



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

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**Ethiopia CS-17
Detailed Implementation Plan**

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Glossary of Acronyms and Terms

<i>Abba olla</i>	Father of the encampment
ACNM	American College of Nurse Midwives
AFP	Acute Flaccid Paralysis
ANC	Antenatal Care
AIDS	Acquired Immune Deficiency Syndrome
ARI	Acute Respiratory Infection
BC	Behavior Change
BCC	Behavior Change Communication
BCG	Tuberculosis Vaccine (Bacillus Calmette-Guerin)
BEOC	Basic Emergency Obstetric Care
BHR/FFP	Bureau of Humanitarian Response/Office of Food for Peace (of USAID, now DCHA/FFP)
BHR/PVC	Bureau of Humanitarian Response/Office of Private and Voluntary Cooperation (of USAID, now DCHA/PVC)
BHT	Bridge-to-Health Team
BSS	Behavioral Surveillance Survey
<i>Bussa</i>	When a person is force by the tribal leaders to take several women as wives, in addition to existing wives.
CAC	Community Action Committee
CBD	Community-Based Distributor
CBO	Community-Based Organization
CBRHA	Community-Based Reproductive Health Agent
CDC	US Centers for Disease Control and Prevention
CDD	Control of Diarrheal Disease
<i>Cheresa</i>	Wise Man/Male Traditional Healer
<i>Chereti</i>	Wise Woman/Traditional Birth Attendant
CHA	Community Health Agent
CHW	Community Health Worker (BHT & HAC members, TBAs, CMWs, CBDs)
C-IMCI	Community-Integrated Management of Childhood Illness
COOPI	Cooperazione Internazionale (Italian NGO)
CM	Community Midwife
CMW	Case Management Worker (CHW trained to do case management)

CS	Child Survival
CS-13	Child Survival-13, <i>WomanWise</i> , the previous CS project in Liben District, funded through the 13 th cycle of the PVO CS Grants Program.
CS-17	The current child survival project in Liben District, <i>Essential Services for Maternal and Child Survival in Ethiopia: Mobilizing the Traditional and Public Health Sectors and Informing Programming for Pastoralist Populations</i> , funded as a cost extension of the CS-13 grant, mainly through the 17 th cycle of the PVO CS Grants Program, is referred to as “CS-17” throughout this document to distinguish it from the previous “CS-13” grant, and for the sake of brevity.
CSTS	Child Survival Technical Support Project (contractor to AID/DCHA/PVC)
CSW	Commercial Sex Worker
DAC	District AIDS Council
DAP	Development Assistance Program (current FFP-funded Liben Title II program)
DCHA/FFP	Bureau for Democracy, Conflict, and Humanitarian Assistance/Office of Food for Peace (of USAID, formerly BHR/FFP)
DCHA/PVC	Bureau for Democracy, Conflict, and Humanitarian Assistance/ Office of Private and Voluntary Cooperation (of USAID, formerly BHR/PVC)
DFOD-MS	Deputy Field Office Director - Management Services
DHAC	District HIV/AIDS Council
<i>Dheda</i>	Groups of ollas that share grazing areas
DHCC	District Health Coordination Committee
DHMT	District Health Management Team
DHO	District Health Office/Officer
DHS	Demographic and Health Survey
DIP	Detailed Implementation Plan
DKT	Ethiopian affiliate of PSI (Population Services International)
DPT/DPT3	Diphtheria/Pertussis/Tetanus Vaccine, and DPT third dose
EFO	Ethiopia Field (Country) Office of Save the Children/US
EFY	Ethiopia Fiscal Year
EmOC	Emergency Obstetric Care
EPI	Expanded Program for Immunization
ERC	Ethiopian Red Cross
ESHE II	Essential Services for Health in Ethiopia II (USAID Ethiopia Mission SO)
ETDF	Emergency Transport and Drug Fund(s)

FFW	Food-For-Work
FGAE	Family Guidance Association of Ethiopia
FGD	Focus Group Discussion
FHI	Family Health International
FO	Field Office
FOD	Field Office Director
<i>Forra</i>	The mobile part of a family and herd, which is composed of young men and older boys who travel long distances with the strong male cattle in search of pasture and water.
FP	Family Planning
FTE	Full-Time Equivalent
FY	Fiscal Year
GOE	Government of Ethiopia
GMP	Growth Monitoring and Promotion
GTZ	The German Agency for Technical Cooperation
HA	Health Assistant
HAC	Health Action Committee
HB-LSS	Home-Based Life-Saving Skills
HF	Health Facility
HFA	Health Facility Assessment
HFMC	Health Facility Management Committee
HH/C-IMCI	Household/Community Integrated Management of Childhood Illness
HIS	Health Information System
HIV	Human Immune Deficiency Virus
HMIS	Health Management Information System
HPN	Health, Population, and Nutrition
HQ	Headquarters
HSDP	Health Services Development Program of the Government of Ethiopia
IACI	Integrated Approaches to Childhood Illness
IEC	Information, Education, Communication
IMCI	Integrated Management of Childhood Illness
IMPAC	Integrated Management of Pregnancy and Childbirth

ISA	Institutional Strengths Assessment
<i>Jalla/Jalletu</i>	Extra-marital sexual partners, both for men and women.
<i>Kafeno</i>	Refers to the sexual practices during the rainy season after plenty of milk has been consumed.
<i>Katena</i>	Community consisting of several villages, but smaller than a PA
<i>Kebele</i>	Peasant Association, administrative division
KPC	Knowledge, Practice, and Coverage
LAM	Lactational Amenorrhea Method
LOP	Life of Project
LSS	Life-Saving Skills (maternal and newborn)
<i>Madda</i>	Traditional community group, comprised of several “ollas” sharing the same water point. Each madda corresponds roughly to one of Liben’s PAs
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MCM	Malaria Case Management
MIS	Management Information Systems
MMR	Maternal Mortality Ratio/Rate
MN	Maternal and Newborn
MN/LSS	Maternal and Newborn Life Saving Skills
MNC	Maternal and Newborn Care
MOH	Ministry of Health
MTCT	Maternal to Child Transmission
MTE	Midterm Evaluation
NCIH	National Council for International Health
NGO	Non-Governmental Organization
NIDS	National Immunization Days
OCA	Organizational Capacity Assessment
OH	Office of Health (of Save the Children/US)
<i>Olla</i>	Borana term for extended family encampment
OPD	Outpatient Department
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy

PA	Peasant Association (“kebele”), an administrative division
PCM	Pneumonia Case Management
PHN	Population, Health, and Nutrition
PIT	Protective Intermittent Treatment
PLG	Program Learning Group
PLI	Pastoralist Livelihood Initiative
PLWHA	People Living With HIV/AIDS
PM	Program Manager
PMTCT	Preventing Mother to Child Transmission
PPS	Probability Proportional to Size
PVO	Private Voluntary Organization
QA	Quality Assurance
RDF	Revolving Drug Fund
RH	Reproductive Health
RHA	Reproductive Health Agent / Regional Health Advisor
RHB	Regional Health Bureau (of the Ethiopian MOH)
SC	Save the Children Federation (USA)
SC/EFO	Save the Children/US Ethiopia Field (Country) Office
SCM	Standard Case Management
SC/OH	Save the Children’s Office of Health
SNL	Saving Newborn Lives Initiative of Save the Children
SO	Strategic Objective
SOS	Sustainable Outreach Service
SPA	Senior Program Assistant (SC staff in Liben District)
STI	Sexually Transmitted Infection / Southern Tier Initiative (USAID/Ethiopia)
TA	Technical Assistance
TB	Tuberculosis
TBA	Traditional Birth Attendant
TOT	Training of Trainers
TT	Tetanus Toxoid
TT2	Tetanus Toxoid, 2 nd dose
TTBA	Trained Traditional Birth Attendant

UNAIDS	United Nations Program on HIV/AIDS
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children’s Fund
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
<i>Waaqeefatta</i>	Traditional followers of one God
<i>Warra</i>	The stationary part of the family consists of women and children who take care of the milking cows, weak or sick cows and calves at the olla.
WHO	World Health Organization
<i>Woreda</i>	District
WRMC	Water Resource Management Committee
ZHD	Zonal Health Department

SECTION I: PROGRAM DESCRIPTION

A. Executive Summary

The site for this five year Child Survival-17 program, *Essential Services for Maternal and Child Survival in Ethiopia: Mobilizing the Traditional and Public Health Sectors and Informing Programming for Pastoralist Populations*, includes all of Liben District in Borana Zone of Oromiya Regional State in southern Ethiopia. The district has a total estimated current population of 138,000, with approximately 58,000 program beneficiaries, of which 26,000 are children under five years of age, and 32,000 are women between the ages of 15 and 49.

Woefully poor access to essential health services contributes to poor maternal and child health in Liben. In August 2000, SC found 34% of sampled 6-59 month-old children in the district underweight, 11% wasted, and 42% stunted. These high rates of childhood malnutrition, local transmission of *falciparum* malaria, and socio-economic conditions in Liben, all suggest the level of under-five mortality in the district is likely similar to that for Ethiopia as a whole, estimated at 166 deaths per 1,000 live births for 1995-99 by the 2000 DHS. Very poor access to essential obstetric care and low contraceptive prevalence also suggests that maternal mortality in the district is likely very high. During recent months, the blood of 48% of apparently healthy donors at Negelle Hospital in the district center has been screened HIV-positive, and HIV prevalence in the district is likely high.

Save the Children (SC) has been supporting two complementary programs throughout Liben since 1997, the CS project (CS-13 through September 2001, followed by CS-17), and a USAID/DCHA/FFP-funded DAP, which currently supports nutrition and breastfeeding interventions in district, along with other development activities, including improving livestock management. Health promotion through 150 “Bridge-to-Health Teams” (BHTs), each composed of a wise woman/TBA, a wise man/male traditional healer, and a young traditional apprentice, has been the central strategy of SC’s health activities in Liben. Health Action Committees (HACs) review and respond to health information from BHTs and TBAs. In April 2000, the American College of Nurse Midwives started providing on-going assistance to improve obstetric care at community and health facility levels by training TBAs and health facility staff in Life Saving Skills.

The CS-17 design is the result of joint planning by staff of the principal program partners, SC and the Liben District Health Office (DHO), during two workshops conducted in Negelle in September 2000 and in February 2002. CS-17 will support six interventions:

- Maternal and newborn care (at 20% of planned intervention-specific effort);
- Pneumonia case management (15%);
- Control of malaria (10%); and
- Control of diarrheal disease (10%), all previously implemented through CS-13;
- Immunization (15%), funded until recently through the DAP; and introduce an
- HIV/AIDS intervention (30%).

These CS-17 interventions will be implemented through the following major strategies:

- Joint DHO/SC design, implementation, and evaluation of approaches to maternal and child health in Liben that inform development of strategies to address the needs of pastoralist populations in other districts of Borana Zone and Ethiopia.

- Continued mobilization of community leaders and traditional practitioners through Bridge-to-Health Teams and Health Action Committees, to support selected MCH services, and to conduct focused education to improve key emphasis behaviors at the household level.
- Introduction and evaluation of community-based case management of childhood illness, to improve access to and use of these services in Liben District, and to inform the nascent development of Community-IMCI in Ethiopia.
- Building capacity of SC, the DHO, and the District HIV/AIDS Council, to provide leadership, coordination, and technical advice for integration of effective HIV prevention, care and support, and mitigation efforts into ongoing community and government activities in Liben District.

CS-17 goals are:

- A sustained reduction in under-five and maternal mortality in Liben District, and;
- CS-17 approaches inform policy or programming for pastoralist areas of Ethiopia in Community-IMCI or reproductive health.

These goals will be achieved through CS-17 results of:

- Improved district capacity to effectively support community health services and activities;
- Improved community capacity to effectively address priority health needs of mothers and children under five;
- Increased use of key health services and improved MCH practices at household level, and;
- Adoption of CS-17 approach by the MOH or by other organizations in Ethiopia.

These results will be achieved through CS-17 intermediate results of:

- Increased availability of selected MCH services in Liben;
- Documented quality of select community MCH services;
- Increased maternal knowledge in Liben of selected MCH issues;
- Dissemination of feasibility and results of implementing innovative CS-17 approaches, and;
- Increased SC/Addis and SC/Liben capacity in behavior change and integrated HIV programming.

The Ethiopia CS-17 Program is funded from September 30, 2001 through September 30, 2006 as a cost extension of CS-13 grant with \$1,250,000 from USAID/DCHA/PVC, matched by a \$416,750 cost-share from Save the Children.

SC has discussed the CS-17 design with several members of the staff of the USAID Mission in Addis Ababa, including Ms. Vathani Amirthanayagam, PHN Chief, Dr. Hana Nekatebeb and Mr. Eshete Yilma, Project Management Specialists, and Ms. Janet Paz-Castillo, Project Development Officer. Although Dr. Hana and Ms. Paz-Castillo have been redeployed to other positions and Missions, respectively, SC has maintained continuous dialogue with Dr. Mary Ann Abeyta-Behnke and Anne Nolan – the new HPN Health Team at USAID.

Principal authors of this DIP are: Ms. Ashley Aakesson, International Hunger Fellow, SC/Liben; Dr. Tedbabe Degefie, Health Advisor, SC/Addis Ababa; Mr. Worku Tefera, CS-17 Training Coordinator, SC/Liben; Mr. Dennis Walto, Deputy Field Office Director for Programs, SC/Addis Ababa; Ms. Kedija Zeino, SC HIV/AIDS Consultant; and, Dr. Eric S. Starbuck, Child Survival Specialist (and contact person for CS-17 at SC in Westport, CT, along with Ms. Carmen Weder, Manager, Office of Health). Most other participants of the February 2002 CS-17 DIP workshop in Negelle also made substantial contributions to the DIP.

B. CSGP Data Form

Field Contact Information

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Project Information

Project Description:	<p>SC and the MOH Liben District Health Office will continue implementation through CS-17 of all four CS-13 interventions: ARI (at 15% of planned intervention-specific CS-17 effort), Malaria (10%), CDD (10%), and Maternal and Newborn Care (20%); and continue important support to the DHO in EPI (15%), previously funded through the DAP. CS-17 will devote 30% of intervention effort to introducing an HIV/AIDS intervention, in order to build SC and DHO capacity in Liben to begin addressing the district's HIV epidemic. These CS-17 interventions will be implemented through the following major strategies:</p> <ul style="list-style-type: none">· Joint DHO/SC design, implementation, and evaluation of approaches to maternal and child health in Liben that inform development of strategies to address the needs of pastoralist populations in other districts of Borana Zone and Ethiopia.· Introduction and evaluation of community-based case management of childhood illness, to improve access to and use of these services in Liben District, and to inform the nascent development of Community-IMCI in Ethiopia.· Building capacity of SC, the DHO, and the District HIV/AIDS Council, to provide leadership, coordination, and technical advice for integration of effective HIV prevention, care and support, and mitigation efforts into ongoing community and government activities in Liben District.· Continued mobilization of community leaders and traditional practitioners through Bridge-to-Health Teams and Health Action Committees, to support selected MCH services, and to conduct focused education to improve key emphasis behaviors at the household level.
Partners:	MOH Liben District Health Office

Project Location:	The CS-17 site includes all of Liben District in Borana Zone of Oromiya Regional State in southern Ethiopia.
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Grant Funding Information

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

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

Beneficiary Residence

Urban/Peri-Urban	Rural
25%	75%

General Strategies Planned

- Advocacy on Health Policy
- Strengthen Decentralized Health System
- Information System Technologies

M&E Assessment Strategies

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

Behavior Change & Communication (BCC) Strategies

- Interpersonal Communication
- Peer Communication

Capacity Building Targets Planned

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

Interventions

Immunization 15%
** CHW Training
** HF Training
*** Polio
*** Classic 6 Vaccines
*** Vitamin A
*** Cold Chain Strengthening
Acute Respiratory Infection 15%
** IMCI Integration
** CHW Training
** HF Training
*** Pneumonia Case Management
*** Case Mngmnt./Counseling
*** Access to Providers/Antibiotics
*** Recognition of ARI Danger Signs
Control of Diarrheal Diseases 10%
** IMCI Integration
** CHW Training
** HF Training
*** Hand Washing
*** ORS/Home Fluids
*** Feeding/Breastfeeding
*** Care Seeking
*** Case Mngmnt./Counseling
Malaria 10%
** IMCI Integration
** CHW Training
** HF Training
*** Training in Malaria CM
*** Adequate Supply of Malarial Drug
*** Access to providers and drugs
*** Care Seeking, Recognition, Compliance

Maternal & Newborn Care 20%
** CHW Training
** HF Training
*** Emergency Obstetrical Care
*** Recognition of Danger signs
*** Newborn Care
*** Postpartum Care
*** Normal Delivery Care
*** Birth Plans
HIV/AIDS 30%
** CHW Training
** HF Training
*** Treatment of STIs
*** Behavior Change Strategy
*** Access/Use of Condoms

C. Description of the DIP Planning and Preparation Process

A CS-17¹ planning workshop was conducted in Negelle from February 6 to 17, 2002, attended by staff of local partners, SC's Home Office, Ethiopia Field Office staff, and staff involved in project implementation. The workshop started by identifying important developments since the initial CS-17 design workshop in September 2000 and submission of the grant application in December 2000, and challenges for CS-17 implementation, and an assessment of how these developments should influence a revised CS-17 design to be described in the DIP. The process was participatory in approach with active involvement of partners, and included several presentations and discussions regarding HIV/AIDS in relation to CS-17, and alternative strategies for EPI, including WHO's approach to "Sustainable Outreach Services" for EPI.² Developments since the September 2000 workshop with potential implications for the CS-17 design include: The new government restructuring, which will bring decision-making and planning responsibility to the District Council, the strategic framework for HIV/AIDS,³ the CS-13 final evaluation, and change in staff both in SC and the DHO. Following initial discussions in plenary, participants divided into small groups to work on intervention designs, strategies, and

¹ The current child survival project in Liben District, *Essential Services for Maternal and Child Survival in Ethiopia: Mobilizing the Traditional and Public Health Sectors and Informing Programming for Pastoralist Populations*, funded mainly through the 17th cycle of the PVO CS Grants Program, is referred to as "CS-17" throughout this document to distinguish it from the previous "CS-13" grant, and for the sake of brevity.

² WHO presentation by Hans Everts on "The Future of EPI," created June 1999.

³ Strategic Framework for the National Response to HIV/AIDS in Ethiopia (2001-2005), National HIV/AIDS Council, June 2001.

cross-cutting issues, before presenting their work to the large group for discussion and decisions. After the end of the workshop, many of the participants continued to work in Negelle, Addis Ababa, and in Westport on sections of the DIP, communicating with each other by e-mail, phone, and courier. Workshop participants included:

- | | | |
|-----------------------------|---------------------------------------|--|
| ▪ Sister Degefech H/Yesus, | SC/Liben | MCH/Nurse |
| ▪ Mr. Worku Tefera | SC/Liben | Training Coordinator |
| ▪ Mr. Tsegaye Sonto | SC/Liben | Health Project Coordinator |
| ▪ Mr. Gebre Tola | SC/Liben | EPI Unit Head |
| ▪ Sister Melkenesh Ketema | SC/Liben | FP Unit Head |
| ▪ Sister Zubeda Abdul Kadir | SC/Liben | Nutrition Educator |
| ▪ Mr. Tefera Jalata | SC/Liben | Nutritionist |
| ▪ Mr. Mohammed Mamu | SC/Liben | HIV/AIDS Unit Head |
| ▪ Ms. Ashley Aakesson | SC/Liben | International Hunger Fellow |
| ▪ Mr. Abrahma Bongassie | SC/Liben | Program Manager |
| ▪ Dr. Tedbabe Degefi | SC/Addis Ababa | Health Advisor |
| ▪ Dr. Eric S. Starbuck | SC/Westport | Child Survival Specialist |
| ▪ Dr. Taye Tolera | DHO, Negelle, and
Negelle Hospital | District Health Office Head,
and Medical Director |
| ▪ Dr. Abera Refissa | Zonal Health Dep., Negelle | ZHD Head |
| ▪ Ms. Kedija Zeino | Addis Ababa | SC HIV/AIDS Consultant |

D. Program Site Analysis

Ethiopia

Over the past three decades, Ethiopia has experienced major conflict and natural disasters with severe socioeconomic consequences. Challenges to improving health at the household and institutional level in Ethiopia are formidable. An immense country with a population of 65 million, it is the second most populous nation in sub-Saharan Africa. Per capita income is \$110 per year and agriculture production is less than it was 25 years ago. Population growth is high, at 2.7% per year,⁴ and exceeds the growth in agricultural production.⁵ Ethiopia is one of the most food insecure countries in the world. It is estimated that even under normal conditions 6.8

⁴ 1990 – 1999. The State of the World’s Children 2001. UNICEF, 2000.

⁵ Agriculture production grows on average at an annual pace of 2.4%.

million people are without the wherewithal to feed themselves throughout an entire year.⁶ Total adult literacy is 36%. Female literacy is estimated at 54% of male literacy.⁷

Ethiopia has some of the world's poorest health statistics and lags behind most of sub-Saharan Africa. Life expectancy is 44 years at birth.⁸ UNAIDS puts Ethiopia's current HIV prevalence at 10.6%,⁹ meaning some three million adults and children were living with HIV/AIDS at the end of 1999, the third largest population of HIV-infected persons in the world.

The Ethiopia 2000 Demographic and Health Survey (DHS) reports a total fertility rate of 5.9 for the country as a whole in 1995 to 1999.¹⁰ The DHS direct estimate of maternal mortality of 871 per 100,000 live births for 1994-1999,¹¹ is lower than a recent WHO/UNICEF/UNFPA model-based estimate of 1,800 for 1995 (yielding a one in seven lifetime risk of maternal death), but just within the model-based estimated MMR range of 790 to 3,200.¹² Most information on the causes of maternal death in Ethiopia is from hospital-based studies likely to be unrepresentative of maternal deaths in communities,¹³ though a community-based study conducted in the Addis Ababa area in 1983 found septic abortion to be the leading cause of death, followed by hemorrhage, and hypertensive diseases.¹⁴

The United Nations estimates that Ethiopia's under-five mortality in 1999 was 176 deaths per 1,000 live births,¹⁵ the Ethiopian Ministry of Health estimates it at 161 for 1996-2001,¹⁶ while

⁶ A recent Food and Agricultural Organization/World Food Program report estimates that over 40% of the country's rural households in Ethiopia do not produce enough food or income to meet basic nutritional needs.

⁷ Federal Democratic Republic of Ethiopia, Ministry of Health, Health and Health Related Indicators, 2001.

⁸ 1990 – 1999. The State of the World's Children 2001. UNICEF, 2000.

⁹ UNAIDS Report on the Global HIV/AIDS Epidemic, June 2000.

¹⁰ Ethiopia 2000 Demographic and Health Survey. Central Statistical Authority, Addis Ababa, and ORC Macro, May 2001.

¹¹ The 2000 DHS, the first national population-based survey to include questions on maternal mortality, found 25% of all deaths among women 15-49 due to maternal causes (substantially lower than the 39% predicted by the UN model). The DHS estimate is based on sibling histories.

¹² Maternal Mortality in 1995: Estimates Developed by WHO, UNICEF, UNFPA. 2001 WHO/RHR01.9 (<http://www.int/reproductive-health/publications/>). This is based on a regression model to predict the proportion of maternal deaths among women of reproductive age (39%).

¹³ Eshetu, Melaku. Maternal Mortality in a Rural Community of Ethiopia: The Case of Mafud District, Northern Shewa. Working Papers on Ethiopian Development, No. 11: January 1996. Reports and Messages from Center for Environment and Development, Norwegian University of Science and Technology.

¹⁴ Kwast BE, Rochat RW, Kidane-Mariam W. Maternal Mortality in Addis Ababa, Ethiopia. Studies in Family Planning, 17:6;1986.

¹⁵ *State of the World's Children 2001*, UNICEF, 2000

¹⁶ Federal Democratic Republic of Ethiopia, Ministry of Health, Health and Health Related Indicators, 2001.

the DHS estimate is 166 for 1995-1999. Principal causes of death of children under five in Ethiopia include diarrhea, pneumonia, malaria, measles, malnutrition, and birth-related causes.¹⁷

Oromiya Regional State (Region 4)

One of the regional states of the Federal Democratic Republic of Ethiopia, Oromiya covers over 360,000 square kilometers, 30% of the country's total. It is also the most populous region, with 87% of its inhabitants rural and engaged in some form of agriculture or agro-pastoral activity. Administratively, the Region is divided into twelve administrative zones, 180 *woredas* (districts), and over ten thousand *kebeles* (also referred to as Pastoralist Associations, or PAs).

Liben District, Borana Zone

The CS-17 site covers all of Liben District, the largest of the twelve districts of Borana Zone of Region 4, in southern Ethiopia. (Not to be confused with Liben Zone of Somali Region, just to the east. Please see maps in Annex 7.) The district center (and location of the DHO and SC's office) is approximately ten to twelve hours driving time from Addis Ababa. Borana Zone has an estimated current population of 1.7 million people,¹⁸ residing in an area of 91,200 square kilometers. Liben District covers 9,900 sq. kilometers. Semi-arid climatic conditions are harsh with low, unreliable, and unevenly distributed rainfall (500-700 mm per year), and very limited amounts of surface water. The long rainy season occurs between March and May, with a short rainy season occurring between September and November. Early warning system data collected by SC and its partners indicate that approximately 65% of the population in Borana Zone can be categorized as poor or destitute, and lack the resources to meet their annual food requirements.

The DHO estimate for the total population of Liben District in 2002 is 138,310. The DHO also estimates that infants comprise 4.43% of the total population of the district, children under five 18.68%, women between the ages of 15 and 49 years 22.9%, pregnant women 5%, and that the crude birth rate is 46.4 annual live births per 1,000 total population. This would mean that there are approximately 6,000 (6,127) infants, 26,000 (25,836) children under five, 32,000 (31,673) women of childbearing age, and 6,400 (6,418) annual live births in Liben District. The DHO's estimate of the total population is very consistent with SC's Liben population spreadsheet estimate for 2002 (of 137,939, based on the 1994 census, "de jure" population projections, and 4.11% urban and 2.23% rural annual growth, as used in 1994 census projections).¹⁹ There is considerable controversy among organizations working in Liben District about which population estimates are most likely to be the most accurate.²⁰ For CS-17, SC plans to use the same estimates as those of the DHO, SC's principle partner in the project.²¹

¹⁷ Based on: Strategic Plan. 2001-2006. USAID/Ethiopia, May 22, 2000

¹⁸ SC population spreadsheet 2002 estimate based on the 1994 census, "de jure" population projections, 4.11% urban and 2.23% rural annual arithmetic growth, as used in 1994 census projections.

¹⁹ However, the census estimates for the percent of the total population in all of Borana Zone under five years of age of 13.16% for urban and 17.67% for rural areas differs somewhat from the DHO estimate. The census also estimated that women 15 to 49 years of age comprise 24.05% of the total population in urban areas and 20.67% in rural areas of the zone.

²⁰ For example, the Liben District Administration estimates that the current population of the district remains 148,000, as cited by SC in the December 2000 CS-17 application.

²¹ SC is aware of concerns about the accuracy of the 1994 census in Liben and the limitations of population projections which may not reflect migration in and out of the district over the last eight years,

There are two towns in Liben District. Negelle, with a population of 33,120, is the administrative center of both Liben District and Borana Zone. The smaller town of Harakelo has a population of 1,448. The total rural population of the district is 103,370 (75% of the district). The rural population is divided into 38 Pastoralist Associations (PAs, or *kebeles* in Amharic), that form the administrative divisions of the district.

The people of Liben District are mainly Afaan Oromo speaking ethnic Borana, Arsi, and Guji, with small pockets of Somali-speaking people, some of them returnees. The majority of Borana and Arsi communities are settled traditionally in extended family encampments called *ollas*, consisting of 20-50 families. Guji communities tend to be more dispersed; while Somali communities vary from small semi-nomadic encampments to densely populated peri-urban pockets of returnee families.

Each *olla* selects an *abba olla* (“father of the encampment”) from among the male heads of household as its leader. *Ollas* are organized into traditional units called *dheda*, groups of *ollas* that share grazing areas; and several *dhedas* comprise a *madda*, literally “people who share the same water point.” *Maddas* correspond, roughly, to the 38 PAs or *kebeles* mentioned above, and are the connection between the administrative units designated by the GOE, the Pastoralist Associations, and traditional pastoralist family and community units.

The inhabitants of Liben District and the rest of the Borana Plateau rely primarily on a pastoralist economy, though people are increasingly, where possible, cultivating small plots of maize, wheat and beans. Liben pastoralists and agro-pastoralists are essentially cattle keepers with goats and sheep and a few camels. The staple food of the pastoralist society is milk (mostly cow, but also camel and goat). During the rainy season, diets can consist of up to approximately 80% milk and butter, and 20% grains, vegetables, and meat, with milk consumption increasing with milk production. Milk production is dependent on livestock health, which in turn depends on water, pasture, and availability of veterinary services. When milk production decreases, more livestock are sold to purchase grain, and the proportion of cereals in the diet increases.

Pastoralism should not be confused with nomadism. *Ollas*, or encampments, are occupied by at least part of the family year-around, except in times of great food or water shortage. Many families have maintained the same encampments as a base for generations. The family and herd are divided into mobile and stationary parts. The mobile part, or *forra*, is composed of young men and older boys who travel long distances with the strong male cattle in search of pasture and water. When water and pasture availability permits, they return to the *olla*. The stationary part of the family, or *warra*, consists of women and children who take care of the milking cows, weak or sick cows and calves at the *olla*. The *warra* may move short distances for forage and water but return to the *olla* each night. The community elders, who are political leaders and managers of resources, also remain close to the *olla*.

The Boran and Guji ethnic groups are organized into generation sets, which succeed every eight years in assuming political power. This system influences all their social, cultural, and economic institutions. It is also through Gada law making assemblies that attempts are made to maintain an ecologically balanced relationship with the environment. A law-making assembly – the Gumi Gayo – is held every eight years, the last being in 1996.

but also believes that more recent population estimates may not be more accurate than the census-based estimates. SC thus proposes to continue using DHO/1994 census-based estimates until more accurate population estimates become available.

The traditional systems of the Borana are changing rapidly. Today 51% of households can be considered poor; these households control about 10% of the cattle herd. Around 18% may be considered wealthy and control about 65% of the cattle herd. The human population is increasing at a net rate of 2.5% per year, with a 50% increase in population possible within 14 years.²² Limited land availability is restricting cattle numbers, and large numbers of cattle die during droughts.

Liben is prone to both natural and manmade emergencies. Cyclical drought and armed conflict in localized pockets pose regular threats to the pastoralist and agro-pastoralist populations. Increasing human and livestock populations and the fragile ecology of the area makes the target population that much more vulnerable to environmental shocks as coping mechanisms become ineffective against both natural and man-made calamities. Water scarcity for both human and animal consumption is one of the greatest problems facing pastoralist and agro-pastoralist communities. Throughout Liben, nearly all rural households use unprotected water sources for human consumption, generally sharing open ponds, shallow wells, and river water sources with their animals. The problem is exacerbated in the dry season when many water sources dry up and people have to travel long distances to obtain water.

It is estimated by GTZ²³ that some 40% of cattle were lost during the last drought (1998-2001) in Borana Zone. This amounts to a loss of some 600,000 to 700,000 cattle, the market value of which is in the order of 840 million Birr (US\$ 100 million). During the same period 43,000 metric tons of 'free' food worth US\$ 10.75 million was imported into the area. The net effect of these livestock losses is rapid and serious loss of food security and livelihood assets at times when they are most needed, and a perceived dependence on external support.

Mothers surveyed for the 2001 KPC stated their religion as Muslim (59%), *waaqeefattaa* or traditional followers of one God (13%), or Christian (25%). Christians are comprised of Orthodox, Roman Catholics, and Protestants. Aside from religion, rural cultural traditions, socio-economic arrangements, and customary laws reinforce patrilineality and the subordinate position of women.

Marriage is universal; and polygyny widely practiced, with men taking up to four (and sometimes more) wives. Age of marriage for girls is usually at 15 to 17 years, but can be as young as 12 to 14 in some communities in the district. Age of first marriage for boys is about 18 to 20. The average household size in Liben District is 6.8, as determined by the DAP baseline survey.

A majority (62%) of mothers surveyed in the KPC conducted in August 2001 reported working away from home.²⁴ Childcare options included: taking the child with her (42%) or leaving the child in the care of older children (24%), relatives (15%), neighbors (8%), or with a husband or partner (9%).

Health Status and Health Services in Liben District

The most valid information on the nutrition status of children in Liben District is from SC's

²² ILCA Systems Study, 1994

²³ Emergency Monitoring Report, GTZ Negelle, 2001

²⁴ In this part of Ethiopia, unlike many other parts of sub-Saharan Africa, it is uncommon for women to bear burdens on their heads. Rather, they carry large loads on their backs, making it difficult for mothers to carry along infants when they go to fetch water or firewood, or perform other heavy chores.

assessments of approximately 500 6-59 month-old children at 18 sentinel sites during the month of August in each of three recent years: 1997, 1999, and 2000. In Liben District, August follows the lean period of comparative food scarcity.²⁵ This data from Liben District is compared in the table below to that for 0-59 month-old children in Oromiya Region and in Ethiopia as a whole, from Ethiopia's Demographic and Health Survey, conducted from February through May, 2000.

