way on all three pillars better assures sustainable changes with amplified results. ESHE annual workplans are developed in consultation with the federal, regional and woreda/district health teams to support the Health Sector Development Program III.

The ESHE emphasis to bring the community into full partnership to improve the health and lives of their families continues to pay increasingly greater dividends. Nearly 28,000 **community health promoters** are now trained and active in their homes and communities. Over the next two years, approximately 20,000 more community health promoters will be recruited and trained. This large cadre of volunteers is instrumental to assist and support the new **health extension workers** to reach their objective to bring health services to the people in their communities. Volunteers assist by first changing their own health behaviors to become community role models, and then sharing action-based messages with their neighbors. **The partnership of health extension workers and volunteer community health promoters is mutually reinforcing.** Health extension workers rely on this active community base to make health impact and

volunteers rely on health extension workers to mentor and encourage their efforts. Over 17,000 community members were oriented this year to the volunteer approach. Approximately 12,000 community health promoters participated in important experience-sharing meetings to review their achievements and find solutions to obstacles they identify.

The health sector is sorely under-financed in Ethiopia. The per capita US \$5.6 per person is far behind the World Health Organization estimate of US \$34 needed to cover the minimum package of health costs for each person annually. In Year 3, ESHE provided technical leadership to the third National Health Accounts. Major strides were also made in advancing the **health care financing legal framework** designed to help Ethiopia increase its financial resources for health. The *Health Service Delivery, Administration and Management Proclamation* is now ratified in the five largest regions: Addis Ababa, Amhara, Oromia, South Nations Nationalities and Peoples, and Tigray. Field implementation has begun. ESHE created a generic implementation manual and then helped adapt it to each region's specific regulations and directives. Year 4 will focus on training to put the new regulations into operation and follow-up to make them work. If successful, increased resources will be available for the health sector to improve the quality and quantity of health services.

Following Year 2's focus on immunization, in Year 3 ESHE concentrated on improving health worker skills through the essential nutrition actions. Over 1,350 health workers were trained in essential nutrition actions: technical and behavior change communication. The LINKAGES Project closely collaborated with ESHE in the three regions by developing training materials, providing trainers, and supporting follow-up to essential nutrition actions training. Health workers are now equipped with small do-

able actions and negotiation skills to bring tangible changes in nutrition to families and their communities. Health extension workers, well positioned to affect change at household level, were included in essential nutrition actions training. With malnutrition underlying one of every two children who die in Ethiopia, this program has met with enthusiasm by health workers and the community.

Integrated Management of Childhood Illness was scheduled to be the focus for next year's health worker skills development. In Year 3, ESHE had the opportunity, however, to assist the national Child Survival Partnership Core Group to revise Ethiopia's national strategy. Based on global recognition that a focus on newborn is needed to address the 40% of under-five deaths that occur in the first month of life, the Core Group worked intensively to incorporate essential newborn care into integrated management of childhood illnesses. **Ethiopia is now the first country in Africa to finalize this adaptation creating: Integrated Management of Newborn and Childhood Illnesses.**

In addition to revising the health worker course, a new level of Integrated Management of Newborn and Childhood Illnesses course was designed for health extension workers. Health extension workers treatment of major childhood killers is limited to oral medications. This course has the potential to greatly decrease child deaths since most children in Ethiopia die at home or in the community prior to seeking care at health centers that are often several hours walk from their homes. The program requires more than training, however, with a regular supply of drugs and supportive supervision being among other critical components for success.

In Year 3, **expanded efforts were made on supportive supervision.** An integrated checklist was developed in collaboration with the three regional health bureaus.

ESHE assisted the regions to train 489 health workers and managers in supportive supervision, as well as plan and budget for regular supervisory visits. Review meetings at regional, zonal and woredas levels are an additional tool used to effectively enhance performance. ESHE provided critical technical and financial resources to facilitate these meetings. For the first time, Oromia called all woreda health officers and administrators to review meetings chaired by the President of Oromia Region in a successful effort to encourage frank discussion and draft innovative actions to stimulate the region's health efforts.

Supporting behavior change through print materials and mass media was further expanded in Year 3. The Family Health Card saw several new editions incorporating important additions, done in partnership with the Health Communications Partnership Project. ESHE printed and distributed over 300,000 Family Health Cards in its focus regions this year, targeting pregnant mothers and under-one children. Workshop for 106 media producers were conducted where they learned how to create their own radio spots and programs to support healthy behaviors.

ESHE and LINKAGES collaborated in a community assessment of behavior change. The assessment targeted 2,200 households from the three regions among communities where community health promoters had been active for at least six months. This assessment not only provided input on the effectiveness of the community approach, but it also measured how effectively the entire ESHE strategy is working. A report of the assessment will be available soon. New policies, increased efforts to strengthen supervisory systems and refresher training of health workers must result in improvements of the health of families at the household level or they have little real value. The bottom line of all our efforts is for the health status of families to show measurable improvements.

In Year 3, additional USAID funds were awarded by the Office of Foreign Disaster Assistance to ESHE to pilot an approach to complement the Community Therapeutic Care program. Community Therapeutic Care focuses on the relatively small group of severely malnourished children. ESHE activities focus on addressing the much **larger number of mildly and moderately malnourished children**, in an attempt to prevent them from becoming severely malnourished. In line with USAID's overall objective to increase resiliency in families and communities to contain bouts of drought and famine, this approach tackles significant missed opportunities. In the new approach, children who are screened for severe malnutrition and are rejected as not being malnourished enough to qualify for therapeutic foods (plumpy nuts), receive appropriate preventive treatment and their care takers nutrition counseling. This approach needs to be incorporated into all Community Therapeutic Care programs as a necessary companion to make a sustainable transition from emergency to development nutrition programs.

I would like to again thank USAID this year, on behalf of John Snow, Inc. and its collaborating partners, for their funding and unreserved support and confidence in our work. ESHE deeply appreciates the privilege of being considered a close partner to the Federal Ministry of Health, regional

health bureaus, zonal health desks, and woreda health offices. In addition to the three regions, 12 zones and 64 focus woredas, more and more of the ESHE efforts are enjoying an expanded effect on the wider Ethiopian health systems, health workers and communities.

For personal reasons, I stepped down as ESHE Project Director at the end of Year 3. I will, however, have the privilege to continue to provide technical support to ESHE over the coming years, returning to Ethiopia on a regular basis. I have learned a tremendous amount from my four years in Ethiopia. Let me take this opportunity to thank you for being my close colleagues. Working together to reach common goals has been one of the most satisfying parts of my experience. I appreciate your dynamic spirits and firm commitments to bring a better future for Ethiopians. I look forward to monitoring your collective efforts towards reaching Millennium Development Goal-4 for Ethiopia!

Sincerely,



Mary A. Carnell, MD, MPH
ESHE Project Director
July 2006

INTRODUCTION

The Essential Services for Health in Ethiopia (ESHE) Project is the USAID/Ethiopia five-year bilateral initiative for child health and health sector reform with the Ethiopian Government. The Project contributes to the achievement of the USAID Mission's *Strategic Objective 14: Human Capacity and Social Resilience Increased* by increasing the effective use of high-impact child health, family planning, and nutrition services, products, and practices (IR14.1).

The Project works in 64 selected woredas serving 15 million people in the three most populated regions of Ethiopia: Amhara, Oromia, and Southern Nations, Nationalities and Peoples' (SNNP). In Amhara and Oromia, 20 woredas per region were selected for intervention (five woredas in each of four zones). In SNNP 24 woredas in five zones and two special woredas were selected for intervention at the request of the Regional Health Bureau (RHB) to permit continuity of the Project's previous program activities in this region.

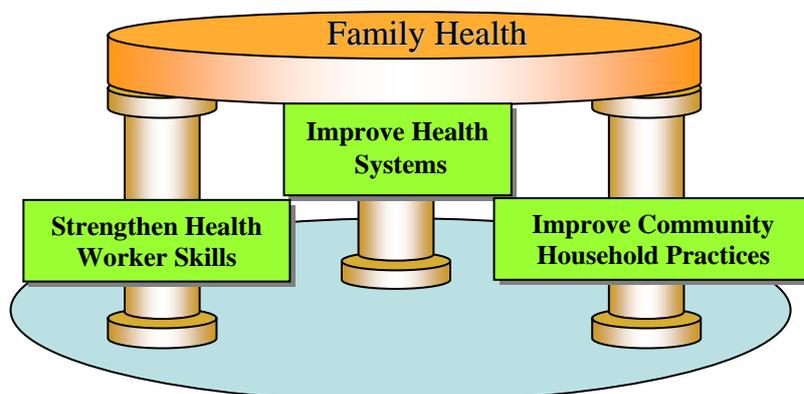
ESHE works in partnership with the Federal Ministry of Health (FMoH) and operates within the existing structures of the regional health bureaus, zonal health desks, woreda health offices, health facilities and the local communities. ESHE assists health offices in

improving the quality and utilization of high-impact child survival interventions through the Expanded Program on Immunization (EPI), Essential Nutrition Actions (ENA), and Integrated Management of Newborn and Childhood Illness (IMNCI) interventions. Key approaches include capacity building, community mobilization, and behavior change communication aimed at improving community and household health practices, improving the health system and strengthening health worker skills.

In the health sector reform arena, ESHE works with the FMoH, regional health bureaus, and woreda offices in improving health care financing (HCF) to institute policy changes aimed at increasing resource availability and allocation to improve health services and ultimately the health status of citizens. Interventions in this component are national and regional in scope and coverage.

ESHE activities are designed to extend beyond the boundaries of the focus kebeles and woredas in the three regions through training and sharing of materials. This expanded impact is already evident as different organizations and regional health bureaus use ESHE training and behavior change materials for their programs.

THE THREE PILLARS



STRENGTHENING HEALTH WORKERS' SKILLS

Child Survival Interventions

Ethiopia is among the 42 countries that together account for 90% of under-five child deaths and among the six countries that account for 50% of deaths of children in the same age group (2003 *Lancet* series on child survival). In Ethiopia, deaths of 472,000 under-five children are caused by diseases, most of which could be prevented or easily treated.

A preliminary report of the Ethiopian *Demographic Health Survey (DHS) 2005* shows improvement in key child health indicators compared to *DHS 2000*. The overall implementation of child survival interventions, however, is still not up to the level needed to save the lives of many whose death could be prevented. There is a need to strengthen efforts underway on key child survival interventions in order to achieve the Millennium Development Goals (MDG)-4: reduction of the under-five mortality rate by two-thirds between 1990 and 2015. For Ethiopia this translates to a reduction from approximately 180 to 60 deaths per 1,000 under-five children. Population level health impact can be achieved only by ensuring optimum coverage and quality of key interventions.

ESHE promotes key child survival interventions including the Expanded Program on Immunization, Essential Nutrition Actions, and the Integrated Management of Newborn and Childhood Illnesses.