Childhood Nutrition Status in Liben District, Oromiya Region, and Ethiopia, 1997 - 2000

Nutrition Status Indicator (Z score cut-off value)	Liben, SC Aug. '97 6-59 mos.	Liben, SC Aug. '99 6-59 mos.	Liben, SC Aug. '00 6-59 mos.	Oromiya, DHS Feb.-May '00 0-59 mos.	Ethiopia, DHS Feb.-May '00 0-59 mos.
Underweight (< -2Z W/A)	41%	28%	34%	42%	47%
Wasted (< -2Z W/H)	7%	4%	11%	10%	10%
Stunted (< -2Z H/A)	43%	NA	42%	47%	52%

Ethiopia is classified by WHO and UNICEF as a country with clinical vitamin A deficiency,²⁶ with a national xerophthalmia survey in the country's four agro-ecological zones finding the highest rates of Bitot's spots in pastoralist areas.^{27,28} Iodine deficiency disorders are not believed to be prevalent in Borana Zone.²⁹

Other valid estimates of measures of health status are not available for either Liben District or Borana Zone. However, socio-economic conditions in Liben, the presence of *falciparum* malaria, and information on nutrition status of 6-59 month-old children (above), suggests that the levels and causes of under-five mortality in the district are likely similar to those in Ethiopia as a whole. In Liben District, low coverage by sparse maternal health services, rudimentary family planning services, unhealthy traditional practices, geographic and cultural barriers to care, and poverty contribute to poor maternal health. SC and the DHO believe that the distribution of causes of maternal death in Liben District likely reflects the distribution of causes in developing countries in general: Hemorrhage, unsafe abortion, hypertension, obstructed labor, sepsis, and indirect causes, including anemia and malaria.³⁰

²⁵ Every year childhood wasting significantly increases in the second quarter. Household food supplies are lowest during the dry period from January through March as families await the start of the rainy season in April, which results in an increase in milk supply. This recurrent period of stress erodes food security and nutritional gains that may have been made during the previous months. Annual monitoring data suggests that a wide network of family members share food resources and children's food needs are prioritized. Dietary patterns from SC's target areas reveal that during the food insecure periods the number of meals is cut down from three per day to one per day.

²⁶ Global Prevalence of Vitamin A, WHO 1995

²⁷ Wolde-Gebriel Z, Demeke T, West CE. Xerophthalmia in Ethiopia: A Nationwide Ophthalmological, Biochemical, and Anthropometric Survey. *European Journal of Clinical Nutrition* 1991;45:469-78

²⁸ Although milk is their primary staple, a number of food taboos prevent pastoralist mothers from feeding their children important complementary foods, such as chicken, fish, eggs, vegetables, and fruits, leading to micronutrient deficiencies.

²⁹ DHO and ZHD staff who participated in the CS-17 design workshop noted that IDD is a problem in the highlands of Ethiopia, but not in Borana Zone, where goiter is very rarely seen.

³⁰ Ross SR. Promoting Quality Maternal and Newborn Care: A Reference Manual for Program Managers. CARE, 1998.

Concrete information on HIV/AIDS prevalence is sorely lacking in all of the Southern Tier of the country, including Liben District. However, during recent months, the blood of 48% of apparently healthy donors at Negelle Hospital in the district center has been screened HIV-positive.³¹ While this data may not be reflective of HIV prevalence in the general population and prevalence in other groups of Liben District is not known, prevalence is likely to be high, given that there is an active commercial sex industry and a military base located in the district, and a mining industry in the adjoining district.

This area has historically been one of the most underserved areas of Ethiopia in terms of health (and other) infrastructure and services. MOH health facilities in Liben District include the 113 bed Zonal Hospital in Negelle, and a total of nine functioning clinics (health stations/posts) outside of Negelle. Hospital staff include four general practitioners, one of whom serves as both Hospital Director and District Health Officer; and 14 Senior and Junior Nurses. The nine facilities outside of Negelle are each staffed by one Health Assistant, while four of these facilities also have a Community Midwife. Outpatient MCH services, including case management of childhood ARI, diarrhea, and malaria, and antenatal, delivery, and family planning services, which are provided from each of these facilities on a daily basis. Childhood and maternal immunization services are provided on at least a monthly basis in all but four of district's Peasant Associations through these facilities and through outreach services, but immunization coverage remains low. (Please see KPC results in Section I.E). A needs assessment carried out in a number of facilities in Liben, in preparation for the LSS training showed critical gaps in staff knowledge and practice in maternal and newborn care, including prevention and management of danger signs during gestation, perinatal, and postnatal periods. (Please see further discussion of MNC services in Section III.F.)

There are no active STI/HIV prevention activities in Liben District, except for several AIDS clubs. There used to be an STI clinic staffed by a medical doctor at the district hospital, but this was closed due to shortage of physicians. In addition to managing STI patients, the STI clinic ran a free certification service for sex workers, who were examined and given certificates pronouncing them free of STIs other than HIV. Sex workers found to be infected were treated free of charge, and only certified after completing the treatment. The District Health Office ran this program in collaboration with the District Women's Affairs department, bar owners, and the municipal administration. Currently, STI services have been integrated into the general outpatient department services and clients have to pay for the service. The sex worker certification has been discontinued. STI services are available at the hospital and clinics. Diagnosis is based on the STI syndromic management approach, but not all providers have been trained in this approach. There are no voluntary counseling and testing (VCT) or other HIV/AIDS counseling services in the district.

There are 13 registered rural drug vendors in Liben Woreda. RDVs are private dispensers of medications, mostly located in towns and/or near MOH health facilities. They are often trained Health Assistants who have moved into the private sector, though registered RDVs sometimes staff their shops with other, less trained, staff. Reports from communities and MOH staff indicate that there are not many unregistered RDVs or informal drug sellers, so most rural communities do not have access to a RDV. MOH guidelines require that RDVs refer all children

³¹ (97/200) Unpublished data, Negelle Hospital, 2001, based on a test for screening blood, which has very high sensitivity and low specificity (resulting in a high percent of false positives, and thus not a good estimate of the sero-prevalence in the population).

with suspected pneumonia and malaria to an MOH facility, although it is recognized that RDVs sometimes give primary health care and medications. KPC data suggest that few children with diarrhea, pneumonia, or malaria are taken to a RDV. Routine supervision of RDVs is the responsibility of the DHO, though supervisory visits have been irregular. Based on their experience in the district, the DHO believes that RDVs in Liben are not playing a major role in providing key maternal and child health services and doubts the benefits of training RDVs.³²

Limited geographic access to health facilities and services is a fundamental constraint in Liben District. The DHO estimates, based on the geographic distribution of people and health providers, that only approximately 40% of the total population of Liben District lives within a ten kilometer (6.2 mile) radius of an MOH or private health provider. The July 1997 *Health Status Information* study conducted in parts of Liben and neighboring Arero District by the Italian NGO COOPI found that 72% of people in these two areas walk more than three hours to reach health services and that only 32% live within ten kilometers of a health facility.

Male traditional healers in Liben, *cheresas*, or “wise-men,” include herbalists, bone setters, religious practitioners, and spiritual healers. These individuals are respected in the community as credible sources of information about health and healing. Moreover, these men act as “gatekeepers” for care-seeking outside of the *olla* or *kebele*. *Cherites*, or “wise women” traditionally provide birth assistance in the district. In most communities, one can find a *cherite* in every *olla* or group of *ollas*. Some *cherites* also practice other healing arts, such as herbalism, massage, bone setting, or female circumcision (e.g., infibulation). Their advice is often sought for children’s health problems, especially diarrhea and fever. Most are women in their mid-forties or older; all are respected by their communities. Although some *cherites* charge for attending a delivery, most accept payment in-kind and whatever is offered. The average number of births assisted on a monthly basis varies greatly from community to community.

While PVOs and NGOs have been encouraged in the past few years by the Government of Ethiopia to work in this area, there are only two international NGOs operating in the district: Cooperazione Internazionale (COOPI), an Italian NGO; and Save the Children (USA). The German Agency for Technical Cooperation (GTZ) is also now operational in the Zone and is engaged in agro-pastoral and health activities. The only national NGO having a visible presence in the district is the Ethiopian Red Cross (ERC). Funded by the German and Japanese Red Cross societies, the ERC is making an ambulance available to Negelle Hospital for emergency, long distance transport for critical cases requiring more sophisticated medical treatment at a referral hospital located 270 kilometers away.

SC has been implementing two complementary programs throughout Liben District since 1997, the CS-13 project through September 2001, followed by CS-17; and a USAID/DCHA/FFP-funded DAP. Maternal and newborn care, malaria, CDD, and ARI interventions were supported through CS-13, while the DAP supported nutrition, immunization until the start of CS-17, and

³² CS-13 identified RDVs as possible health providers in communities and developed training materials that focused on basic concepts of pharmacology, side effects of drugs, and case management of diarrhea, pneumonia, and malaria. The guidelines encouraged referral to MOH facilities for sick children. All 13 registered RDVs were trained. However, there is concern that trained RDVs often demonstrate a ‘knowledge-practice gap’- although they are aware of correct standards of practice, they do not observe these standards because they have a profit motive for selling more drugs. The involvement of RDVs in CS-17 was a subject of much debate among SC and DHO staff during the DIP workshop in Negelle, concluding with a decision that CS-17 would not focus limited resources on RDV training or supervision.

family planning activities until the start of support from NGO Networks for Health in 2001. The DAP aims to “make a sustainable improvement in availability of, access to, and utilization of food for approximately 17,500 pastoralist households in Liben District.”³³ Availability of and access to food are addressed through DAP activities to improve livestock management, while utilization is addressed through the DAP’s “human health” interventions, implemented through, and helping to build the capacity of, the same SC, MOH, and community-level structures supported through CS-13 and CS-17, including the Health Action Committees (HACs), and Bridge-to-Health Teams (BHTs). Through the DAP, HAC and BHT members have been trained and supported to educate fellow community members in nutrition and immunization; MOH immunization activities have been supported, including EPI+ campaigns, routine outreach activities, and the cold chain. DAP-supported activities have included food supplementation for children, based on the results of weight-for-height screening, and for women during the last trimester of pregnancy and first six months postpartum. These food supplementation activities are integrated with nutrition education/food demonstration, EPI, and other preventive MCH outreach activities conducted by SC and MOH staff. The DAP has contributed to the CS-13 and CS-17 goals of improving access to MCH services through constructing and equipping two new health posts in Liben District, both now fully functional MOH facilities.

E. Summary of Baseline and Other Assessments

1. CS-17 HIV/AIDS Situation Analysis

A number of factors that facilitate the spread of HIV/AIDS were identified through focus group discussions and contacts made with rural elders, traditional death society members, commercial sex workers, women from urban and rural areas, the Liben District HIV/AIDS Council, an anti AIDS club focal person, and the head of the District Health Office and Medical Director of the District Hospital. In addition, the team visited the district hospital and collected various reports. The purpose of the discussion was to understand existing knowledge about HIV/AIDS and STIs, availability and use of condoms, risky sexual behavior prevailing in the area, harmful traditional practices that enhance the spread of the virus, treatment seeking behavior, and whether there are stress coping mechanisms traditionally existing in the target community. Due to limited time, the team was unable to conduct a focus group discussion with youth, which will be very important to understand determinant behaviors and special problems among youth. After having passed through the aforementioned process, the team identified the following factors that facilitate the spread of HIV/AIDS in Liben District:

- Low level of awareness and misconceptions about the disease;
- Incomplete information perceived by all the groups;
- Harmful traditional practices like polygamy, pre- and extra-marital sexual relations;
- High number of demobilized soldiers in the target area;
- Presences of large number of mobile military population;
- Limited HIV/AIDS prevention interventions;
- Presence of displaced population;
- Permanent cross border mobile population for business purposes;

³³ as well as 7,500 pastoralist households in the neighboring Filtu District (to the east of Liben District) of Liben Zone in Somali Region.

- Silence about the epidemic and denial about the existence of the virus and the magnitude of the epidemic;
- HIV sero-prevalence among apparently healthy blood donors at Negelle Hospital in the district center is approximately 48%,³⁴ which is much higher than the national prevalence among blood donors, and since these people do not know their status, they keep spreading the virus;
- The existence of a large number of prostitutes;
- Rampant unwanted pregnancies, especially among sex workers and student girls, and common practice of illegal abortion and consequent death;
- Increased incidence of rape due to various reasons;
- Tuberculosis and pneumonia are the 2nd and 3rd leading causes of morbidity respectively, while STIs are the 5th, based on the morbidity report for 2001 from Negelle Hospital;
- The 1st and the 2nd leading causes of death are pulmonary TB and pneumonia;
- The discontinuation of STI syndromic management and free certification services for sex workers in the district hospital;
- Delayed treatment seeking behavior for STIs; and
- Low capacity of District HIV/AIDS Council to play its leadership role, due to low level of knowledge and skills and frequent structural changes that have resulted in changing of Council members.

(Please see detailed report of the CS-17 HIV/AIDS Situation Analysis in DIP Annex 2.)

2. CS-17 HIV Behavioral Surveillance Survey

Family Health International (FHI) and UNICEF, with local partners including SC, are currently conducting a nation-wide first of its kind HIV behavioral surveillance survey (BSS). The survey will be conducted every two years and will track six target groups. These groups are selected because of high prevalence of HIV and the size of the groups, their importance to the national economy, and the potential for infecting other groups. The six target groups include in school and out of school youth, female commercial sex workers, long distance drivers, farmers and pastoralists, military personnel, and factory workers. The BSS will help establish a monitoring system that will track behavioral trend data for high risk and vulnerable target groups which influence the HIV epidemic in Ethiopia, provide information on behavioral trends of key target groups in some of the areas where voluntary counseling and testing is being offered, provide information to help guide program planning, provide evidence of the relative success of HIV prevention efforts in selected sites, and will obtain data in a standardized format, which will enable comparison with other behavioral surveillance studies carried out in other countries. Sampling frames are calculated for each target group. Survey instruments cover socio-demographic characteristic of respondents; sexual behavior; knowledge and use of condoms; knowledge about STIs and STI treatment-seeking behavior; knowledge, attitudes, and opinions about HIV and AIDS; exposure to HIV prevention interventions; and stigma. A preliminary analysis will be performed for each target group, to identify those topics that need further illumination through qualitative research. It is assumed, the investigators will conduct 8 FGDs, one with each of the target groups.

Liben District is one of the target areas. The target groups in Liben include in school and out of school youth, commercial sex workers, and pastoralist community members. Trained interviewers are conducting individual interviews. The first round of results is expected by

³⁴ The DHO reports that their test for screening blood is 100% sensitive, but only 60% specific.

August 2002. Key indicators that are being tracked are those which define aspects of behavior important to the spread of HIV, behaviors that HIV prevention programs generally try to change.³⁵ Tracking of these indicators over time will provide a way to track changes in these behaviors over time.

CS-17 will use the BSS to track progress in HIV intervention behavior change. The BSS data will complement qualitative data collected using focus group discussions with different groups in Liben District during the DIP workshop by SC's HIV Consultant.

3. Institutional Strength Assessment of SC's Home Office Backstopping of CS Grants

SC completed an ISA in February and March 2002 with assistance from CSTS using the CSTS ISA methods and tools. ISA inputs included:

- Completion of an organizational profile by SC's CS Team in Westport.
- A self-assessment conducted in Westport with in-person participation of all three members of the Office of Health CS Team, as well as SC/Westport staff from Human Resources, Finance, and International Programs; and written input from the OH Manager and the Regional Health Advisors for Asia and Africa.
- Field input: Eight field respondents were identified by SC/OH for this assessment, each of whom works closely with one of SC's eight current AID/DCHA/PVC-supported CS projects. These eight respondents are either CS field project managers or Field Office (country office) health program managers who support CS field projects. Responses were received by CSTS from six of these eight field respondents. The mode of response was "one individual completed the guide after reflecting on guiding questions" for three respondents and "multiple individuals participated in a group discussion and then scored" for three others. Reasons for non-response can, in one case, be linked to the newness of staff in key positions and thus difficulty in identifying an appropriate respondent.
- A self-assessment results-sharing and capacity improvement prioritization meeting conducted in Westport with in-person participation of all those who participated in person in the self-assessment, as well as participation by phone of the Regional Health Advisor for Asia.

Data analysis involved the following methods:

- Scores were calculated by capacity area.
- The range of scores provided information on where there was agreement and for identifying 'critical questions.'
- Within each capacity area:
 - Questions with highest scores were examined to identify areas of strength; and
 - Questions with lowest scores were examined to identify areas for improvement or further assessment.
- Quantitative data was supplemented by qualitative input from ISA participants through discussion and recommendations.

³⁵ MEASURE Evaluation/ UNAIDS/ WHO guide to monitoring and evaluation of National AIDS Programs.

According to the section of the ISA final report on findings, “General Trends and Overall Scores of SC/OH Capacity Areas:”³⁶

- “The positive scores received both from the field and central office suggest that the SC/OH, working within an established agency of formidable experience, is a strongly performing PVO unit.
- “The SC/OH has a strong sense of self-efficacy in all six areas of capacity, as demonstrated by the homogeneity of scores obtained across the board.
- “Field scores are – overall – strongly congruent with OH scores.
- “Technical skills and knowledge, Management and governance, Organizational Learning and Human resources management are assessed as the strongest areas of capacity, with high agreement between field and OH.
- “The last two capacity areas, Administrative procedures and structures, and Financial management, are the two weakest areas of the six, though both are performing at relatively strong levels.”

(Please see Section G, below, for a discussion of priorities for capacity building of SC’s Office of Health with regard to child survival.)

4. Organizational Capacity Assessment of SC’s Ethiopia Field Office and the Liben DHO

SC’s Ethiopia Field Office has submitted a formal request to Pact/Ethiopia to conduct an Organisational Capacity Assessment in the near future of:

- The EFO in Addis Ababa,
- The CS-17 impact areas of Negelle, Liben District,
- Counterpart government offices in Negelle,
- SC’s urban RH programme in Addis Ababa, and
- SC’s refugee programme in Jijiga.

(Please see Annex 2 for more information related to this assessment.)

5. Knowledge, Practices, and Coverage Survey

SC conducted a KPC Survey in Liben District in 1997 to provide baseline data for the CS-13 project. A second KPC was conducted in 2001. SC is utilizing the results of the 2001 survey both as a way to evaluate achievement of CS-13 objectives and as a baseline for CS-17.

Survey Methodology: The Rapid Knowledge, Practice, and Coverage (KPC) Survey questionnaire developed by the Johns Hopkins University, School of Hygiene and Public Health, PVO Child Survival Support Program, was adapted, pre-tested, and used for the 1997 and 2001 surveys. Questions included the areas of maternal health, diarrhea, pneumonia, malaria, child nutrition, immunization, water, and health services. Basic population characteristics such as ethnic group, sex, age, marital status, religion, education, and economic activities were also included.

³⁶ Institutional Strengths Assessment. *Final Report*. Save the Children. Office of Health / Child Survival. Westport, CT, 03/13/2002. ISA Facilitators: Lea Bethune, Consultant; Eric Sarriot, CSTS. Page 10.

The sampling design employed was two-stage cluster sampling using probability proportional to size (PPS). At the first stage clusters were selected randomly from a list of PAs. At the second stage, selection of a constant number of households from each of the selected cluster was undertaken from both rural and urban areas. A total sample size of 360 households, roughly the same size as the 1997 survey, was taken from rural and urban areas, 24 clusters from rural and 6 from urban. The selection of initial households in both urban and rural areas was done based on WHO/UNICEF EPI random walk methods.

A two-day training was given in Negelle for ten enumerators and two supervisors. The training focused on the objectives of the survey, sample selection procedures, interviewing techniques, and ethical considerations. The survey was conducted with two teams. Each team consisted of five enumerators and a supervisor. The teams collected data from July 25 to August 2, 2001.

Results: The overall results of the 2001 KPC indicate that access to and utilization of services like immunization and antenatal care remain limited. Only 19% of children 12 to 24 months old were fully immunized, 32% were vaccinated for measles, and 21% of respondents had TT2 during their last pregnancy. The KPC accepted only the presence of immunization cards to indicate coverage, so these figures are almost certainly below actual rates of coverage. (DHO administrative estimates for the same antigens are 34% of infants fully immunized, 43% for measles in infants, and 26% for pregnant women receiving TT2.) Nevertheless, it is clear that the availability, quality, and/or demand for immunization services need improvement. The KPC used the presence of maternal health cards to measure the % of women who had at least one antenatal visit during their last pregnancy. This figure was 22%, although an additional 19% reported that they had had cards but lost them. SC will incorporate WHO's recommendations regarding Strategic Outreach Services into CS-17's regular EPI and antenatal programs to improve coverage of both immunization and antenatal care.

Mothers reported that 36% of their young children were delivered by trained personnel (25% by trained TBAs, and 11% by health professionals). Knowledge of danger signs related to pregnancy was very low. Using effective BC approaches to increase women's knowledge about when they need to seek emergency care for pregnancy-related complications will complement the CS-17 LSS/HB-LSS maternal and newborn care activities.

Although 83% of mothers initiated breastfeeding within the first few hours after delivery, breastfeeding is not exclusive, with 90% of children 3 to 5 months old given water, tea, or milk in the 24 hours prior to the survey. Complementary foods for 6 to 24 month olds are not very diverse. 93% received milk in the week prior to the KPC, but only 45% received oil or fat (added to food), 16% received meat, 9% received fruit, and 4% received leafy green vegetables. Nutrition education through community health workers will continue as a complementary activity funded through the DAP.

Reported care seeking behaviors for diarrhea, pneumonia, and malaria indicate that mothers do not differentiate effectively between illnesses that can be treated at home, and those which need treatment from trained personnel. Caretakers reported seeking care at equal levels for all three illnesses (diarrhea 64%; pneumonia 63%; and malaria 68%). Respondents who sought care reported seeking care at health facilities, hospitals, or private clinics equally for diarrhea (89%) and pneumonia (92%). It should be noted that respondents' reported levels of care seeking at health facilities were much higher than the facility records of number of cases treated. One positive indicator is that 10% or fewer of respondents reported seeking care from drug vendors or untrained traditional healers for each illness. Self-reporting may not reflect actual care

seeking behaviors, but it does reflect attitudes about desirable care seeking behaviors. Relatively low numbers of caretakers are aware of the signs of diarrhea, pneumonia, or malaria that should prompt immediate care seeking from trained personnel.

The KPC asked about how children were treated at home for the last episode of diarrhea. 73% of mothers breastfed the same or more during their child's last episode of diarrhea. 26% of mothers used ORT (ORS sachet, cereal based, or home available fluids) to treat the diarrhea. Urban women were almost three times more likely than rural women to use ORS sachets (31% vs. 11%), probably due to greater availability of the packets in urban areas. 48% of caretakers reported treating diarrhea with anti-diarrheals.

The limited access to health facilities, combined with the KPC results regarding caretaker knowledge about when care should be sought versus when treatment can be given at home, indicate a real need for the community based case management of diarrhea, ARI, and malaria that SC will implement through CS-17. The results regarding home treatment of diarrhea reinforce the need for targeted, pre-tested BC messages and approaches at the community and household levels reinforcing positive nutrition, hygiene, and care taking behaviors.

(Please see the summary report of the KPC survey in Annex 2.)

F. Program Approach

Broad Program Approach

SC and the MOH Liben District Health Office will continue implementation through CS-17 of all four CS-13 interventions: ARI (at 15% of planned intervention-specific CS-17 effort), Malaria (10%), CDD (10%), and Maternal and Newborn Care (20%); and continue important support to the DHO in EPI (15%), previously funded through the DAP. CS-17 will devote 30% of intervention effort to introducing an HIV/AIDS intervention, in order to build SC and DHO capacity in Liben to begin addressing the district's HIV epidemic. These CS-17 interventions will be implemented through the following major strategies:

- Joint DHO/SC design, implementation, and evaluation of approaches to maternal and child health in Liben that inform development of strategies to address the needs of pastoralist populations in other districts of Borana Zone and Ethiopia.
- Introduction and evaluation of community-based case management of childhood illness, to improve access to and use of these services in Liben District, and to inform the nascent development of Community-IMCI in Ethiopia.
- Building capacity of SC, the DHO, and the District HIV/AIDS Council, to provide leadership, coordination, and technical advice for integration of effective HIV prevention, care and support, and mitigation efforts into ongoing community and government activities in Liben District.
- Continued mobilization of community leaders and traditional practitioners through Bridge-to-Health Teams and Health Action Committees, to support selected MCH services, and to conduct focused education to improve key emphasis behaviors at the household level.

CS-17 builds on the central strategy of CS-13, community mobilization and health education through "Bridge-to-Health Teams" (BHTs). BHTs were introduced and discussed with local leaders by SC's community mobilizer in two to five visits to each of the "Peasant Associations"

(PAs) in Liben District between April 1998 and March 1999. Each of 150 communities elected a three-member BHT composed of a *chereti* (wise woman/TBA), a *cheresa* (wise man/male traditional healer), and a young traditional apprentice. At least two thirds of the 450 BHT members are influential, respected traditional healers or birth attendants, and most traditional healers in the district are BHT members. SC and District Health Office (DHO) partners trained BHTs to provide health education for home treatment of watery diarrhea; recognition and care-seeking for pneumonia, malaria, and pregnancy-related danger signs; and to promote use of antenatal care, family planning, and immunization services at MOH health facilities and at joint SC/MOH outreach sites. Together with the staff from the nearest health facility, Health Action Committees (HACs) in every PA each support four to six BHTs, and review and respond to health information from BHTs and TBAs. Service Area Teams, composed of MOH health facility staff and SC Senior Program Assistants temporarily posted to facilities, train and support BHTs and HACs.

CS-17 Goals and Results

CS-17 goals are: A sustained reduction in under-five and maternal mortality in Liben District, and; CS-17 approaches inform policy or programming for pastoralist areas of Ethiopia in Community-IMCI or reproductive health.

These goals will be achieved through CS-17 results of: (1) Improved Liben District capacity to effectively support community health services and activities; (2) Improved community capacity in Liben to effectively address priority health needs of mothers and children under five; (3) Increased use of key health services and improved MCH practices at household level in Liben District, and; (4) Adoption of CS-17 approach by the MOH or by other organization in Ethiopia.

These results will be achieved through CS-17 intermediate results of: (1) Increased availability of selected MCH services in Liben; (2) Documented quality of selected MCH services; (3) Increased maternal knowledge in Liben of selected MCH issues; (4) Dissemination of feasibility and results of implementing innovative CS-17 approaches, and; (5) Increased SC/Addis and Liben capacity in behavior change and integrated HIV programming.

IMCI and the CS-17 Approach to Integration of Interventions

The MOH “has endorsed IMCI as a main strategy to reduce under-five mortality and morbidity and to promote health, growth, and development of children.”³⁷ IMCI activities started in three regions (outside of Oromiya Region) in 1998. The pace of IMCI implementation gathered momentum after the development of the five-year IMCI strategic plan in May 2000. In March 2001, the first national IMCI review and re-planning workshop was conducted, with the participation of all regions, except for Gambella. As of late 2001, 40 health facilities in Ethiopia were implementing IMCI. The MOH recognizes a “strong need for optimal involvement of NGOs and the private sector to support the scaling-up of IMCI implementation.”

Implementation of the household and community component of IMCI (HH/C-IMCI) is beginning this year in selected zones of Amhara and Tigray regions. For HH/C-IMCI, “during the initial implementation phase, Ethiopia will emphasize a selected number of WHO/UNICEF

³⁷ Department of Family Health, MOH. National and Regional IMCI Plan of Action 1994 EFY (2001-2002).

generic family practices to complement what is being done in components one and two of IMCI.”³⁸

CS-17 will focus on approaches to HH/C-IMCI, including improving household practices related to child health and increasing use of child health services, such as immunization and care seeking at health facilities for ill children. SC will continue to seek Federal MOH concurrence for community-based case management of pneumonia, malaria, and diarrhea on a pilot basis, as an important opportunity to inform the ongoing development of HH/C-IMCI in Ethiopia. As IMCI components 1 and 2 are introduced in Borana Zone and Liben District (now planned for 2003),³⁹ CS-17 will support the DHO in IMCI-related efforts focused mainly on health facilities, including planning and management; training; logistics and supply; and supervision, reporting, monitoring, and evaluation.

CS-17 implementation of EPI and MNC interventions will continue in an integrated way through CS-13 and DAP approaches of service delivery and approaches to behavior change through BHTs/TBAs, HACs, MOH health facilities, and joint DHO/SC DAP/EPI/ANC outreach activities. STI/HIV/AIDS, the only new intervention in CS-17, will be implemented by integrating HIV activities into ongoing district programs such as: (1) supporting the District HIV/AIDS Council and promoting multi-sectoral programming, (2) supporting and strengthening the current MOH practice of integration of syndromic management of STIs into OPD services at health facilities, (3) including STI/HIV prevention messages in EPI and Nutrition outreach BC activities, (4) including HIV prevention and control topics in training for all community-based health volunteers, and (5) including a minimum set of HIV topics in training for SC DAP staff.

Process to Involve In-Country Organizations in CS-17 Design and Implementation

SC and the District Health Office are the only organizations in Liben supporting community health activities. The DHO was SC’s principal partner in CS-13. The initial CS-17 program design described in the application submitted to USAID in December 2000 was the result of joint planning by staff of Save the Children, the Liben District Health Office, and the previous Head of the Borana Zonal Health Department, during a workshop conducted in Negelle from September 25th to 28th, 2000. Five members of the DHO participated in the four-day workshop, including Dr. Abera Reffisa, the District Health Officer at the time, who now serves as Head of the Borana Zonal Health Department. Participants discussed health needs and services in Liben District in relation to national health policies and programs, and worked together to select interventions, define strategies, and outline the roles and relationships of SC and the DHO in the program. Decisions were informed by CS-13, DAP, and MOH experience in Liben District, and by focus group discussions conducted with community leaders and BHT and HAC members during the CS-17 design period. (Please see DIP Section I.C, above, for discussion of the role of the DHO in the CS-17 DIP workshop; and Section I.D, above, for a description of services provided by the DHO in the district.)

Relationship with Other Health-Related Activities and Roles of Major CS-17 Partners

CS-17 is closely integrated with MOH health activities in Liben District, building on the close relationship developed through CS-13, which concluded with the full-time participation of the

³⁸ Federal Ministry of Health. Implementation Strategy for the Household and Community Component of Integrated Management of Childhood Illness (IMCI) in Ethiopia. 2001-2004. (undated document).

³⁹ Oromia Health Bureau IMCI Plan (2000 – 2004).

District Health Officer in the CS-13 final evaluation. The DHO has played an active role in CS-17 design and planning workshops over the last 1.5 years, and joint SC/DHO planning and management of MCH activities through a DHMT will be a focus of district-level collaboration through CS-17. SC is continuing its key role in supporting MOH immunization activities throughout the district. BHTs and HACs are continuing to promote the effective use of MOH MCH services among members of their communities. SC's Senior Program Assistants (SPAs) work out of MOH health facilities with MOH health staff, and work with MOH Health Assistants to prepare a joint health facility/ CS-17 monthly report using the standard MOH format with additional space added for reporting of community-level activities.

Save the Children will: play a leading role in managing CS-17, an important role on the District Health Management Team, support the District HIV/AIDS Council; lead formative HIV research, other baseline and final assessments, and development/revision of training and BC curricula and materials; with MOH partners, train and support (on at least a quarterly basis) health facility staff, and through Service Area Teams train and support HACs, BHTs, and TBAs; sponsor the training of three Community Midwives at Negelle Nursing School; monitor HIS performance and findings, health worker performance, and availability of essential supplies/equipment with MOH partners, and; conduct immunization/ ANC/ DAP outreach sessions together with MOH facility staff.

The District Health Office will: co-manage CS-17 with SC; chair the DHMT; participate in baseline and final assessments, and development/ revision of training and BC curricula and materials; with SC, train and support (on at least a quarterly basis) health facility staff, and through Service Area Teams, train and support HACs (including quarterly meetings with HACs), BHTs, and TBAs; provide facility-based MCH services; with SC, monitor HIS performance and findings, and health worker performance; ensure availability of essential supplies/equipment at facilities and for outreach activities, and; conduct immunization/ ANC/ DAP outreach sessions together with SC. (Please see jointly developed agreement between SC and the DHO in DIP Annex 3.)

CS-17 Synergies in Liben District with SC's Pastoralist Livelihood Initiative

SC is now requesting Development Assistance (DA) funding from the USAID / Ethiopia Mission to undertake a Pastoralist Livelihood Initiative (PLI) in four contiguous districts, including Liben, over the next five years. The PLI will integrate the use of Title II food commodities through a new approved DAP with the DA funds to address three Strategic Objectives:

1. Improved health and nutritional status among women and children in the target area;
2. Improved natural resource management by pastoralists in the target areas; and
3. Increased pastoralist income and income/asset diversification in target areas.

Communities will be mobilized and empowered to build decision-making and technical skills through Community Action Committees (CACs), and through health, water, and natural resource management committees. As part of the PLI sustainability plan, targeted groups will additionally develop community-managed savings plans that will be available to continue priority development activities after the five year PLI program has ended. CACs will function as a coordinating body for all technical committees trained by SC that function in the community to facilitate change and skills development by pastoralist families/ individuals, such as BHTs, HACs, Natural Resource Management Committees, and Water Resource Management

Committees. The CACs will ensure integration and coordination of development activities and messages. At least 35% of the members of all CACs will be women.

Resources such as training materials and technical assistance will be shared to build synergy between the PLI and CS-17. Outside of Liben District, the new DA/DAP program plans to implement a variety of human health activities based on CS-13 and CS-17 strategies and experience. In Liben District, the PLI will complement CS-17, focusing on nutrition and breastfeeding interventions:

Nutrition: The PLI plans to phase-in growth promotion activities gradually. In each PA, two BHT members will be trained to organize and facilitate GMP sessions with support from SC staff. GMP sessions will include: Interpretation of growth curves with mothers, focusing on the weight changes between sessions; Problem identification and counseling, highlighting practices of positive deviant mothers as role models,⁴⁰ reaching consensus on next steps; Referral to health services when these are needed and available; Participatory problem analysis and action planning, including presentation of consolidated growth data at community meetings, planning actions needed at the community and program levels to support and enhance actions at the household level, and; Monitoring how well the actions worked – for individual children, and for all children in the community/program. The impact of the GMP activities on nutritional status in the pilot PAs will be compared with those where GMP are not being conducted. SC will coordinate efforts in this area with the World Bank’s Food Security project, which includes an extensive growth promotion and monitoring activity to be implemented in selected districts of Oromiya Region. Further uptake of the activity by the Ethiopian government will depend on the feasibility and success of the pilot program.

A similar pilot approach is planned for establishing breastfeeding support groups. Lactating mothers participating in the GMP activities, who have children faltering in their weight gain will be encouraged to join support groups for breastfeeding. Following GMP sessions these mothers will meet and follow the *La Leche League Model* initiated in Bolivia. In this model participants meet every month for about 60 minutes to share breastfeeding experiences and problems and to explore alternative solutions with other mothers from their own villages. TBAs and BHT members will facilitate these meetings. In time, mothers who have had successful breastfeeding experiences will be identified to lead future meetings.

In addition, other communication channels will be used to promote improved nutrition practices. Along with nutrition education by BHTs, HACs, and MOH staff, opportunities for public campaigns will be identified, such as market days and festivals. The core messages that will be communicated through the education campaigns will address the following:

- Immediate and exclusive breastfeeding for 6 months;
- Appropriate practices for complementary feeding;
- Iron and vitamin A supplementation;
- Child feeding during illness;
- Child development milestones and nutritional status of children;
- Impact of food taboos;

⁴⁰ A positive deviance inquiry conducted by SC in 2000, showed that despite the harsh socio-economic conditions in the pastoral areas, some mothers had successfully maintained weight gain and nutritional status of their children. These mothers will be used as role models to share their knowledge about child rearing and care giving.

- Nutritional demands of pregnancy and the importance of maternal weight gain.

Experience from the current DAP strongly suggests that timely injection of food assistance in combination with community asset development, and provision of basic health and water services, is the most appropriate response to address chronic malnutrition that sustains the relief to development continuum.⁴¹ In the new DAP, SC proposes to use food commodities to promote maternal and child health as follows:

- For the first three years of the LOP (FY03- FY05) provide a three month family ration that meets one-third of an average family’s food requirements per day.
- All families in a community who have a child under two years of age will be eligible for the short-term family ration.
- The distribution of commodities will be undertaken just prior to, and/or during the period of greatest food need (January through March), where inadequacy of food in the household is determined as a critical factor that contributes to nutritional risk among mothers and children under two.
- At the end of three years, family rations will be suspended, while continuing all other interventions including community asset diversification, water point development, health services and education for behavior change to promote sustainable changes in nutritional status.

Community health workers, especially those with additional training in nutrition activities, will participate in conducting the food distribution and end use monitoring of donated commodities. HACs and BHTs, with support from government officials, will identify families eligible for rations. Food will be distributed on a monthly basis for three months. In the first year, the adequacy of the ration, use, and impact on households, communities, and markets will be monitored closely through qualitative information gathering and through the annual monitoring surveys.

⁴¹ SC’s experience with supplementary feeding in the last DAP also demonstrated that distribution of family rations targeted at malnourished children alone was inadequate in reducing the levels of stunting and underweight in a meaningful manner. Thorough analysis of trends and data suggest that the most appropriate and efficient use of food to meet maternal and child health and nutrition needs is a short, but substantial injection of nutrient dense foods into the household. Rather than focusing on the malnourished child or continued monitoring of children, the data suggests that it is better to identify the period of greatest food need and provide a family ration that acts as a safety net; preventing acute food insecurity, destitution, and malnutrition in pastoralist families. The final evaluation of the DAP recommended a similar approach, where the focus is shifted from the management of malnutrition to enhancing the family’s access to essential food resources during critical food insecure periods of the year. This is also in keeping with the recommendations from DCHA/FFP and FANTA to use a more “preventive” approach to malnutrition, where the problem is addressed in a preemptive fashion. Thus, in the new DAP, SC will use food resources proactively to bridge annual food gaps, reduce disinvestments, sustain livelihood, and build much needed community assets to withstand future shocks. This timely, focused and short-term food distribution will reduce logistics costs, and permit program staff to concentrate on more sustainable strategies for longer-term development.

Family Planning

SC's family planning activities in Liben District are currently supported through NGO Networks for Health, following initial implementation through the current DAP. SC is seeking and anticipates continued funding to support the evolving/planned FP strategy,⁴² which includes:

- Integrating family planning clinical and counseling services with existing safe motherhood and new HIV/AIDS programming;
- Promoting synergy of community and facility-based approaches to increase quality, access, and availability of FP services;
- Designing locally acceptable and understandable FP education materials for CHWs;
- Improving MOH and SC staff performance in FP programming, and;
- Dialoging with religious leaders, men, and cultural leaders to increase their support for FP.

Planned activities include:

- FP refresher training for TBAs, BHTs, HACs, and for the existing 90 FP Community-Based Distributors in all PAs of the district;
- Basic training on reproductive health and counseling for MOH and SC staff;
- Post Abortion Care training in counseling and care for MOH staff;
- FP service provision through CBDs;
- Support for FP activities through MOH facilities;
- Community mobilization for FP through BHTs and HACs, and;
- Production of materials for community-level FP education.

CS-17 Strategies for Innovation and for Informing Programming Beyond Liben District

The very poor access to health services for the rural population of Liben District is a problem very much shared by the rural communities of the other nine mostly pastoralist districts of Borana Zone, and common to pastoralist areas in other parts of the country. This is in part a result of the lack of any clear health sector strategy for providing essential health services to pastoralist communities, a problem discussed at the January 1999 MOH Pastoralist Areas Health Services Design Workshop, in which SC participated. The workshop participants, including those representing Oromiya Region, were unable to fully support any particular strategy for addressing the health needs of pastoralist areas, recognizing the need for more information and experience as a basis for appropriate approaches. The Workshop report on Oromiya identifies geographic access as the key determinant of health service coverage for pastoralist areas, calls for implementation of approaches for improving access, particularly with regard to the “most pressing causes of death,” notes the importance of strengthening District Health Offices in pastoralist areas, and identifies “Mobile Community Health Agents” as one option for increasing access.⁴³

SC is continuing to play an active role in advocating at national and regional levels for appropriate approaches to meeting health and other needs of pastoralists. At national level, SC is seeking to influence policies and programming for pastoralist areas through the Pastoralist

⁴² SC's EFO plans to submit an application in response to an anticipated RFA, and is also seeking foundation funding to continue FP activities in Liben District.

⁴³ Proceeding of Pastoralist Areas Health Services Design Workshop, January 23-26, 1999, MOH, March 1999, Oromiya Group, Proposal of Possible Intervention Strategies.

Forum, in which SC continues to play a key role. The Forum includes NGOs working in pastoralist areas, meets once a year in Addis Ababa, and brings issues important for pastoralist areas to the attention of the Government of Ethiopia. At regional level, SC plans to play an active role in the Oromiya Region Pastoralist Commission, which is currently being established.

CS-17 approaches which SC believes have good potential for uptake to improve maternal and child health services in other pastoralist areas include: working with traditional health practitioners through BHTs (also a focus of CS-13 and the DAP); training TBAs in maternal and newborn Home-Based Life Saving Skills (with technical support from the ACNM which began in April 2000), and; community-based case management of childhood illness. SC hopes to place public health students in summer internships in Liben District to design plans for evaluating and documenting the feasibility and results of these CS-17 approaches.

Activities with coalitions of NGOs: SC is participating in the CORE Polio Eradication Initiative along with other CORE-member PVOs in Ethiopia. SC vehicles in Liben District transport SC and DHO staff and vaccine for National Immunization Day activities, and BHTs and HAC mobilize communities for participation in NIDs.⁴⁴

Challenges

Important new challenges for CS-17 will include the current insufficient MOH supply of STI drugs, and the lack of voluntary HIV counseling and testing (VCT) services in Liben District. SC is working with the DHO to source additional STI drugs from other international organizations, and is in discussions with the Centers for Disease Control and Prevention (CDC) on establishing a sentinel surveillance site for HIV/AIDS VCT at Negelle Hospital. Prospects for this SC leveraged activity are high, and SC expects the site to become operational late in 2002.

Re-supply of cotrimoxazole and Fansidar for malaria and pneumonia treatment at community level will be another important challenge as this approach is introduced. CS-17 will work with HACs in the concerned PAs to establish a sustainable system of drug re-supply, through sale of cotrimoxazole and Fansidar, or through a revolving drug scheme, based on the success of current DAP-supported Community Managed Savings Groups and drug re-supply system for community-level animal health activities, an approach which is also receiving increased MOH attention and support.⁴⁵

G. Organizational Development

Strengthening the PVO

Institutional Assessment of SC's Office of Health and Organizational Needs to Be Addressed: Based on findings from the analysis of ISA input from SC staff based in Westport and in the field (please see Section E, above), the two-member CSTS/ISA team made the following initial

⁴⁴ More substantial CORE PEI activities in Ethiopia were planned in 2000 (and SC's Ethiopia Field Office submitted an application in February 2000 for PEI activities), but not implemented due to USAID/Washington funding constraints. Recently, the USAID Mission in Ethiopia has provided funds for limited CORE PEI activities.

⁴⁵ Program Action Plan for the Health Sector Development Program, MOH, August 1998, pages 12, 19, & 20.

recommendations to the SC/OH team for discussion, clarification, amendments, and prioritization:

1. The systems needing most attention appear to be in the area of financial management. Timely access to cost information, not only by line item and grant category, but also by activity, is needed. In addition, financial management and analysis training of more CS staff in OH and the field appears to be a felt-need.
2. Enhance focus on quality assurance (QA) in all programs. The importance of QA to project success and long-term sustainability is paramount. However, QA was less of a perceived need among field-based ISA respondents.
3. Examine the balance of roles and responsibilities between Westport-based CS specialists and the OH Regional Health Advisors, to advance some of the suggestions and recommendations stemming from this assessment.
4. Other identified areas for improvement include: the conduct of organizational capacity assessments with local field partners, the design and implementation of sustainability strategies, and behavior change communication (BCC) interventions.
5. Develop a more systematic approach to building management, leadership, crosscutting, and technical skills for field staff through training, mentoring, site visits, and temporary duty/acting assignments.
6. Continue to focus on including target communities in all aspects of project design, implementation, and evaluation, and ensure that lessons learned about community engagement in one program are systematically shared. Developing standards and systems for their dissemination would support consistency in level and quality of community engagement efforts across projects.
7. More country-specific managerial support to the field may be indicated, as well as more frequent management training for field staff.
8. Institutionalize periodic review of staffing needs for OH and the field against program requirements and funding levels.
9. Explore increasing the translation of selected programmatic documents into local languages.

After a discussion of ISA findings and recommendations, participants in the ISA results sharing and capacity improvement prioritization meeting on March 7, 2002, developed two criteria for establishing priority among the issues: *feasibility* and *highest impact*. They reviewed each issue and assigned a value from 1 to 3 for each criterion and each issue. For example: “identifying costs by activity” was assigned a “1” for feasibility and a “2” for impact. Once the criteria were applied by the group to each issue and a value or score assigned for each criterion, the scores were totaled by issue. The final prioritization matrix follows:

ISA Final Prioritization Matrix

Type of Recommendation	Sub Category (Comments)	Feasibility 3 = easy	Impact 3=high	Sum of Scores	Rank 1=high
1. Costing activities & finance training	a. Field training/clarification regarding budget line-item flexibility	3	3	6	1
	b. Training & providing on- or off-the-books Activity Costing for program managers	1	2	3	
2. Diversify donor base & increase resource mobilization		2	3	5	3
3. Further development & implementation of a Quality Assurance program		1	3	4	
4. Number, roles & responsibilities of RHAs	c. Clarify roles & responsibilities of SC/OH, the RHAs, & CS team	3	1	4	
	d. Augment the CS team, and/or the number of RHAs	2	2	4	
5. Capacity assessment & sustainability	e. Train field staff in & implement capacity assessments at field level.	3	2	5	4
	f. Sustainability (developing a systematic approach)	1	2	2	
6. Further develop BCC support capacity by adding a Behavior Change Communication Specialist.		2	3	5	2
7. A more systematic approach to building field capacity in management, leadership, & technical & cross-cutting (M&E, research, training, etc.) skills & knowledge.	(A quality management review process is becoming an agency initiative, so it is not so hard to support this.)	2	2	4	
8. Explore “translations” / access to key documents in the field	g. Explore issue of translating documents into other languages	3	1	4	
	h. Respond	1	2	3	

Following the prioritization exercise, the resulting high priority issues were organized in three categories: Easy to achieve; Hard to achieve; and, On-going processes:

Easy and should do quickly:

- Field training/ clarification regarding budget line-item flexibility.
- Clarify roles and responsibilities among OH, the RHAs, and the CS Team.
- Train field staff in and implement capacity assessments at the field level.
- Explore issue of translating documents into local languages.

Hard:

- Further develop BCC support capacity by adding a Behavior Change Communication Specialist.

- Further development and implementation of a Quality Assurance program.
- Augment the CS team, i.e., the number of RHAs.

On-going within SC or OH, but needing more focus and/or OH attention:

- Diversify donor base and increase resource mobilization for CS.
- A more systematic approach to building field capacity in management, leadership, and technical and crosscutting (M&E, research, training, etc.) skills and knowledge.

ISA findings are being shared with other members of the OH staff, and with Westport and field-based staff who participated in the ISA. Results from the ISA are already being used by the CS Team to plan priority CS-related activities for SC's *Every Mother Every Child High Impact Initiative*. ISA findings will contribute to upcoming meetings regarding OH CS Team staffing needs, and will inform the continuing OH/CS strategic planning process. However, as ISA findings and resulting priorities for capacity building are closely related to all eight of SC's current CS projects, these priorities for capacity building will not be reflected in the organizational development objectives for increasing SC's capacity specifically through CS-17.

Institutional Assessment of SC's Ethiopia Field Office and Local CS-17 Partners, and Organizational Needs to Be Addressed: Following the EFO Organizational Capacity Assessment (OCA) currently being undertaken by PACT, SC expects to have a detailed breakdown of both internal (SC) and external (Liben DHO) child survival strengths as well as areas needing improvement. The scope of work for the OCA includes an evaluation of SC organizational capacity in Ethiopia including Addis Ababa headquarters, child survival programming impact areas in Liben and other representative programming areas. The OCA will also cover MOH district counterparts in the child survival programming. With this valuable information, when coupled with the CS-13 final evaluation recommendations, SC will have a clear blueprint for improved programming measures to be taken by the EFO and local counterparts. SC will apply for internal capacity building resources such as the Gates Foundation supported "Saving Newborn Lives" funds and others to address these shortcomings. These resources will assist the EFO in filling identified gaps and also increasing the home office TA to build programming capacity of both the EFO and the Liben impact area.

The EFO is also going through a much-needed structural realignment that will increase the level and consistency of TA available directly from the FO. One addition to FO staff is the position of "Assistant Director for Training and Technical Support," which has been added to the Field Office senior management structure. This position was created to oversee the various specialty areas of programming within the EFO (Human Health, Animal Health, Water Point Development, and Primary Education) and is directly responsible for quality assurance of health and other programming initiatives. It is expected that the Assistant Director, who reports to the DFOD for Programs, will assist in increasing best practices sharing between programs and also create more of a learning dynamic within the EFO. Secondly, the EFO is adding an expatriate HIV/AIDS Care and Support Specialist in June 2002. This newly funded position will work mainly under the HIV/AIDS High Risk Corridor initiative but will assist the EFO to increase programming capacity in other HIV/AIDS efforts such as CS-17 as well.

Organizational Development Objectives for Increasing SC's Capacity through CS-17: Through CS-17, the EFO seeks "increased SC/Addis and SC/Liben capacity in behavior change and integrated HIV programming" (CS-17 IR-5). CS-17 objectives related to this intermediate result are:

- EFO Behavior Change Specialist hired (by October 2002) and retained;
- Behavior change strategy for all CS-17 interventions designed and implementation started (by March 2003);
- HIV prevention efforts effectively integrated into ongoing community and government activities through CS-17; and
- SC/Liben staff participate in 5 HIV-related training courses, workshops, and/or experience sharing visits during CS-17.

The focus of EFO organizational development efforts related to CS-17 may be revised following the completion of the Organizational Capacity Assessment with Pact/Ethiopia.

Processes Used to Collect Baseline Capacity Data: Please see Section E, above.

Sharing CS-17 Lessons Learned with Other SC Programs & with the International Child Survival Community: SC's "Program Learning Group" is the main medium for sharing lessons learned among SC's health programs. The "PLG" is composed of senior health staff based at SC's Field Offices and in the Home Office, and meets annually for four to five days following the Global Health Council meetings to share field experiences and research results, and to receive technical updates from other team members and external experts. Experiences and technical updates from the CS-13 project have been presented and discussed at several recent PLG meetings, including most recently, a presentation in June 2000 by the American College of Nurse Midwives (ACNM) on their work with CS-13 to develop a plan for Liben District to train trainers of birth attendants in Life-Saving Skills (LSS) and Home-Based LSS.

Lessons learned through CS-13 have already been disseminated within the broader child survival community. The ACNM has presented their work on HB-LSS in India and in Liben to an audience of PVO staff at the NGO Networks for Health Project in Washington, D.C. CS-13 has become the case study for a semester-long course at Emory University's Rollins School of Public Health.⁴⁶ CS-13 baseline study methodology, linking KPC Survey findings on care seeking with health facility assessment findings on quality of case management, was presented at NCIH in 1998,⁴⁷ and is the basis for a manuscript which has been submitted for publication in the East African Medical Journal.⁴⁸ The Ethiopia CS-13 baseline health facility assessment experience was also the impetus for CORE's Monitoring and Evaluation Working Group to commit to its development of a broader, simpler Health Facility Assessment tool that embraces not only child health but also maternal and reproductive health and nutrition. SC will continue to share lessons learned through CS-17, particularly with other PVOs through the CORE Group, in which SC staff actively participate.

Strengthening the Local Partner

SC's primary local partner in the CS-17 project is the District Health Office. Negelle town serves as the administrative center of both Liben District and Borana Zone, so the Zonal Health

⁴⁶ "Strategies in International Health" (Drs. Stan Foster and Jim Setzer)

⁴⁷ Aschenaki K, Marsh DR, Kedamo T, et. al. Community- and Facility-Based Information Illuminate the Pathway to Maternal and Child Survival in Liben Woreda, Ethiopia. National Council for Int'l Health, Arlington, VA, June 25-27, 1998.

⁴⁸ Marsh DR, Aschenaki K, Kedamo T, Manoncourt S, Gebreyes K, Pasha O, Waltensperger K, "Community and Facility Surveys Illuminate the Pathway to Child Survival in Liben *Woreda*, Ethiopia."

Department has played a significant role in past interventions. Currently, however, the government of Ethiopia is undergoing a restructuring, where resources and planning, budgeting, and decision-making authority are being decentralized from the zonal departments to district offices. In addition to this, Negelle Hospital will become an administrative entity separate from the District Health Office. The restructuring is just beginning, so it is difficult to gauge the impact it will have on CS-17. Certainly if it is carried out as planned, SC's primary partner, the District Health Office, will be strengthened both in fiscal and human resources, and in decision making authority, which can only have a positive impact on the CS-17 interventions.

Result-1 of the CS-17 results framework is improved Liben District capacity to effectively support community health services and activities. The indicators for this result measure whether the DHO is utilizing a data driven approach to health management, whether DHO facility-based staff are adequately supporting Health Action Committees (the community level health management teams), and whether the District HIV/AIDS Council is actively planning, implementing, and monitoring HIV/AIDS activities in Liben.

During CS-13 the DHO and SC jointly developed a Health Management Information System that included reporting forms and information flows from community-level health workers, through health facilities, to the DHO and SC's health program coordinator. A Microsoft Access based database was designed so that information compiled monthly from each PA could be entered, stored, analyzed, and used for monitoring current interventions, and planning new ones. An HMIS team comprised of DHO staff would analyze the data, and then report to the District Health Management Team. The DHMT comprises DHO and SC staff, and was to meet once a month to discuss and utilize PA-level data, as well as the overall situation in Liben. This structure was operating for a few months, but staff turnover at the DHO resulted in a discontinuation of database use and regular DHMT meetings.

Staff turnover is a continual problem for capacity building and the sustainability of SC's programs. However, the DHO has committed to regular meetings of the DHMT, and utilization of the HMIS database. One strategy they will use to accomplish this is making upkeep of the database and attendance at DHMT meetings part of the responsibilities of several staff, so that if one leaves, the others will continue meeting, and will train the replacement. SC will use a similar strategy to ensure that at least one SC staff member attends DHMT meetings.

Through CS-17's Maternal and Newborn Care and community-based case management interventions, SC will continue to increase the capacity of facility-based DHO staff to monitor and support CHWs. Facility-based staff will be trained in Life Saving Skills (LSS), and in Training of Trainers for Home Based Life Saving Skills (HBLSS). This will enable them, in collaboration with SC's facility based Senior Program Assistants, to supervise TBAs who are trained in HBLSS, and to give them follow up training.

Close supervision and follow up trainings to reinforce learning will be critical to the success of community-based case management of malaria, pneumonia, and diarrhea. Facility-based staff, both from the DHO and SC, will be given training of trainers on the curricula that will be used to train the Case Management Workers (CMWs). DHO and SC staff at health facilities will jointly supervise the CMWs, reviewing each case with them to ensure that they are following appropriate steps in diagnosis, treatment, and follow-up.

HIV/AIDS is a new focus both for SC and for the DHO and Zonal Health Department in Liben. A critical step to ensuring effective, sustainable HIV/AIDS programming in Liben is to strengthen the newly established District HIV/AIDS Council. SC will involve the Council in

planning, implementing, and evaluating SC's HIV/AIDS interventions. In addition, SC will help to forge links between the Council and already existing church and school based HIV/AIDS voluntary organizations. Establishing communication flows between community level and district level health workers has been an effective way to improve the support and supervision of CHWs, and to keep DHO staff informed of PA-level health trends. SC will build on this experience to strengthen community and district level structures for combating HIV/AIDS.

Community Capacity

Bridge-to-Health Teams and Health Action Committees are the third focus of capacity building through CS-17, highlighted in Result-2: "Improved community capacity in Liben to effectively address priority health needs of mothers and children under 5." CS-17 will build capacity of HACs to plan and support, and BHTs to provide, key maternal and child survival services at the community level. Selected BHT members will be trained to treat childhood pneumonia and malaria, and TBAs trained in Home-Based LSS. CS-17 will build on the knowledge and skills developed through CS-13 to enable BHTs to continue to educate other members of their communities in key aspects of maternal and child health; and to enable HACs to support BHT members, collect information from BHTs, and plan MCH activities. Service Area Teams of SC and MOH staff posted at health facilities will support HACs, BHT members, and TBAs, through visits to each PA on at least a quarterly basis, and more frequently following the introduction of new activities (such as ARI/malaria case management, drug revolving funds, and LSS). Findings from these regular support visits will help determine topics for future visits, meetings, and refresher training. BHTs and HACs are a focus of CS-17 capacity building at the community level because of the desire to build on the work through CS-13 and the current DAP with BHTs and HACs and complement work with these groups through the new DAP.

Training

CS-17 Summary Training Plan for the Five Year Life of the Project

Training Activity by Intervention	Number of Trainees by Project Year				
	Year 1	Year 2	Year 3	Year 4	Year 5
1. HIV/AIDS/STI					
1.1 Peer Educators training on HIV/AIDS	10	10	10	10	
1.2 CBO training on home-based care and support	10	10	10	10	
1.3 BHT & HAC training on HIV/AIDS/STI prevention	450	423	423		
1.4 District HIV/AIDS Council training on program designing	7		7		7
2. Maternal & Newborn Care					
2.1 TOT for MOH staff on HBLSS	5		5		
2.2 LSS training for DHO and HF staff	12		12		
2.3 HBLSS training for TBAs		197	300	300	
2.4 HBLSS orientation for HACs & BHTs	114	54			
2.5 Community Midwives training		3			
3. Community Based Case Management					
3.1 Health facility staff training on PCM/MCM/CDD		5	10	21	
3.2 CMWs training on PCM/MCM/CDD		10	20	42	
3.3 HAC refresher training in PAs with Community-Based Case Management		60	120	252	
3.4 BHT refresher training in PAs with Community Based Case Management		60	120	252	
4. Immunization (EPI)					
4.1 Modular EPI training for MOH staff & SPAs	15		15		15
5. Other					
5.1 District health planning and management training	5		5		5

CS-17 Detailed Training Plan for Years One and Two

Training Activity by Intervention	Year 1			Year 2			Methods	Days		Trainees	Trainers
								Y1	Y2		
1. HIV/AIDS/STI											
1.1 Peer Educators training on HIV/AIDS			x		x		Discussion, Role play	5D	5D	10 sex workers	SC DHO
1.2 CBO training on Home-Based care and support on HIV/AIDS			x			x	Discussion	3D	3D	10 Anti-Aids club members	SC DHO
1.3 BHT & HAC training on HIV/AIDS/STI			x	x	x	x	Discussion, Role play	2D	2D	846 HAC BHT	SC DHO
1.4 District HIV/AIDS Council training on program design & grant seeking			x				Discussion	3D		7 District Council members	SC DHO
2. Maternal & Newborn care											
TOT for MOH staff on HBLSS						x	Lecture, Discussion		5D	5 SC & DHO	SC DHO
2.1 LSS training for DHO and HF staff			x				Clinical practice	7D		18 DHO, HF staff	SC DHO
2.2 HBLSS training for TBAs					x		Picture, Discussion		12 D	300 TBAs	SC DHO
2.3 HBLSS orientation for HACs/BHTs				x		x	Pictures, Discussion	3D	3D	168 HAC & BHT	SC DHO
2.4 Community Midwives training					x		Lecture Clinic. Practice		6 mo	3 local women	Negelle Jr. Nurs. School
3. Community Based Case Management											
3.1 Health facility staff training on PCM/MCM/CDD					x		Discussion, video, practice		5D	5 HF staff & SPAs	SC DHO
3.2 CMWs training on PCM/MCM/CDD						x	Discussion, video, practice		15 D	10 CHWs	HF, SC, & DHO staff
3.3 HAC & BHT orientation on CB-CM training in 5 PAs						x	Discussion, demonstrat.		2D	60 HAC 60 BHT	HF, SC, DHO
4. Expanded program on Immunization (EPI)											
4.1 Modular training for MOH staff & SPAs on EPI				x			Discussion, demonstrat.	5D		15 HF staff & SPAs	SC DHO
5. Other											
5.1 District health planning and management training			x				Lecture, Discussion	3D		DHO EPI, MCH units (5)	SC Zonal Health Depart.

Monitoring and Evaluating the Effectiveness and Impact of Training

CS-17 staff will conduct regular supervision and support visits to monitor post-training performance. SC's Health Program Coordinator, Training Coordinator, and MOH health facility staff and SPAs will monitor the performance of BHT and HAC members, Case Management

Workers, and TBAs using checklists. These support/supervisory visits will be used to review recent activities; identify problems or performance gaps, and work with CHWs/staff to address gaps, solve problems, and improve performance; provide positive feedback; and plan future activities. The CS-17 Training Coordinator will also develop checklists for post-training follow-up with community members to assess CHW and program performance from community perspectives. Findings from these supervisory visits will allow the Training Coordinator and other CS-17 staff to develop refresher training plans to address identified needs.

References

EPI:

- MOH, Training Modules on EPI for Clinic/HP-Based Staff, 1992.
- SC, Training Manual for BHTs and HACs, 1999.

CDD, ARI, and Malaria:

- Case Management of Childhood Illnesses. Community Health Worker's Guide to Management of the Child Aged 0 – 5 Years with Cough or Difficult Breathing, Diarrhea, and Fever. CARE/Kenya CICSS Project. (Charts revised 6/20/2000). Case Management of Childhood Illnesses on Cough or Difficult Breathing, Diarrhea, or Fever. Training Guide for Community Health Workers. (Revised 10/7/98).
- Guidelines for Malaria Diagnosis and Treatment for frontline health workers in Ethiopia, MOH.
- Malaria Prevention and Control Methods (Amahric). Malaria and Other Vector Borne Diseases Control Unit, Epidemiology and AIDS Control Department, Ministry of Health, Addis Ababa, July 1999.

MNC – HB-LSS:

- American College of Nurse Midwives, Home Based Life-Saving Skills, Guidelines for Policy Makers and Trainers, Field Testing Draft 5, March 9, 2001.

HIV:

- Frank D. Cox, The AIDS BOOKLET, 4th edition, summer 1997 update
- Making prevention work, Global Lessons Learned from the AIDS control and prevention (AIDSCAP) project, 1991-1997 October 1997.
- HIV/AIDS prevention from the field, Family Health International volume III, Number 3 November 1996
- Training Modules on AIDS Education. (Four booklets in one set.) PACT Publications
- Women and HIV/AIDS: An International Resource Book
- Home Based Care Training Manual. WHO
- AIDS in Ethiopia (Amharic Version), 3rd edition, March 2001
- Curriculum for the Training of Community-Based Reproductive Health Agents, MOH, Ethiopia, June 1997.

H. Sustainability

CS-17 Sustainability in the Context of SC's Pastoralist Livelihood Initiative

Approaches to sustainability through SC's Pastoralist Livelihood Initiative (PLI) / food security program in four contiguous districts, including Liben, will support CS-17 efforts related to capacity building and sustainability. SC will promote sustainability through the PLI in several ways. First and foremost, SC employs a strategy of capacity building at several levels. Community decision-making and technical skills will be developed through Community Action Committees (CACs), and through health, water, and natural resource management committees. As part of the PLI sustainability plan, targeted groups will develop community-managed savings plans (a successful approach under the current DAP) to continue priority development activities after the five year PLI has ended. CACs will function as a coordinating body for all technical committees trained by SC that function in the community to facilitate change and skills development by pastoralist families/ individuals, such as BHTs, HACs, Natural Resource Management Committees, and Water Resource Management Committees. The CACs will support integration and coordination of development activities and messages. The sustainability of animal health activities will be promoted through cost recovery by Community Animal Health Workers who sell their services to the communities they serve (a successful approach under the current DAP). Water point development will be sustained through community managed savings plans and, in some communities, based on their decision, through cost recovery.⁴⁹ The PLI will also increase the capacity of government department staff through skills development, especially in areas such as TOT, conflict resolution, computer operations, community development, and community outreach. SC plans to phase over all DAP II activities in Liben District by the end of the five-year program in all sectors, including water point, animal health, pasture reclamation, and nutrition, as sector activities will either be completed or well established through strengthened government offices.

CS-17 Sustainability Definition and Objectives

CS-17 will continue CS-13 approaches to sustainability, by nurturing (1) district, (2) community, and (3) household-level capacities to continue delivery and use of essential promotive, preventive, and case management services, for maternal and child health, with minimal external input.⁵⁰ CS-17 seeks a sustained reduction in under-five and maternal mortality in Liben District (CS-17 Goal 1) through:

- (1) Sustained support for community health committees, workers, and activities (HACs, BHTs, trained TBAs, community-based case management);
- (2) Sustained delivery of key maternal and child survival services at the community level; and
- (3) Sustained increase in use of key health services and improved MCH practices at household level in Liben District.

⁴⁹ For example, several communities in Liben District that developed water points during DAP I have begun to charge for water, especially as the dry season approaches, as a way of prolonging the useful life of their community resource.

⁵⁰ Revised from the definition of "developmentally sound sustainability in: Foster S. Sustaining the benefits of child survival collaboration, prepared for the Private Voluntary Organization Child Survival Support Program, Baltimore: Johns Hopkins University, September 1995, p 8.

These elements of sustainability are very much related to the CS-17 results related to capacity building at district and community levels (please see table of CS-17 Goals, Results, Intermediate Results, and Selected End of Program Objectives, in DIP Section II.H.1):

- R-1: Improved Liben District capacity to effectively support community health services and activities; and,
- R-2: Improved community capacity in Liben to effectively address priority health needs of mothers and children under 5.

In addition, CS-17 also seeks

- (4) Approaches to Community-IMCI or reproductive health which inform policy or programming for other pastoralist areas of Ethiopia (CS-17 Goal 2), which also involves sustainability, as the uptake of some CS-17 approaches by other organizations would mean that the approach is sustained.

CS-17 Goal 2 is supported by Result-4: Adoption of CS-17 approach by MOH or by other organization; and by CS-17 Objective 23: MOH or other PVO/NGO in other district of Ethiopia has written plans for implementation of CS-17 approach to C-IMCI, MN/LSS, or BHTs.

CS-17 Strategies for Sustainability and Uptake

(1) Sustained support for community health committees, workers, and activities partly depends on continuing support from the District Health Office and health facilities after the end of CS-17. CS-17 will work with MOH health facility staff to provide HACs, BHTs, and trained TBAs with good training and support, and to establish mechanisms for the re-supply of drugs during these five years, thereby increasing facility capacity to provide a lower but sufficient level of support after SC staff depart. During this time, community-level providers will be trained, and additional facility staff, including Community Midwives trained through CS-17, will continue to be posted by the DHO to the currently under-staffed health facilities in the district. CS-17 promotes institutional DHO/health facility sustainability through: (a) targeting key public health problems with strategies consistent with those of the MOH; (b) training and supporting existing health staff, and relying on and strengthening existing structures without creating new structures; (c) the role of DHO in joint CS-17 planning and management through the District Health Management Team; (d) cooperative and supportive community/ health facility structures (Health Facility Management Committees and HACs); and through (e) the continuity of MOH staffing and services independent of SC.

(2) Sustained delivery of key maternal and child survival services at the community level: Reviewers of successful PVO approaches to sustainability have concluded that one of the most effective strategies appears to be strengthening the knowledge and skills of community health workers in response to community needs,^{51,52} which is very much a focus of CS-17. At the community-level, CS-17 works through existing traditional practitioners, whose continuity of work does not depend on the project. BHTs are being trained and supported to conduct health behavior change activities in their communities. TBAs are being trained and supported to use

⁵¹ Powers, Mary Beth. *Sustainability Findings of 12 Expanded PVO Child Survival Projects*. USAID, June, 1995.

⁵² Foster, Stanley. *Sustaining the Benefits of Child Survival Collaboration: Communities, Governments, PVOs,, CSSP, and USAID/BHR/PVC: Lessons Learned – 1991 – 1994*, USAID, September, 1995.