Immunization

Immunization has proved to be one of the most important and cost-effective interventions for child survival. According to World Health Organization (WHO) estimates immunization prevented close to

20 million deaths globally in the past two decades. ESHE woredas– in partnership with the three regional health bureaus – realized improved EPI coverage this year. Future efforts will focus to consolidate and sustain these gains.

In year 3 ESHE organized EPI refresher training to improve essential skills of health workers in the health facilities and to ensure safe and effective immunizations. With the high turnover of health workers in there is a continued need to organize in-service trainings annually. Accordingly a total of 847 health workers benefited from such training in Project Year 3 in the three regions (See Annex I).

Training Type	Participants			
	Amhara	Oromia	SNNP	Total
ENA				
ENA/Tech.	31	23	-	54
ENA/BCC TOT	83	-	34	117
ENA/BCC	410	420	506	1,336
EPI for Health Worker	277	172	398	847
IMNCI Training			24	24

Following the refresher training, frequent follow-up visits were made to health facilities to provide on-the-job training and encouragement and to assess the quality of program implementation. Assessments to-date are very encouraging.

In ESHE woredas in Amhara annual coverage for DPT1 is 98% and DPT3 is 89%, indicating good access to immunization services and continuity of service delivery. (See Annex II) The drop out rate from DPT1 to DPT3 is 9%. In ESHE woredas in Oromia, annual coverage for DPT1 and DPT3 is 102% and 91% respectively, indicating a high level of access to immunization services with a dropout rate of 11%. Similarly, in SNNP ESHE woredas DPT1 annual coverage has reached 100% while DPT3 is 95% with a dropout rate of 5%. The dropout rate

indicates the proportion of children who start the immunization series but fail to complete the series to DPT3. Less than 10% dropout rate is the international goal recommended by WHO.

Annual measles coverage in ESHE woredas is 72% in Amhara, 66% in Oromia, and 92% in SNNP. As measles vaccination is given at nine months of age, a large proportion of children who received DPT3 did not go on to receive the measles immunization in Amhara and Oromia

In general, EPI coverage is at an acceptable level measured against WHO's recommendation of 80% of under-one children with a drop out rate of less than 10%. However, efforts are required to improve measles coverage in both Oromia and Amhara project areas as it is below the 80% goal.

Nutrition

Promoting appropriate infant and child feeding is crucial for child survival. Optimal nutrition boosts the immune system to protect against diarrhea, pneumonia, malaria, measles and neonatal sepsis. Inadequately nourished children suffer delayed motor development, stunting or early growth retardation, increased risk of infection, and/or death. In Ethiopia, poor nutrition contributes to one out of every two deaths of under-five children.

In collaboration with the LINKAGES Project, extensive work has been accomplished in advocacy and capacity building at both policy and implementation levels. Different types of training were organized for regional, district and health facility health workers to integrate ENA into key child survival programs and other basic health service activities. Considerable work remains to empower regional and district management to scale-up work started in training community workers in community-based ENA. This training will target health

extension workers, community health promoters and others.

ENA promotes nutrition behaviors that are do-able and scientifically proven to improve the nutrition of women and children. ENA integrates key actions and counseling into on-going interventions and existing contacts in health facilities and communities. Two major ENA courses are provided in ESHE focus areas: ENA Technical and ENA-BCC.

ENA-Technical provides technical updates on approaches to improve women's and children's nutrition with emphasis on infant and young child feeding. The four-day course for regional health bureau staff enables them to prioritize key nutrition behaviors. These behaviors address the health and nutrition needs of children and women in their region.

The ENA-BCC six-day course provides frontline health workers with the opportunity to build their counseling and negotiation skills in optimal breastfeeding and complementary feeding practices, feeding of the sick child, women's nutrition, and promotion of micronutrients. In Project Year 3 -1,336 health workers were trained in ENA-BCC in the three regions.

Integrated Management of Childhood Illnesses and Integrated Management of Newborn and Childhood Illnesses

WHO and the United Nations Children's Fund (UNICEF) developed the global Integrated Management of Childhood Illness (IMCI) approach which offers simple and effective methods of preventing and managing the leading causes of child illness and death. Diarrhea, pneumonia, measles, malaria, and malnutrition –often in combination – account for more than 70% of deaths and health facility visits for under-five children. IMCI focuses on reducing mortality and morbidity associated with these major causes of illness.

IMCI, however, does not fully address preventing the 40% of under-five deaths that occur in the newborn period—the first 0-28 days. ESHE, as a member of the Core Working Group of the Child Survival Partnership, worked this year to adapt IMCI to include essential newborn care, care of the sick newborn and HIV/AIDS detection and referral. In addition, the standard IMCI course was shortened to make roll-out faster and more economical. The quantity of reading was reduced to facilitate teaching lower level health workers. Internal experts from the government, UNICEF, WHO, Save the Children/USA and USAID were assisted by outside consultants from John Snow Inc./Nepal and WHO/AFRO in this exciting process that led to the field testing of both sets of training materials this year.

Two IMNCI courses were developed and field tested in Bolosso Sore Woreda, an ESHE focus woreda in SNNP. A six-day IMNCI course targets health workers in health centers while a five-day course is designed for HEWs assigned at health posts. The course for health workers includes instructions on both oral and injectable medications to treat: diarrhea, malaria and pneumonia. The HEW course limits treatment to the use of oral medications and referral of severely ill children. The new IMNCI courses are the first of their kind in Africa.

An emphasis on essential newborn care is particularly suited to HEWs who reside in

communities. They have the mandate and the opportunity to care for newborns at birth and in the crucial first week of life. With only 10% of deliveries currently taking place in health centers, standard health workers have little opportunity to assist at this decisive time. The FMoH is optimistic that HEWs can make a significant contribution to reducing newborn deaths which are a significant obstacle keeping Ethiopia from reaching its MDG-4 for child survival. IMNCI offers one critical new approach that can help Ethiopia achieve MDG-4 if it can be effectively implemented.

National IMNCI Review and Strategic Planning Workshop

The FMoH organized the national IMNCI Review and Strategic Planning Workshop in June, 2006, which all regional health bureaus and major health partners attended. Five ESHE central and regional staff actively participated in this ground-breaking forum which set new directions and standards for child care in Ethiopia. The major breakthrough is the adapted training materials and the consensus reached to use new approaches to train health workers and HEWs in IMNCI. Future efforts will be to implement the newly developed approach and aggressively scale-up IMNCI pre-service and in-service training. Careful attention to supporting training with sufficient drug logistics and supervision is needed.



ESHE trained health workers practice recording information for sick children on IMNCI formats during clinical practice at Wolayita Soddo Health Center

Community Mobilization Program

ESHE’s Community Mobilization Program interventions focus on building the capacity of communities to improve the health of their families and to advocate for increased use of health services. The Community Mobilization Program activities for Project Year 3 included:

- Expansion of the Community Health Promoter Initiative in the three regions.
- Collaboration with LINKAGES on the development of training materials and rollout of community nutrition promoters in selected communities.
- Implementation of the *Kokeb Kebele* Program for health and education.
- Collaboration with LINKAGES to conduct an assessment of the BCC/Community strategy and its impact on caretaker practices.

Trainings in Communication and Community Mobilization (Project Year 3)				
Training Type	Participants			
	Amhara	Oromia	SNNP	Total
CHPI/CNP				
CHPI TOT/ TVETI Orientation	76	143	197	416
CHP 1st round	4,781	3,550	10,154	18,485
CHP 2nd round	-	-	1,062	1,062
CNP TOT	-	69	42	111
CNP 1st round	-	85	686	771
CNP 2nd round	-	-	459	459

Community Health Promoters Initiative

Ethiopia has a significant number of trained community health workers in different categories, an increasing number of health facilities, and a high number of new graduates from health professional training institutions. Despite these important inputs, community access to basic services has remained poor.

BEING A CHP HELPED MY FAMILY

“Unlike my first child, I took my second baby to a health facility for vaccination on time,” says W/ro Selam Melak, a 26 year old mother of two.

W/ro Selam is one of the community health promoters in Tebelima Community of Gojam Zone in Amhara Region.

W/ro Selam continues, “I was eight months pregnant when I was selected and trained as a community health promoter in my kebele. At the training I learned that immunization can protect children from different diseases. Now I regret that my first child did not receive any vaccination as I did not know about its importance. I will make sure my baby will get all the vaccinations before his first birthday.”



“I will make sure my baby will get all the vaccinations before his first birthday.”

The launch of the CHPI in the three ESHE regions marks a significant step by communities to improve the health of their families. CHPI builds the capacity of communities to improve child and family health through the promotion of small doable actions that lead to improved health for children and families. When parents are informed about how to better care for their families, they make effective changes in their households. Since program roll-out, the CHPI has received an extremely positive reception from communities, frontline health workers and managers alike.

Community health promoters are volunteers, selected by the community, who attend short, two-day trainings on key health themes. The training emphasizes action-based messages to bring about positive changes in health behaviors. Promoters are encouraged to first take action in their own home, and then promote messages among their friends and neighbors. In this way, the CHPI draws on volunteers' natural motivation to help their own families.

CHPI was scaled-up dramatically in the three regions during this year. In coordination with its partners, ESHE staff oriented over 17,000 community members representing kebele administrations, religious groups, women's groups, elders, and HEWs to the CHPI initiative. By the end of Project Year 3, nearly 28,000 CHPs have been trained in all three regions, with 18,485 new CHPs trained during Year 3 alone. ESHE's goal is to train 50,000 to 60,000 CHPs during the life of the Project.

An integral component of the CHPI is the provision of support and encouragement to health promoters. Through experience sharing meetings CHPs share their experiences, learn from one another, and as a group identify common problems and solutions. HEWs and health facility staff also share their experiences related to the initiative and how they can better collaborate with CHPs. More than 12,000

CHPs participated in experience sharing meetings during the past year. Review meetings have also been held with woredas and zones to strengthen coordination and planning of the CHPI.

Twenty community festivals were conducted to celebrate community and CHP's achievements. Community festivals encourage promoters and community leaders to continue activities for improved family health and increased use of health services by the community. An important aspect of the festival is that promoters receive certificates to recognize their efforts and prizes are awarded to individual kebeles who demonstrate progress. During festivals, CHPs present key health messages through dramas, traditional song, and dance. Contests and games are also held. Success stories highlight activities in the community and health facility staff report on major achievements, promoters' efforts, challenges and forthcoming activities.

Collaboration Between CHPs and Health Extension Workers

CHPI is particularly important as it complements the HSEP goal to increase community access to preventative services. Some 30,000 HEWs are to be trained over the next few years.

ESHE actively works to strengthen HEW community mobilization activities by involving HEWs in CHPI. With one CHP to 50 households, CHPs expand the promotion and organizational work of HEWs who are responsible for 500 households. Approximately 10 times more promoters than HEW will be working in each community in program areas. Similarly, the newly deployed HEWs have contributed greatly to the support and organization of CHPs. At monthly meetings, CHPs discuss progress they have made and the challenges they face with the local HEW. Together they try to find solutions to the challenges posed in the community.