Home-Based Life-Saving Skills in their ongoing antenatal, delivery, and postpartum activities. Case Management Workers will be selected among current BHT members and community malaria workers to manage non-severe childhood pneumonia, malaria, and diarrhea in their communities. Beyond CHW knowledge and skills to address maternal and child health needs, the DAP and CS-17 aim through their work with Community Action Committees (CACs) and HACs to develop community capacity to work together to identify and address needs. Learning how to set priorities, use information to analyze their situation, plan, implement, and evaluate their efforts as a group, are basic skills that can be applied to any aspect of community life.

(3) Sustained increase in use of key health services and improved MCH practices at household level: CS-17 seeks to increase use of key MCH services and practices by:

- Increasing the availability of key MCH services, through community-based case management of non-severe childhood pneumonia, malaria, and diarrhea; home-based LSS through trained TBAs, and outreach immunization and antenatal services;
- Ensuring the quality of key community MCH services from both a technical and community perspective, through training, on-going support, involvement of existing/traditional practitioners, and collaborative health services/ community mechanisms; and
- Increasing maternal/ household-level knowledge of key MCH issues through the approaches to behavior change described in Section I.I, below.

(4) Innovative CS-17 approaches sustained through uptake of these approaches by the MOH or by other organizations in other parts of Ethiopia: A key CS-17 sustainability strategy involves introducing new approaches to Community-IMCI and to serving pastoralist populations, which if shown to be feasible and successful, have good potential for uptake by other organizations beyond Liben District, thus sustaining the approach. This approach to sustainability reflects the difficulty of measuring the sustainability of program activities and benefits during the life of CS-17 (beyond aspects of sustainability addressed by objectives for capacity building), and the belief that sustaining important innovative approaches on a larger scale through “uptake” by other organizations may be more meaningful than a concept of sustainability which focuses only on the project site. Thus, SC in Ethiopia seeks to take advantage of opportunities to contribute to evolving national approaches to meeting the key health needs of pastoralist populations and nascent development of Community-IMCI. To promote future “uptake” of successful strategies beyond Liben, CS-17 will document the feasibility and results of community-based case management, HB-LSS, and behavior change through BHTs, and disseminate findings of successful approaches using a variety of methods.

CS-17 Devolution / Phase-Out Strategy

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

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

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

Diversification of Funding: As mentioned above, in addition to receiving support from the DAP / DA Food Security funding pool, Liben District is currently included in USAID’s special objective known as the STI. A primary component of the STI is maternal and child health, and thus, funding prospects for further strengthening core activities appear good. Additionally, SC has initiated contact with European donors to supplement revolving drug funds and continue refresher-training activities. Finally, SC will reach into private moneys to further develop and sustain interventions initiated under CS-17.

Sustainability Assumptions and Constraints

- Financial sustainability is challenged by abject poverty. Indeed, drought-prone areas of Africa will require external assistance for the foreseeable future. Nonetheless, this project: (1) plans credible cost recovery through revolving drug funds; (2) embraces traditional healers; (3) employs efficient strategies (volunteers, HH/C-IMCI, HB-LSS, synergy with DAP) targeting “best buys” in international health, and; (4) does not provide incentives that create expectations that cannot be fulfilled at the local level without continued CS-17 support.
- Key features in the health sector environment in Ethiopia include the launching of the Health Services Development Program (HSDP) and the incorporation of the IMCI in the plan for the next five-year period by the MOH at central and regional levels. The extended program assumes that there will be increased resources for district health through the HSDP, financed by the GOE and donors, and support for implementation of alternative financing strategies involving RDFs, and user fees at MOH facilities.
- In keeping with the MOH HSDP, the DHO will continue posting additional staff at facilities.
- The community and the MOH at various levels, will maintain and continue to build on current collaboration with SC and with each other.
- Utilizing traditional systems, and developing initiatives in collaboration with communities, will lead to improved awareness and promote healthy behavior and local problem solving.
- No natural disasters resulting in massive displacement and disruption of community structures will occur during CS-17, and the district will continue to enjoy relative political stability.

I. Behavior Change Strategies

Overall CS-17 Strategy for Behavior Change

The main CS-17 strategy for behavior change will be continued mobilization of community leaders, traditional practitioners, and Community Health Workers (BHTs, TBAs, CMWs, and HACs) to conduct focused education to improve key emphasis behaviors at the household level, building on CS-13/DAP experience with this joint SC/DHO approach.

The CS-13 mid-term and final evaluations found that BHTs (comprised of TBAs, male traditional healers, and young traditional apprentices) are respected in their communities as credible sources of information about health and healing, and as “gatekeepers” for care seeking outside of the community. BHTs were trained through CS-13 and the DAP in emphasis behaviors and adult education skills to deliver Liben context-specific BC messages through various IEC channels, including:

- Home visits;
- Public talks and demonstrations at fixed health facilities and outreach sites;
- Meetings of *olla* and *kebele* leadership;
- Food-for-work committees, and other community groups, and;
- Religious functions and schools.

HACs are composed of trained TBAs and other traditional providers, other community leaders, and *kebele* women’s sub-committee members. In CS-17, HACs will continue to meet regularly with TBAs, BHTs, and now CMWs, to review their activity tallies and to carry out community level analysis, mobilize the community for action, and send the report to the Service Area Team (SAT). HACs and BHTs will continue to be supported by Service Area Teams composed of SC Senior Program Assistants and MOH Health Assistants posted at health facilities in the district. Regular supervision through HACs and SATs will ensure consistency of messages and appropriate coverage of each intervention area throughout the project life.

Targeting

In CS-13, BC was carried out at the community level to change care seeking and household behaviors, and at health facility level to increase the quality of case management. Largely because of the continued reality of very limited access to health facilities, most behavior change activities through CS-17, as well as the DAP, will be targeted to caretakers, families, and communities to change key care taking and care seeking behaviors. Limited BC at the health facility level will focus on improving health worker capacity to support CHWs, especially CMWs, and technical skills related to the syndromatic management of STI/HIV/AIDS.

Key Emphasis Behaviors by Intervention Area

Key behaviors on which BC efforts will focus have been established based on the results of the 1997 and 2001 KPC surveys, ethnographic findings from 1998, and experience over the course of CS-13. The epidemiological context, feasibility, felt community needs, and USAID/Ethiopia Mission recommendations and consultation have also contributed to deciding on the key behaviors to be changed. The emphasis behaviors for each intervention area follow:

MNC: Areas of emphasis will be antenatal care, birth planning, utilizing trained TBAs or health professionals for all deliveries, clean delivery practice, recognition and prompt care seeking for danger signs, postpartum care, breastfeeding, and child spacing. Key messages will include:

- All women between ages of 15-45 should be immunized with tetanus toxoid before delivery

to protect themselves and their babies.

- All delivery assistants (regardless of background and training) should use the three cleans: clean hands; clean cutting of the umbilical cord (terminating the practice of coating the tip of the cord with substances such as butter); and clean delivery surface. However, health professionals or TTBAAs are the safest option for home delivery, both for mother and newborn.
- Women and/or family members should seek emergency care if any of the following occur to a pregnant woman or during delivery: (1) any vaginal bleeding before labor; (2) heavy bleeding during labor; (3) severe headaches and/or fits; (4) swollen hands and feet; (5) fever; (6) smelly vaginal discharge; (7) labor from morning till nightfall or vice versa; or (8) any part of the baby showing except the head.
- Women and/or family members should seek emergency care if any of the following occur to a woman after giving birth (1) fever; (2) excessive bleeding; or (3) smelly vaginal discharge.
- Begin breastfeeding immediately after birth to reduce postpartum hemorrhage and nourish and protect your newborn.
- Many babies in our area die very soon after the first sign of serious illness is recognized. Babies with any one of the following signs should not be treated at home or by traditional methods, but need to be brought to a health facility (or a CMW in communities where they are present) as soon as possible:
 - Stopped feeding or vomits every feed;
 - Difficult breathing;
 - Fits / convulsions;
 - Floppy / not responsive / not crying; or
 - Very low or very high temperature.

Diarrhea: Emphasis behaviors will include prevention and home treatment of diarrhea, including nutritional rehabilitation to reduce frailty, and recognition and care seeking for severe diarrhea. Key messages will address the following:

- Continue breastfeeding and feeding food, and increase fluids during diarrhea and other illnesses;
- Mix and administer ORS, or appropriate home-available fluid, correctly;
- Seek appropriate care for signs of severe diarrhea (bloody diarrhea, lasting 14 days or longer, or signs of dehydration);
- Increase feeding for two weeks starting immediately after illness;
- To promote good health and nutrition and prevent diarrhea and other illnesses:
 - Breastfeed exclusively for about 6 months;
 - From about six months, provide appropriate complementary feeding;
 - Continue breastfeeding until 24 months;
 - Take infant for measles immunization as soon as possible after the age of 9 months; and
 - Wash hands with soap at appropriate times.

Pneumonia: The main objectives of our communication effort are: (1) to teach caregivers to recognize signs of likely pneumonia; (2) to seek appropriate care promptly; and (3) to discourage any identified harmful practices. Key messages will include:

- Fast or difficult breathing among children is a sign of serious illness responsible for many childhood deaths in our area.
- Children with fast or difficult breathing cannot be treated at home or by traditional methods and need to be brought to a health facility (or a CMW in communities where they are present) on the same day.
- Children treated for pneumonia or malaria need to take the complete course of antibiotics, even if they seem better sooner.
- Children under treatment for pneumonia or malaria who get sicker or who do not improve in two days must return to the facility (or to the CMW).

Malaria: Emphasis behaviors for this intervention will focus on enhancing recognition of symptoms of uncomplicated malaria; early and appropriate care-seeking; full-course treatment; recognition of severe malaria; and prompt, appropriate care-seeking for severe malaria. Key messages will include:

- Fever is likely to mean malaria. Young children and pregnant women are at special risk for severe complications if untreated. Treatment should be sought from a health facility or CMW, in communities that have them.
- Individuals under treatment for malaria who get sicker or who do not improve in 2 days must return to the facility (or to the CMW).
- Children who have convulsions or sleepiness from which they cannot be aroused must be taken immediately to the health facility.

HIV/AIDS: Emphasis behaviors for this intervention will target behavior change in different groups of the community. Key messages will include:

- Have one faithful partner, abstain from sex, avoid early premarital and extramarital sex, or use a condom consistently;
- Protected sex requires two people willing to use protection. This is true for family planning as well as for STI and HIV prevention;
- Urethral discharge, genital ulcers, and burning while passing urine are signs of an STI. Early and complete treatment are essential. Take your partner for treatment also.
- STIs are curable, and should be treated because STIs can facilitate HIV transmission;
- HIV infection is mostly transmitted through unsafe sex, but can also be transmitted through untested blood transfusion, and through cutting tools that have contact with HIV-contaminated blood.
- If a mother is HIV-positive, then HIV can also be transmitted from a mother to her child during pregnancy, delivery, or breastfeeding. However, antenatal care, clean delivery practices, and exclusive breastfeeding for the first six months, can minimize this risk. Even if the mother is infected with HIV, the chance of HIV transmission through exclusive breastfeeding is low, and may be less than the health risks to the baby of not breastfeeding.⁵³

⁵³ “HIV passes via breastfeeding to about 1 out of 7 infants born to HIV-infected women. But in many situations where there is a high prevalence of HIV, the lack of breastfeeding is also associated with a three- to five-fold increase in infant mortality.” “IF a mother knows she is infected, AND IF breastmilk substitutes are affordable and can be fed safely with clean water, AND IF adequate health care is available and affordable, THEN the infant’s chances of survival are greater if fed artificially. HOWEVER, IF infant mortality is high due to infectious diseases such as diarrhea and pneumonia, OR IF hygiene, sanitation, and access to clean water are poor, OR IF the cost of breastmilk substitute is prohibitively high, OR IF access to adequate health care is limited, THEN breastfeeding may be the safest option even when the mother is HIV-positive.” Breastfeeding and HIV/AIDS. Frequently Asked

- A healthy looking person can be infected with HIV;
- HIV is not transmitted through casual contact like handshake, kissing, eating or living together, or by mosquito bites. As long as one does not touch blood or have unprotected sex, one has nothing to fear from touching a person with HIV/AIDS;
- AIDS comes from HIV when the body's defense mechanism deteriorates;
- Common disease seen in AIDS include fever, diarrhea, weight loss, cough-TB, and skin lesions. It is very important to seek treatment for these problems because they are treatable conditions; and
- A person with HIV/AIDS needs their family's love and support, needs good food, and needs to maintain good hygiene.

Existing Data, Previous Experience, and Gaps Identified (Please also see Section E. Baseline and Other Assessments, above.)

The CS-13 final evaluation concluded that the project had established a strong, trusted network of CHWs who regularly carry out educational activities throughout Liben. The October 1999 CS-13 midterm evaluation noted that “producing behavior change in a fairly remote population, who are perfectly intelligent even if illiterate, who live precariously off arid and not very fertile land and keep the same traditions and values that their fathers and forefathers have for generations, is the challenge faced by CS-13. By co-opting the principle keepers of those traditional ways and values and teaching them to be the agents of behavior change in their new roles as BHTs and HACs, CS-13 is using an approach that is not only appropriate, but is also, as far as can be determined at this stage of project development, quite effective.” However, the final evaluation found that CS-13 had had only mixed success in changing key emphasis behaviors at the household level. Key behaviors that were improved included initiating breastfeeding immediately after birth (42% in 1997, 82% in 2001), and utilizing trained personnel for deliveries (17% in 1997, 36% in 2001). Key behaviors that didn't change included a woman knowing three or more pregnancy danger signs (3% in 2001), and treatment of diarrhea with anti-diarrheals (from 25% to 48%).

The CS-13 final evaluators concluded that the “lack of BCC/ IEC materials and job aids, among BHTs, HACs, and SPAs may have contributed to the ‘message confusion’ noted in the midterm evaluation”, and that “regular supervision of BHT/ HAC BCC activities by SPAs/ HAs is important for promoting consistent use of appropriate health messages. BCC/ IEC materials and/or job aids are important for promoting consistent use of appropriate health messages and for promoting the practice of standard case management among health providers.”

In general the following quote from the CS-13 DIP holds true for the findings of the 2001 KPC:

“The findings from the 1997 KPC indicated that Liben mothers recognize their children's illnesses, yet care-seeking behavior is misguided. Despite long distances, caretakers were more likely to seek care for diarrhea (which should usually be managed at home) than for possible pneumonia and/or malaria which require antibiotics. More mothers gave anti-diarrheal medications than ORS, although 47% (171/365) were familiar with ORS preparation...

...a major implication of the findings is the need to focus IEC/BCC messages to mothers and caretakers on (1) identification of danger signs for pneumonia and malaria and promotion of swift care-seeking; (2) home management of diarrheal

Questions (FAQ). LINKAGES. Updated, May 2001.

episodes with ORT (e.g. sachets and home-available fluids); (3) the importance of antenatal care; and (4) immediate and exclusive breastfeeding for benefit of mother and baby.”

Neither SC nor the DHO have implemented a full scale STI/HIV/AIDS intervention in Liben. The baseline for this intervention will be the FHI survey, which is currently being carried out in the district. The need for further exploration of sexual beliefs and practices among all the ethnic groups, to fully understand these and to develop appropriate messages and approaches for behavior change, will be addressed through CS-17 formative research.

Findings from focus groups and key informant interviews carried out in 1998 will continue to guide BC plans for the other CS-17 interventions. These include the following key determinants:

- Mothers and caretakers commonly believe that diarrhea is caused by “the will of God” or “by the wind,” and are generally unaware of preventive measures. They are familiar with the signs of dehydration, sometimes interpreting these as an indication that the child is near death, but not something that can be alleviated by action on their part.
- In Somali communities, mothers recognize difficult or fast breathing and chest in-drawing as danger signs, believe that these difficulties are caused by droughts, and traditionally treat them with roots and fruits collected from wild trees. Arsi, Guji, and Borana also believe that pneumonia is caused by the evil eye and is considered as dislocation of bone (locally called ‘*Ceku*’). They treat with massage, spiritual cures, and roots collected from wild trees.
- Malaria (with the exception of cerebral malaria) is not given due attention by parents. Among mothers reporting that their children had “fever” in the prior fortnight, only 30% sought treatment. On the other hand, group interviews confirmed that malaria was recognized as one of the top three illnesses that affected children under five years of age.
- Because of cultural beliefs some tribe members do not eat parts of the meat from a slaughtered animal, and avoid foods like fish and chicken.
- Harmful practices also include; polygamy and pre- and extra-marital sex (locally called ‘*Jaalaf jaaltuu*’) and delays in seeking care from health facilities among people with signs of STI. Individuals and families often hide HIV/AIDS cases so they do not lose their social status in the community. For STI cases, many seek care at private health facilities only as a last resort after treatment from a traditional healer fails.
- Religious barriers against using modern family planning. Children are the “gift of God” and some people consider many children an important factor in maintaining the status of their ethnic group in relation to other groups in the area.

BC/IEC Activities During CS-17

Strengthening BC activities at every level is crucial for achievement of CS-17 objectives. CS-17 will continue the CS-13 approach to behavior change, but with an increased focus on carefully designed IEC materials, and support to health workers to provide consistent clear communication to communities over the life of the project. The first step towards increasing the quality of BC activities will be hiring a BC Officer at the SC EFO level to build internal capacity. S/he will revise the CS-17 BC strategy in collaboration with the SC/Ethiopia Health Advisor, SC/Liben Training Coordinator, Health Coordinator, and health staff, the DHO, and Liben community members. The following is a list of activities that will be guided/conducted by the BC Officer, roughly in chronological order:

- Assessing the information gaps indicated by the 2001 KPC survey, including evaluating current CHW training manuals, IEC materials, and BC messages for their appropriateness to the Liben context, and conducting qualitative research with CHWs and community health workers. The qualitative study will further explore determinant factors that influence behavior change under each intervention, and how to incorporate local language, sayings, and beliefs more effectively into BC materials. The study could be integrated with HIV/AIDS/STI formative research.
- Based on the results of the assessment, revising CHW training/health education manuals so that they are effective for illiterate trainees, utilizing more illustrations and local language, and incorporating existing audio-visual aids (Video films). Exploring existing illiterate materials that are used by other organizations in the country (MOH, World Vision, CRS, & FGAE) that can be adapted and used in Liben situation. Designing locally acceptable and understandable BC materials and/or job aids for CHWs.
- Field testing the revised or newly developed training and IEC materials/CHW job aids before they are produced in large numbers. This process may include knowledge-based pre- and post-tests for CHWs, and observing the CHW educational activities using the new materials with the community, then discussing with the community immediately to evaluate how much correct information they understand and believe, and asking them if they decided to change any behaviors based on BCC.
- Producing the newly developed materials in sufficient quantity to be useful (i.e. BC materials/ CHW job aids sufficient to have at least one per *ketena*).
- As new CS-17 approaches (HIV/AIDS, community-based case management, and new approaches to EPI) are introduced to PAs, SC will provide refresher courses for BHTs, HACs, TBAs, and CBDs in those PAs utilizing the new materials. Trainings will focus especially on the areas where gaps were indicated, such as diarrhea treatment, pregnancy danger signs, and EPI, and on adult education skills. Courses will include a pre- and post-test of trainees' knowledge and a participatory course evaluation to identify unclear areas.
- Strengthening the support and supervision system for CHWs' BC activities by developing supervisory job aids and strategies to reinforce new knowledge and skills on the job. Training MOH/SPAs on health education methodology and how to approach and counsel mothers will increase their motivation and commitment to ensuring the effectiveness of BCC at the community level.
- Strengthening the HMIS so that SC/MOH staff will review reports, analyze, interpret and give timely feedback to CHWs to address gaps in behavior change messages indicated by reports.

HIV: The CS-17 HIV/AIDS intervention will be SC's first substantial HIV-related effort in the district, and will build on limited MOH STI/HIV related activities in Liben. Much of the HIV TA will be provided by members of SC's growing team of Ethiopia, Africa, and U.S.-based HIV specialists. The BC strategy for STI/HIV prevention and care and support will be further developed and implemented through the following activities:

- Formative research to develop BC strategies and materials for the HIV/AIDS/STI intervention, and for the development of training materials and curricula for trainers of community groups, sex workers, and health workers in HIV/AIDS/STI. This research may be integrated with the overall BC assessment.

- Training DHO and health facility staff in HIV/AIDS/STI prevention and syndromic management.
- Expanding BHT and HAC responsibilities to include BC activities on HIV/AIDS/STI. Training CHWs on BCC for HIV/AIDS/STI prevention and care. Developing appropriate BC materials for use in facilities, drug shops, and in communities. Integrating HIV/AIDS/STI prevention messages with EPI, MCH, and Nutrition outreach BC activities.
- Training peer educators from among sex workers, and supporting people living with AIDS to share their experiences with the community. Strengthening HIV/AIDS/STI prevention activities through HIV/AIDS clubs organized in schools and churches.
- Supporting the newly established multi-sectoral District HIV/AIDS Council and promoting multi-sectoral BC activities.
- Strengthening BC activities on condom usage through Community Based Distributors, HACs and BHTs. For the effectiveness of the program, condoms will also be provided through a condom social marketing program, which the SC Ethiopia Field Office is developing in collaboration with DKT/PSI/Ethiopia. Access to condoms will be improved by increasing condom distribution outlets through CBDs and other volunteers, including peer educators.

J. Quality Assurance

Dimensions of quality which will be a focus of CS-17 include:

- Technical performance (the degree to which the tasks carried out by health workers/volunteers meet expectations of technical quality). CS-17 will promote technical performance of TBAs in HB-LSS using methods developed by ACNM. This involves training TBAs using ACNM participatory training methods and materials,⁵⁴ and use of ACNM methods and forms to promote detailed discussion/feedback between trainers/supervisors and TBAs about the care provided by TBAs to individual women. CS-17 will use materials developed by CARE⁵⁵ with support from the U.S. Centers for Disease Control and Prevention (CDC) for training CHWs in Siaya, Kenya in case management of pneumonia, malaria, and diarrhea, which are based on the WHO materials for training CHWs in ARI case management.⁵⁶ CHW training activities will include practice at a health facility in assessment of ill children and counseling of mothers, and viewing and discussion of the WHO ARI case management video. CHWs will be required to successfully pass an assessment of their case management skills before being allowed to treat children in their communities. UNICEF beeping timers or watches with second hands will be provided to all health workers trained in SCM.

⁵⁴ American College of Nurse Midwives, Home Based Life-Saving Skills, Guidelines for Policy Makers and Trainers, Field Testing Draft 5, March 9, 2001.

⁵⁵ Case Management of Childhood Illnesses. Community Health Worker's Guide to Management of the Child Aged 0 – 5 Years with Cough or Difficult Breathing, Diarrhea, and Fever. CARE(K)-CICSS Project. (Charts revised 6/20/2000). Case Management of Childhood Illnesses on Cough or Difficult Breathing, Diarrhea, or Fever. Training Guide for Community Health Workers. (Revised 10/7/98).

⁵⁶ WHO. 1992. Treating Children with a Cough or Difficult Breathing: A Course for Community Health Workers. [http://www.who.int/chd/publicationslications/ari/chw/cough/cou_chw.htm]

- Access to services (the degree to which health services are unrestricted by geographic, economic, social, organizational or linguistic barriers). CS-17 will improve access to selected MCH services through training and support for TBAs in HB-LSS; CHWs in community-based case management of malaria, pneumonia, and diarrhea; and through the introduction of key HIV services.

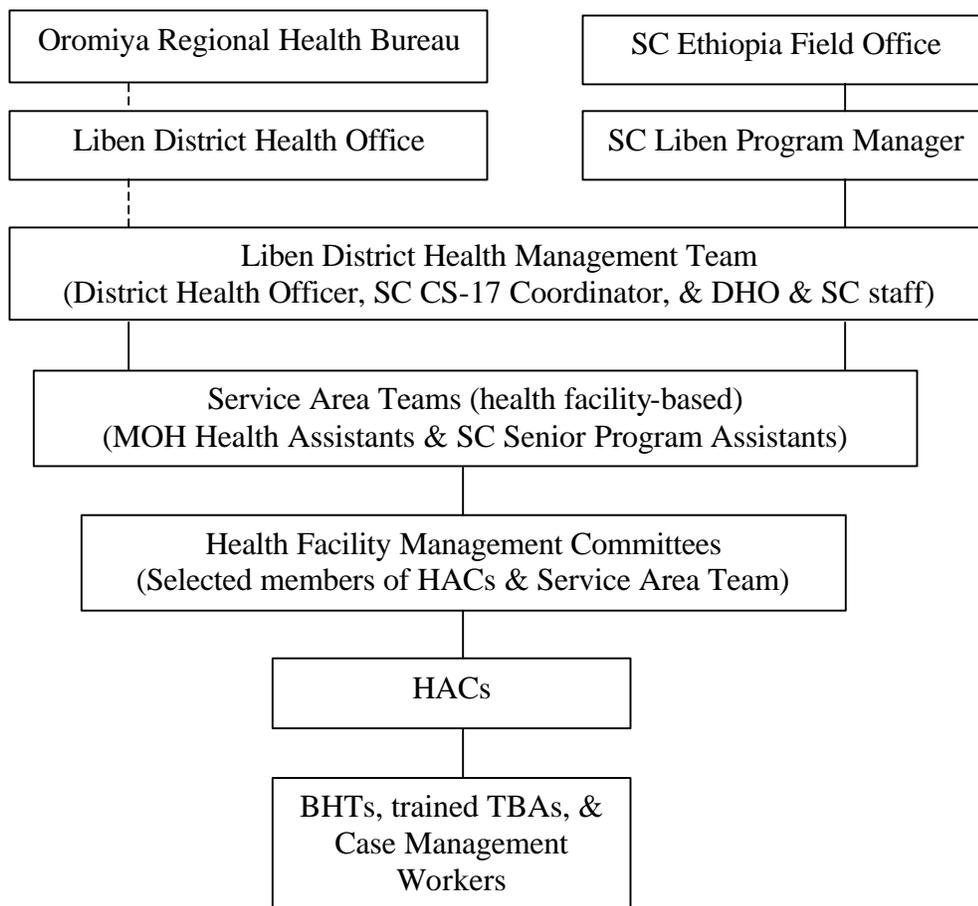
CS-17 will seek the *maximum achievable* level of quality, appropriate to the situation in Liben District, acknowledging both resource limits and the ideal/optimal levels of quality. Standards will be defined through the training materials used (ACNM for LSS, CARE/Kenya for community-based case management). SC staff will monitor key aspects of performance of CS-17-supported organizations, committees, and volunteers through quarterly DHMT meetings, and through regular visits to HACs, BHT members, TBAs, and health facilities. Quarterly supervision and support visits to each PA by SC's Senior Program Assistants and health facility staff will monitor and support: HACs (including review of activities, problems, and plans; and support for and reporting from BHTs and CHWs); TBAs (including review of cases, reports, problems, LSS knowledge); CHWs trained in ARI and malaria case management (including review of cases, reports, problems, and supply of cotrimoxazole and Fansidar, with more frequent visits during the initial pilot. Please see Section III, below). Findings from these regular support visits will help determine topics for future visits, meetings, and refresher training. The EFO's new Assistant Director for Training and Technical Support," will be responsible for quality assurance of SC's health and other programming initiatives.

SECTION II: PROGRAM MANAGEMENT

A. Management Approach

Management Structure (Please see the SC/Ethiopia CS-17 Organizational Structure in Annex 7.)

CS-17 Summary Management Structure



SC's management strategy for CS-17 has been significantly modeled by past experience and the recommendations of the CS-13 and DAP final evaluations. These reports cited the need for increased technical support both in Negelle and from Addis Ababa and a greater level of senior management involvement in program implementation. The key features of our management strategy are:

- An internal and external teaming strategy that brings in-depth knowledge of maternal and child health, Liben District, and extensive Ethiopia-based experience implementing culturally appropriate programs in cooperation with the MOH and communities.
- Key operational partnerships that maximize resources and project impacts.
- A lean organizational configuration with a clear division of functions and a single line-management structure.

- A support structure in Addis Ababa and the United States staffed with personnel experienced in community mobilization, maternal and child health, and HIV/AIDS.
- A commitment to transparent processes and involving frequent dialogue with colleagues and partners.

CS-17 seeks to promote program ownership and prospects for sustainability at the DHO, health facility, and community levels through its approach to program management. The new management structure will increase DHO staff roles in CS project management, as well as ownership of project activities and results.⁵⁷ Sharing of management responsibilities will allow both SC and DHO staff to further develop technical expertise in management, planning, and decision-making, while allowing the staff of both organizations to tap into the local knowledge and expertise gained by staff in both organizations through implementation of CS-13, the DAP, and DHO MCH activities in the district.

CS-17 will be managed at the district-level by the Liben District Health Management Team (DHMT), consisting of the Liben Program Manager (SC), the District Health Officer (DHO), the CS Project Coordinator (SC), the CS Assistant Project/Training Coordinator (SC), the District MCH Coordinator (DHO), the MCH Nurse (SC), the Monitoring and Evaluation Unit Head (SC), and the Finance Manager (SC). Coordination among partners will occur through DHMT meetings and/or quarterly program reviews including key field and management staff from all partners.

At the health facilities level, Service Area Teams, which consist of SC and MOH staff at the facility level, will be responsible for providing support to HAC and BHT members, and to TBAs and CMWs, and working together with selected HAC members in Health Facility Management Committees.

(Please see discussion of responsibilities of SC and the DHO in Section I.F and in Annex 3, and discussion of staff responsibilities in Section II.B, below.)

Support for CS-17 from SC's Home Office

Regular technical and administrative assistance and monitoring of CS-17 from SC's Office of Health in Westport, CT, will include: Review and revision of annual reports, and other technical documents; organization of and participation in mid-term and final evaluations; annual program review and technical assistance visits to the site; support for special activities, including the sub-grant to ACNM and internships in Negelle; technical backstopping through frequent e-mail correspondence encouraging the field office to seek technical materials and guidance from the home office, and prompt responses to queries from Ethiopia; and financial backstopping, including regular monitoring of project budget pipelines and support for sub-grants.

The Office of Health Program Learning Group is the main vehicle for exchange of non-CS-17-specific technical information and updates between the Home Office and Field Office and for sharing of lessons learned. The EFO's Health Advisor participates in annual PLG meetings and will soon be added to the PLG e-mail listserv. In addition, administrative backstopping of the Ethiopia Field Office for CS-17 is also provided by other units at SC's Home Office in Westport, including the Human Resources, Grants Management, and Finance units.

⁵⁷ Compared to the CS-13 project management structure.

B. Human Resources

SC's Office of Health (please see section above for main duties)

- Child Survival Specialist (20% FTE for CS-17), Dr. Eric S. Starbuck: Technical backstopping and guidance (particularly with regard to community-based case management).
- Manager (20%), Ms. Carmen Weder: Financial backstopping, including regular monitoring of project budget pipelines and support for sub-grants

SC Staff Based in Addis Ababa

- Deputy Field Office Director for Programs (25%), Mr. Dennis Walto: The Ethiopia Field Office is currently being led by Mr. Dennis Walto, who is the Acting Field Office Director until the new Director is in place. Prior to his coming to Ethiopia, Mr. Walto served as the Deputy Program Director for the Georgia Assistance Initiative, an \$11 million Umbrella Grant supported by USAID. In this capacity, he was responsible for quality assurance and grants management of sector programming in health, shelter /social infrastructure, agriculture / food security and micro-enterprise, as well as developing a community based emergency response network. Mr. Walto has extensive health-programming experience in the Horn of Africa and since 1992 has managed programs in Burundi, Rwanda, Somalia, and Southern Sudan, in addition to Angola and Namibia. In total, Mr. Walto brings more than 17 years of community development programming experience to the SC and CS-17. With regard to CS-17, Mr. Walto will:
 - Be the primary Senior Management backstop for CS-17 and represent the program to the USAID Mission and in USAID's HPN Unit Meetings;
 - Ensure that program quality of all interventions is meeting SC and industry standards or recommend appropriate actions, including technical assistance to rectify program shortfalls;
 - Together with the DFOD-MS, design and deliver grants management training for project staff and counterparts to strengthen their institutional capacity;
 - Direct quarterly impact area planning meetings to assure activities are on schedule and that benchmarks are being met; and
 - Document and explore both internal and external opportunities to share EFO program best practices and insure impact area cross-fertilization.
- EFO Health Advisor (25%), Dr. Tedbabe Degefie. As the EFO Health Advisor, Dr. Tedbabe brings 15 years of clinical health and three years of public health programming experience to SC and CS-17. Dr. Tedbabe is a Pediatrician with extensive experience in HIV/AIDS, IMCI, EPI, and training of health workers. (Please see CV in Annex 4). With regard to CS-17, Dr. Tedbabe will:
 - Oversee preparation of quarterly work-plans of all CS-17 health staff;
 - Direct technical assistance and coordinate with the M&E Unit to maximize impact area benefit and assure program quality;
 - Direct internal and external technical assistance and contractual needs/inputs to insure program quality;
 - Assess training needs to further develop the skills of project staff, partners, and government counterparts; and
 - Monitor and conduct data verification visits that validate program reporting.

- Care and Support Specialist (10%), to be named: The EFO additionally has added the position of Care and Support Specialist - to be named - who will oversee HIV/AIDS interventions at the community level. This position will balance the medical skills of Dr. Tedbabe with a community-based programming focus. The responsibilities of this position in the EFO include the tasks listed below, which will include CS-17:
 - Provide technical support to HIV/AIDS prevention components of CS-17 including support for improving access and quality of related services (eg. STI and VCT);
 - Design and support implementation of care and support activities with Save the Children staff and local partners. This will include: Home- and community-based palliative care for PLWHA; Systems for community-based management for opportunistic infections, linked with facility-based care and the public health system; Development of a positive living package for HIV+ people who learn their sero-status through HIV testing and development of peer support mechanisms; Establishment of linkages and referral systems with facility based treatment and related preventive services as feasible (HIV/AIDS and TB care, plus FP/RH services, and MCH interventions to reduce risk of MTCT);
 - Coordinate with NACS and MOH to ensure that prevention, care and support activities are consistent with national strategies and guidelines for expanding the reach of programs and services. This will include collaboration with national and regional public health and HIV/AIDS authorities to ensure that there is interest and support for pilot initiatives, and therefore commitment to future expansion and replication based on program learning through CS-17 care and support activities;
 - Develop training and capacity building activities for local partners for supporting home based care, and other elements of the care and support package. Adapt care and support materials use in training community volunteers for home based palliative care and support activities;
 - Coordinate with other technical assistance organizations working in Ethiopia to ensure that program activities meet evolving program standards, and to consolidate capacity building efforts; and
 - Identify indicators and establish monitoring and evaluation systems for evaluating the effectiveness of prevention, care, and support programming.

- BCC Specialist (15%), to be named: An expatriate BCC Specialist who is in the process of transitioning her position to a local hire is currently on the staff of the EFO. The BCC Specialist works primarily on the High Risk Corridor Initiative, but is expected to lead all BCC strategic planning and intervention strategies for the EFO. The BCC Specialist will provide a 15% level of effort in CS-17 to:
 - Work together with the SC and government counterparts in the evaluation of the existing BCC strategies/materials/messages employed by both MOH and NGOs operating in the program area;
 - Develop key messages and appropriate BCC strategies targeting the high-risk groups and behaviors identified through the BSS;
 - Work with the team in documentation of the lessons learned in SC's BCC activities countrywide; and
 - Coordinate the development and field-testing of manuals that will assist implementation of SC's BCC activities, including the expansion of BCC targeting HIV/AIDS/STIs into other areas by the public or private sector, or community groups.

SC Staff Based in Liben District

All SC CS-17 staff are from Oromiya Region, and all are fluent in Oromo. CS-17 staff include members of all of the district's ethnic groups except for ethnic Somalis.⁵⁸

- Liben Program Manager (25%), Mr. Abraham Bongassie: This position is funded primarily through the Title II DAP. The Program Manager supervises all field-based sector coordinators, and is responsible for administration, financial management, and linkages with other sectors.
- Child Survival Project Coordinator (100%), Mr. Tsegaye Sonto, is responsible for the oversight of health activities for SC in Liben District. He supervises SC health staff in the Liben impact area; provides reports for internal and government use on SC health programming in the impact area; facilitates program cooperation with the MOH at all levels; and works with Addis Ababa based SC staff to develop plans for health programming in the Liben impact area. (Please see Mr. Sonto's CV in Annex 4.⁵⁹)
- CS-17 Assistant Project/Training Coordinator (100%), Mr. Worku Tefera: Responsible for assisting the CS Program Coordinator with the overall planning and implementation of CS-17 activities, including monitoring the development of community-based providers; ensuring productive collaboration with the DHO and other local partners; organization and implementation of training activities for all CS interventions; district health planning and management for SC and MOH staff, including materials development; and coordination with partner organizations.
- Maternal and Child Health Nurse (100%): Sister Degefech H/Yesus coordinates maternal and newborn care, and the PCM, malaria, and CDD interventions. She is the focal person for expansion of LSS and HB-LSS training in Liben, and mobilizing the DHO, HF staff, and the community for improved maternal and newborn care. Together with other SC and MOH counterparts, the MCH Nurse's responsibilities include: (1) advocacy for maternal and child health from community to zonal levels; (2) mobilization of women at community level for family health, focusing on maternal and newborn care; (3) inputs for training MOH personnel, community-based providers, BHT members, and CS-17 partners; (4) assistance to develop messages and to test innovative delivery channels (drama, song, etc.); (5) motivating and planning with MOH counterparts; and (6) work with the EPI Unit Head and the Nutrition Unit Head (DAP-funded). SC's CS Project Coordinator supervises the MCH Nurse.
- EPI Unit Head (100%): Mr. Gebre Tola will work closely with the MCH Nurse to support the DHO and health facilities in Liben to maintain the cold-chain, efficient operation of static and outreach immunization activities in coordination with other preventive services, assist with documentation and analysis of reports of immunization activities, mobilization of communities for improved coverage, and provide technical support to NIDs in the district. The EPI Unit Head will provide monthly and quarterly reports to the CS Project Coordinator on immunization activities in Liben.

⁵⁸ Ethnic Somalis represented 8% of the mothers interviewed during the August 2001 KPC survey.

⁵⁹ Concurrence from BHR/PVC for appointment of Mr. Sonto to the post of CS Project Coordinator was received by SC on March 2, 2001.

- HIV/AIDS Unit Head (100%): Mr. Mohamed Mamu. Responsibilities include, together with other SC and MOH counterparts: (1) advocacy for community mobilization for control of HIV and STIs; (2) assistance in training MOH personnel, community-based providers, BHT members, and CS-17 partners in HIV/AIDS/STIs; (3) assistance in developing messages and testing innovative delivery channels (drama, song, etc.); and (4) planning with MOH counterparts.
- HIS/M&E Head (50%): Mr. Adamu Beyene, under the supervision of the Liben Program Manager, the M&E Head is responsible for monitoring and managing health information systems, including entry and analysis of all project-related data, and facilitation of monthly meetings with the HMIS Team. This position is currently 50% funded through CS-17 and 50% under the Title II DAP.
- Community Relations Head (100%): Mr. Godana Jarso is responsible for all aspects of community organizing and community relations, including interface with partners and development of HACs. The position is currently funded through CS-17 and occupied by a person with post-secondary training and significant experience in community organizing.
- Senior Program Assistants (9 at 100%): Mr. Kote Ibrahim, Miss Metawot Negash, Miss Adugna G/ Silassie, Miss Keneni Mekonen, Mr. Chuluka Dolo, Mr. Zeneb G/Tsadik, and three SPAs to be hired, are responsible for implementing and monitoring all project interventions in their respective service areas. Working closely with MOH staff at the clinics, they provide technical and supervisory support to HACs, BHTs, and TBAs, documenting quarterly review sessions with the HACs and the HFMC. SPA are Health Assistants with excellent communication skills, including written and spoken English, and qualifications in nursing and midwifery, or public health. The SPAs are supervised by the Training Coordinator.
- Project Accountant (50%): Mr. Kasshun Gemedu, under the supervision of the Liben Program Manager, is responsible for keeping project books in compliance with SC and donor policies and practices. This position is currently 50% CS-17 and 50% DAP funded.
- Secretary (100%), Miss Abebech Mengesha.
- Drivers (Two at 100% each): Mr. Hassan Legese, and Mr. Melecha Kulla.

MOH Staff and Volunteers

MOH staff and volunteers involved in CS-17 are identified by level of effort and duties below.

MOH and Community Volunteers: Estimated Percent Effort & Principal Roles in CS-17

Number/Organization/Title	Location	Effort	Principal Roles in CS-17
1 Zonal Health Department Head	ZHD, Negelle	5%	Participate in PCM pilot, training, DHO review meetings, DIP preparation
1 ZHD MCH Coordinator	ZHD, Negelle	15%	Participate in PCM pilot, training, DHO review meetings
1 ZHD HIV/AIDS Coordinator	ZHD, Negelle	15%	Participate in TOT, support the DHO in HIV/AIDS
1 District Health Officer	DHO, Negelle	10%	MOH/SC CS-17 Coordination, DIP preparation
2 MOH Statisticians	DHO & ZHD	40%	Entry and analysis of data
3 MOH Physicians	Negelle Hospital	25%	Support, supervise, & train MOH staff, attend review meetings, treat <5s
4 MOH Midwife Nurses	Negelle Hosp.	35%	CS training, CS outreach services
3 MOH Nurses	Negelle Hosp.	30%	CS training, CS outreach services
14 MOH Health Assistants	Hosp. / Clinics	50%	Treat <5s, support HACs & BHTs
7 Community Midwives	Clinics	50%	Provide MNC at health facility, support TBAs
1 District AIDS Council focal person	DAC, Negelle	15%	Participate in TOT, Coordinate HIV activities in the district
Members of 9 community-based organizations	Communities	*30%	Participate in HIV prevention activities and AIDS care and support
Members of 5 anti-AIDS clubs	Negelle & Harakello	*30%	Participate in HIV prevention activities and AIDS care and support
468 HAC Members	Communities	*10%	Support BHTs & TBAs, review & discuss BHT & TBA forms & send to facilities, plan & help conduct health education activities
450 BHT Members	Communities	*20%	Health education, data collection
58 Case Management Workers (many on BHTs)	Communities	*20%	Manage childhood pneumonia, malaria, & diarrhea, refer serious cases to facilities
300 TBAs (many are on BHTs)	Communities	*30%	Provide community-based MNC services

Percent effort in CS-17 for all volunteers (in the last six rows of the table) refers to estimated volunteer time in CS-17 activities, including participation in training programs and meetings, in estimated hours per year divided by 1,800 work hours per year.

CVs of Key Staff and Technical Backstopping

Please see Support for CS-17 from SC's Home Office in Section II.A, above, and CVs of key staff who have joined SC since the CS-17 application was submitted to USAID in December 2000, in Annex 4.

Qualifications and Experience of PVO Staff with Regard to Each Intervention

Dr. Degefie, SC's Health Advisor based in Addis Ababa, is a pediatrician with eleven years of CDD, ARI, malaria, and MNC-related clinical experience and three years of CDD, ARI, malaria, and MNC-related experience teaching nursing students and CHWs. She also has three years of HIV-related clinical experience and one year of HIV-related research and program evaluation experience, and three years of EPI-related experience teaching nursing students and CHWs. Dr. Starbuck, SC's CS Specialist based in Westport, has four years of field experience implementing a published PCM study in Nepal and subsequent experience providing technical guidance in PCM.

Recruitment Issues

SC's Program Manager in Negelle (who oversees all SC supported programs in Liben District) has served in this position since before the start of CS-13. However, over the four-year course of CS-13, four different persons served in the position of Health Coordinator, and the Health Training Coordinator position was vacant for a total of approximately two of the four years. The CS-13 final evaluation concluded that, "a major factor for the turnover seems to be dissatisfaction with the salary given for working in the harsh and remote environment of Liben District."

All senior positions related to CS-17 are currently filled. The Government of Ethiopia has recently instituted a 40% hardship allowance for this area, which the EFO is also applying to SC staff. In addition to this 40% salary increase, SC staff are also receiving salary increases averaging approximately 10%.

C. Contingency and Security Plan

Although there has not been any security incident in the CS-17 impact areas, recurrent drought, tribal conflicts, and car accidents due to bad road conditions are potential security risks. Since 2001, the EFO has developed security procedures and guidelines, which outline potential risks, threats, and security measures for personnel, offices, vehicles, and residential areas. The guidelines describe security measures under normal/ routine circumstances and during emergencies.

Personal Security: Individual staff members need to be responsible and disciplined about observing organizational security measures and competent to the extent that they can make situational judgments and retain the necessary principles of conduct and self-control during moments of crisis. Staff are required to adhere to these guidelines, and to maintain a constant awareness of the prevailing situation. Moreover, each staff member has the responsibility to maintain contact and communications with senior staff when security measures are seen to have been neglected in the area of operation, around the office, or during and after working hours. Staff members should notify their immediate supervisors about where he/she is going and when he/she expects to be back. SC staff should also keep updated on changes in telephone and contact address. It is against SC policy for staff member to carry a weapon unless it is an official part of his/her job. Staff members who decide to have a weapon in their home must be in compliance with the local laws of the duty station. Staffs should respect local curfews. Depending on the local security situation, activities outside working hours should be approved by a senior staff member of SC.

Office Security: The purpose of office security is to deter or stop intrusion, minimize risks of attack, avoid abuse and misuse of agency resources, and protect the agency from theft. All offices are guarded 24 hours a day.

Vehicle Security: Due to rough roads and inaccessible impact areas, car accidents are a potential risk for staff. A vehicle policy is in place, which is being used in all impact areas.

Residence Security: The guidelines also outline precautionary measures for international staff residences.

SC will use local officials and authorities, local intelligentsia, published/unpublished articles and reports, local ‘risk assessors’ (local residents ‘monitor’ the security of their locality). These will include, for example, lorry/taxi-drivers, owners of business, and local traders and merchants. This information is regularly fed to SC’s Program Manager in the area (or his alternate). Telephone, FAX, and radio communication between impact areas and the EFO are the main communication methods.

During emergency phases, security procedures and individual responsibilities are clearly spelled out. The various phases are: One—Precautionary; Two—Restricted Movement; Three—relocation; Four—Program Suspension, and Five—Evacuation. The designated Senior Officer (SO) on duty within an office, an Impact Area Program Manager, or the Field Office Director (FOD) may declare a phase one alert at their discretion.

The Emergency Manager and the FOD/Deputy Field Office Director (DFOD) are responsible for leading the development of the security plan as well as reviewing and updating it. The FOD/DFOD will lead the security management team, declare the various phases of security, lead SC security briefings; guide the review and update of the security policies and procedures of the EFO; and will maintain close communication with SC’s Westport office and Africa Area office in Addis, as well as with government, UN, and other appropriate authorities.

Continuity of CS-17-supported services should threats or crises occur is fostered by CS-17 participatory approaches, the intensity and variety of collaborative efforts in implementing community-level interventions, by empowerment of communities for decision making and strong community ownership of the program, and by SC’s close relationship with government offices and programming.

D. Technical Assistance Plan

CS-17 will require assistance with formative research to develop behavior change strategies and materials, particularly for the STI/HIV/AIDS intervention, and for the development of training materials and curricula for trainers of community groups, sex workers, and health workers in STI/HIV/AIDS interpersonal communication, peer education, and counseling. Much of this TA will be provided by the EFO’s new Behavior Change Officer based in Addis Ababa and by SC’s growing team of Ethiopia, Africa, and U.S.-based HIV specialists. TA for further development and expansion of LSS activities will continue through the American College of Nurse Midwives (ACNM). SC will request technical assistance from ACNM or another suitable agency for review and strengthening of TBA curriculum, possible MNC facilities assessment, and TOT in obstetric first aid. It is hoped that this can be arranged on a cost-sharing basis, perhaps with the participation of other interested PVOs in Ethiopia. CARE/Kenya has provided TA to CS-13/-17 in the form of algorithms and training materials for case management of childhood pneumonia, malaria, and diarrhea at the community level, which are currently being adapted for use in Liben.

SC and MOH staff hope to visit CARE's Siaya project site to learn more from CARE's experience implementing community-based case management.

E. Information Management

Information is exchanged between Office of Health staff based in Westport and Washington, D.C. and Ethiopia Field Office staff mainly using e-mail. The EFO presently has a single e-mail address, requiring EFO administrative staff to print out and pass along hard copies of messages to the EFO Health Advisor and others staff. The EFO is on the Health PLG listserv. According to the EFO, the Health Advisor should have an individual e-mail account by April 2002. She will be on the Health PLG listserv as soon as she has an individual e-mail account. The EFO has access to the internet, but individual technical staff members currently do not have access to the internet at their own work stations. This feature will be added for senior staff, including the Health Advisor, in 2002. The EFO Health Advisor communicates with CS-17 staff during her visits to Negelle and during visits by CS-17 staff to Addis, as well as by phone and fax. Communications between the EFO and SC's office in Negelle remains an important challenge, with frequent breakdown of communication. But SC hopes that this will change with the current renovation of the telecommunication lines, and introduction of e-mail in the near future, which will allow Negelle to dial into the EFO server. All CS-17 staff are fluent in the English language. SC Field Offices exchange information on health programs through meetings in person at the annual meeting of the Health PLG and using the Health PLG listserv.

F. Financial Management

SC is responsible for all financial transactions and budget control, and has a strong financial management system in place. SC/Westport has overall responsibility for the budget, and conducts budget monitoring in collaboration with the EFO finance unit. The EFO has clear written procedures for disbursement and accounting of financial transactions. There is also a clear line of authority for financial payments. The CS-17 PC can only authorize payment up to about \$250 and the PM up to about \$6,250. Amounts above \$6,250 are authorized by the FOD.

Budget requests and advance clearances are done on a monthly basis. The Liben impact area has a computerized system for tracking all expenditures on monthly basis. All requests for activities are based on job registration, which has to be completed at least one month before the advance request is submitted. Funds are transferred to the project's bank account. Monthly financial reports come to EFO, from where reports from all impact areas are collected and sent to Westport, and a consolidated report sent back to the EFO. Budget monitors are prepared monthly by the EFO's Finance Unit in Addis. Copies of the monthly budget monitors are given to the impact area PM. The M&E Unit has the responsibility of crosschecking that the registered job is completed before more money is disbursed for a similar activity by the sector.

The DHO is involved in CS-17 project planning, management, and routine implementation. The DHMT will oversee and plan activities, and will include enough permanent staff to ensure that district capacity is maintained, even when staff turnover occurs. The DHMT will have quarterly review and planning meetings, and budgeting and monitoring meetings with the Liben Program Manager.

G. Logistical Management

This is not a project that requires heavy logistical support. The main logistical support is given to the project by SC's Ethiopia Field Office. Bulk purchase and quarterly office supply requests are submitted to the Field Office's Procurement Officer who is responsible for procurement and delivery of the purchased supplies to project site. As CS-17 is being implemented in complimentary ways with the DAP, activities are coordinated, particularly regarding use of vehicles. Essential supplies such as ORS, vaccines, and drugs are provided by the MOH. The MOH does have its problems in this regard. The MOH HAs report that they are able to replenish their drug supplies on a quarterly basis, but the supply lasts for only about a month. The situation has been severely exacerbated by two things: (1) The MOH budget for drugs at the facility level has been cut in half, while (2) it has notified the public that drugs are to be free. Thus, the demand far outstrips the supply. One of the HAs reports that he adjusts to this in his patient care by giving prescriptions to people that he knows can afford to pay and sending them to the local drug vendors, while saving the drugs he has available for those he knows would not be able to pay. Through regular joint supervisory visits, support will be provided for health workers to reduce the inappropriate use of antibiotics documented in the CS-13 2001 HFA.

H. Monitoring and Evaluation

H. 1. Program Goals and Objectives

CS-17 Goals, Results, Intermediate Results, and Selected End of Program Objectives

Goal 1: Sustained reduction in under-five and maternal **mortality** in Liben District.

Goal 2: CS-17 approaches **inform policy / programming for pastoralist areas of Ethiopia** in Community-IMCI or RH.

R-1: Improved Liben District capacity to effectively support community health services & activities.

- District Health Management Team has met 3 or more times in last year & has used data to plan activities.
- District HIV/AIDS Council meets regularly, plans, & monitors HIV/AIDS activities in Liben.

R-2: Improved community capacity in Liben to effectively address priority health needs of mothers & children under 5.

- 80% of PAs have had 3 or more HAC members participate in 3 or more meetings with MOH staff over the previous year.
- 80% of CMWs trained in pneumonia case management had no stock-out of cotrimoxazole in the previous month.

R-3: Increased use of key health services, & improved MCH **practices** at household level in Liben District.

- 70% of infants have received measles immunization.
- 50% of births attended by trained TBA or health professional.
- 30% of respondents report condom use last time they had sex with non-regular partner.

R-4: Uptake & Sustainability: Adoption of CS-17 approach by MOH or by other organization in other area of Ethiopia.

- MOH or other PVO/NGO in other district of Ethiopia has written plans for implementation of CS-17 approach to C-IMCI, MN/LSS, or BHTs.

IR-1: Increased availability of selected MCH services in Liben District.

- 100% of rural PAs have an MOH facility or CMWs trained through CS-17 in ARI or malaria case management.
- 100% of rural PAs have TBAs trained in HB-LSS.

IR-2: Documented quality of selected community MCH services in Liben.

- CMWs report completing all PCM steps correctly for 80% of children under five assessed for pneumonia.
- TBAs report completing all HB-LSS steps correctly for 50% of mothers/newborns with complications.

IR-3: Increased maternal knowledge in Liben District of selected MCH issues.

- 65% of mothers report either fast breathing or difficult breathing as a sign of child illness needing treatment.
- 50% of mothers report knowledge of at least 2 maternal danger signs during postpartum period.

IR-4: Dissemination of feasibility & results of implementing innovative CS-17 approaches.

Feasibility & results of implementing CB-ARI/malaria case management, HB-LSS/LSS, and/or BHTs, through CS-17, presented at conference, in publication, through media, and/or site visit.

IR-5: Increased SC/Addis & Liben capacity in behavior change & integrated HIV programming.

- EFO Behavior Change Specialist hired (by Oct. 2002) and retained.
- BC strategy for all CS-17 interventions designed & implementation started (by March 2003).
- HIV prevention efforts effectively integrated into ongoing community & government activities through CS-17.

CS-17 Capacity Building Results, Indicators/Sources,
Measurement Methods, Baseline Values, and End of Project Targets by Intervention

Result / IR	#	Indicator ^{indicator source}	Method	Basel.	Target	Interv.
R-1: Improved Liben District capacity to effectively support community health services & activities.	1	District Health Management Team has met 3 or more times in last year & has used data to plan activities. ⁽¹⁾	Minutes MTE & FE	No	By MTE & FE	All
	2	District HIV/AIDS Council meets regularly, plans, & monitors HIV/AIDS activities in Liben.	Final evaluation	No	Yes	HIV
	3a	% of PAs from which three or more HAC members have participated in three or more meetings with MOH staff over the previous year. ⁽¹⁾	Health facility records	NA	80%	All
R-2: Improved community capacity in Liben to effectively address priority health needs of mothers & children under 5.	3b	% of PAs from which three or more HAC members have participated in three or more meetings with MOH staff over the previous year. ⁽¹⁾	Health facility records	NA	80%	All
	4	% of CMWs trained in pneumonia case management with no stock-out of cotrimoxazole in the previous month.	CMW survey	NA	80%	ARI
	5	% of CMWs trained in malaria or pneumonia case management through CS-17 from whom reports were received in past quarter.	Health facility records	NA	80%	ARI Mal.
	6	% of BHTs which in the last 6 months have conducted 1 or more community education activity for each CS-17 intervention & turned in 4 or more monthly reports to HACs. ⁽¹⁾	BHT forms at health facilities	NA	80%	All
	7	% of HACs which in the last 6 months have reviewed BHT, TBA, or CMW reports, & have sent reports to health facility. ⁽¹⁾	BHT forms at health facilities	NA	80%	All
IR-5: Increased SC Addis & Liben capacity in behavior change & integrated HIV programming.	8	EFO Behavior Change Specialist hired and retained.	MTE & FE	No	Oct. 2002	All
	9	BC strategy for all CS-17 interventions designed & implementation started.	MTE & FE	No	March 2003	All
	10	HIV prevention efforts effectively integrated into ongoing community & government activities through CS-17.	MTE & FE	No	Yes	HIV
	11	Number of HIV-related training courses, workshops, & experience sharing visits in which SC/Liben staff have participated during CS-17.	CS-17 records	0	5	HIV

Indicator sources: 1: CS-13; 2: Current DAP; 3: KPC 2000+ CATCH / KPC 2000+; () indicator modified.

CS-17 Results and Indicators Related to Use of Health Services and Health Practices
Measurement Methods, Baseline Values, and End of Project Targets by Intervention

Result / IR	#	Indicator ^{indicator source}	Method	Basel.	Target	Interv.
R-3: Increased use of key health services and improved MCH practices at household level in Liben District.	12	Total rate of treatment for pneumonia in <5s by CMWs in all PAs with CMWs trained in PCM (number of treatments per <5 per year).	CMW Records	NA	0.2 ⁶⁰	ARI
	13	% of respondents reporting condom use last time they had sex with non-regular partner. ⁶¹	FHI survey	NA	30%	HIV
	14	% of respondents reporting condom use every time they had sex with any non-regular partner over past 12 months. ⁶²	FHI survey	NA	20%	HIV
	15	% of births attended by trained TBA or health professional. ^{1,2}	KPC	36%	50%	MNC
	16	% of all mothers of children <2 receiving TT2+ before last child's birth (card). ^{2,3}	KPC	21%	50%	EPI
	17	% of pregnant women receiving TT2+.	DHO	26%	55%	EPI
	18	% of all 12-23 month olds who received measles immunization (by card only). ^{2,3}	KPC	32%	60%	EPI
	19	% of infants who received measles immunization.	DHO	43%	70%	EPI
	20	25% of all 12-23 month olds fully immunized (by card). ^{2,(3)}	KPC	19%	40%	EPI
	21	25% of infants fully immunized.	DHO	34%	60%	EPI
	22	% of children <2 with diarrhea in the past 2 weeks receiving more fluids than usual & same or more food than usual during illness. ⁽³⁾	KPC	8%	50%	CDD

Indicator sources: 1: CS-13; 2: Current DAP; 3: KPC 2000+ CATCH / KPC 2000+; () indicator modified.

⁶⁰ The actual incidence of WHO algorithm positive pneumonia is very difficult to measure accurately, and is likely to vary between sites. The Global Burden of Disease and Injury Series (Murray CJL, Lopez AD. Volume II, Global Health Statistics, Harvard University Press, 1996, Table 105) estimates an average incidence of "lower respiratory infection" of 0.45 episodes per infant/child under five per year in developing countries. The actual incidence of algorithm positive pneumonia in children in Ethiopia is unknown. However, SC believes that an effective community-based case management program in rural Liben District, a very high mortality setting, should achieve rates of treatment of at least 0.2.

⁶¹ "Number of male/female respondents who used a condom the last time they had sex with a non-regular (i.e. non-spousal, non-cohabiting and non-commercial) partner, over number of male/female respondents who have had sex with at least one non-regular partner in the past 12 months."

⁶² Number of male/female respondents who used a condom every time they had sex with any non-regular (i.e. on-spousal, non-cohabiting and non-commercial) partner over the past 12 months, over number of male/female respondents who have had sex with at least one non-spousal, non-cohabiting and non-commercial partner in the past 12 months."

**CS-17 Results and Indicators Related to Uptake, Availability, Quality, and Knowledge
Measurement Methods, Baseline Values, and End of Project Targets by Intervention**

Result / IR	#	Indicator ^{indicator source}	Method	Basel.	Target	Interv.
R-4: Uptake/ Sustainability: Adoption of CS-17 approach by MOH or by other organization.	23	MOH or other PVO/NGO in other district of Ethiopia has written plans for implementation of CS-17 approach to C-IMCI, MN/LSS, or BHTs.	Reports of MOH or other orgs.	No	Yes	All
IR-4: Dissemination of feasibility & results of implementing innovative CS-17 approaches.	24	Feasibility & results of implementing CB-ARI/Mal. case management, MN/LSS, and/or BHTs, through CS-17, presented at conference(s), in publication, through media, and/or site visit.	CS-17 reports, & final eval.	NA	Yes	ARI MNC
IR-1: Increased availability of select MCH services in Liben.	25	% of rural PAs which have an MOH facility or CMW(s) trained through CS-17 in ARI or malaria case management.	CS-17 Records	19%	100%	ARI Mal.
	26	% of rural PAs with TBAs trained in HB-LSS. ⁽¹⁾	“	36%	100%	MNC
IR-2: Documented quality of select community MCH services in Liben District.	27	% of children under five assessed for pneumonia for which CMW reported completing all PCM steps correctly.	CMW report to superv.	NA	80%	ARI
	28	% of mothers/newborns with complications for which TBAs reported completing all HB-LSS steps correctly.	HB-LSS tracking form	NA	50%	MNC
IR-3: Increased maternal knowledge in Liben District of selected MCH issues.	29	% of mothers reporting either fast breathing or difficult breathing as a sign of child illness needing treatment.	KPC	21%	65%	ARI
	30	% of mothers who report knowledge of at least 2 maternal danger signs ⁶³ during the postpartum period. ^{(1),3}	KPC	NA	50%	MNC
	31	% of respondents who identify consistent condom use, mutually monogamy, & abstaining from sex, as methods of reducing risk of HIV. ⁶⁴	FHI survey	NA	50%	HIV
	32	% of respondents who identify 2 or more signs/symptoms of STIs.	FHI survey	NA	25% incr.	HIV

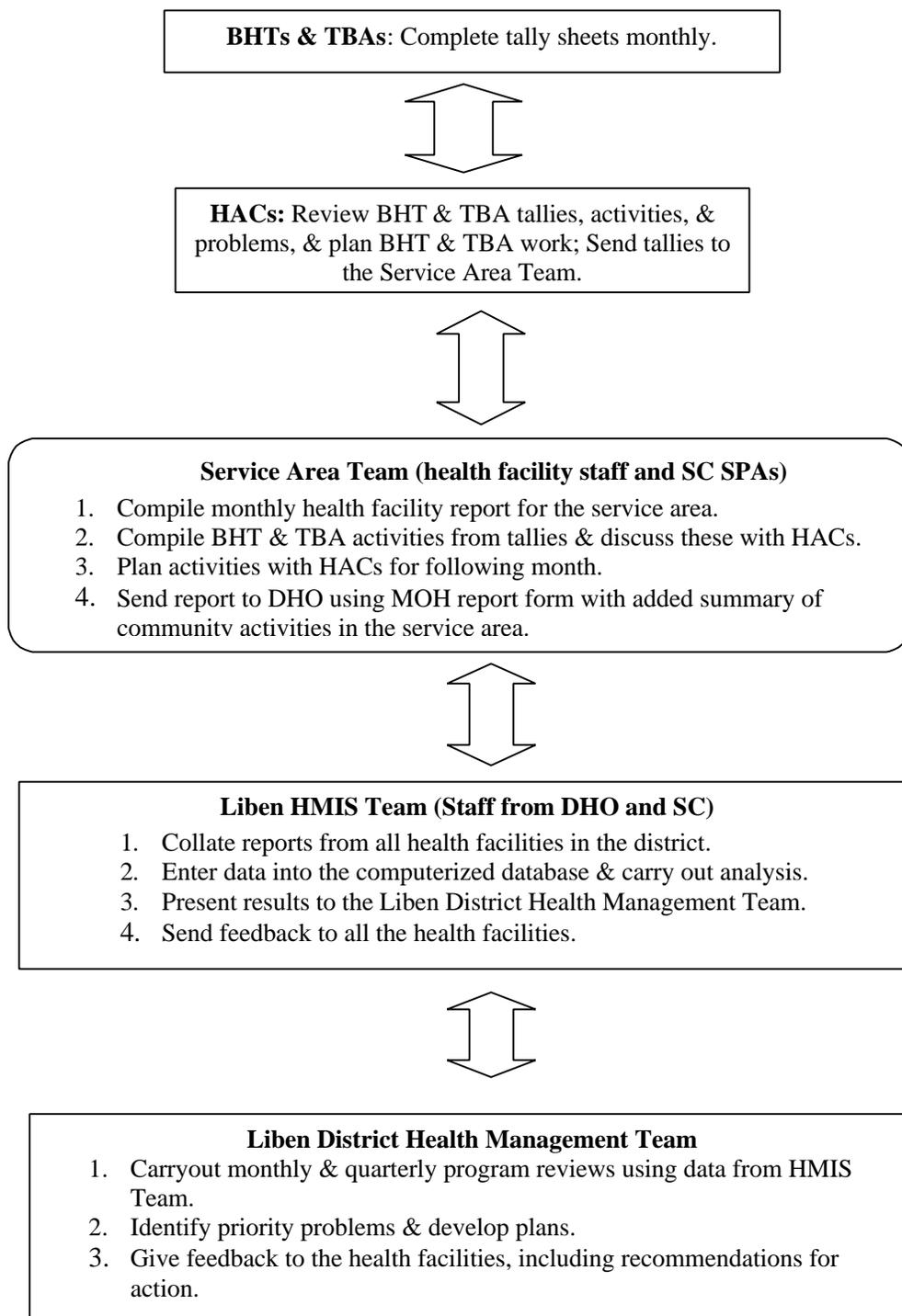
Indicator sources: 1: CS-13; 2: Current DAP; 3: KPC 2000+ CATCH / KPC 2000+; () indicator modified.

⁶³ At least 2 of the following 3 signs: fever, excessive bleeding, smelly vaginal discharge (KPC 2000+ postpartum care module).

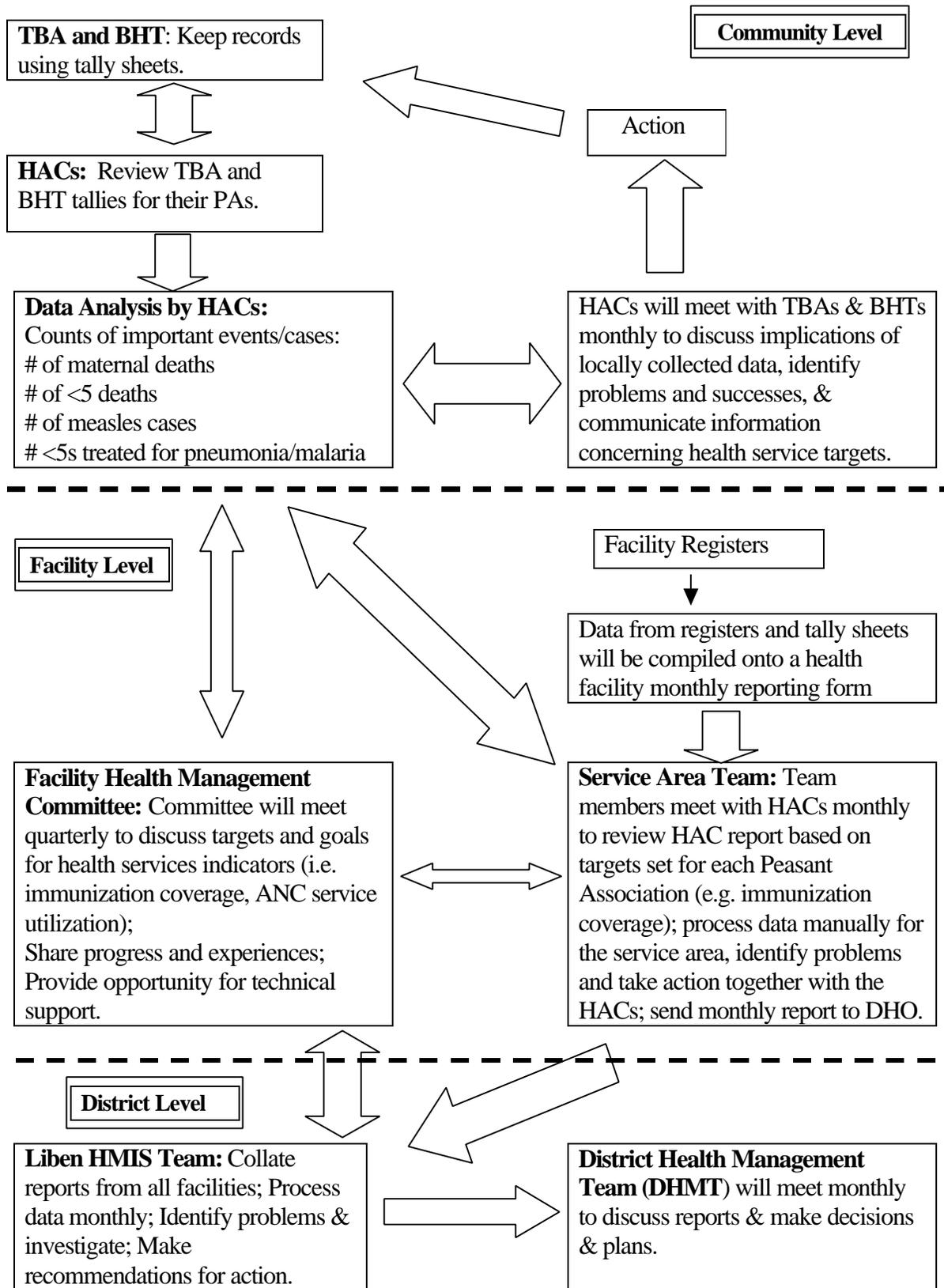
⁶⁴ “Number of male/female respondents able to identify consistent condom use, mutually monogamy between HIV negative partners, and abstaining from sex as methods of reducing the risk of contracting HIV, in response to prompted questions over total number of male/female respondents surveyed.”