There are encouraging results in communities where HEWs and CHPs work together in the promotion of infant and

promoters in selected areas. The primary task of CNPs is to inform and negotiate with mothers to help them adopt optimal feeding practices, such as

HEALTH EXTENSION WORKER APPRECIATES ASSISTANCE FROM CNPs AND CHPs

Elfinesh Duko is a HEW assigned at Sore Homba Health Post, Wolayita Zone. Elfinesh coordinates the activities of 32 community health and nutrition promoters who transmit health and nutrition messages in the kebele. She explains the value of these volunteers and says, "I work in a large kebele where there are many households. If it were not for the CNPs and CHPs, I would not be able to reach all the houses. The volunteers live among the community. They have the opportunity to talk about health during coffee ceremonies, public gatherings and when they visit newly born children. I cannot overemphasize the value of CNPs and CHPs. They have simplified my life greatly."



Elfinesh (left) demonstrates the contents of the Family Health Card in a group exercise.

exclusive breastfeeding, timely introduction of complementary foods, and frequency and variety of feeding. Similar to CHPs, CNPs are volunteers, selected by the community, who attend short trainings for the promotion of small do-able actions that lead

young child feeding practices, latrine construction, immunization, and Vitamin A distribution. Feedback from visits to households during community follow-up by Project and health facility staff show a high level of CHP activity and positive response on the part of caretakers to the messages they promote: of 677 households interviewed 78% had been visited by CHPs; of 245 mothers visited with children less than 6 months 86% are exclusively breastfeeding their children; of 228 mothers visited with children 12-23 months 66% were fully immunized. Additional IMNCI themes are being phased in after competency is gained in initial themes. In Year 4, ESHE will work to strengthen capacity and skill of HEW to train and support CHPs. Integration of the Community Health Promoter's Initiative into the Health Service Extension Program with rapid scale-up of the community-based initiatives will be given the highest priority.

Community Nutrition Promoters

ESHE collaborated with LINKAGES to rollout trainings for community nutrition

to improved nutritional practices in households.

In line with USAID overall objectives to increase resiliency in families and communities to continued bouts of droughts and famines, this approach tackles significant missed opportunities. In the new approach, children who are screened for severe malnutrition and are rejected as not being malnourished enough to qualify for therapeutic foods (plumpy nuts), now receive appropriate preventive treatment and nutrition counseling. A large cadre of volunteer CHPs are supported by CNPs more focused on negotiating nutritional changes. Together, they promote nutrition action messages to all families, proactively attempting to prevent malnutrition rather than waiting for malnourished children to be identified. This approach needs to be incorporated into all CTC programs as a necessary companion to make a sustainable transition from emergency to development nutrition programs.

In the context of the emergency in Bolosso Sore Woreda, where approximately 11,000

children are moderately malnourished, CNPs' activities focus on counseling care

education related problems, propose solutions, set specific goals, develop plans

Bekelech Beza (left), a 22 year old mother of four children is a CHP and is attending second phase training to become a CNP in SNNP. The training focuses on exclusive breastfeeding for six months and positioning and attachment during breastfeeding. "I learned at the CNP training that holding the breast between the fingers, which we normally do, prevents the baby from getting the milk easily and makes breastfeeding less enjoyable for the mother as the nipples may hurt," says Bekelech after attending the CNP training.



takers on optimal feeding practices for good growth and development of their children and to prevent malnutrition. Malnourished children are at increased risk of death due to common diseases such as pneumonia, diarrhea, malaria and measles. The 686 CNPs trained during Project Year 3 provide an important input to improve the nutritional status of children in the Woreda, complementing existing CTC programs that focus on severely malnourished children. Oromia also began training of CNPs late in Year 3, training 85 CNPs in two woredas that are prone to recurrent drought and emergencies.

Kokeb/Model Kebeles Initiative

ESHE is working with Health Communication Partnership (HCP), Pathfinder International, and World Learning Ethiopia to implement the *Kokeb Kebele* and *Model Kebele Initiative* in two woredas in SNNP and Amhara. Community orientation meetings, training of action committees, and quarterly review meetings took place in eight SNNP kebeles this year.

The *Kokeb Kebele Initiative* integrates health, education and HIV/AIDS activities at the community level. The *Initiative* mobilizes and builds the capacity of communities to identify health and

and implement activities to attain those goals. Through newly created and/or strengthened links between existing groups, community leaders can more effectively draw upon the kebele's own resources, utilizing parent teachers associations, community health promoters, community-based reproductive health agents, and other social and religious community structures (edir, religious, women's, and youth groups), to attain the identified and agreed upon development goals.

Behavior Change Communication

ESHE's behavior change communication approach recognizes the complex nature of changing behavior and as a result strives to reach multiple audiences using multiple channels. To improve household practices ESHE is promoting small do-able health actions through community volunteers, BCC materials, and mass media.

Community Health Promoters

CHPs focus on what can be done in their own household and shared with family and friends. Trainings of CHPs concentrate on infant and young child feeding, immunizations, and sanitation and hygiene. Trainings emphasize practice on interpersonal communication and

negotiation skills with caretakers to problem solve and promote optimal practices.

mothers who fully immunize their children before their first birthday. CHPs also use the

COMMUNITY HEALTH PROMOTER GAINS CONFIDENCE TO COUNSEL

"I learned health messages at the training organized for community health promoters. But, I was confused as the new messages contradicted what I thought I knew. I could not believe that immediate breastfeeding to the newborn would facilitate the expulsion of the placenta and reduce bleeding," says W/ro Abeba, a famous traditional birth attendant in Amhara Region. She was selected by her community to attend CHP training.



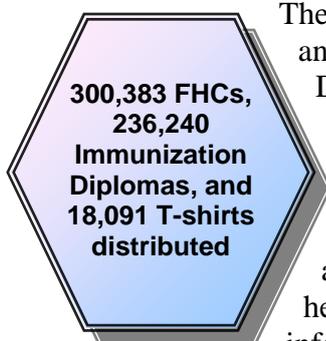
W/ro Abeba (right) explains the contents of the Family Health Card to an expecting mother

"In my village, I have attended many deliveries for long. When a baby is delivered, I used to ask the mother to sit on a pit to expel the placenta. The newborn would not be allowed to get breast milk unless the placenta is expelled in the usual way and this could take up to three days in some cases. Some mothers become weak when sitting on the pit for long. To make things worse, I used to give orders to mothers to discard the colostrums because I thought they were bad for the baby."

"Before transmitting the messages I learned in the training to mothers, I tested my new knowledge with my pregnant cow and goat, and to my surprise, I found out that immediate breastfeeding to newborns helps expel the placenta in time even in animals. If it works for cattle, it should work for mothers, too," says W/ro Abeba.

"I have now the confidence to counsel pregnant mothers before delivery." W/ro Abeba continues, "Our traditional practice during delivery is substituted by simple and healthy actions that help save the life of the baby and mother. All the mothers I counseled after I became a CHP breastfed their newborns after delivery without discarding the colostrums," proudly adds W/ro Abeba.

BCC Materials



The Family Health Card and Immunization Diploma are the main tools CHPs and health workers use to promote health actions. The FHC is a critical home-based health education and information booklet that guides through small do-able actions needed to keep their child healthy. CHPs distribute the FHC to pregnant women and mothers with under-one year old children. Immunization Diplomas are awarded to

FHC and Immunization Diploma to promote health actions in their villages. In addition, T-shirts with health messages and illustrations are given to CHPs for recognition by their communities.

Mass Media

Mass media also supports the community BCC approach. In Project Year 3, six immunization, 11 breastfeeding and 14 complementary feeding spots were transmitted via 12 regional radio stations almost daily in Amharic and Oromiffa. Following media producers training for 107 participants, immunization and nutrition messages in seven different languages on national and regional radio stations were

integrated into programs on health, agriculture, children, women, and social affairs. Messages were aired frequently on Radio Ethiopia and Radio Fana in a variety of programs including serial dramas, continuities and other programs. Ethiopian Television produced and aired six 20-minute programs in three languages on breastfeeding, complementary feeding and ESHE's high quality, evidence-based child survival approach. Nutrition messages also continuously appeared in private and public Amharic newspapers.

The Sidama educational radio station in SNNP took the initiative to translate, produce and broadcast EPI and breastfeeding spots in the Sidama language. The SNNP Bureau of Education produced 240 lesson scripts incorporating child survival messages to be aired in the coming academic year.

ESHE co-facilitated two complementary feeding and women's nutrition radio spot development workshops with LINKAGES in November 2005 and February 2006. These workshops built the capacity of radio station staff to produce interesting and effective health programs. Producers from the public and private media shared experiences during the workshop sessions and their relationship with the FMOH's Health Education Center and RHBs was strengthened.

Behavior Change Communications Skills for Health Extension Workers

To harmonize the BCC approach and create a meaningful link between CHPs and HEWs, ESHE provided communication and community mobilization skills training for TVETI instructors in the three ESHE regions. The instructors integrated communication and community mobilization skills into their lesson plans for training subsequent batches of HEWs.

ESHE is a member of the Pre-service and In-service Integrated Refresher Training (IRT) Group for HSEP. It assisted with development of information, education and communication (IEC) and monitoring and evaluation (M&E) modules for IRT training and provided the training for newly recruited TVETI instructors and for woreda health teams in Oromia, SNNP and Tigray. The FHC, Immunization Diploma and Community Health Promoter Initiative were introduced in the IEC component of the IRT. ESHE also coordinated the development of training materials and a TOT for the *Monitoring and Evaluation Module*. This *Module* introduced a nationally standardized monthly reporting format for HEWs to help them collect and report accurate and appropriate data to be used for decision making at different levels of the health system.

IMPROVED HEALTH SYSTEMS

ESHE is working with the FMoH to improve financing and management of the health system. ESHE conducted various studies which serve as input in the formulation of health care financing legal frameworks and identification of priority areas for health care financing reform. In addition, efforts were made to improve the quality of health services through the establishment of special pharmacies at hospitals and health centers. ESHE provides technical assistance to build the capacity of FMoH staff in data analysis for decision making and supports review meetings related to issuance of regional legal frameworks. During Project Year 3, health facilities in SNNP implemented HCF reform in the areas of revenue retention and systematized fee-waiver.

Another key component of health systems strengthening is performance improvement. ESHE is working with RHBs, the ZHDs and WorHOs in all three regions to develop systems, tools and capacity to promote continuous improvement in health staff performance. Performance improvement is the means by which ESHE initiatives will be institutionalized and sustained, leading to improved service quality and access.

Health Care Financing Reform

The Commission for Macroeconomics and Health at WHO recommends developing countries spend at least US\$34 per person to deliver essential health services. Expenditures for health in Ethiopia in the most recent year for which data is available (1999-2000) was US\$5.6 per person, far lower than recommended and considerably less than the Sub-Saharan Africa average of US\$13.

The health care financing component of ESHE is working to address the under funding by improving the financial resources available in the sector including introduction of different financing options as

well as enhancing efficient allocation and utilization of resources to ensure sustainable and quality health coverage. This ESHE effort is nationwide. At federal and regional levels ESHE works in close collaboration with the FMoH and the Ministry of Finance and Economic Development, RHBs, Bureaus of Finance and Economic Development (BOFEDs) and other partners.

Trainings to Strengthen Health Systems (Project Year 3)				
Training Type	Participants			
	Amhara	Oromia	SNNP	Total
HMIS	-	23	-	23
Supervision	185	172	132	489
HCF TOT		-	80	80

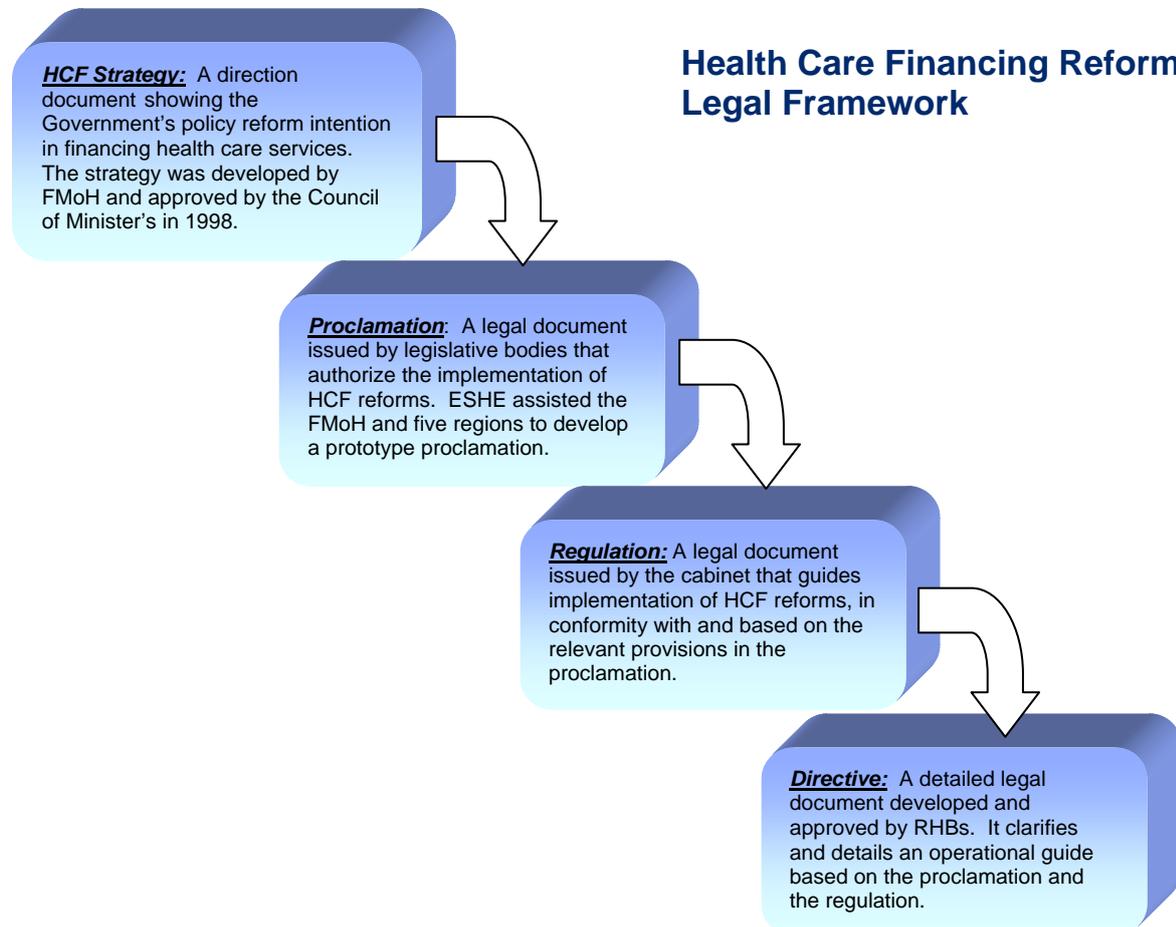
Legal Framework

The Federal Government designed and ratified a health care financing strategy in 1998 which aims at increasing resources to the health sector; improving allocation and use of resources within the sector and enhancing equity in delivery of health care services. The need for providing legal backing was appreciated to implement the various policy changes and reform initiatives included in the strategy. In relation to this, the Project assisted the FMoH and RHBs in preparation of the necessary legal frameworks. The Project assisted in designing prototype legal documents as well as adoption and ratification of the documents through facilitation of consultative and policy dialogue forums among relevant actors in the respective regions.

The legal framework contains provisions related to revenue retention which allows collection and use of revenues by health facilities. It also allows introduction of hospital autonomy through establishing hospital boards and public hospitals are allowed to outsource non-clinical services and establish private wings. In Ethiopia,

user fees for health care services were introduced fifty years ago and there is strong need to revise them. However, revision of user fees should be made following improvement in quality of health care and

Year, discussions were held with the Ministry, especially with the Medico-Legal Service and the Planning and Programming Departments to review the draft legal documents and to submit them to the



with due consideration for ability and willingness to pay. Along with user fees an appropriate and well functioning fee waiver system for those who are not able to pay for health care is required. The legal framework has provisions for user fee revision and required for rationalizing the fee waiver and exemption system.

Federal Council of Ministers through the FMoH.

The Project continues working with the FMoH, Planning and Programming Department to facilitate ratification of the Federal *Health Service Delivery, Administration and Management Proclamations (HSDAM)* and accompanying *Regulations*. The revised draft *Proclamation*, a concept paper on its need, and a justification note were submitted to the Federal Council of Ministers through the FMoH in March 2005. During the Project

Significant achievements were made in terms of finalizing the review and approval process of the legal framework within and beyond the three ESHE focus regions. All ESHE regions passed the *Regulations* and developed their respective *Directives* to provide detailed guidance on implementation of the reform. The ESHE team drafted *Directives*, and facilitated consultative meetings with the RHBs.

ESHE worked with the Tigray RHB to finalize the legal framework and the Tigray Regional Council ratified the *Proclamation* which increased the number of regions with ratified *HSDAMP* to five, including Addis Ababa. The regulations are expected to be

endorsed by the Tigray Regional Cabinet soon.

Health Care Finance Implementation

Following ratification of the legal documents, preparatory measures were taken to implement the reform. The *Health Care Financing Implementation Manual* developed in Project Year 3 is a technical document which provides detailed guidance on the steps to follow, formats to use, and a timeline for performing the tasks to implement HCF reforms. The *Manual* gives detailed guidelines on implementation of health care financing reform in the context of the broader decentralization process. The *Manual* describes revenue collection and use mechanisms including linking the revenue retention and use with the decentralized planning and budgeting process, lists the process steps and decision-making mechanism for user fee revision, and reviewing and revitalizing the fee waiver system. In addition, the *Manual* establishes an in-built M&E system for implementation of health care financing reform. The final draft of the *Manual* was reviewed during a consultative meeting held with participants from FMOH, MOFED, RHBs and BOFED of Amhara, Oromia, SNNP, Addis Ababa, and Tigray Regions. The meeting was an important forum to bring on-board relevant stakeholders to improve the draft, ensure ownership of the *Manual* and the reform implementation process.

The *Manual* was adapted in Amhara, SNNP and Oromia Regions based on the region's *HSDAM* Proclamation, regulation and other considerations. The ESHE team translated the *Manual* into Amharic—the working language for Amhara and SNNP— and will continue the process of translation into Oromiffa in the first quarter of Year 4.

Two TOTs were conducted at the national level on the *HCF Implementation Manual* to create a critical pool of trainers. Also, two zonal level TOTs were conducted in SNNP. Eighty participants from zonal and special

woreda health and finance departments and offices attended the trainings. In some zones and woredas of the SNNP, revenue retention has commenced, and the training served as a forum to share experiences and to discuss and resolve operational challenges. Next steps were also defined and technical and other support required at regional, zonal, woreda and facility levels discussed.

Health Care Financing Trainings

Health Sector Reform

ESHE organized training in HCF reform for high-level government officials from Addis Ababa, Amhara, Oromia, and SNNP Regions and technical staff from FMOH, WHO and other relevant partners. Training topics included health sector reform, health care financing, and health insurance. The training equipped participants with basic techniques of costing and user fee setting and revision in health service delivery.

Health Financing and Marginal Budgeting for Bottlenecks Flagship Course

ESHE, in collaboration with the World Bank Institute and the FMOH, organized the flagship course *Health Financing and Marginal Budgeting for Bottlenecks* for the first time in Ethiopia. Twenty-seven RHBs participants and ESHE staff were trained in essential health sector reform components, particularly health care financing. The *Marginal Budgeting for Bottlenecks* model, a planning and budgeting tool used to estimate resource implications of health outcome targets through removing bottlenecks in the health system, was presented and discussed. The mix of resource persons and the course content were highly appreciated by participants.

Health Sector Reform Flagship Course

ESHE facilitated participation of high-level RHB officials and the ESHE HCF Team Leader in the World Bank flagship course, *Health Sector Reform and Sustainable Financing*, held in Washington, D.C. October 17 to November 4, 2005. This was a global course conducted by the World Bank Institute and Harvard University staff for government policy makers, technical advisors and key technical staff of multi-lateral and bilateral partners. Participants were introduced to the basics of health economics, concepts of health sector reform and health care financing. They learned skills and techniques related to implementation of health sector and health care financing reform.

Strengthening Special Pharmacies

ESHE continues to assist in strengthening special pharmacies. In collaboration with the Pharmaceutical Administration and Supply Services (PASS) a *Special*

Pharmacy Operational and Management Guideline Revision and Consultation Workshop was organized. The revised *Guideline* will be finalized, printed and disseminated in the first quarter of Year 4. At the regional level, a checklist was prepared and supportive supervision conducted in 21 special pharmacies in Amhara and 11 special pharmacies in Oromia in collaboration with the RHBs. ESHE also engaged in organizing and conducting special pharmacy trainings for federal hospitals. A total of 18 staff from five federal hospitals in which medical directors, heads of administration and finance and pharmacy departments participated. ESHE assisted PASS in preparation of project proposals for establishment of over 800 special pharmacies.

National Health Account

ESHE in collaboration with the Federal Ministry of Health and other partners undertook the third round of National Health Accounts (NHA) survey based on data for

Special Pharmacy Generates Income for Hospital



Part of the new building for drug store, dispensary, laboratory and pharmacy office constructed with the profit generated from the special pharmacy in Felege Hiwot Referral Hospital.

Felege Hiwot Referral Hospital is a health facility chosen for a special pharmacy in Amhara Region. Ato Tariku Mohammed, head of the special pharmacy in the Hospital, says, "The pharmacy is the only unit in the hospital that is independently owned, managed and administered and has the confidence of the hospital management. It is helping to solve challenges facing the Hospital. Hospital management is now able to decide what to do with the profits the special pharmacy generates based on agreed-upon priorities.