H. 2. Program Monitoring and Evaluation Plan

CS-17 Health Information System: Roles and Data Flow



CS-17 Community and Health Services Monitoring



The CS-17 approach to monitoring and evaluation is participatory in nature, involving local partners. MOH Health Assistants, SC SPAs, and HAC members are members of the Facility Health Management Committee which will meet quarterly to discuss targets and goals for health service indicators (i.e. immunization coverage, ANC services utilization); share progress and experiences, and provide an opportunity for technical support. Except for the community level data collection tally sheets, other reporting formats are those used by the MOH, with community-level information added to the MOH facility-level reporting format. Reports come through the MOH system from health facilities to the DHO, not through a separate or parallel channel. Other than routine monitoring tools, CS-17 will have a mid-term and final evaluation, and conduct a KPC survey towards the end of the project.

At the community level, TBAs and BHTs keep records using tally sheets (Please see Annex 7). HACs collect and review the tally sheets for their PAs. The data collected includes counts of important activities performed and events or cases like numbers of maternal deaths, measles cases and under five deaths (to be added to the BT tally), and treatment for pneumonia and malaria (by CMWs). HACs will meet with TBAs and BHTs monthly to discuss implications of the reports, identify and discuss problems and successes. Then the reports are given to the health facility. At the facility level, data from registers and tally sheets will be combined onto a health facility monthly reporting form. Service Area Team members meet with HACs monthly to review HAC report based on targets set for each PA (e.g. immunization coverage); process data manually for the service area, identify problems and take action together with the HACs, and the send report to the DHO.

TBA and BHT tally sheets were developed by CS-13 and will be used for monitoring at the community level. SC has supported the development of computer software for data entry and analysis at the district level through the CS-13 grant, which will be tested for six months beginning in April 2002. However, until this new system is determined to be useful, emphasis will be on manual data collation and analysis. At the end of each month the HMIS team will present its findings to the District Health Management Team.

CS-17 will use data from the following sources to track performance: Forms from HACs, BHTs, trained TBAs, Case Management Workers, supervisory checklists, MOH facility-based records and registers, and midterm and final evaluations.

CS-17 will use the same population estimates as the Liben District Health Office. The 1994 census is used to determine population denominators using estimates of annual population growth rates of 4.11% for urban and 2.23% for rural areas. Women between 15 and 49 years of age are estimated to be 22.9% of the total population, infants 4.4%, and children under five 18.7%. The annual number of live births is estimated from the total population and the crude birth rate of 46.4.

Data from both the community and the facility is reported on a monthly basis, while evaluations will be done about two years into the program and towards the end of the five-year program.

Trained TBAs, Case Management Workers, and BHT members are the front line data collectors at the community level, while MOH Health Assistants and SC Senior Program Assistants collect and collate data at the health facility level. Each trained TBA covers an average of about 73 households, each BHT member covers an average of about 49 households, while each CMW will cover about 284 rural households.⁶⁵ They collect data at the time of service delivery, and thus

⁶⁵ Based on the DHO's total population estimate for the district in 2002 of 138,310, 75% of which is rural,

don't use most of their time for data collection. They also collect data on important events which they hear about, such as cases of measles and maternal deaths, but are not expected to conduct household visits to obtain information.

Both MOH Health Assistants and SC SPAs working in the facilities collect data at the facility level, and aggregate community and facility data for reporting to the DHO. Service Area Teams (MOH Health Assistants and SC SPAs) assure quality of data by meeting with the HACs from the area to review and aggregate data and use it for action.

At health the facility level, for the purpose of maintaining uniformity of reporting instruments throughout Borana Zone, the MOH monthly report form is used unaltered, while a page summarizing the community level data is used in Liben District by the facilities reporting to the DHO. Service Area Teams, composed of MOH and SC staff at each facility, will provide supervisory support to HACs on a monthly basis, reviewing data collection done by the HACs and actions taken by the community. The Service Area Teams will integrate data from the HACs with data from the health facilities and outreach sites. They will calculate key indicators, identify problems, and take action at their level, and compile a report that incorporates problems identified, actions taken, and request for assistance required from the DHO. The Service Area Team will have quarterly meetings with the Health Facility Management Committee (HFMC), consisting of one or two representatives from all the HACs to review performance and plan for the following quarter. Discussions during these meetings may include illustrations of comparative coverage indicators for the different HACs, using the Ethiopian flag (with green, yellow, and red colors, as in Bolivia where SC has found this approach useful). If coverage for a PA falls in the red margin it would illustrate danger, and the team would facilitate investigation of problems and solutions, and provide support to the HAC to bring improvement. Coverage in yellow would be an alert to less than good performance, while green would represent good coverage to be recognized by awards or incentives.

At the DHO level, the HMIS team, consisting of the Liben DHO Statistics Clerk, MCH Coordinator, and Sanitarian, and SC's M&E Coordinator, will be responsible for data entry, initial analysis, and identifying problems. SC has supported the development of computer software for data entry and analysis at the district level through the current CS-13 grant, which will be tested for six months beginning in April 2002. SC's staff and DHO staff will be trained on the use of the data base. However, until this new system is determined to be useful, emphasis will be on manual data collation and analysis. At the end of each month the HMIS team will present its findings to the District Health Management Team. The DHMT will carry out monthly and quarterly program reviews using key health service, morbidity, and management data, identify priority problems and develop plans, give feedback to the health facilities including recommendations for action, and send the report to the Borana Zonal Health Department.

Data is computerized at SC Negelle and Addis levels. After testing new software, this will be done at the DHO level as well.

Quarterly supervisory visits, with observations of sick child management, will provide technical support to monitor and improve health workers performance. The visits will be done using checklist to assess knowledge, skills, practices, and the health facilities supplies, drugs, and equipment. Health workers at the facility levels will also conduct quarterly supervisory visits to

average household size of 6.3, 300 trained TBAs, 450 BHT members, and 58 CMWs.

community-based providers (e.g., TBAs, CHWs) to assist them in carrying out the counseling of caretakers in early detection of signs and symptoms.

CS-17 will use MOH guidelines and training manuals for health facility staff, CARE's training manual and algorithms will be used to train community health workers on community case management. These tools will be used to improve health workers performance. Supervisory checklists will be developed for supervision of community health workers to be used to promote quality of service.

Several approaches will be used to remind health workers of tasks for management of sick children and of key messages. SC, together with the DHO, will develop memory-jogging cards describing case management tasks and key messages to be used by Case Management Workers and BHT members. Supervisory checklists for use by HAs and SPAs when they observe CHWs doing case management or health education will also be used to monitor and improve CHW performance.

The EFO will give support to strengthen the M&E skills of SC and MOH staff responsible for data management. SC has supported the development of computer software for data entry and analysis at the district level through the CS-13 grant, which will be tested. Several staff members will be trained to use the database for data management so that data analysis will not depend on one individual. At the DHO level, the HMIS team, consisting of the Liben DHO Statistics Clerk, MCH Coordinator, and Sanitarian, and SC's M&E Coordinator, will be responsible for data entry, initial analysis, and identifying problems.

The CS-13 HIS has enabled BHTs and TBAs to collect vital data at the community level. While the CS-13 non-literate forms introduced at the community level have been useful for monitoring BHT, TBA, and HAC activities and strengthening HF-community links, revisions had to be made to promote community ownership of the system, and community analysis and utilization for concrete action. The new approach at the community level is designed to make the community-level component more than a mere extension of the facility reporting system. It builds on the current community structure and the non-literate reporting instruments to increase the level of community involvement in data analysis and utilization. The system allows HACs or BHTs to detect, investigate, and respond to important events, such as a case of measles, an increase in cases of diarrhea, or a maternal death. This approach is designed to empower communities to take action, allow communities to be heard at higher levels, and allow them to participate in initiatives of the Service Area Team or the DHO. The methods used in both data collection and analysis are simple and do not need a lot skill and are thus sustainable.

H. 3. Evaluation Plan

CS-17 proposes to conduct a midterm evaluation during the second and third weeks of July 2003, and submit the report of the evaluation to USAID by the end of October 2003, conduct the final KPC survey in May 2006, and conduct the final evaluation starting during the first week of August 2006, and submit the report of the evaluation to USAID by the end of December 2006. CS-17 plans to follow the current guidelines for midterm and final evaluations, issued by BHR/PVC in May 2000.

I. Budget

There have been no changes to the program's site, location, selection of interventions, number of beneficiaries, international training costs, international travel, or the procurement plan that have budget implications, since submission in August 2001 of a revised CS-17 budget (reflecting SC's current indirect cost rate of 16.98%), to the USAID Office of Procurement.

J. Work Plan

This work plan reflects discussion and planning during the CS-17 startup workshops among SC and DHO staff. SC and the DHO regularly uses work plans for project monitoring and follow-up. As part of its quarterly evaluations, SC reviews its activities against those programmed in the work plan. Staff work together to analyze any problems encountered.

CS-17 Work Plan for the Five Year Life of the Project

Activity	Project Year				
	Year 1	Year 2	Year 3	Year 4	Year 5
Procurement of supplies	v				
DIP preparation	v				
Hire Behavior Change Specialist	v				
Hire 3 SPAs	v				
Zonal and DHO level orientation meetings	v				
District level planning meeting	v				
Prepare community-based case management curriculum	v				
Prepare HIV/AIDS/STI curriculum	v				
Revise previous BHT & HAC training curricula	v				
Design Training manuals/ educational materials/teaching aids & field test (with technical assistance from SC/EFO)	v				
1. Immunization (EPI)					
1.1. Ongoing support DHO EPI activities	v	v	v	v	v
1.2. Supply cold chain equipment for 2 health facilities		v			
1.3. Print EPI cards	v	v	v	v	
2. HIV/AIDS/STI					
2.1. Awareness raising					
2.1.1. Health education at HFs, outreach sites, and community gatherings in integrated manner with other activities	v	v	v	v	v
2.1.2. Incorporate HIV/AIDS/STI topics in all training curricula and introduce HIV/AIDS/STI topics in all SC/DAP staff training	v	v	v	v	v
2.2. HIV/AIDS/STI vulnerability reduction					
2.2.1. Promote condom utilization through BCC	v	v	v	v	v
2.2.2. Enhance safe obstetric practice by teaching TBAs & mothers re. birth planning & providing gloves to TBAs through FP intervention	v	v	v	v	v
2.3. Capacity Building					
2.3.1. Build SC HIV BCC capacity	v	v	v	v	v
2.3.2. Build capacity of District HIV/AIDS Council					
2.3.2. Facilitate STI drugs, VCT, condom & glove supply		v	v	v	v
2.3.3. Support CBOs & Anti-AIDS clubs, including training	v	v	v	v	v
2.3.4. IEC materials production/adaptation	v	v	v	v	
3. Maternal & Newborn Care					
3.1 Support MOH ANC activities at static & outreach sites, support & supervision of TBAs	v	v	v	v	v
3.2 IEC materials production/adaptation		v			
4. Training					
4.1 HIV/AIDS/STI					
4.1.1 District HIV/AIDS Council training on program design and seeking grants	v		v		v

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

Activity	Project Year				
	Year 1	Year 2	Year 3	Year 4	Year 5
4.1.2 CBO training on home-based care & support	v	v	v	v	
4.1.3 BHTs and HACs training on HIV/AIDS/STI	v		v		
4.1.4 Peer educators training	v	v	v	v	
4.1.5 Facilitate start up of VCT service	v	v	v	v	
4.1.6 Facilitate STI training of MOH staff		v	v	v	
4.1.7 Facilitate non-formal basic education in collaboration with MOH on HIV/AIDS		v		v	
4.2 Maternal & Newborn care					
4.2.1 LSS training for DHO and HF staff	v		v		
4.2.2 HB-LSS training for HACs/BHTs	v	v			
4.2.3 HB-LSS training for TBAs	v	v	v		
4.2.4 Community Midwives training		v			
4.3 Community Based Case Management					
4.3.1 Training of health facility staff on CB-CM		v	v	v	
4.3.2 CHW case management training		v	v	v	
4.4 Expanded program on Immunization (EPI)					
4.4.1 Modular EPI training of MOH staff & SPAs	v		v		v
4.5 HACs & BHTs					
4.5.1 HAC & BHT refresher training in PAs selected for Community-Based Case Management		v	v	v	
4.6 Other					
4.6.1 District health planning & management training	v		v		v
5. Community-Based Case Management					
5.1 Siaya, Kenya (CARE) site visit	v				
5.2 Develop/acquire training materials/video, job aids/timers, supervision checklist, CMW reporting formats		v	v	v	
5.3 Select CMWs with ZHD malaria office	v				
5.4 Drug supply/RDF		v	v	v	
5.5 Train SC/MOH staff as CMWs trainers & supervisors		v	v	v	
5.7 Train CMWs in case management		v	v	v	
5.8 Refresher training for HACs & BHTs to support CMWs and do health education on recognition/care seeking		v	v	v	
5.9 Follow-up supervision, reporting		v	v	v	

CS-17 Detailed Work Plan for the First Year of the Project

Activity	Month											
	10	11	12	1	2	3	4	5	6	7	8	9
Procurement of supplies							v					
DIP preparation					v							
Hire BC specialist									v			
Hire 3 SPAs										v		
Zonal and DHO level orientation meetings						v						
District level planning meeting						v						
Design PCM/MCM/CDD curriculum						v	v					
Design HIV/AIDS/STI curriculum						v	v					
Revise BHT tally sheet											v	
Revise previous BHT & HAC training curricula						v	v	v				
Design training manuals/ educational materials/teaching aids & field test (with technical assistance from SC/EFO)										v	v	v
1. Immunization (EPI)												
1.1 Ongoing support for DHO immunization activities	v	v	v	v	v	v	v	v	v	v	v	v
1.2. Print EPI cards									v			
2. HIV/AIDS/STI												
2.1. Awareness raising												
2.1.1. Health education at facilities, outreach sites, and community gatherings in integrated manner with other activities						v	v	v	v	v	v	v
2.1.3. Incorporate HIV/AIDS/STI topics in all training curricula and a minimum set of HIV/AIDS/STI topics in SC/DAP staff training						v	v	v				
2.2. HIV/AIDS/STI vulnerability reduction												
2.2.1. Promote condom use through BCC						v	v	v	v	v	v	v

CS-17 Detailed Work Plan for the First Year of the Project (cont.)

Activity	Month											
	10	11	12	1	2	3	4	5	6	7	8	9
2.2.2. Enhance safe obstetric practice by teaching TBAs & mothers re. birth planning and supply gloves through FP/NGO Networks						v	v	v	v	v	v	v
2.3. Capacity Building												
2.3.1 Build SC HIV BCC capacity and support District HIV/AIDS Council												v
2.3.2 Support CBO, Anti-AIDS club, including training						v	v	v	v	v	v	v
2.4 Care and support												
2.4.1. Strengthening CBO through mobilizing local resources and funding organization						v	v	v	v	v	v	v
2.4.2 IEC materials production/adaptation						v	v	v	v	v	v	v
3. Maternal & Newborn Care												
3.1 MOH ANC support at static & outreach sites, follow up support & supervision of TBAs						v	v	v	v	v	v	v
3.2 IEC materials production/adaptation										v		
4. Training												
4.1 HIV/AIDS/STI												
4.1.1 District HIV/AIDS counsel training on program design										v		
4.1.2 CBO training on home based care & support											v	
4.1.3 BHT & HAC training on HIV/AIDS/STI								v				
4.1.4 Peer educators training										v		
4.1.5 MOH staff training on VCT												v
4.2 Maternal & Newborn Care												
4.2.1 LSS training for DHO and HF staff									v			
4.2.2 HB-LSS training for HACs/BHTs									v	v		
4.2.3 HB-LSS training for TBAs											v	v
4.3 Immunization												
4.3.1 Modular training for MOH staff & SPAs										v		
4.4 Community-Based Case Management (PCM/MCM/CDD)												
4.4.1 Prepare training devices, such as video for training											v	
4.4.2 Select CMWs with ZHD malaria office									v			
4.5 District Health planning and Management training											v	

CS-17 Detailed Work Plan for the Second Year of the Project

Activity	Month											
	10	11	12	1	2	3	4	5	6	7	8	9
1. Expanded Program on Immunization (EPI)												
1.1. Support ongoing DHO immunization activities	v	v	v	v	v	v	v	v	v	v	v	v
1.2 Supply cold chain equipment to 2 health facilities	v											
1.3. Print EPI cards	v											
2. HIV/AIDS/STI												
2.1. Awareness raising												
2.1.1. Health Education at HF, outreach sites and community gatherings in integrated manner with other activities	v	v	v	v	v	v	v	v	v	v	v	v
2.1.2. Incorporating HIV/AIDS/STI topics in all training curriculums and a minimum set of HIV/AIDS/STI topics in SC/DAP staff training	v											
2.2. HIV/AIDS/STI vulnerability reduction												
2.2.1 Promotion of condom utilization through BCC	v	v	v	v	v	v	v	v	v	v	v	v
2.2.2. Enhancing safe obstetric practice by teaching TBAs and mothers emphasizing birth planning and supply of gloves through FP intervention	v	v	v	v	v	v	v	v	v	v	v	v
2.3. Capacity Building												
2.3.1. Build HIV BCC capacity and support District HIV/AIDS Council	v	v	v	v	v	v	v	v	v	v	v	v
2.3.2 Support CBO & Anti-AIDS club, including training	v	v	v	v	v	v	v	v	v	v	v	v
2.3.3 IEC materials production/Adaptation	v											
3. Maternal & Newborn Care												
3.1 MOH ANC support at static and outreach sites, follow up support and supervision of TBAs	v	v	v	v	v	v	v	v	v	v	v	v
3.2 IEC materials production	v											
4. Training												
4.1 CBO training on home-based care and support on HIV/AIDS		v	v	v	v	v	v	v	v	v	v	v
4.2 Peer educators training				v								
4.3 MOH staff training on STI syndromic management & counseling		v										
4.4 Non-formal basic education facilitators training on HIV/AIDS			v									
5. Maternal & Newborn care												
5.1 HB-LSS training for HACs & BHTs					v							
5.2 HB-LSS training for TBAs		v										
5.3 Community Midwives training	v	v	v	v	v	v						
6. Community Based Case Management												
6.1 Training of health facility staff in PCM/MCM/CDD			v									
6.2 CHWs case management training				v								

SECTION III:

DETAILED PLANS BY INTERVENTION

A. Integrated Management of Childhood Illness

1. MOH Strategies, Activities, and Training Materials

Please see DIP Annex 8 for selected sections of the following documents:⁶⁶

- Department of Family Health, MOH, *National and Regional IMCI Plan of Action 1994 EFY (2001-2002)*, pages 1 and 3-9.
- Federal Ministry of Health, *Implementation Strategy for the Household and Community Component of Integrated Management of Childhood Illness (IMCI) in Ethiopia. 2001-2004*, pages 1-5 and 16.
- The cover/table of contents and CDD-related pages of the Ethiopia MOH/WHO/UNICEF 35-page chart booklet, *Management of Childhood Illness*, containing outpatient case management algorithms/ protocols for the sick young infant and for the sick child.

Component I: Outpatient case management protocols for the young infant (age one week up to two months) and for the sick child (up to five years) are adapted for Ethiopia (please see Annex 8) from the generic WHO/UNICEF guidelines. Sick newborns are not covered by IMCI, but will be covered through IMPAC (Integrated Management of Pregnancy And Childbirth). Pre-service training in IMCI for students in schools of midwifery, nursing, and medicine, is a strength of the program in Ethiopia.

Component II: Component II includes drug availability and management, IMCI management and supervision, and the information/reporting system (MIS). The MOH is currently developing tools for Component II. Activities will include:

- Ensuring distribution of essential drugs to facilities with IMCI-trained staff and improving drug management at health facilities;
- Improving planning at the national and district levels;
- Improving district-level supervision; and
- Review and revision of the MIS.

Component III: For HH/C-IMCI, “during the initial implementation phase, Ethiopia will emphasize a selected number of WHO/UNICEF generic family practices to complement what is being done in components one and two of IMCI.”⁶⁷

Current Stage of IMCI Implementation and Schedule for the Future: The MOH “has endorsed IMCI as a main strategy to reduce under-five mortality and morbidity and to promote health, growth, and development of children.”⁶⁸ IMCI activities started in three regions (outside of Oromiya Region) in 1998. The pace of IMCI implementation gathered momentum after the

⁶⁶ In keeping with DCHA/PVC guidance to “limit annexes to those essential to understand the program,” the entire contents of these documents have not been included in the DIP, but are available upon request from Tedbabe Degefi at SC’s Ethiopia Field Office, or from Eric Starbuck (phone: 203-221-4151, e-mail: estarbuck@savechildren.org) in Westport.

⁶⁷ Federal Ministry of Health. *Implementation Strategy for the Household and Community Component of Integrated Management of Childhood Illness (IMCI) in Ethiopia. 2001-2004*. (undated document).

⁶⁸ Department of Family Health, MOH. *National and Regional IMCI Plan of Action 1994 EFY (2001-2002)*.

development of the five-year IMCI strategic plan in May 2000. In March 2001, the first national IMCI review and re-planning workshop was conducted, with the participation of all regions, except for Gambella. As of late 2001, 40 health facilities in Ethiopia were implementing IMCI. Implementation of the household and community component of IMCI (HH/C-IMCI) is beginning this year in selected zones of Amhara and Tigray regions. The Family Health Team Leader for Oromiya Region has recently been trained in IMCI, and will soon start overseeing initial implementation of Component I in the region. Implementation of Component III may begin in Liben District as early as 2002/03.

2. Role of CS-17 in IMCI

The MOH officially recognizes a “strong need for optimal involvement of NGOs and the private sector to support the scaling-up of IMCI implementation.” CS-17 will focus on approaches to HH/C-IMCI, including improving household practices related to child health, and increasing use of child health services, such as immunization and care seeking at health facilities for ill children. CS-17 also hopes to introduce community-based case management of childhood illness in Liben District on a pilot basis.

Several intervention studies in developing countries have demonstrated that Community Health Workers (CHWs) can effectively manage non-severe childhood pneumonia using oral antibiotics, and that this approach, endorsed by the World Health Organization in 1988,⁶⁹ can have a substantial impact on all-cause under-five mortality.⁷⁰ The overlap in the clinical presentation and treatment of malaria and pneumonia in children suggests that all health workers involved in case management of malaria also need to assess children for signs of pneumonia and treat pneumonia when indicated.⁷¹ Thus, the staff from the Borana Zonal Health Department, the Liben DHO, and SC, who participated in the September 2000 CS-17 design workshop, concluded that CS-17 would address woefully poor access to case management services in Liben District by training and supporting a limited number of CHWs in case management of non-severe malaria, pneumonia, and diarrhea, on a pilot basis, with Oromiya Regional Health Bureau and central MOH concurrence. SC will continue to seek Federal MOH concurrence for community-based case management of pneumonia, malaria, and diarrhea on a pilot basis.⁷²

⁶⁹ Case Management of Acute Respiratory Infections in Children: Intervention Studies. Report of a Meeting. WHO, 1988 (WHO/ARI/88.2). “The experience in the studies indicates that Community Health Workers can be trained to responsibly dispense antimicrobials for pneumonia according to a simple classification of ARI.”

⁷⁰ Sazawal, S., and R. E. Black. “Meta-Analysis of Intervention Trials on Case-Management of Pneumonia in Community Settings.” *Lancet* (1992; 340): 528–33.

⁷¹ WHO. April 1991. The Overlap in the Clinical Presentation and Treatment of Malaria and Pneumonia in Children: Report of a Meeting. (WHO/ARI/92.23; WHO/MAL/92.1065) [<http://www.who.int/chd/publications/ari/malpnu.htm>]

⁷² The current Liben District Health Officer supports community-based case management of pneumonia, malaria, and diarrhea on a pilot basis through CS-17. The December 2000 letter of support to SC for CS-17 from the Head (at the time) of the Health Programs Department of the Oromiya Regional Health Bureau noted that the RHB “fully supports” CS-17 plans, as described in the original application, including “Pneumonia Case Management (including the pilot implementation of community-level case management).” However, the current Head of the Borana Zonal Health Department notes that the previous Head of the Oromiya RHB Health Programs Department is no longer in this post, and advises SC to seek higher-level support for community-based PCM. The Head of the National IMCI Task Force

SC is currently adapting materials developed by CARE⁷³ with support from the U.S. Centers for Disease Control and Prevention (CDC) for training CHWs in Siaya, Kenya. The Liben CS Team plans to accept the CARE/Kenya invitation to visit the Siaya project site in Siaya. SC hopes to train approximately two literate CHWs per PA in five PAs with particularly poor access to health facilities. Health facility staff and SC Senior Program Assistants (who are all Health Assistants) will be trained in case management, CHW supervision, and intensive monitoring of these pilot activities. MOH and/or SC Health Assistants will meet with CHWs every two weeks to review case management activities, including a detailed review of each child treated for pneumonia with the CHW based on CHW records, and selected visits to households of treated children. Case management skills of trained CHWs will be re-assessed at a health facility during a refresher training/review meeting conducted approximately three months after initial CHW training. (Please also see Sections C, D, and E, below, on CDD, ARI, and malaria.)

A decision to scale-up case management activities through training additional CHWs in Liben District will be based on a thorough review of pilot activities by SC, the DHO, the Borana ZHD, the Oromiya Regional Health Office, and the National IMCI Task Force. SC hopes that CS-17 experience with community-based case management will inform the ongoing development of Community IMCI in Ethiopia through SC's role as a member of the National IMCI Task Force.

CS-17 also hopes to contribute to the development of approaches and materials for IMCI-related "community sensitization" and "IEC." As IMCI components 1 and 2 are introduced in Borana Zone and Liben District, CS-17 will participate in and support the DHO in IMCI-related efforts with health facilities, including planning and management; training; logistics and supply; and supervision, reporting, monitoring, and evaluation. However, the focus of CS-17 IMCI-related activities with health facilities will be on working with facility staff to support case management at community-level. This approach marks a shift away from earlier CS-13 focus on activities to improve the quality of case management at health facilities. This approach by SC and CS-17 to involvement in IMCI is supported by the Head of the National IMCI Task Force.⁷⁴

3. Specific Components of the CS-17 IMCI Strategy

B. Immunization

Negelle Hospital data shows that there was a measles outbreak in FY 2000, with 52 reported cases. In 2001, there were three cases of AFP in the district, with stool specimens sent for two of these cases, but no information received to date on laboratory findings. There were no cases of neonatal tetanus reported in 2001 in the district, though under-reporting is suspected, as access to health facilities is poor, use of MOH health services limited, and the surveillance system weak.

SC had been supporting DHO immunization activities in Liben through the DAP until the start of CS-17. Eight health facilities in the district provide immunization services to mothers, children,

has advised SC that CS-17 should seek a mandate from the MOH at the Federal level before initiating CB-PCM on a pilot basis, and suggests that key MOH staff accompany SC staff on a visit to see community-based case management activities in Siaya District, Kenya.

⁷³ Case Management of Childhood Illnesses. Community Health Worker's Guide to Management of the Child Aged 0 – 5 Years with Cough or Difficult Breathing, Diarrhea, and Fever. CARE(K)-CICSS Project. (Charts revised 6/20/2000). Case Management of Childhood Illnesses on Cough or Difficult Breathing, Diarrhea, or Fever. Training Guide for Community Health Workers. (Revised 10/7/98).

⁷⁴ Dr. Teshome Desta, personal communication, February 21, 2002.

and women of reproductive age. Static EPI services are provided at the hospital on a daily basis, in two clinics weekly, and in five clinics only on a monthly basis. Monthly EPI outreach activities are conducted at 28 sites, though four PAs are not covered by any EPI service due to their inaccessible location.

According to 2001 KPC survey, immunization coverage in Liben District for children 12-23 months was 32% for measles, 28% for DPT3, while 19% were fully vaccinated. Compared with the 1997 survey, there was only a small increase in coverage. But as the surveys based immunization status only on EPI cards, there was likely substantial underestimation of coverage. DHO administrative estimates of coverage are higher (please see table below). The national figures, based on data from immunization cards only, according to the DHS 2000, are 17% for measles, 16% DPT3, and 12% fully vaccinated. The DPT dropout rate is 17% for Liben District, compared to 10% for the country as a whole in the Ethiopia DHS 2000. The CS-13 final evaluation noted problems which may have contributed to continuing low coverage, including physical inaccessibility and poor infrastructure, poorly organized outreach activities, and limited attention to immunization during health education sessions.

Liben DHO Data on EPI Performance in Liben District, FY 2001

Vaccine	# Immunized	Target Group*	Coverage
BCG	4,636	6,127 Infants	76%
DPT3	2,875	“	47%
Measles	2,639	“	43%
Fully Immunized	2,057	“	34%
TT2+	4,689	31,673 Women 15-49	15%
TT2+	1,817	6,916 Pregnant Women	26%

* Based on an estimated total population of 138,310

To increase coverage, CS-17 will implement strategies to (1) increase supply, (2) increase demand, and (3) promote sustainability. To promote sustainable improvements in immunization services and coverage in the least accessible parts of the district, CS-17 will adopt selected elements of WHO's EPI strategy for Sustainable Outreach Service (SOS). SOS aims to deliver tailor-made immunization services on the basis of periodic contact with people who have limited or no access to health services due to their geographical remoteness. It builds on experience from various countries and draws on lessons from polio NIDs, combines the delivery of immunizations with additional interventions, depending on specific needs, and is heavily based on community participation. SOS reaches under-serviced populations, decrease mortality / morbidity, strengthens routine EPI services, and provide other health services. SOS strategies include services integrated into the routine EPI system and periodic NID like campaigns. In Liben, there will be three rounds of immunization sessions per year using all antigens, allowing children to be fully immunized after one year of SOS services. ANC and FP service delivery will be integrated with EPI outreach activities. This strategy will first be piloted for one-year period in the PAs where there are no EPI services. Then after assessing whether the approach is successful in Liben District or not, it will be scaled up to cover more PAs if found successful.

Number of PAs to be Covered by Immunization Strategy & Year

Strategy	Year 1	Year 2	Year 3	Year 4	Year 5
Static	8	10	10	10+ *	10+ *
Outreach	28	22	20	18	16
SOS	4	6	8	10	12

* In the 4th & 5th year, the MOH may construct additional facilities.

To increase demand for immunization services in all areas where EPI is available, more attention will be given to health messages addressing immunization. Community workers will be provided with pictorial teaching aids and trained in their use. Community members will be mobilized for immunization through influential local and religious leaders. CHWs will identify drop-outs in their respective Ollas, Ketenas, and PAs, and counsel family members to use immunization services. HACs will organize a Village Health Day every month to facilitate immunization outreach sessions.

In health facilities where static immunization service is being provided, efforts will be made to gradually increase EPI service provision to a daily basis to reduce missed opportunities. Two new health facilities will be provided with cold chain equipment. Outreach activities will be jointly planned with the DHO and the concerned communities/HACs.

The Service Area Teams will have quarterly meetings with the Health Facility Management Committees (HFMC), consisting of one or two representatives from all the HACs, to review performance and plan for the following quarter. Discussions during these meetings may include illustrations of comparative coverage indicators for the different HACs, using the Ethiopian flag (with green, yellow, and red colors, as in Bolivia where SC has found this approach useful). If coverage for a PA falls in the red margin it would illustrate danger, and the team would facilitate investigation of problems and solutions, and provide support to the HAC to bring improvement. Coverage in yellow would be an alert to less than good performance, while green would represent good coverage to be recognized by awards or incentives.

Some of staff that were trained in EPI through the current DAP have moved out of the district, so EPI training will be given to SC and MOH staff using MOH/UNICEF training modules. The topics include cold chain management, injection safety, and sterile technique. SC and the DHO will plan and conduct joint quarterly supervision visits and give feed back to health facility staff on immunization performance.

Vitamin A

MOH policy is to distribute vitamin A to mothers within six to eight weeks after delivery (such as at the time of BCG), and for children at age nine months with measles immunization. SC has been assured by the MOH EPI Department and by the Oromiya Regional Health Bureau that CS-17 will be supplied with adequate quantities of vitamin A capsules to be given to all infants/children presenting for measles immunization at static, outreach, and SOS sites.⁷⁵

⁷⁵ As SC recognizes that vitamin A supplementation of all 6-59 month olds (and perhaps from a younger age) every four to six months has great potential for substantially reducing under-five mortality, the EFO will pursue opportunities with the MOH to introduce regular supplementation activities in Liben District.