Ato Tariku explains that the Hospital used to be ranked as one of the most poorly performing service delivery institutions measured against civil service delivery standards. "This year, we ranked first!" he exclaims. "One of the major contributing factors to this great achievement is the existence of the special pharmacy in the Hospital. In addition, the technical support given by the Regional Health Bureau and ESHE -including training on how to operate and manage pharmacies, drug selection and pricing as well as supportive supervision by the Regional Health Bureau- has enabled the availability of essential drugs and supplies at affordable prices. Funds are also now available for priority needs of the Hospital from the profit generated with reasonable mark-up decided by the management."

To-date, the Hospital has been able to access more than Birr 700,000 generated by the special pharmacy for the construction of a new modern laboratory and appropriate drug storage and dispensing rooms. The special pharmacy, the new laboratory and other improvements have enabled the Hospital to fulfill its role as a regional referral hospital. The revenue generated also enables the Hospital to pay monthly allowances as incentive for hospital pharmacy personnel, administrative and finance staff. The capital of the special pharmacy substantially increased from Birr 50,000 to more than Birr 800,000, including fixed assets.

the period July 1, 2004-June 30, 2005 (EFY 1997). In this round, in addition to the general NHA, sub-accounts were constructed for child health and reproductive health.

National Health Account: is an expenditure tracking tool that measures the financial pulse of a national health system. NHA track general health expenditures from sources to financing agents (FMoH, RHB, insurance corporations, etc) then to health care service providers. NHA also helps to track expenditures for specific disease category or public health concern. Expenditures in areas of child health, reproductive health, malaria, HIV/AIDS are tracked with the tool.

Data was collected and analyzed from primary and secondary sources. The primary data was collected from 346 entities [261 employers, 34 non-governmental organizations (NGOs), 29 providers, 13 donors, and nine insurance companies]. The survey covered all regions

except Somali, Benshangul-Gumz and Gambella. The ESHE health care financing team played a lead role in the survey and data analysis together with consultants from the PHR*plus* Project. Analysis of the general NHA and sub-analyses on reproductive health and child health will be finalized and results disseminated in the first quarter of Project Year 4.

Performance Improvement

Performance improvement under the ESHE project means: a) defining performance expectations through the development and dissemination of standards for service delivery and management; b) processes for regular supervision and support to explore how far the expectations are met; c) monitoring service delivery outcomes through using routine health information; d) mechanisms (review meetings) for sharing experiences among staff at different levels and geographical locations and planning for

further performance improvement; and e) building government capacity at all levels to implement and sustain performance improvement initiatives.

Supportive Supervision

During the year, standards for service delivery and management, integrated supervisory checklists for each level of the system, and guidelines for conducting supportive supervision were developed and disseminated during trainings. A total of 489 staff from RHBs, ZHDs, WorHOs, and health centers were trained in supervision. ESHE regional and cluster staff assisted each level to include quarterly supervision visits in their annual work plans and budgets to promote institutionalization and provide technical assistance in conducting supportive supervision. Limited financial support was provided to those levels where funds were a barrier to conducting supervision. Recently, ESHE regions have started planning and budgeting for supportive supervision activities.

The regional level training in supportive supervision included participants from non-ESHE focus zones, so that the standards, checklists, supervision guidelines and skills in supervision were disseminated region-wide. Project staff provided technical assistance to non-ESHE zones as they conducted supervision training for their staff to support expanded impact of ESHE activities.

Performance Scoring System

In order to facilitate the monitoring and reporting of performance standards by managers at all levels, an innovative approach to score results from integrated supervisory checklists was developed. The checklists are administered by government staff enabling them to score the quality of performance of the facilities they supervise each quarter and to report progress over time at regular review meetings. The system will

be field tested and implemented during Project Year 4.

Data for Decision-Making: Health Management Information System

A Health Management Information System (HMIS) is a critical base for decision making and planning. ESHE provides training in HMIS data collection and use of data for decision making. In Year 3 HMIS refresher training was given to 23 staff from

regions, another example of the expanded impact of ESHE activities.

Orientation to HMIS sessions was given to 420 staff from WorHOs and health centers in Oromia during quarterly review meetings. The orientations proved useful to share information with wider audiences and created common grounds for on-the-job support. It was an opportunity to share key aspects of HMIS refresher trainings with staff that do not attend these trainings.



Workshop participants reviewing and refining the Integrated Supervisory Checklists.

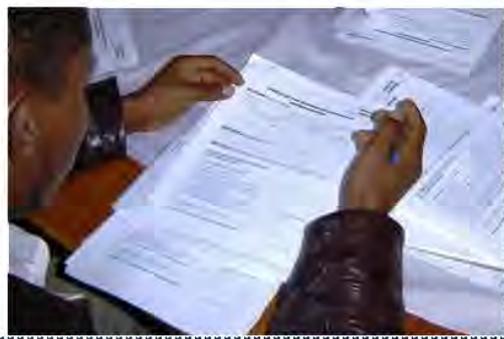
Integrated Supervisory Checklists Improve the Quality of Supervision

“Our previous supervision checklists were not integrated, but developed for use of individual programs. They were bulky and used for data collection rather than supervision,” says Ato Asfaw Bekele, Planning and Program Department Head of Oromia Regional Health Bureau. “Previously it was difficult to integrate and coordinate supervision activities at all

levels. Every department was planning and conducting its supervision using separate checklists.” Ato Asfaw continues, “After ESHE assisted us through supervision trainings and adoption of Integrated Supervisory Checklists, we are experiencing a very encouraging outcome regarding implementation of supportive supervision. Using Integrated Supervisory Checklists has made our lives easy. It is well designed and accepted by all staff.”

As part of strengthening the health system, in collaboration with Oromia Regional Health Bureau, ESHE developed Integrated Supervisory Checklists for use at all levels of the health system.

Ato Asfaw Remarks, “the Checklists have improved the quality of supervision outcomes as they incorporate quality indicators. They have enhanced inter-departmental collaboration and harmony and ensure optimal utilization of resources. I can now supervise all the departments in my office using the Integrated Supervisory Checklists.”



Health Management Information System Monitoring at the Community Level

With the large scale rollout of HEWs to health posts in kebeles, the FMOH is interested in a comprehensive monitoring system for community-level service

Oromia RHB and selected zones. Over two consecutive years, 200 health managers and staff from health facilities in ESHE zones received training on HMIS. SNNP Regional Health Bureau provided HMIS refresher training to non-ESHE zones with technical assistance from ESHE staff. This is an exemplary initiative being shared with other

delivery. Such a system would permit HEWs and their supervisors to track the progress of this new level of worker and assure that their contribution is captured by overall health statistics. ESHE staff worked in collaboration with an international consultant from the BASICS Project to develop draft reporting forms and registers to be used for routine reporting in health posts.

Monthly Health Management Information System Data Review and Follow-up Actions

Following HMIS refresher trainings and orientations, the majority of WorHOs and health facilities in all three regions established HMIS review teams. These teams review HMIS data on quantitative achievements against targets and make decisions on actions necessary to improve outcomes. Typical actions taken include HMIS data cleaning to improve information quality, identifying and seeking solutions for low performance and developing and updating performance monitoring charts.

All WorHOs and health facilities in the ESHE-focus areas have updated performance monitoring charts and have HMIS review team minute books. Minute books contain actions taken or proposed by HMIS review teams. They provide

supplementary information to supervisory teams to assess HMIS activities and serve as a permanent record.

Woreda Health Profiles

In partnership with zonal and WorHO staff, regional ESHE teams collect, compile and regularly update the *Woreda Health Profile* for ESHE focus woredas. *Woreda Health Profiles* provide reliable data for planning and decision making. The profiles are updated annually.

Review Meetings

Review meetings are an important tool for promoting improved performance. Review meetings bring staff together regularly to review their achievements against their workplans and targets, to share good practices and to agree on strategies for overcoming problems. ESHE provided technical and financial assistance for conducting quarterly review meetings at all levels. ESHE staff developed *Guidelines for Review Meetings* to assist staff at each level to plan, organize, prepare for and conduct effective review meetings with key stakeholders. These *Guidelines* will be shared with RHB managers at a consensus-building workshop early in Year 4.

MONITORING AND EVALUATION

The ESHE M&E system monitors program implementation and assesses project effectiveness. It is engaged in assembling and analyzing the multitude of program data that flows from regional offices and various project surveys. It provides feedback that determines where the Project stands in terms of achieving pre-set indicators and goals. (See Annexes III and IV)

The M&E component contributed to strengthening the use of information to improve and sustain the service delivery environment and mobilize community members in focus woredas and regions. Various data from project records, checklists, HMIS data, training database, baseline surveys, mid term evaluation, and end line surveys are used to gauge progress over time

Bolosso Sore Baseline Survey

To provide baseline data for the OFDA/ESHE activity in Bolosso Sore, ESHE in collaboration with the RHB conducted a baseline survey of 2,400 Bolosso Sore households. The objective was to collect data on child immunization, feeding practices and nutrition, maternal health care service, and family planning. The survey will be used to gauge the success of project interventions focused on prevention and treatment of malnourished children in the woreda.

Behavior Change Communication/Community Assessment

A joint ESHE and LINKAGES assessment was conducted in May/June 2006 to determine community behavior change in ESHE Project areas where CHPs had been trained and active for at least six months. The assessment serves as a mid-term status report on community health behavior change. Cluster sampling was used to select 2,208 households per region. A total of

6,624 households were interviewed in the three regions.

Information was gathered on ENA, EPI, use of latrines, hygiene, use of insecticide treated nets, Vitamin A supplementation, sick child treatment, and contacts with a community health promoter. Results, for both projects, could be used to advocate continuation of the nutrition and community-based interventions. Preliminary results of the assessment were shared with USAID, ESHE and LINKAGES staff.

Community Monitoring

ESHE and LINKAGES developed an approach for monitoring community activities and progress on key health indicators. The objective is to stimulate communities to review their progress on immunization, sanitation, and feeding practices. A checklist was developed for the community approach and tested in Amhara Region. The checklist assists supervisors to mentor household practices, counsel mothers and provide feedback to CHPs and HEWs. Currently, the three ESHE regions are implementing the community monitoring approach.

Follow-up Visits

ESHE integrated checklists were used by Project staff to standardize follow-up on knowledge and skills transferred to health managers and health workers through various training. Quarterly follow-up visits were conducted at each WorHO and monthly at five health facilities and communities from each woreda. In Year 3, ESHE staff conducted 166 follow-up visits to WorHOs and 754 visits to health facilities using Project checklists. Community visits were made to 587 CHP kebeles.

During follow-up visits, ESHE staff guided health managers and health workers on how to conduct regular supportive supervision

visits and HMIS review meetings, how to calculate EPI coverage, how to prepare EPI monitoring charts, how to interpret data for decision-making, how to store vaccines in an appropriate compartment, use of an injection safety box and use of BCC materials. In community follow-up visits, ESHE staff guided HEWs and CHPs on how to better collaborate in promoting healthy household practices in the community.

In most areas, the findings were encouraging. Health managers and health workers have shown progress in using the knowledge and implementing skills acquired during trainings. Support was given in areas demonstrating poor recording and reporting, inadequate and inappropriate use of tally sheets, errors in determining eligible targets, poor practice of cold chain monitoring, irregular supportive supervision visits, low DPT3 coverage and high dropout rate.

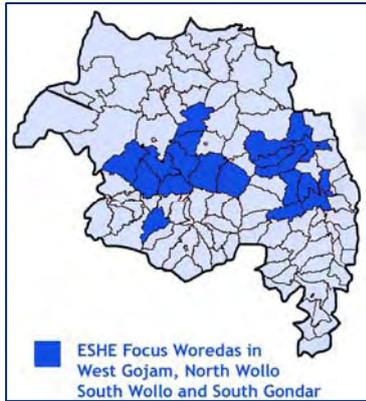
Results of follow-up visits were compiled quarterly, analyzed and distributed for internal and external use. Feedback was provided to ESHE offices for their follow-up and action. Annex III shows results of follow-up visits to health facilities and households.

Other

- As a monitoring mechanism, field visits were used to spot check use of monitoring tools at various levels.
- Regional monthly meetings were used to give technical advice on the use of monitoring tools and results.
- ESHE has joined the recently established USAID M&E partners' forum which is a venue to ensure appropriate sharing of best practices, effective communication of information and coordination of activities for M&E focal persons.

REGIONAL OVERVIEWS

AMHARA REGION



The Amhara National Regional State is the second largest in Ethiopia with an area of 170,752 sq. kms and a population of 19.7 million. The average

growth rate is 2.7%. Almost 90% of the Region's population is rural, living in heavily populated farming communities (111 persons/sq. km). Even though the remoteness of many communities presents a formidable challenge to the provision of health care, there is an improvement in the potential health service coverage in the Region (87%) compared to last year's 53%.

In partnership with the Amhara Regional Health Bureau ESHE operates in 20 woredas (population of 4.85 million) of the Region to improve child survival and strengthen the health system and health workers' skills. The Project implements programs working in partnership with existing structures of the government health sector at all levels and with local communities. The ESHE health sector reform component provides technical support to improve mobilization of resources to the sector and allocation and use of available resources across the entire Region. This program has been coupled with accelerated expansion of primary health care facilities and clustering of health posts.

ESHE's capacity building activities and experience sharing through supportive supervision and review meetings have

demonstrated impact on non-ESHE areas in the Region.

Major Achievements in Amhara in Project Year 3

Strengthening Health Worker Skills

- Provided EPI Refresher training to 130 health workers and 147 health extension workers.
- Trained 31 regional and zonal health managers in ENA- technical, 296 health workers and 114 HEW on essential nutrition actions-behavior change communication and established a pool of 83 training facilitators at woreda level to roll out ENA-BCC.
- Trained 185 health managers on supportive supervision.
- Provided 122 health workers refresher training on Operation and Management of Special Pharmacies.
- Conducted follow up visits to 176 health facilities.

Improving Community and Household Practices

- Trained 4,781 new CHPs and held experience sharing review meetings and field visits for 2,169 promoters.
- Distributed Family Health Cards to 83,444 care takers and 4,959 CHPs and HEWs, and 74,990 Immunization Diplomas to health facilities for distribution among their client population.

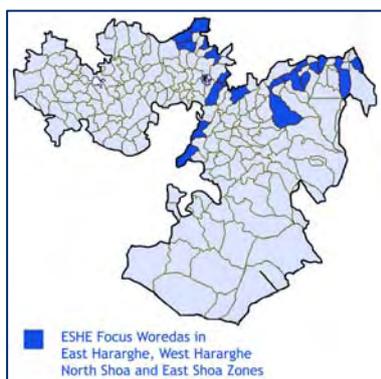
Achievements Vs. Targets in Amhara Focus Woredas July 1, 2005 – June 30, 2006 (%)			
Indicator	Baseline 2002/2003	Year 3 Target	Year 3 Achieved
DPT3	63	80	89
Polio3	61	70	NDA
Vitamin A	NDA	65	88
DPT1-DPT3 Dropout	9	<10	9
NDA: No data available			

- Trained 25 media producers from regional educational media stations, Amhara mass media agency, and youth amateur promotional clubs on child survival themes.
- Trained 76 instructors from seven technical vocational education and training institutes on communication skills and community mobilization.
- Conducted follow-up visits to 119 communities.

Improving Health Systems

- Established legal framework for health care financing reform ratification and issuing of *Health Service Delivery, Administration and Management Proclamation, Regulations and Directives*.
- Adapted the *HCF Implementation Manual* for the Region.
- Received approval for the *Directive for Revenue Retention and Utilization* from the RHB and submitted to the Regional President's Office for special appraisal.
- Assisted the RHB, zone health desks and woreda health offices to incorporate quarterly supportive supervision and review meetings in their annual plans.
- Supported six ZHD and 25 WorHO to conduct quarterly supportive supervision visits.
- Supported four ZHD and 22 WorHO to conduct quarterly review meetings.
- Conducted follow-up visits to 61 WorHOs.
- Assisted sub-national and national immunization day campaigns integrating them with routine immunizations.

OROMIA REGION



Oromia is the largest region in Ethiopia having an estimated population of 26 million and a high fertility rate of 2.9%. 89% of the

population is rural. Infant and child mortality is high in the Region where 10 out of 100 babies born alive die before celebrating their first birthday, and 14 out of 100 die before their fifth birthday [Demographic Health Survey (DHS) 2000] due to the weak health system, poverty, rampant preventable and treatable infectious diseases, and nutritional deficiencies.

Health services in Oromia are delivered through 29 hospitals, 183 health centers, 715 clinics and 921 health posts. The estimated health service coverage is 62%. The geographic distribution and settlement pattern of the population unfavorably affects health service utilization of existing health facilities.

ESHE works through the existing structures of the regional health bureau, zonal health desks, woreda health offices and local communities in 20 woredas of the Region where 4.5 million people are expected to be direct beneficiaries of Project activities. The Project assists respective health offices in improving the quality and utilization of high-impact child survival interventions in the form of the Expanded Program on Immunization, Essential Nutrition Actions and Integrated Management of Newborn and

Childhood Illnesses by improving community and household practices, strengthening health system and health workers skills.

Besides the encouraging results obtained in ESHE woredas, working in partnership with the RHB and ZHDs has proved to be an effective way of expanding impacts of ESHE interventions to non-ESHE areas.

Major Achievements in Oromia in Project Year 3

Strengthening Health Worker Skills

- Trained 172 health workers in EPI Refresher Training.
- Trained 420 health workers and HEWs in ENA, and organized ENA technical training for 23 health managers and TVETI instructors.
- Trained 143 health workers and HEWs in Community Health Promoters Initiative training of trainers.

Achievement Vs Targets in Oromia Focus Woredas			
July 1, 2005 - June 30, 2006 (%)			
Indicator	Baseline 2002/2003	Year 3 Target	Year 3 Achieved
DPT3	35	80	91
Polio3	NDA	80	84
Vitamin A	NDA	80	99
DPT1-DPT3 Dropout	29	<10	11
NDA: No data available			

- Trained 172 regional health managers, experts and woreda health workers in

supportive supervision.

- Trained 23 regional health bureau staff in HMIS refresher training.
- Conducted follow up visits to 385 health facilities.

Improving Community and Household Practices

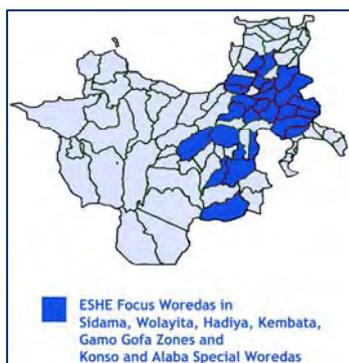
- Trained 3,587 CHPs and conducted community review meetings for 4,428 CHPs.

- Trained 22 media producers from the regional health and educational bureaus, and educational radio stations on child survival themes.
- Conducted follow-up visits to 328 communities.

Improving Health Systems

- Introduced a system to involve HEWs in training, follow-up, and assisting day-to-day CHP activities.
- Translated the ratified *HSDAM Regulations* from Oromiffa to Amharic and English.
- Assisted the RHB in amending the integrated supervisory checklists and performance standards and disseminating them to relevant health offices.
- Supported two ZHDs and 24 WorHOs to conduct supportive supervision.
- Conducted follow up visits to 76 WorHOs.
- Assisted sub-national and national immunization day campaigns integrating routine EPI.

SOUTHERN NATIONS NATIONALITIES AND PEOPLES REGION



The Southern Nations, Nationalities and People's Region has an area of 118,000 sq. km. and a population of 15.3 million - 20% of the nation's total. Approximately 93% of the population lives in rural areas. The population density of the 24 ESHE woredas is 92 persons per sq. km.

The Region's potential health service coverage has grown from 28% in 1993 to 48% at present through services provided in 16 hospitals, 161 health centers, 179 developing health centers and 1,314 health posts,

ESHE partners with the SNNP Regional Health Bureau in planning, implementing and following up child survival and health sector reform interventions of the Project.

Approximately six million people (40% of the Region's population) in the 24 ESHE woredas are directly benefiting from ESHE interventions. These interventions are transferred to non-ESHE areas as a result of the collaboration with government counterparts at regional, zonal, woreda, and community levels.

Major Achievements in SNNP in Project Year 3

Strengthening Health Worker Skills

- Trained 353 HEWs and 45 health workers in EPI.

- Trained 164 HEWs and 342 health workers in ENA.
- Trained 197 health professionals in CHPI-TOT to maintain a pool of trainers.
- Trained 80 staff from zonal, Special Woreda Finance and Economic Development Offices and health departments in HCF implementation.
- Trained 132 woreda health managers in supportive supervision.
- Conducted follow-up visits to 169 health facilities.

Improving Community and Household Practices

- Conducted 114 sensitization meetings on CHPI for 3,790 community participants.
- Conducted 112 CHPs review meetings in 317 kebeles, and trained 10,154 CHPs.
- Trained 40 TVETI tutors on community mobilization and communication skills.

Achievements Vs Targets in SNNP Focus Woredas July 1, 2005 - June 30, 2006 (%)			
Indicator	Baseline 2002/2003	Year 3 Target	Year 3 Achieved
DPT3	60	80	95
Polio3	50	80	94
Vitamin A	NDA	80	93
DPT1-DPT3 Dropout	19	<10	5
NDA: No data available			

- Trained 25 producers from Educational Mass Media, Radio Voice of South and Sidama radio on

script-writing for breastfeeding and complementary feeding practices for airing of radio spots.