Involvement in Polio Eradication Efforts

SC is participating in the CORE Polio Eradication Initiative along with other CORE-member PVOs in Ethiopia. SC vehicles in Liben District transport SC and DHO staff and vaccine for National Immunization Day activities, and BHTs and HAC mobilize communities for participation in NIDs.⁷⁶

C. Control of Diarrheal Disease

MOH Protocols

Please see DIP Annex 8 for selected pages of the Ethiopia MOH IMCI chart booklet related to the management of acute watery diarrhea, dysentery, and persistent diarrhea in children, recommended home fluids, and policy on the use of vitamin A for children with diarrhea. Although cotrimoxazole remains the recommended first line antibiotic for dysentery in this chart booklet, *Shigella* in Ethiopia is commonly resistant to cotrim, making quick access to Naladixic Acid important.⁷⁷

DAP Water Supply and Sanitation Activities

During FY03-FY07, the new DAP will utilize food-for-work (FFW) labor to establish 25 hand-dug wells (in the four districts), capped with in-country manufactured AFRIDEV[®] hand-pumps to provide households with year-round clean supplies of drinking water. It is estimated that each well will provide drinking water for approximately 250 households per day. Wells will be sited based on findings from a natural resource inventory. Recognizance and communication with the government and other NGOs operating in the target area that may have implemented some water point development activities in the past will also be done to ensure that wells are sited in locations that have not failed in the past and that are appropriately placed relative to other water sources so as to avoid taxing the underground water availability and/or leading to pasture degradation in the immediate area. During FY03-FY06, SC will also replace 21 non-functioning hand pumps that have been installed during previous NGO and/or government funded community development activities.

As a part of all water resource development activities, Water Resource Management Committees will be established and trained to oversee the management and maintenance of local water resources. Communities will be provided with a set of hand tools for pump maintenance and repair and given the organizational and management training needed to establish a Community Managed Savings Plan to cover the costs of well maintenance and repair. This strategy has proven to be a successful method for promoting water resource sustainability during the water resource development activities from FY98-FY01 through the current DAP. In conjunction with all water point development activities, users will be trained in water resource management and appropriate sanitation/hygiene practices using an integrated water program approach. This

⁷⁶ More substantial CORE PEI activities in Ethiopia were planned in 2000 (and SC's Ethiopia Field Office submitted an application in February 2000 for PEI activities), but not implemented due to USAID/Washington funding constraints. Recently, the USAID Mission in Ethiopia has provided funds for limited CORE PEI activities.

⁷⁷ Dr. Teshome Desta, Head, National IMCI Task Force, personal communication, February 21, 2002.

approach divides activities into three components – community ownership and management, technical implementation, and hygiene and sanitation education.

Based on findings from the DAP I Final Evaluation, water interventions have proven to be an effective entry point to spark off complementary development activity. Therefore, CACs will work with WRMCs to train and promote several messages through water activities including, but not limited to: hygiene and sanitation (with help from BHT and HAC members); community savings and reinvestment; community asset creation and maintenance; water point and watershed protection; and appropriate use of natural resources including water and pasture.

CS-17 CDD Intervention

The CS-17 CDD intervention will focus on continuing CS-13 efforts of educating caretakers about prevention and home care for diarrhea through BHT and HAC members, and community-based case management. CHWs involved in malaria and pneumonia case management will assess ill children for the type of diarrhea (acute watery, bloody, and/or persistent) and severity of dehydration, treatment or refer based on the assessment, and counsel caretakers on home care and prevention. A focus of training and supervisory activities will be on improving the skills of CHWs to effectively counsel caretakers about: the early use of fluids available in the home (including milk, yogurt, cereal-based gruels, soups, and water); continued breastfeeding; frequent feeding of small amounts of food; catch-up feeding following recovery; recognition of and prompt care seeking at health facilities for dehydration, dysentery, and persistent diarrhea; and prevention, including hand washing and safe disposal of human feces. CS-17 will attempt to provide CHWs trained in case management with ORS packets for free distribution for children with signs of (non-severe) dehydration or profuse watery diarrhea.

D. Pneumonia Case Management

Current Rate of Treatment of Childhood Pneumonia

Although pneumonia is likely a leading cause of under-five deaths in Liben, as in the rest of Ethiopia, very few cases of childhood pneumonia are being treated by health facilities in the district. (Please see table below.) Based on an approximate expected incidence of between 0.3 and 0.6 algorithm positive (not x-ray positive) episodes per child per year, this suggests that (very roughly) only between 5% and 16% of the expected pneumonia cases among <5's are being treated at MOH health facilities in the district (which is not at all surprising, given the poor access to facilities for much of the population).

Rate of Classification/Treatment of Pneumonia/Severe Pneumonia
In Children Under Age 5 by all MOH Facilities of Liben District

	July 1999 - June 2000	July 2000 - June 2001
Hospital	252	357
All clinics	501	819
Total cases seen	753	1,176
Pop. < 5	25,000	25,000
Treatment Rate	0.03 per <5 per year	0.05 per <5 per year
Expected Incidence ⁷⁸	0.3 – 0.6 per <5 per year	0.3 – 0.6 per <5 per year
Estimated coverage	5% - 10%	8% - 16%

In the 2001 KPC Survey, 9% (33) of the 360 interviewed mothers reported seeking care at MOH health facilities for their child under 24 months of age with cough and fast/difficult breathing in the previous two weeks. Reported care seeking at health facilities for recent episodes of ARI needing assessment doubled during the life of the project, exceeding the CS-13 objective. Among those mothers who reported seeking care, reported use of MOH health facilities increased very substantially from baseline KPC findings, while reported use of private drug vendors decreased very substantially. Among the 36 mothers who reported seeking care for their child with a cough and fast/difficult breathing in the final survey, 33% reported seeking care at a hospital or health center and 58% at a health post, health station, or clinic, while only 3% reported using a drug vendor.

KPC survey findings of high rates of self-reported care seeking at MOH health facilities for children with signs of possible pneumonia during the preceding two weeks are consistent with reported care seeking for childhood diarrhea and for malaria/fever in the same survey. To compare maternal reports of care seeking at facilities with facility information on children seen, the CS-13 final evaluation collected data on the numbers of cases of ARI (excluding ear infections), diarrhea, and malaria or fever in children under 24 months of age from the registers of the Negelle Hospital OPD and four of the district's clinics, for the period from July 3 through July 18 (which approximately covers the two week recall period of the KPC survey):

⁷⁸ The actual incidence of WHO algorithm positive pneumonia is very difficult to measure accurately, and is likely to vary between sites. The Global Burden of Disease and Injury Series (Murray CJL, Lopez AD. Volume II, Global Health Statistics, Harvard University Press, 1996, Table 105) estimates an average incidence of "lower respiratory infection" of 0.45 episodes per infant/child under five years of age per year in developing countries. In most sites with high under-five mortality, the incidence of algorithm positive pneumonia is probably most likely to be in the range of 0.3 to 0.6 episodes per under-five per year.

Children <24 Months Recorded at Five Liben Health Facilities, 7/3-18

Facility	ARI	Diarrhea	Malaria/Fever
Negelle Hospital OPD	20	5	12
Mogayo clinic	13	6	11
Algae clinic *	Very Few	Very Few	Very Few
Jidolla clinic	12	10	8
Harakello clinic	14	18	6
Approx. total cases	59+	39+	37+

* Algae clinic, open for only two days during this period, saw very few cases.

In the KPC survey, 9% (33) of the 360 interviewed mothers reported seeking care at MOH health facilities for their child under 24 months of age with cough and fast/difficult breathing in the previous two weeks. If this were representative of all of Liben District (which 30 cluster KPC random sampling attempts to approximate), then this corresponds to roughly 1,000 mothers reporting having sought care for their child with ARI during a two-week period.⁷⁹ As is the case with KPC surveys in other settings, rates of reported care seeking appear inconsistent with health facility data on the numbers of children seen. In the final KPC survey, 43 mothers reported seeking care at MOH health facilities for diarrhea and 23 for malaria/fever in the previous two weeks, suggesting over-reporting of care seeking for these conditions as well. In the KPC survey, it seems likely that caretakers reported *knowledge* of where to seek care when asked where they should take a sick child, rather than *actual* practice.⁸⁰

CS-17 Pneumonia Intervention

CS-17 Approach to Improving Access to Case Management: CS-17 will continue to support activities introduced through CS-13, but hopes to focus on substantially improving access to pneumonia case management services, initially on a pilot basis in approximately five PAs with poor access to health facilities, by training approximately two literate CHWs per PA in case management.

Quality of Case Management: CS-17 will use materials developed by CARE⁸¹ with support from the U.S. Centers for Disease Control and Prevention (CDC) for training CHWs in Siaya, Kenya in case management of pneumonia and malaria, which are based on the WHO materials for training CHWs in ARI case management.⁸² CHW training activities will include practice at a health facility in assessment of ill children and counseling of mothers, and viewing and

⁷⁹ (138,000 total population) X (8% < 24 months) X (33/360 mothers reporting care seeking at MOH facilities) is a rough approximation.

⁸⁰ This example illustrates the use of data from health facilities/workers to verify/refute KPC Survey findings on self-reported care seeking, rather than the use of KPC data on self-reported care seeking for ARI needing assessment (ANA) to “verify” estimates of pneumonia treatment rates (as the 12/2001 DCHA/PVC DIP guidelines suggest on page 28).

⁸¹ Case Management of Childhood Illnesses. Community Health Worker’s Guide to Management of the Child Aged 0 – 5 Years with Cough or Difficult Breathing, Diarrhea, and Fever. CARE(K)-CICSS Project. (Charts revised 6/20/2000). Case Management of Childhood Illnesses on Cough or Difficult Breathing, Diarrhea, or Fever. Training Guide for Community Health Workers. (Revised 10/7/98).

⁸² WHO. 1992. Treating Children with a Cough or Difficult Breathing: A Course for Community Health Workers. [http://www.who.int/chd/publicationslications/ari/chw/cough/cou_chw.htm]

discussion of the WHO ARI case management video. CHWs will be required to successfully pass an assessment of their case management skills before being allowed to treat children in their communities. UNICEF beeping timers or watches with second hands will be provided to all health workers trained in SCM. CHWs will be trained to treat children with signs of non-severe pneumonia with oral cotrimoxazole. All severe pneumonia, very severe disease, and cases of cotrimoxazole treatment failure, will be referred to health facilities.

Malaria/Pneumonia Overlap: There is substantial *falciparum* resistance to chloroquine in Ethiopia. In southern parts of the country, where 40% of malaria is *plasmodium vivax*, chloroquine should be given along with Fansidar for presumptive malaria.⁸³ The MOH in Ethiopia does not advise using cotrimoxazole alone in children who may have both *falciparum* malaria and pneumonia, recommending the use of both cotrim and Fansidar, as well as chloroquine in areas with *vivax*. SC will work with the National IMCI Task Force to adapt CARE/Siaya algorithms (in which cotrim alone is used) to Ethiopia.

Prompt Care Seeking: Recognition of pneumonia signs and prompt care seeking will continue to be promoted through education of community members by BHTs and HACs. Education will focus on recognition of pneumonia in older infants and children, on recognition of signs in young infants (through messages specifically for pregnant women and mothers of newborns), and on prompt care seeking.

E. Control of Malaria

Malaria Case Management

CS-17 hopes to introduce community-based case management of childhood malaria, along with community-based case management of pneumonia, initially on a pilot basis in five PAs, training approximately two literate CHWs per PA, and using the same training materials adapted from those of CARE/Kenya, as will be used for the pneumonia intervention (please see the description of the pneumonia intervention above). As with pneumonia, CHWs will be trained to treat children with signs of non-severe malaria, and refer all children with signs of severe illness and cases of treatment failure. Monitoring and supervision of CHWs in malaria case management will be integrated with monitoring and supervision of CHWs with regard to ARI case management, and scale-up malaria case management activities through training additional CHWs in Liben District based on a thorough review of pilot malaria and ARI case management activities.

Antenatal Prevention and Treatment

Based on hospital data, there were 1,144 new and 2,461 repeat ANC visits to Negelle Hospital in 2001. The proportion of new attendees with anemia and malaria was 0.1, while for repeat attendees it was 0.04. In 2001, five pregnant women were admitted to the maternity ward for severe malaria and one woman died. Severe anemia was a commonly observed complication of malaria.

Studies in stable malaria transmission areas (with occasional epidemics) of southern Ethiopia show low placental loads of malaria. For this reason, the current MOH policy regarding malaria

⁸³ Dr. Teshome Desta, Head, National IMCI Task Force, personal communication, February 21, 2002.

in pregnancy does not recommend PIT.⁸⁴ At the facility level, diagnosed cases are treated using the standard guidelines, while community health workers are advised to refer malaria in the first trimester of pregnancy, and treat with SP those cases who present in second and third trimesters.

F. Maternal and Newborn Care

Current Services

Birth Attendants in the Program Area: There are approximately 6,400 live births in Liben District every year.⁸⁵ According to the KPC survey conducted in 2001:

- 11% of births in the district were attended by health professionals,
- 25% by CS-13-trained traditional birth attendants,
- 29% by untrained TBAs,
- 17% by family members,
- 10% by neighbors, and
- 8% were unattended (woman herself without assistance).

KPC results from the urban clusters indicate that 47% of births in urban areas are attended by health professionals, while in rural areas only 2% are attended by health professionals. Negelle Hospital conducts approximately 275 deliveries per year. Other facilities in the district conduct very few or no deliveries.

Current Emergency Obstetric Care Capability: Negelle Hospital is the referral site for the rural health facilities in Liben District, some of which are as much as 90 km. from the hospital. The closest higher-level referral site for Negelle is Yirgalem Hospital, which is about 300 km away, seven hours by car. Negelle Hospital has a total of 113 beds, with 22 beds for MCH, 6 for gynecology, and 10 for pediatrics. There is often no lighting for procedures as Negelle often experiences electricity outages, all electricity is cut off from 1 :00 a.m. to 7:00 a.m. every day, and the hospital does not have its own generator. The hospital can provide emergency obstetric care, including limited surgical obstetrics, anesthesia, medical treatment of sepsis and shock, blood transfusion, and labor monitoring, though Negelle currently lacks a Surgeon, and the only physician able to perform cesarean sections will soon leave the hospital.

Program Approach

Curricula and materials for training Liben TBAs in maternal and newborn Home-Based Life-Saving Skills (HB-LSS) and health facility staff in Life-Saving Skills (LSS) were developed for CS-13 with the assistance of the American College of Nurse Midwives. The LSS and HB-LSS training is aimed at equipping facility and community workers with skills which can reduce mortality due to five major causes: hemorrhage, sepsis, unsafe abortions, hypertensive disorders, and obstructed labor. MOH and SC trainers began training TBAs in HB-LSS in 2001.

CS-17 will strengthen maternal and community practices by: education of women, men, other family members, and community “gate-keepers” through trained TBAs, other BHT and HAC members, and health facility/outreach staff. Health facility staff and TBAs will work with pregnant women and their families to develop realistic birth plans, including plans for using

⁸⁴ The MOH plans to disseminate the results of a recent study at a workshop in March 2002, and may modify current guidelines.

⁸⁵ DHO estimate of current total population of 138,310 and CBR of 46.4.

trained birth attendants and contingency plans for obtaining emergency transport, and provide education on pregnancy-related danger signs, including signs during the postpartum period, nutritional requirements during pregnancy, newborn care and immediate and exclusive breastfeeding, and using antenatal outreach and health facility services.

Through HB-LSS the TBA learns in addition to providing care, how to help the families and community members learn how to be involved in providing emergency care for complications. It is a team effort in the community and home. The HB-LSS aim is to equip many persons in each community with emergency skills. For example, HBLSS teaches the pregnant woman, her family, her home caregiver, and the TBA what to do for a postpartum hemorrhage. A trainer teaches the TBA how to recognize and care for postpartum hemorrhage. The TBA, using the illustrated card called Too Much Bleeding After the Baby is Born, comes to agreement with the family members on the signs of hemorrhage and then on the steps for slowing the bleeding, giving shock care, and referring to a skilled provider.

CS-17 will improve access to MNC services through: monthly MOH ANC outreach clinics to selected sites in the service areas of each health facility; 300 TBAs trained in HB-LSS; staff at each facility trained in LSS; and posting of three female Community Midwives at health facilities in the district following their CS-17-supported training at Negelle Junior Nursing School.

CS-17 seeks to establish partnerships and referral relationships between trained TBAs and facility-based skilled birth attendants (such as Community Midwives). SC will also seek to facilitate training for one or two Negelle Hospital physicians in EOC, including cesarean sections, within Ethiopia.⁸⁶

Access from rural communities to rural health facilities in Liben District, and from these facilities to Negelle Hospital, remains a very substantial challenge. In the past, SC in Liben has provided support to the hospital to maintain the district's single ambulance, which is used more to transport patients from Negelle to Yirgalem, than to bring patients to Negelle. SC and DHO staff have considered a number of options over the last several years for improving access to BEOC and EmOC, including district-wide development of alarm and transport schemes involving local transportation methods (such as donkey and camel carts) and use of two-way radios at health facilities to improve ambulance services, but have concluded that these approaches are either infeasible, too costly, or unsustainable. However, through CS-17, SC and health facility staff will work with HACs to identify any feasible local options for emergency transportation, and TBAs will work with pregnant women and their families to develop realistic birth plans, including contingency plans for obtaining emergency transport.

Quality of MNC will be improved through a continuing partnership with ACNM for training of TBAs in HB-LSS for maternal and newborn care, and training health facility staff (nurses, Community Midwives, and MOH Health Assistants) in Life Saving Skills and as HB-LSS trainers/ supervisors.

SC and Negelle Hospital trainers who have been trained in Life Saving Skills by the ACNM will train nurses, midwives, and health assistants at Negelle Hospital in LSS and as HB-LSS trainers of TBAs. ACNM LSS topics include the following:⁸⁷

⁸⁶ MSF offers a six-month course in Ethiopia.

⁸⁷ ACNM. Life-Saving Skills Manual for Policy Makers and Trainers. 1998.

- Module 1: Introduction (maternal mortality/morbidity causes, role of midwife and community).
- Module 2: Antenatal Risk Assessment/Management (anemia, pregnancy induced hypertension, eclampsia, fundal height).
- Module 3: Labor Management using Partograph (monitor, record, interpret, take action).
- Module 4: Episiotomy/Repair of Lacerations (prevent, cut, inspect, give local anesthesia, repair, care).
- Module 5: Prevention/Treatment of Hemorrhage (active management of third stage, manual removal placenta, bimanual compression, inspection with vaginal speculum, digital evacuation).
- Module 6: Resuscitation (immediate care of infant, APGAR, cardiopulmonary resuscitation).
- Module 7: Prevention/Management of Sepsis (universal precautions, prevent and manage infections in mother/newborn).
- Module 8: Hydration/Rehydration (shock care, rehydration methods).
- Module 9: Vacuum Extraction (indications, dangers, procedure).
- Module 10: Labor/Delivery Problems (abnormal position/presentation, uterine inertia, cord prolapse), manual vacuum aspiration (post-abortion care).

These nurses, midwives, and health assistants trained at Negelle Hospital will continue training TBAs in Home-Based LSS, including:

- Basic prevention of anemia and tetanus. Good diet, iron, Vitamin A, tetanus toxoid.
- Clean, safe home delivery and immediate newborn care, good hygiene, hand washing, delivery preparation, clean delivery, prevention of harmful practices, infant care (warm, dry, skin-to-skin, cord care, exclusive breast feeding, eye care).
- Home monitoring during postpartum (monitor uterus and bladder, breast feeding, reduce work load).
- Recognition and initial management and appropriate referral of selected complications such as maternal hemorrhage, infection, prolonged or obstructed labor, and infant resuscitation.

HB-LSS addresses initial management/appropriate referral for all major killers (for the mother: antenatal, postpartum, and post-abortion hemorrhage; infection during pregnancy, postpartum, and post-abortion; obstructed and prolonged labor; pregnancy induced hypertension and convulsions. For the baby: birth asphyxia; premature/small for gestational age; and neonatal sepsis including tetanus.).

The HB-LSS program combines instructional meetings, written materials, and illustrative cards to educate families/TBAs on how to assist women and their newborns. TBAs are trained through respectful negotiation and discussion, taking into consideration traditional practices, to come to agreement on these activities. Why each activity is done is also part of the discussion. The steps in an HB-LSS training meeting include:

- Step 1 *Review the Previous Meeting* to learn if there is any information the participants did not understand or agree with;

- Step 2 *Find Out What the Participants Have Experienced* to learn about the participants' experiences with the problem and what they have done to manage the problem;
- Step 3 *Share What the Trained Health Worker Has Learned* about the problem;
- Step 4 *Come to Agreement About What To Do*, deciding together on safe and acceptable actions to help solve the problem;
- Step 5 *Practice the Agreed Actions* until all participants feel comfortable and competent;
- Step 6 *Determine How You Will Know the Actions are Good* to empower participants to evaluate their own actions; and
- Step 7 *Discuss What We Can Do to Prevent the Problem* to identify realistically feasible and acceptable prevention strategies.

The HB-LSS training is based on teaching picture cards and practical application on the following topics:

- Introduction
- Women and baby problems
- Problem prevention
- Referral
- Too much bleeding
- Sickness with pain and fever
- Birth delay
- Swelling and fits
- Too many children
- Babies trouble breathing at birth
- Baby born too small
- Baby falls sick

TBAs are trained in postpartum and newborn care for the first day, and for forty-eight hours, one week, and one month after delivery. In HB-LSS postpartum training for the family, family care giver, and TBA is divided into:

1. Prevent bleeding too much after baby is born (all six weeks postpartum);
2. Bleeding too much after baby is born (whenever too much bleeding is noted);
3. Prevent problems after baby is born: First actions (first hours after birth); and
4. Prevent problems after baby is born: Other actions (all six weeks postpartum).

1. Prevent bleeding too much after baby is born:

- Rub uterus to monitor and keep it hard;
- Empty bladder;
- Baby to breast soon after birth and every 2-3 hours;
- Drink 1 cup liquids at least each time baby breast feeds and eat at least 4 times a day;
- Rest: no work and no lifting for 12 days;
- Practice LAM and other family planning.

2. Bleeding too much after baby is born:

- Call for help: to help give care, get transport/money for referral if needed;
- Make womb hard: rub womb, nipple stimulation, put baby to breast;

- Empty bladder;
- Rub womb and hold with two hands (external bimanual compression);
- Put a pad FIRMLY between the legs on place that is bleeding;
- Do not put anything in birth canal;
- Referral.

3. Prevent problems after baby is born: First actions:

- As soon as the baby is born: hold and wipe the baby's face. Dry and cover all of baby. Rub baby's back;
- Keep womb hard;
- Tie and cut cord;
- Empty bladder;
- Woman in semi-sitting position, help baby attach to breast as soon as possible;
- Put placenta in waterproof container.

4. Prevent problems after baby is born: Other actions:

- Woman and baby bathe daily, air dry cord stump;
- Pass urine often, wash genitals front to back after passing urine;
- Drink 1 glass liquid at least every time of breast feeding, eat at least 4 times a day;
- No work or lifting for 12 days, baby sleeps with mother;
- Watch for problems and take action as they occur.

HB-LSS supplies are those things available at home or in the community, like a basin, soap, water, cloths of any kind, fluids available in the home, razor blade to cut the cord, and traditional cord tie material. For HB-LSS, the closer to home the supplies are, the more they will be available and used. HB-LSS includes sessions for families to learn what they need to get ready before the baby is born so they have all of these things in place before the birth. CS-13 supplied the TBAs with birthing kits, and CS-17 may re-supply TBAs with gloves (using non-CS-17 funds), but a sustainable re-supply remains a constraint.

TBAs maintain non-literate records of pregnancy outcomes, including referrals and maternal and peri/neonatal deaths. The CS-17 Service Area Teams will review all identified maternal deaths and near-misses with HACs, looking for preventable factors and plan actions to address identified problems. Midwives or other MOH staff, along with SC Senior Program Assistants, will support TBAs at quarterly meetings with HACs (including comparing tallies of deliveries and postnatal visits to population-based expectations). Health facilities will tally visits for ANC and PNC. Project staff and MOH counterparts will conduct quarterly quality of care assessments of all maternal care providers through record reviews, client and/or provider interviews, or direct observation, comparing findings with pre-determined standards of care, using LSS checklists developed in collaboration with ACNM.

SNL: Ethiopia has been designated by SC's global Saving Newborn Lives initiative⁸⁸ as an SNL program learning country. The first SNL team planning visit to Ethiopia is scheduled for June

⁸⁸ Saving Newborn Lives, an initiative led by Save the Children/US, with the support of the Bill & Melinda Gates Foundation, seeks to draw attention and apply resources to the critical need for improved neonatal care. SNL works to promote the adoption of affordable and sustainable interventions in communities and countries where death rates are highest and people have limited access to known, life-saving interventions. In addition, the initiative supports action research to define new and better ways to

2002. SNL will likely partner with the Ministry of Health and UNICEF to support large-scale tetanus toxoid immunization campaign activities in Ethiopia. SNL will help create an innovative communication strategy for the campaign. As SNL develops its activities in Ethiopia over the next year, the initiative may offer other technical support to CS-17 in essential newborn health, which may include:

- Technical review and advice on CS-17 approaches to newborn health;
- Piloting newborn care assessment tools to inform a strategy to promote and maintain household and/or TBA behavior that is essential to newborn health and survival;
- Sharing of relevant research findings, program models, training curricula, and/or behavior change strategies;
- Support in raising awareness of neonatal health priorities within Ethiopia and advice on advocacy approaches;
- Training of SC and/or DHO staff; and
- Inclusion in and/or information about relevant regional networks.

G. STI/HIV/AIDS Prevention

Although no reliable data is available on the status of the HIV/AIDS epidemic in Liben District, there are epidemiological factors indicating the presence and possibly high prevalence of HIV infection in urban and peri-urban parts of the district. Qualitative data gathered by SC indicate that there are high-risk sexual behaviors which facilitate the rapid spread of the epidemic, including polygamy, and pre- and extra-marital sexual relations, *Jalla*, *Jalletu*, and *Kafeno*. *Jalla* and *Jalletu* are extra-marital sexual partners, both for men and women. *Kafeno* is a term that refers to the sexual practices during the rainy season after plenty of milk has been consumed. *Bussa* is when a person is forced by the tribal leaders to take several women as wives, in addition of existing wives. The community accepts these high-risk sexual behaviors. In addition to this, there is low level of awareness, and misconceptions as well as silence and denial, about the epidemic. This is compounded by the fact that there have been only very limited preventive activities to date in the district. There is also considerable population movement for business purposes, which facilitates the spread of the HIV infection. Members of pastoralist communities move between districts to graze their animals. The presence of a large mobile military presence, demobilized soldiers, unemployment, a displaced population, a large number of commercial sex workers, and endemic poverty all facilitate the rapid spread of the epidemic.

The only sero-prevalence data available for the district is from apparently healthy blood donors and suspected HIV cases seen in the hospital. During recent months, the blood of 48% (97/200) of apparently healthy donors at Negelle Hospital in the district center has been screened HIV-positive.⁸⁹ In addition, tuberculosis is the leading reported cause of morbidity and mortality. Unwanted pregnancies, especially among sex workers and student girls with resultant illegal abortion and consequent severe complications are a very common. Delayed treatment seeking for STIs is common. Along with these situations that facilitate the rapid spread of the epidemic among different groups of the population, the District HIV Council is in its infancy, and has been

improve newborn survival. Action research results will inform policies and programs, and successful models will be taken to scale through a network of partners at the local, national, and global levels.

⁸⁹ Based on a test for screening blood, which has very high sensitivity and low specificity (resulting in a high percent of false positives, and thus not a good estimate of the sero-prevalence in the population).

unable to play its leadership/coordinating role due to frequent structural changes and staff transfers.

The Government of Ethiopia's strategic framework for HIV/AIDS⁹⁰ has identified prevention of mother to child transmission (PMTCT) as key a intervention area for implementation of successful programs to prevent the rapid spread of HIV/AIDS. In Ethiopia, 250,000 children under the age of five have already been infected with HIV. However, programs addressing PMTCT are in their infancy. The national policy, with the objective of minimizing vertical transmission of HIV from mother to child involves the following strategies:

- Expand primary prevention measures to protect women of child bearing age from becoming infected with HIV;
- Strengthen FP services in order to enable women to avoid unwanted pregnancy;
- Develop standard policies and guidelines on management of HIV-positive pregnant mothers, including anti-retroviral therapy for PMTCT;
- Improve capacities of public and private health services for PMTCT programs;
- Provide VCT services integrated in ANC and post-natal care;
- Design pilot projects which can be implemented in other parts of the nation;
- Provide support for alternative feeding to breast milk;
- Make anti-retroviral treatment available at affordable price; and
- Link PMTCT with care and support.

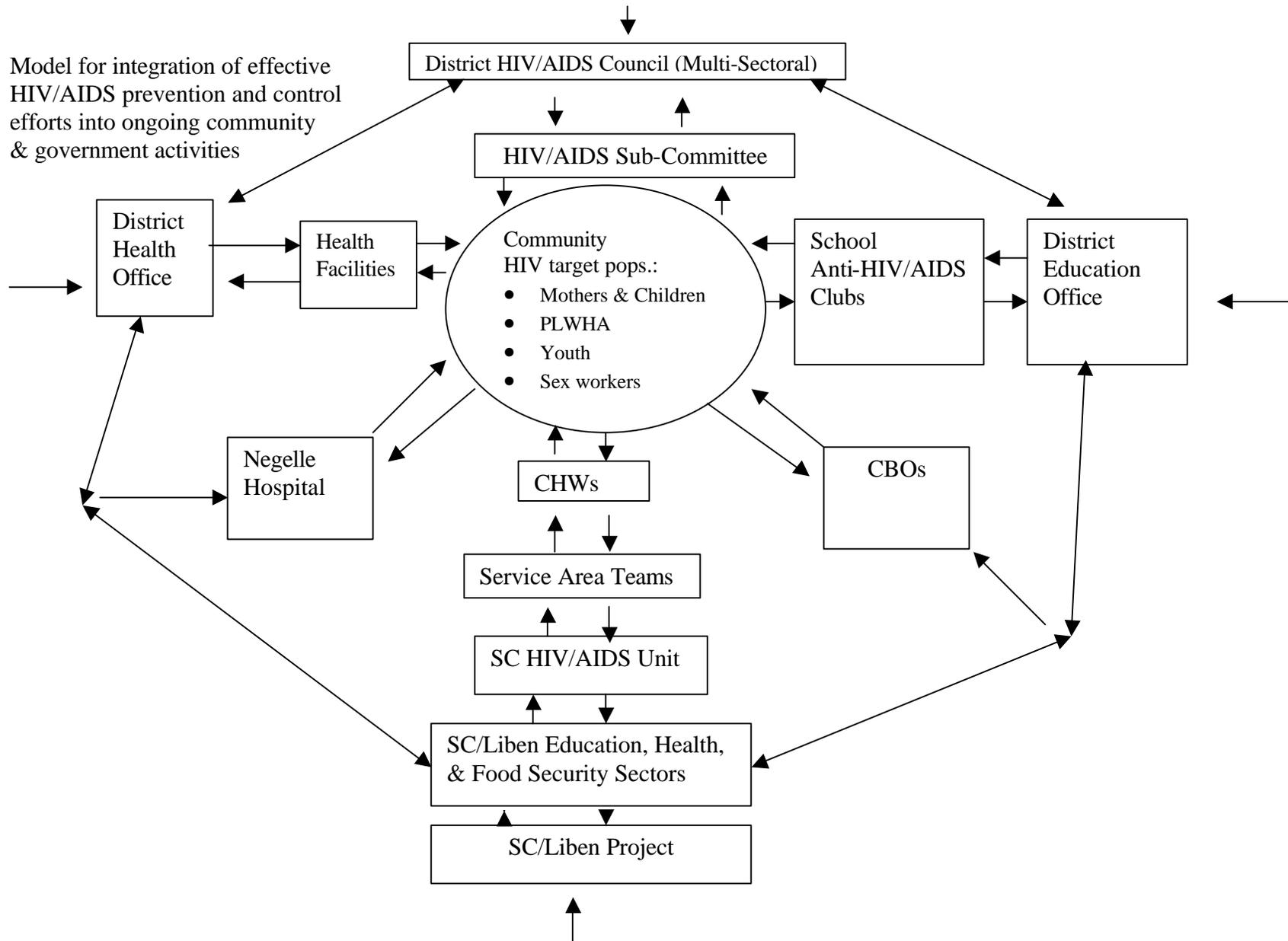
CS-17 will:

- Build the capacity for HIV programming in Liben District, of SC, the District HIV/AIDS Council, and the DHO, through training, experience exchange visits, and joint implementation of HIV activities.
- Focus on strategies to changing the determinants of the HIV risk behaviors among women, youth, and CSWs, identified during the CS-17 planning process, and advocate at the community and national levels to ban specific high-risk sexual behavior prevailing in Liben District (including *jalla*, *jalletu*, and *kafeno*). HIV/AIDS/STI behavior change materials will be collected, adapted, copied, and/or produced; and health facility staff, HACs, BHTs, TBAs, CBDs, and SC education facilitators trained and supported in conducting behavior change activities with target groups.
- Provide technical support to selected CBOs currently active in HIV-related activities in Liben District, such as training in home-based care for the Save Yourself Anti-AIDS Club (which is presently working in AIDS care and support in Liben).
- Seek to facilitate (with technical and financial support from other sources):
 - the establishment of VCT in the district;
 - the supply of condoms to health facilities and CBDs, STI drugs for facilities, and gloves for TBAs; and
 - training of MOH staff and private providers in STI syndromic management.

The chart below identifies important entry points for CS-17 HIV activities and shows the relationships among CS-17 HIV partners.