- Distributed, 78,175 Immunization Diplomas to health facilities and 201,955 Family Health Cards to care takers and communities.
- 140 community follow-up visits were conducted to mentor and encourage implementation of training provided.

Improving Health Systems

- Prepared *Decentralized Budgeting and Planning Manual* in collaboration with the Regional Bureau of Finance.
- Adapted the *HCF Implementation Manual*.
- Supported eight zonal and 28 woreda supportive supervision visits.
- Assisted 10 zonal and 40 woreda performance reviews.
- Developed, printed and distributed health profiles to all ZHDs, WorHO, health facilities and partners.
- Conducted follow-up visits to 29 WorHOs.

Bolosso Sore- Office of Foreign Disaster Assistance Project

Since September 2005 ESHE has implemented the Office of Foreign Disaster Assistance (OFDA)-funded “Health and Nutrition Sector Interventions to Complement Community Therapeutic Care Project” in Bolosso Sore Woreda. The goal is to mitigate the negative effects of the recurrent drought and famine on the health and nutrition status of children under-five. ESHE conducted intensive training of CHPs and CNPs to rapidly reach all Bolosso Sore kebeles with health and nutrition messages.

Nine health extension workers were trained in IMNCI.

COLLABORATION AND COORDINATION

ESHE believes collaboration with partners is an essential element to bring about desired change.

Conducting health partner forums is one of ESHE's most significant successes. NGOs, government health-sector counterparts, and other health partners are invited in meetings to share technical expertise and experiences, to harmonize activities, and to avoid duplication of efforts. ESHE has initiated the establishment of health partner forums in the three regions and a health and nutrition forum in Bolosso Sore Woreda.

Collaboration between partners working in child health facilitated harmonization of technical approaches and strategies, preparation of joint action plans and resource inputs to facilitate the achievement of common goals. The Ethiopia Child Survival Partnership is an example of collaboration. Members include the FMoH Family Health Department as Chair, WHO, UNICEF, USAID, ESHE, Canadian International Development Agency, and the World Bank. Save the Children/USA will soon join with its contribution in essential newborn care.

The Partnership created a number of opportunities for ESHE to contribute to national child health accomplishments.

PARTNERSHIP BRINGS SUCCESS

"We will be able to achieve our targets in health if we bring our resources together and work in an integrated manner," says Ato Akako Alano, Head of the Bolosso Sore Woreda Health Office during the partners meeting held at the ESHE Project Office.

According to Ato Akako, the monthly meeting aims to create a situation in which all governmental and non-governmental organizations work in an integrated manner to ensure proper utilization of resources with no duplication of efforts.

"I appreciate the initiative taken by the ESHE Project for bringing us together to create this forum. This is our third meeting. We discussed and came up with a strategy on how to coordinate the inputs of all the volunteers in Bolosso Sore Woreda trained by partners," adds Ato Akako.

Ato Akako says that the ESHE Project works in close collaboration with the Woreda Health Office. "ESHE staff share information with us and plan activities with us. The program is feasible and accepted by the community. And most of all, ESHE has introduced an approach that fights dependency. The Project avoids making unnecessary promises and encourages communities to utilize their own resources in bringing about change in their behaviours for their own benefit."

The partners forum in Bolosso Sore Woreda has ESHE, International Medical Corps, Rural Development Office, Woreda Finance Office, Woreda Health Office, African Humanitarian Action, and Catholic Hospital as its members.



Ato Akako Alano, Head, Bolosso Sore Woreda Health Office

IMNCI training materials development and EPI national coverage survey (June 2006) were two major activities. The Child Survival Partnership Core Committee has been instrumental in developing the IMNCI training approach and material adaptations. ESHE played a major role in organizing and financing workshops and sponsoring international and national consultants to assist in the process. The ESHE Deputy Director was Chairperson of the Core Committee for the EPI survey and the Project's three Regional Child Survival Specialists served as supervisors in their respective regions.

The *Kokeb Kebele Initiative* is another way ESHE collaborates with health and education partners. ESHE is working with SNNP and Amhara RHBs and USAID

partners (HCP, Pathfinder International and World Learning) to implement the *Kokeb/Model Kebele Initiative* in SNNP and Amhara. It is a combined effort to bring together health and education interventions for better results.

ESHE worked with UNICEF to distribute 1.3 million Immunization Diplomas to non-ESHE areas in Project regions. The support included preparing distribution lists, providing orientation to non-ESHE staff, and follow-up to ensure the diplomas were properly distributed.

To strengthen ESHE health care financing reform efforts smooth working relationships have been created with regional BOFEDs. These regional bureaus have shown a keen interest in assisting the Project with decentralized budgeting and planning trainings and in rolling-out financial rules and regulations at zonal and woreda levels.

ESHE is a member of the National Logistics Master Plan Committee which is established to prepare a strategic document for ensuring drugs and health supplies throughout

Ethiopia. ESHE staff participated with UNICEF and the DELIVER Project in the SNNP regional assessment and provided technical input to the master plan in the area of HCF reform and revolving drug funds.

ESHE collaborated with the World Bank Institute and UNICEF in organizing and holding flagship courses in Ethiopia. Travel, expert time and daily subsistence of the highly experienced and qualified Institute staff was covered by the Bank, participant travel costs were paid by ESHE. A UNICEF health economist was also involved and facilitated the training.

ESHE and the USAID Global Program, *PHRplus*, collaborated in conducting the third round NHA. *PHRplus* sent two NHA professionals twice for the training and initial preparation as well as for classification and analysis of the survey data. Most of the cost of these two professionals was covered by *PHRplus*. *PHRplus* provided continued support to the NHA exercise after the two visits. ESHE covered all cost of data collection and data analysis.

CHALLENGES AND CONSTRAINTS

- EPI activities have been compromised in some woredas due to a shortage of spare parts for refrigerators to maintain the cold-chain. Delayed maintenance of motorbikes used by health facilities and WorHOs is also a problem affecting outreach services for routine EPI.
- High staff turnover in the basic health services affects timely implementation of some project activities because of the need to reorient new staff on project interventions. Similarly, counterparts at all levels in the public sector are faced with competing priorities, which make realizing planned activities difficult.
- Shortage of equipment and drugs and the need for sustained supervision pose a challenge to implementing full-scale IMNCI.
- Shortage of manpower at health facilities, with the resulting work pressure for existing staff is an obstacle to effectively counseling of mothers about child feeding.
- There have been delays in ratifying the HSDMA Regulations and Directives by regional cabinets and RHBs. This is causing delays in implementing HCF reforms.

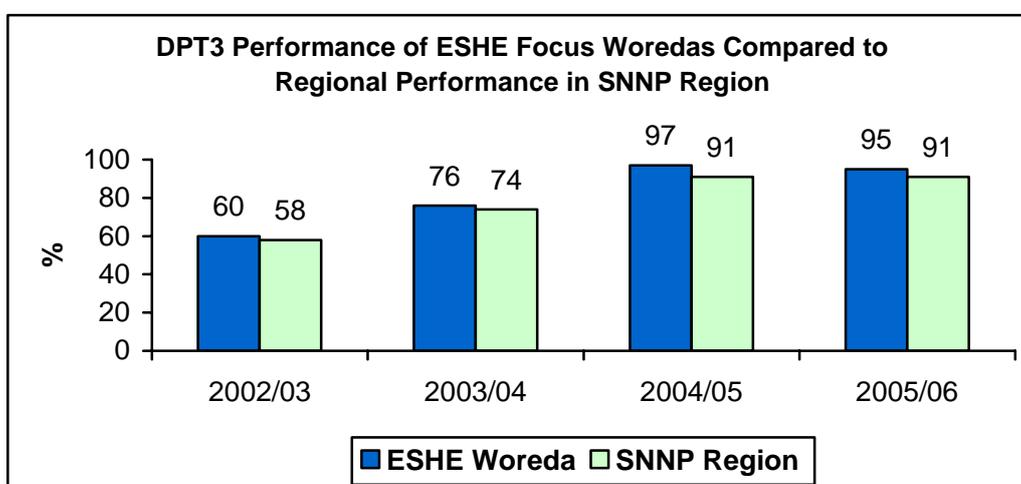
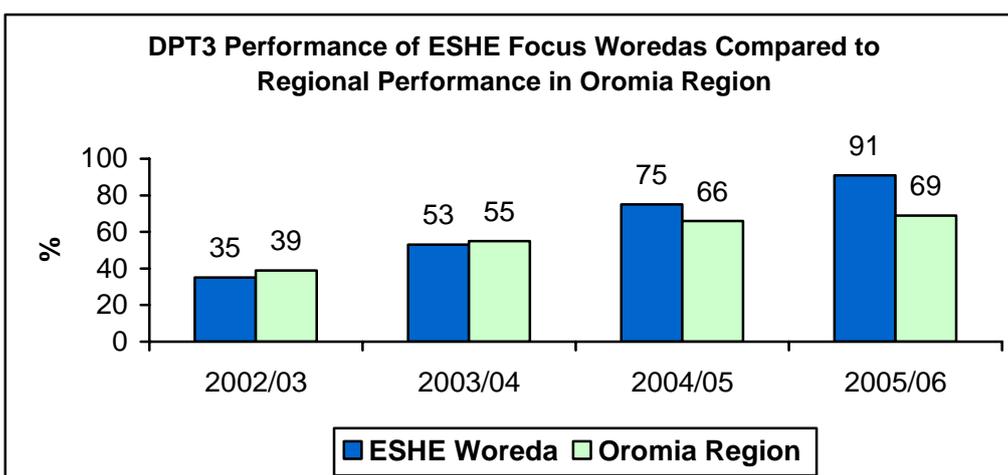
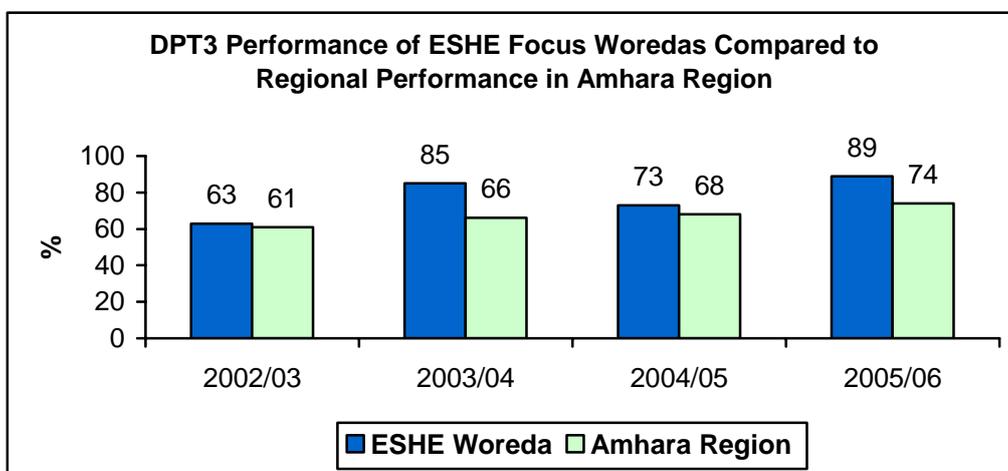
LESSONS LEARNED

- In health centers without regular follow up and supportive supervision, new skills can quickly be forgotten and workers return to old habits. Any training provided to health workers and community volunteers is fruitful only with intensive on-the-job follow-up and mentoring.
- Timely community review meetings are essential to reinforce skills and knowledge of CHPs and sustain implementation activities.
- Placing WorHO, health center staff and HEWs at the forefront during community review meetings and supportive supervision ensures ownership by counterparts and sustainability.
- Collaboration between HEWs and CHPs brings noticeable improvement in healthy household practices through consistent follow up and support.
- Frequent staff turnover at the woreda level requires constant training of trainers to maintain the pool of trainers.
- Close collaboration with the media enhances promotion of key health messages and actions. ESHE has scaled-up its work with media and is reaching more people with consistent messages.
- Coordination forums at all levels are a useful approach to avoid duplication of efforts and confusion among various partners as well as maximize the efficient use of scarce resources.
- Continuous dialogue and consultation with relevant partners including finance offices is essential to realize health care finance policy change and reform

ANNEX I: Summary of Trainees by Thematic Area -1998 FFY

Training	Amhara			Oromia			SNNP			Bolosso Sore			National			Project Year 3 Total			Life of Project 2003-2006
	M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F	Total	
CHP/GNP																			
CHPI TOT/ TVETI Orientation	67	9	76	57	86	143	84	71	155	6	36	42	-	-	-	214	202	416	918
CHP 1st round	2,663	2,118	4,781	2,244	1,306	3,550	4,446	4,372	8,818	642	694	1,336	-	-	-	9,995	8,490	18,485	27,723
CHP 2nd round	-	-	-	-	-	-	-	-	-	529	533	1,062	-	-	-	529	533	1,062	1,062
GNP TOT	-	-	-	-	23	46	69	-	-	8	34	42	-	-	-	31	80	111	111
GNP 1st round	-	-	-	0	85	85	-	-	-	20	666	686	-	-	-	20	751	771	771
GNP 2nd round	-	-	-	-	-	-	-	-	-	10	449	459	-	-	-	10	449	459	459
ENA																			
ENA/Tech.	26	5	31	22	1	23	-	-	-	-	-	-	-	-	-	48	6	54	124
ENA/BCC TOT	74	9	83	-	-	-	-	-	-	21	13	34	-	-	-	95	22	117	281
ENA/BCC	213	197	410	168	252	420	238	268	506	-	-	-	-	-	-	619	717	1,336	1,433
EPI																			
Health Worker	70	207	277	95	77	172	114	284	398	-	-	-	-	-	-	279	568	847	2,457
IMNCI																			
Training	-	-	-	-	-	-	-	-	-	4	20	24	-	-	-	4	20	24	24
HMIS																			
Refresher	-	-	-	22	1	23	-	-	-	-	-	-	-	-	-	22	1	23	199
Supervision																			
Training	141	44	185	151	21	172	119	13	132	-	-	-	-	-	-	411	78	489	551
HCF																			
TOT	-	-	-	-	-	-	72	8	80	-	-	-	22	5	27	92	13	105	105
Training	127	30	157	923	62	985	-	-	-	-	-	-	17	0	17	1,067	92	1,159	1,159
Ethiopian flagship													19	2	21	19	2	21	21

ANNEX II: Charts on DPT3 Coverage



ANNEX III: Follow-up Visit Results

Follow-up Visits to Health Facilities: Quality of Expanded Program on Immunization Services

Quality Indicator	Amhara %	Oromia %	SNNP %
Provide EPI daily	90 (n=161)	76 (n=382)	63 (n=169)
Use of safety box	98 (n=176)	95 (n=384)	89 (n=169)
Functioning refrigerator	90 (n=157)	77 (n=336)	87 (n=169)
Use of foam pad	59 (n=176)	49 (n=371)	63 (n=169)
EPI monitoring chart in place and up-to-date	80 (n=174)	69 (n=383)	85 (n=169)
Provide EPI +	82 (n=174)	36 (n=373)	58 (n=169)

Follow-up visits to Health Facilities: Availability of Oral Drugs and Vaccines

Oral Drug and Vaccine	Amhara %	Oromia %	SNNP %
ORS	92 (n=152)	81 (n=378)	92 (n=168)
Cotrimoxazole	92 (n=143)	74 (n=385)	86 (n=168)
Anti-malaria drug	93 (n=76)	90 (n= 89)	55 (n=121)
Mebendazole/Albendazole	89 (n=147)	81 (n=385)	91 (n=97)
BCG vaccine	99 (n=158)	95 (n=300)	91 (n=169)
Polio vaccine	97 (n=158)	87 (n=300)	93 (n=169)
DPT vaccine	99 (n=158)	97 (n=302)	92 (n=169)
Measles vaccine	99 (n=158)	90 (n=292)	89 (n=169)

Follow-up visits to communities: Household Practices

Health Practices in Visited Households	Amhara %	Oromia %	SNNP %
Children received first milk (0 – 5 months)	83 (n=59)	94 (n=126)	73 (n=60)
Children put to breast within an hour of birth (0-5 months)	68 (n=59)	86 (n=126)	42 (n=60)
Fully Children vaccinated (12 – 23 months)	45 (n= 33)	58 (n=125)	89 (n=70)
Fully vaccinated children who receive ID	39 (n=33)	21 (n=125)	53 (n=70)
Exclusively breastfeed children (0-5 months)	90 (n=59)	83 (n=126)	88 (n=60)
Children started timely complementary feeding (6-9 months)	72 (n=25)	79 (n = 58)	76 (n=51)
Households have latrine	68 (n=131)	48 (n=382)	82 (n=188)
Households store water in narrow necked/covered container	68 (n=92)	34 (n=382)	94 (n=188)
Households visited by HEWs	50 (n=92)	18 (n=157)	28 (n=164)
Households visited by CHPs	92 (n=131)	84 (n=382)	54 (n=164)
Households have FHC	68 (n=131)	66 (n=382)	36 (n=188)

ANNEX IV: ESHE Performance Indicators Target Vs Achievement-EFY 1998

Indicator	Operational Definition	Survey Baseline			Routine HMIS Baseline			Year 3 Target (Routine)			Year 3 Achieved (Routine)		
		Amhara 04 (%)	Oromia 04 (%)	SNNP 03 (%)	Amhara 02/03 (%)	Oromia 02/03 (%)	SNNP 02/03 (%)	Amhara (%)	Oromia (%)	SNNP (%)	Amhara (%)	Oromia (%)	SNNP (%)
IR 14.1 Use of high impact health, family planning, and nutrition services, products and practices increased													
DPT3	No. of children 12-23 mo. old vaccinated with DPT3 by age 12 months/no. of children 12-23 months old surveyed	49	33	46	-	-	-	-	-	-	-	-	-
	No. DPT3 doses dispensed to children to 0-11 months old /estimated no. of surviving infants	-	-	-	63	35	60	80	80	80	89	91	95
Protected against neonatal tetanus	% women with children 0-11 months old who received at least two TT doses during last pregnancy or adequate no. before that pregnancy	41	48	62	-	-	-	-	-	-	-	-	-
	No. children 12-23 months old vaccinated with OPV3 by age 12 mos./no. of children 12-23 months old surveyed	50	39	57	-	-	-	-	-	-	-	-	-
Polio3	No. OPV3 doses dispensed to children to 0-11 months old/estimated no. of surviving infants	-	-	-	61	NDA	50	80	80	80	NDA	84	94
	Number of children 0-5 months exclusively breastfed / children 0-5 months surveyed	75	45	54	-	-	-	-	-	-	-	-	-
Vitamin A	No. of children 6-23 months receiving vitamin A supplementation/no. of 6-23 mo. olds surveyed	18	30	13	-	-	-	-	-	-	-	-	-
	No. of Vitamin A supplements dispensed to 6-59 months olds during EOS sessions	-	-	-	-	-	-	65	65	88	99	99	93
Sub-IR 14.1.2 Availability of key health services and products improved													
Availability of Essential Child Vaccines	BCG Vaccine	77	78	84	-	-	-	-	-	-	99	95	91
	Polio vaccine	95	83	87	-	-	-	-	-	-	97	87	93
	DPT vaccine	98	58	90	-	-	-	-	-	-	99	97	92
	Measles vaccine	98	85	92	-	-	-	-	-	-	99	90	89
	ORS	98	92	100	-	-	-	-	-	-	92	81	92
	Cotrimoxazole/Ampicillin	80	65	89	-	-	-	-	-	-	92	74	86
Availability of Essential oral drugs	Anti-malaria	98	88	97	-	-	-	-	-	-	93	90	55
	Mebedazole/Albendazole	95	62	84	-	-	-	-	-	-	89	81	91
	Vitamin A	75	40	66	-	-	-	-	-	-	84	74	92
	Chloramphenicol injections	-	-	-	-	-	-	-	-	-	75	38	41
	Gentamycin injection	-	-	-	-	-	-	-	-	-	59	32	49

Indicator	Operational Definition	Survey Baseline			Routine HMIS Baseline			Year 3 Target (Routine)			Year 3 Achieved (Routine)		
		Amhara 04 (%)	Oromia 04 (%)	SNNP 03 (%)	Amhara 02/03 (%)	Oromia 02/03 (%)	SNNP 02/03 (%)	Amhara (%)	Oromia (%)	SNNP (%)	Amhara (%)	Oromia (%)	SNNP (%)
Sub-IR.14.1.3 Quality of key health services improved													
DPT1 to DPT3 dropout rate	% children 0-11 months who received DPT1 minus % who received DPT3 / % of 0-11 mos. olds who received DPT1	21	33	29	9	29	19	10	10	10	9	11	5
% WorHOs conduct supervision quarterly	WorHOs conducted quarterly supportive supervision to half health facilities/ WorHOs visited by ESHE staff in the last quarter	19	6	40	-	-	-	50	50	50	87	83	56

Training

Indicator	Operational Definition	Amhara			Oromia			SNNP			Total		
		Target	Achieved	% Achieved									
Sub-IR 14.1.1 Community support for high impact health interventions increased													
Community													
CHP Trained	No. of Community Health Promoters trained in ESHE-supported training	5,000	4,781	96%	6,000	3,550	59%	5,000	8,818	176%	16,000	17,149	107%
# Kebeles with CHP		190	210	111%	225	67	30%	250	697	279%	665	974	146%
Sub-IR 14.1.2 Availability of key health services and products improved													
Technical Trainings													
EPI		220	277	126%	220	172	78%	575	398	69%	1,015	847	83%
ENA		220	524	238%	220	420	191%	295	506	172%	735	1,450	197%
Health Managers													
Management Supervision/ HMIS		100	185	185%	100	195	195%	100	132	132%	300	512	171%

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