⁹⁰ Strategic Framework for the National Response to HIV/AIDS in Ethiopia (2001-2005).

Model for integration of effective HIV/AIDS prevention and control efforts into ongoing community & government activities



SECTION IV: ANNEXES

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Annex 1. Response to Final Evaluation Recommendations

Copies of the CS-13 final evaluation were distributed, and findings, conclusions, and recommendations presented and discussed in detail, during the CS-17 DIP workshop in Negelle. Final evaluation recommendations¹ appear in italics, with information on how these recommendations are being addressed below.

1. *“The availability of key program supports (essential drugs, delivery kits, for example) should be reviewed with MOH counterparts, and strategies for improving availability developed.”*

These issues were discussed among SC and DHO staff during the February 2002 DIP workshop in Negelle, and will likely be a continuing focus of CS-17 and DHMT efforts. Although HB-LSS makes use of supplies available in homes and communities (please see Section III.F), re-supply of gloves for TBAs is a particularly strong felt need among both trained TBAs and CS-17 staff. EFO staff have learned that funds from the NGO Networks for Health project may be used to purchase gloves, though re-supply remains a problem. Antimicrobials for community-based case management of childhood malaria and pneumonia will be re-supplied through a revolving drug fund modeled on the current successful DAP-supported animal health RDFs.

2. *“The technical quality of training, health education, supervision, immunization outreach needs to be reviewed and modified to ensure that it is consistent with technical standards and tailored to address common barriers to behavior change. Some additional data may be required in order to identify why some health behaviors have not changed, why outreach activities (for example immunization) are not reaching communities, and constraints on changing the practices of facility-based health workers.”*

The EFO is currently in the process of substantially increasing its capacity to provide technical and administrative support to CS-17, with four senior Addis Ababa-based staff, including a new BCC Specialist, each devoting from 10% to 25% effort to CS-17 support (as described in Section II.B). Plans for improving project performance in behavior change are described in Section I.I, on “BC/IEC Activities During CS-17.”

3. *“The HMIS system also needs to be reviewed and a number of elements strengthened, particularly the analysis and use of data for making program decisions.”*

This will be a focus of the DHMT. Plans for improving the analysis and use of data for making program decisions are discussed in Section II.H.

4. *“More nutrition messages could be included in routine household and community education. In particular, nutrition needs to be better integrated into routine community-based activities.”*

Nutrition activities have been, and will continue to be, a focus of the DAP/PLI, rather than CS-13/-17. Plans for the more effective integration of substantially revised nutrition activities into

¹ From the Conclusions and Recommendations section, pages 56-60, of the report of the final evaluation of CS-13.

community-based activities through the PLI are discussed in Section I.F (in the sub-sections on CS-17 synergies and nutrition).

5. *“Little work has been done on improving the quality of referral - this will be essential to reducing mortality in the long term. A number of options might be considered, including the use of local transportation (such as donkeys and camels), improved ambulance services to health stations from the district, and the development of community funds for transportation. In addition, there may be a role for community-based case-management for childhood pneumonia and malaria - community health workers can be trained to assess and classify children with fever and fast or difficult breathing, and then to give Cotrimoxazole or Fansidar, if necessary. This approach requires close supervision to observe and reinforce practices - and a sustainable mechanism for supplying essential drugs to CHWs. Community-based standard case management must be consistent with national policies on the use of antimicrobials by community health workers.”*

Access from rural communities to rural health facilities in Liben District, and from these facilities to Negelle Hospital, remains a very substantial challenge. In the past, SC in Liben has provided support to the hospital to maintain the district’s single ambulance. Though options for improving referral and transportation, including district-wide development of alarm and transport schemes involving local transportation methods (such as donkey and camel carts) and use of two-way radios at health facilities to improve ambulance services, were a subject of substantial debate in Negelle following the final evaluation, SC and DHO staff have concluded that these approaches are either infeasible, too costly, or unsustainable. However, through CS-17, SC and health facility staff will work with HACs to identify any feasible local options for emergency transportation, and TBAs will work with pregnant women and their families to develop realistic birth plans, including contingency plans for obtaining emergency transport. CS-17 plans to implement community-based case management of childhood malaria, pneumonia, and diarrhea, initially on a pilot basis, following central MOH approval (as described in Section III.A).

6. *“A number of approaches could be considered to strengthen district capacity including: more involvement of key district staff in project planning and management; more involvement of district staff in routine implementation; formation of a DHMT to oversee and plan activities, and with enough permanent staff to ensure that district capacity is maintained even when staff turnover occurs. In addition, district staff should be engaged in the process of identifying local and other partners for the support of activities in the long term.”*

CS-17 is attempting to implement these recommendations, including re-activating the DHMT with broader DHO representation, as described in several sections of the DIP.

7. *“Staff turnover in key positions (particularly the health coordinator and the training coordinator) has compromised the quality of field activities. Strategies for reducing staff turnover should be carefully and seriously considered including; improving local benefits; and improving outside training and other incentives. In addition, the availability of technical support to staff in Negelle has been erratic. Local staff should have regular and direct technical support - the technical advisor should visit the Negelle office for at least a month each quarter -*

staff in Negelle should have direct access to the technical supervisor whenever they feel it is necessary.”

SC’s Program Manager in Negelle (who oversees all SC supported programs in Liben District) has served in this position since before the start of CS-13. However, over the four-year course of CS-13, four different persons served in the position of Health Coordinator, and the Health Training Coordinator position was vacant for a total of approximately two of the four years. The CS-13 final evaluation concluded that, “a major factor for the turnover seems to be dissatisfaction with the salary given for working in the harsh and remote environment of Liben District.” All senior positions related to CS-17 are currently filled. The Government of Ethiopia has recently instituted a 40% hardship allowance for this area, which the EFO is also applying to SC staff. In addition to this 40% salary increase, SC staff are also receiving salary increases averaging approximately 10%. The EFO is also substantially increasing its capacity to provide technical and administrative support to CS-17, with four senior Addis Ababa-based staff each devoting from 10% to 25% effort to CS-17 support (as described in Section II.B). The Deputy Field Office Director for Programs and the EFO’s Health Advisor will each support CS-17 at a 25% level of effort, with a substantial proportion of this time spent in Negelle.

8. *“The CS-17 grant will need to investigate approaches to improving the sustainability of: vaccination outreach services (and antenatal care outreach); supplementary feeding outreach; facility-based SPAs (funded by SC). While it is recognized that external resources will be required for some time to support these activities, approaches to ensuring their sustainability could include; identifying alternative sources of funding for vaccination outreach and staff salaries (local NGOs, MOH sources, other donors); and integrating nutrition activities into the community-based program (for example, strategies for improving home feeding practices and other locally available options for improving the calorie intake of young children could be considered as part of routine BHT and HAC activities).”*

Sustainable approaches to immunization outreach services was a focus of discussion during the CS-17 DIP workshop, which included a presentation of WHO’s EPI strategy for Sustainable Outreach Service (SOS). To promote sustainable improvements in immunization services and coverage in the least accessible parts of the district, CS-17 will adopt selected elements of SOS, integrating ANC and FP outreach services with EPI outreach. This strategy will first be piloted in the PAs where there are no EPI services (please see section III.B). Supplementary feeding outreach is not sustainable. SC’s rationale and plans for a new approach to supplementary feeding, including phase-out after three years, and for integrating nutrition education into ongoing community-based activities, are described in Section I.F (CS-17 synergies, nutrition). The posting of SC SPAs at health facilities is not designed to be sustainable. Through CS-17, the SPAs will focus on building community capacity to address key MCH needs and facility capacity to support these community activities on a less intensive scale following the withdrawal of SC staff and improvements in community capacity. SC is helping to build the capacity of facility-based health services in Liben District in a sustainable way by constructing, equipping, and supplying new facilities (through the DAP) which are then taken over and staffed by the DHO, by training local women as Community Midwives who are then posted to local facilities and paid by the DHO, and through joint efforts to build DHO capacity to support health facilities in the district. The identification of alternate sources of funding is addressed in Section I.H.

Annex 2. Report of Baseline Assessments

- (A) CS-17 HIV/AIDS Situation Analysis: Please see the summary of this assessment in DIP Section I.E and the full report of the assessment below.
- (B) CS-17 HIV Behavioral Surveillance Survey: Please see the summary of methods for this ongoing assessment in DIP Section I.E.²
- (C) Institutional Strength Assessment of SC's Home Office Backstopping of CS Grants: Please see the summary of this assessment in DIP Section I.E.³
- (D) Organizational Capacity Assessment of SC's Ethiopia Field Office and the Liben DHO: Please see the draft terms of reference for this assessment below.
- (E) Knowledge, Practices, and Coverage Survey: Please see the summary of this assessment in DIP Section I.E, and the summary report of the assessment, including a copy of the interview questionnaire, below.

² In keeping with DCHA/PVC guidance to “limit annexes to those essential to understand the program,” the BSS tools have not been included in the DIP, but are available upon request from Tedbabe Degefi at SC’s Ethiopia Field Office.

³ In keeping with DCHA/PVC guidance to “limit annexes to those essential to understand the program,” the tools used for this assessment have not been included in the DIP, as they are very similar to the generic questionnaires developed by CSTS, but are available upon request from Eric Starbuck (phone: 203-221-4151, e-mail: estarbuck@savechildren.org) in Westport.

(A) CS-17 HIV/AIDS Situation Analysis
(From: Report on Incorporating HIV/AIDS Interventions into CS-17)
SC/Negelle, February 18, 2002

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Background

Globally, Ethiopia has the 16th highest HIV/AIDS prevalence of any country and the third largest number of people living with HIV/AIDS (PLWHA). One of every 11 people living with HIV/AIDS in the world is Ethiopian. National adult prevalence is estimated to be 7.3% (Ministry of Health 2000). Adult prevalence in Addis Ababa is estimated to be 16.8%, other urban adult prevalence is 13.4% and rural adult prevalence is 5%. Life expectancy is already falling and the epidemic is systemically undermining the country's effort to reduce poverty, especially its investment in health education and rural development.

The impact of HIV/AIDS in Ethiopia has been devastating. Already, an estimated 2.9 million Ethiopian adults and 250,000 children are living with HIV/AIDS, more than in any other country except South Africa and India. Approximately 750,000 Ethiopian children are estimated to have been orphaned by AIDS. In urban areas, AIDS patients occupy half of the hospital beds. About 90% of reported cases of AIDS are between the ages of 20 and 49, the most important years from both an economic and parenting standpoint. Among this group, AIDS is now the leading cause of death. Stigma, fear, and denial are still common.

HIV/AIDS Situation Analysis/Assessment

A number of factors that facilitate the spread of HIV/AIDS have been identified during the planning process through focus group discussions and contacts made with rural elders, traditional death society members, commercial sex workers, women from urban and rural areas, the district

HIV/AIDS council, an anti AIDS club focal person, and the head of the district health office and medical director of district hospital. In addition, the team visited the district hospital and collected various reports.

Focus group discussions were held with **male elders** from 60-76 years old, from the Borena ethnic group. The team tried to find out the risk perception, if any prevention activities are undertaken, and if (what) some sort of community coping mechanisms during stress traditionally exist. The following questions were raised:

- Do you know about HIV/AIDS virus and its mode of transmission?
- Do you think the virus exists among this community?
- What are the sexual practices of this particular community and harmful traditions that you think may contribute to the transmission of the virus?
- Is forced marriage for girls common among the community?
- Are condoms accessible? Are condoms used in the community and if so, who is using them?
- Are there any social support mechanisms in the community that help the family during death, accident and sickness?

Based on the response of the participants, they did not know about mother-to-child transmission of HIV, however, they did know about other modes of transmission. High levels of pre-marital and extra marital sexual practices among both sexes and the incidence of rape by soldiers were stated as sexual practices in the area. Tonsillectomy, gum extraction and scrubbing of throats on children were cited as harmful traditional practices. No forced marriage is practiced.

The elders believed that the virus exists in the community due to the high-risk practices and suspected cases of AIDS deaths in the villages. Concerning preventive activities, awareness creation activities have been carried out by SCF-USA in the target community for two years although they are not officially integrated into the CS-13 or DAP projects. Furthermore, condoms are made available through SCF/NGO network and the DHO through community based distributors. Demand for condoms and their use increased in the rural areas among youth, but it is hardly used among men and women. One community member said that condoms encourage sex, while unsafe sex is highly practiced in the area. There is a traditional community social support system to assist members of the tribe affected by accidents, death, illness, or looting. All tribe members who can are obliged to support the victim and the family. This support system is called **Bussa Gonofa** in local language.

Currently, the community is involved in identifying orphans to prepare the orphans profile of the respective village as per the request from kebele/Pastoralist Association (PA) HIV/AIDS sub committees.

A focus group discussion was also held with **eight rural women** from Oromo and Somali ethnic groups, who were between 25–40 years old. The purpose of the discussion was to know whether they know about HIV/AIDS and its transmission, STIs, sexual practices, harmful traditional practices existing in the community that enhance the spread of HIV, treatment seeking behavior for STIs and knowledge about condoms.

Questions raised during discussion were:

- Do you know about HIV/AIDS and how it is transmitted?

- Do you know about STIs?
- What types of STIs?
- Do people seek treatment for STIs?
- Where do people seek treatment for STIs?
- Do you know about condoms?
- Are there suspected deaths of AIDS patients in the community?

The participants responded that they all know about HIV/AIDS and came to know as the result of the health education given to them by the TBAs from SCF-US. They know about transmission via sexual relations but did not know about mother-to-child transmission and HIV transmission through blood transfusions. Traditional sexual practices are invisible in the area, but polygamy is common. Incidence of rape has increased recently. They also said that it is hard to tell what men are doing outside their home. Traditional practices (tonsillectomy and tooth extraction) are practiced in the community. Concerning STIs they said that they know many people are sick from STIs (specifically Gonorrhoea and Syphilis). In the rural areas people seek treatment from the traditional healers and a few of them come to health facilities as a last resort. All of them know about condoms but only three of them have seen one.

Regarding suspected deaths of AIDS in the community, they observed three deaths that occurred after a long time of illness. Three deaths occurred in one family: the husband, wife, and youngest child. They manifested tremendous weight loss, chronic diarrhoea and skin infection. They left four orphans behind.

Problems:

Lack of awareness about the virus

It is hard for women to tell what their husbands are doing outside their home

Recommendation:

Ongoing education about the virus

Focus group were held with traditional death societies leaders and included 12 people aged 40-75 years who came from five kebeles of Negelle town. The following questions were raised during the discussion to learn about the risk perception, if any prevention activities are undertaken and whether they are feeling the impact of the disease. The following questions were raised:

- Do you know about HIV/AIDS and how it's transmitted?
- Do you think that it exists in the community? Why?
- Are there significant changes in the trends of deaths among the members and their families?
- What problems is the Idir facing as the result?
- Do you know the cause of death of the members?

They respond that they know about the HIV virus by getting information through various sources (media, orientation workshop by the district HIV/AIDS council and SCF-USA). The HIV virus exists in the community, and the members stated that they usually hear and see that the causes of death are tuberculosis, pneumonia and chronic diarrhoea, which failed to respond to treatment. Moreover, they observe the dead body with skin infections (multiple ulcers) and tremendous weight loss (almost skin and bone) while preparing the body for burial. The death rate has

increased among members and their families, and the Idir are sometimes forced to contribute from their pockets to help the families pay for the burial. As a result, they reviewed their rules and decided to minimize the payments for an extended family member's death that occurred somewhere else (Merdo) to cope with the stress. In the year 1993 (Ethiopian Calendar, Sep. 11, 2000 – Sep. 10, 2001, AD) in four Idir a total of 68 (41 Female and 27 male) members aged from 15-50 died. In 1994 (EC), with in six months 24 (11 Female and 13 Male) died. One of the Idir didn't give a death report.

Problems Encountered by the Participants:

- The practice of hiding the sero-status of the individuals by health professionals and its effect on putting members of the family and others at risk.
- Lack of levels of awareness of HIV/AIDS.
- Elders are forced to take care of their double-orphaned grandchildren.
- Poor quality and inadequate health service provision in the district hospital.
- Lack of drugs in the hospital, and inability of the majority of the poor people to buy the drugs. Further, the community is forced to buy drugs illegally imported through the neighboring countries from private pharmacies, and often the drugs have already lost their potency during transportation.
- The discontinuation of awareness creation activities after the district HIV/AIDS council started them.
- Conflict of interest among the health professionals.

The team also conducted a discussion with **urban women**, from 23-45 years old who came from four kebeles of Negelle town. The purpose of the discussion was to know whether they know about HIV/AIDS and its transmission, STIs, sexual practices, harmful traditional practices existing in the community that enhance the spread of virus, treatment seeking behavior for STIs and knowledge about condoms.

Questions raised during discussion were:

- Do you know about HIV/AIDS and how?
- Do you know about STIs?
- What types of STIs?
- Do people seek treatment for STIs?
- Where they seek treatment for STIs?
- Do you know about condoms?
- Is there suspected deaths of AIDS patients in the community?

The participants responded that they know about HIV/AIDS through the media and only one of them knew from attending a meeting at the kebele. All know about modes of transmission except mother-to-child transmission and blood transfusion. All had also heard about Gonorrhoea and Syphilis. Concerning the treatment, no one wants to talk about it if he gets sick. They know that the STI can be cured if treated and do not know where people go for treatment. Surprisingly, one participant has said that she does not believe in what the media and the people are talking about and asked whether this disease has existed for generations or is new. All of them know and have seen the condom but they said that they do not dare to ask their husband to use condoms. All of them said that it is hard to tell about the sexual practices of their husbands and are afraid to talk about it. Regarding risky sexual behavior, participants said that the incidence of rape, including

young girls and housewives by the military, has increased in the town. Unwanted pregnancies and subsequent deaths due to illegal abortion are also common. Harmful traditional practices like tonsillectomy and gum extraction were also mentioned as common in the area.

Problems:

Lack of awareness

Fear to negotiate for the use of condom

Recommendations:

Increase level of awareness of the community everywhere

Reinforce the implementation of laws

The team approached one of the **anti AIDS clubs (Save Yourself)** to know the overall situation of the club. A discussion was held with Ato Wegayehu Kidane, the health coordinator of the club. Ato Kidane is professionally a laboratory technician, and currently works for a private clinic called Liben.

The questions the team asked were:

- When and how was the club established?
- How many members does the club have?
- What are the activities the club is involved in?
- What is the source of its income?
- Does the club promote condom use among the members?
- Have you ever had sick members because of HIV/AIDS or death?
- Is there any incidence of STIs among members?
- Where do youth usually seek treatment for STI?

According to Ato Wegayeh, the club was established in 1998, as the result of the observation of the increased burials in the graveyards in the church by a few members of the club. They have been observing the helpless sick people who come to the church and died there for years. Currently the club has 60 members (26 females and 34 males). The members have divided themselves into caregivers and supporting members. The supporting members are those who earn some sort of income and commit themselves to cover part of patients' needs, while the caregivers are those who look after the patients (feeding, washing, etc). The club started its activities with moral education for youth who are coming to the church and integrated HIV/AIDS prevention intervention. Their HIV/AIDS prevention message was designed on the basis of the level of the information the members had, which was identified through a pretest.

The club mobilized resources from the members and worked with church administration. This helped them to secure houses built on the graves in the church to use as "dropping centers" for suspected AIDS patients in need of care. They also made an arrangement with church administration to channel the food that is usually brought to the church for these helpless patients, and secured an office in the church compound. The club has also equipped its office and furnished the dropping center on its own. Youth participation has also increased.

In addition to education care and support the club has tried to look for the patients' families and reunited three patients with their families in Addis Ababa and Jimma. The club members

accompanied the patients while they traveled. They buried four patients whom they had been looking after. They have close contact with the district hospital and the hospital informs the club when the patients are admitted. The club members take turns visiting the patients, taking whatever they can to ease his/her loneliness and provide emotional support.

Ato Kidane responded that they do not promote condom use among youth but tell them that it has to be the last option and discourage premarital sex. The club hasn't experienced sickness or death among members. However that doesn't mean that there is no infection among members. Ato Wegayehu has noticed that the youth seek treatment in the private clinics where he works.

Problems Encountered by the Club:

Lack of training of the members on home-based care

Lack of support from the district HIV/AIDS council and NGOs working in the area

The team also conducted a focus group discussion with **14 commercial sex workers** from 19-27 years old who are working in two bars in Negelle town. The intention of holding this discussion was to know their risk perception, condom use, treatment seeking behavior for STIs, major problems they face in relation to their work, how and why they became CSWs, and where the majority of CSWs are coming from.

The participants were asked the following questions:

- Have you ever thought about HIV/AIDS and its mode of transmission?
- Have you ever thought that you are at risk?
- Do you use condom? Is it always available?
- Do you know about STIs? Would you name them?
- Do you ever exposed to STIs?
- Where do you go to seek treatment?
- What problems do commonly face being in this profession?
- Why did you join this profession?
- Did you try other alternatives before you joined this profession?

They responded that they know about the virus and the mode of transmission through the media and education given to them by the health professionals and anti AIDS club. They also know that they are at risk for contracting the virus. All of them responded that they use condoms and that they are also available. Regarding the knowledge of STIs, some of them mentioned Gonorrhoea and Syphilis while other didn't want to talk about it. Regarding the exposure to STIs some of them admitted that they were infected and treated in the private clinics because the district hospital discontinued free treatment. Others were not comfortable discussing what happened to them.

The respondents joined the profession as the result of: conflict with family; peer pressure, misled by girl/boy friends or relatives; attracted by the materials (gold, clothes, etc) when current prostitutes go back to their original place to visit their family; and rape by a family member. Some of them had worked as a housemaid before becoming CSWs and were forced to leave the work as the result of rape by the employers. Regarding their place of origins, the respondents came from Addis Ababa, Almgena, Gondar, Jimma, Asela and Nazreth.

Problems Encountered by the Participants:

- Their clients resist condom use and most of them usually mislead them and tear the condom once they put it on and get in.
- Physically abused by the client when the CSW shouted for help. Exposed to STI and only recognized it after a long time.
- Unwanted pregnancies and forced to go to illegal abortionist and suffer from resulting complications.

The team also contacted Ato Tadesse Bahiru the head of the **District HIV/AIDS Council** to know the state of the council and the activities undertaken so far. The following questions were raised:

- How long ago was the council established?
- What activities have been undertaken since its establishment?
- What are the prevailing risky behaviors in the area?
- Are there any problems encountered?

The multi-sectoral HIV/AIDS council was five-months old at the time of the discussions. Within this period the council established sub-committees in all PAs and kebeles as well as conducted orientations about HIV. There was project preparation to facilitate utilizing the World Bank grant for 42 kebeles. Until now, only six rural kebeles have used the form for a project proposal. Currently the council has opened the account but not yet received the funding. Ato Bahiru stated that harmful traditions of sexual practices are prevalent, and substance addiction (chat and alcohol) is very common.

Problems:

- Frequent organizational changes and the subsequent change of personnel as a result.
- Lack of knowledge and skills to lead the council.
- The members usually don't come for the meetings, but send their delegates instead which affects the flow of information and doesn't encourage a sense of responsibility and ownership.
- There will be more organizational changes in the near future.
- Delayed information about the grant from the region.

Recommendations:

- Build the council's capacity.
- Strengthen the sub-committee at the kebele and PA levels.
- Increase awareness at all levels to slow down the spread of HIV.

The team made a short visit to the **district hospital** to meet the head of the District Health Office and the Medical Director of the hospital. The purpose of the visit was to know whether the DHO is actively functioning and if not why, to learn about the existing health facilities and staffing, and to collect morbidity and mortality data.

The questions asked were:

- Is the DHO actively functioning and if not, why?
- How many staff are there in the district and peripheral health facilities?

- What are the major problems of the hospital?
- Where do you get drug supplies from?

According to Taye Tollera, Medical Director of the district hospital and the Head of the District Health Office (DHO), there are five clinics and four health posts. All are functioning except one due to security reasons as the result of a border dispute between Somalis and Oromo. There are a total of 77 health professionals (5 MDs, 11 SNs, 14 JNs, 20 HAs, 4 Midwives, 1 Anesthetist, 2 Pharmacists, 6 laboratory technicians, 3 junior lab technicians, and 3 Sanitarians). The staff at both the clinic and the health post level are health assistants, but primary health workers in two health posts. In addition, there are health assistants who are employed by SCF-US to work as senior program assistants. The hospital staff supervises the clinics, but the frequency of the supervision is insignificant. The hospital is currently getting their drug supply from donors and the Ministry of Health; however, there are problems with supply consistency. In addition, as a result of the provision of free treatment that began in the district during the drought, everyone expects to continue to receive free treatment.

According to the morbidity report of the district hospital for the year 1993 (EC), tuberculosis and pneumonia are the second and third leading causes of morbidity, while STIs are the eighth leading cause of morbidity. In the 1994 (EC) six-month report, TB and pneumonia remain in the same position, but STIs became the fifth leading cause of morbidity. The place of STIs would have been different had the reports from the private clinics been collected and compiled accordingly, since most people seek treatment from the private clinics. Pulmonary TB was the leading cause of mortality in the 1993, while TB was the second leading cause for the first six months of 1994.

Problems:

- Lack of medical equipment, especially lack of delivery sets, suction machines and poorly functioning oxygen cylinder.
- Lack of essential drugs.
- High staff turnover.

Summary of the Findings

These focus group discussions were meant only to identify risks and perceptions for planning purposes. They are not meant to replace the formal formative research that will take place at the beginning of CS-17. The team conducted focus group discussions with rural and urban men and women, and commercial sex workers. The purpose of the discussion was to know the existing knowledge about HIV/AIDS and STIs, availability and use of condoms, common risky sexual behavior in the area, harmful traditional practices that enhance the spread of HIV, treatment seeking behavior, and whether there are stress coping mechanisms traditionally existing in the target community. Due to the limited time, the team was unable to conduct a focus group discussion with youth, which will be very important to understand the determinant behaviors and special problems among youth.

After having passed through the aforementioned process, the team identified the following challenges:

- Low level of awareness and misconceptions about HIV.

- Incomplete information by all the groups.
- Harmful traditional practices like polygamy, pre and extra marital sexual relations.
- High number of demobilized soldiers in the target area.
- Presences of a large, mobile military population.
- Limited HIV/AIDS prevention interventions.
- Presence of displaced population.
- Permanent cross border mobile population for business purposes.
- Silence about the epidemic and denial about the existence of HIV and the magnitude of the epidemic.
- HIV sero-prevalence among the blood donors at Negelle Hospital in the district center is reported to be approximately 27%, which is much higher than the national prevalence among blood donors. Since these people did not know their status, they keep spreading the virus.
- The existence of a large number of prostitutes, violence against them and the delicate issue of condom negotiation.
- The rampant unwanted pregnancies especially among sex workers and student girls and high practice of illegal abortion and resulting complications, including death.
- Increased incidence of rape due to various reasons, including the role of military personnel.
- Tuberculosis and pneumonia are the second and third leading causes of morbidity respectively, while STIs rank fifth in the 2001 morbidity report from Negelle Hospital.
- The first and second leading causes of death are pulmonary TB and pneumonia, respectively.
- The discontinuation of STI syndromic management and free certification services for sex workers in the district hospital.
- Delayed treatment-seeking behavior for STIs.
- Low capacity of district HIV/AIDS council to play an effective leadership role due to the low level of knowledge and skill and frequent structural changes that have resulted in high council member turnover.

Opportunities

Opportunities that exist currently for the incorporation of the HIV/AIDS intervention are:

At the Macro Level: The African leaders are committed and demonstrate their solidarity towards mitigation and impact reduction. The Ethiopian government has committed to mitigating the epidemic and its impact. It has established the multi-sectoral HIV/AIDS Secretariat at the national level and the HIV/AIDS Council at the regional and district levels. A national HIV/AIDS policy and strategic framework has been released to create an enabling environment. There is significant experience in the country towards the prevention of HIV/AIDS. The Ethiopian government has secured funds from the World Bank that could be channeled to the grassroots level for the prevention, control, and care and support of HIV/AIDS.

At the Micro Level:

Organizational level: SCF-US has rich experience in adolescent reproductive and sexual health for school youth and vulnerable orphans. It also has good working relationships with stakeholders and as a result knows the prevailing high risk behaviors for youth. The ongoing nutrition, non-formal basic education, and mother and child health care activities are helpful in serving as entry points. HIV/AIDS awareness raising has been undertaken for the last two years through CHW. SCF-USA Liben project has recently established an HIV unit and the unit has

started working on awareness raising for the primary school children in the community. Condoms and other limited contraceptive methods have been made available through the NGO Networks for Health for family planning, and are made accessible to the community through volunteer distributors.

Community Level:

- Trained personnel (TBAs, HACs, BHTs) in the community.
- Ongoing services like home deliveries, condom provision and limited family planning.
- HIV/AIDS kebele level council established.
- The existence of anti-AIDS clubs (one of which is working on care and support in the church).
- The community members are highly interested in working with SCF-USA on the prevention of HIV/AIDS.

Constraints:

- Condom supply: not known yet what will happen concerning the regular condom supply after NGO Networks for Health is phased out.
- TBA Kit replenishment, especially gloves due to the extreme shortage.
- Inconsistency of health messages related to behavior change, communication skills and knowledge about CHW based on the CS-13 evaluation. Concern that the CHWs will be overloaded when an HIV/AIDS component is included.
- Budget is allocated only for limited activities while the need, risk and impact are huge and demand a full package of interventions to be effective.
- The challenge to provide related services after awareness raising efforts, due to the narrow scope of CS-17 for the implementation of HIV/AIDS strategies.
- High mobility of local population to look for pastures would result on the discontinuation of preventive message and undermine the effectiveness of behavior change.
- Additional staff required for the unit, while budget is not sufficient.
- Frequent organizational changes at the district HIV/AIDS council will affect planning and implementation.

Relationship with Existing Program

Undertaking the CS intervention by itself cannot reduce child morbidity and mortality. There are a number of factors that indicate a high prevalence of HIV/AIDS and its impact in the target area. The first behavior surveillance survey that is currently under way will provide data about prevalence and high-risk groups in the future. The high-risk behaviors that are practiced in the town and rural areas by the target community will jeopardize all the past and future interventions of SC-US Child Survival programs due to the nature and burden of the epidemic and its multi-sectoral impact. It would be vital to design and implement an HIV/AIDS intervention through CS-17.

(D) Pact Ethiopia

ToR for Undertaking an Organizational Capacity Assessment of SCF/USA

I. Background

Pact's Organizational Capacity Assessment Tool (OCAT) was designed to gain a thorough understanding of the existing capacity of local NGO partners and to help Pact design appropriate interventions to enhance their capacities. By design, the tool is inclusive and participatory and assists partner NGOs in examining their own organizational effectiveness. The assessment examines seven components of organizational development: governance, management practices, human resource development, financial resource management, service delivery, external relations, and sustainability. Almost all of Pact's partners have not only undertaken the OCAT but also have openly acknowledged its benefits to their organizations. Currently, over 105 NGOs have participated in the OCA, 83 of which are Pact partners. The first round of OCAs served as a baseline and subsequent organizational assessments monitor changes in the capacity of the organizations as a result of participating in the intensive training and mentoring component of Pact Ethiopia's program. Over 40 organisations have undergone the Re-OCA process while some others are still in process.

The OCA tool was developed in response to a need to identify the individual needs of partner NGOs and examine the impact of Pact Ethiopia capacity building activities. Conceived in Ethiopia, the OCAT is seven years old and has traveled to several countries in the world, being utilized as an important tool in various development programs. It has also been under continuous review and improvements have been made to meet the diverse needs and conditions of NGO operations in different countries.

II. Pact Ethiopia's Experience—OCAT

The Organizational Capacity Assessment Tool (OCAT) provides Pact and the NGOs with baseline information regarding the organization's strengths and weakness. NGOs see the OCAT results as a "mirror" reflecting their own capacity. Pact's OCAT is a unique tool because of its participatory nature of involving all the staff and its effective inclusion of all the main aspects of organization development with a strong mission-focus. There is a direct and clear link between the NGOs' missions to support to the poor and their own organizational capacities to implement activities towards those goals. Pact's OCAT can be used to assess the strengths and weaknesses of any organization, and there is an important emphasis on the organization's ultimate beneficiaries, be that environmental conservation or school age children in rural Ethiopia, etc.

During the OCA process with the first set of 35 partners, Pact had to familiarize NGOs with the tool and train them in the skills necessary to fully utilize the OCAT and its results. Organizational development was a relatively new concept to many of them, and at first many NGOs resisted the assessment because they saw it as another evaluation. However, after further explanation and experience with the tool, the NGOs better understood the benefit this type of self-assessment has on their ability to implement projects and on Pact's ability to provide targeted support and technical assistance.

As well, this tool can be used for the following purposes:

- Diagnostic instrument
- Baseline measurement
- Educational tool
- Instrument for team building
- Mechanism for identifying financial and technical assistance needs
- A complement to audit and impact reports
- A first step for system building
- Rapid assessment
- Monitoring and evaluating progress

In addition, NGOs have begun using their OCA reports as a means of marketing to donors. As well, donors have appreciated the transparency of these NGOs and have provided many with resources as a result of the OCA report.

The OCA is conducted with the full participation of NGO staff and stakeholders as they use the tool to examine, in depth, their ability in each of the seven areas of organizational development. The team of consultants used to implement the OCA tool with each of the NGOs utilized the following strategic and operational management components as benchmarks of where a NGO stands in terms of its capacity:

1. Governance: the provision of leadership and direction to an organization.
2. Management Practices: the mechanisms intended to coordinate the activities and facilitate processes of policy actuation within an organization.
3. Human Resources: the availability and best use of human resources such as staff members, volunteers, constituents, donors, board members to fulfil the goals of an NGO.
4. Financial Resources: the resources required to run a NGO and the mechanisms set in place to account for them.
5. Service Delivery: the programs and services carried out by NGOs that are appropriate, cost-effective, and of quality.
6. External Relations: interaction between an organization and actors in its environment.
7. Sustainability: the long-term continuation of an organization, program, or project.

Each of these seven criteria is further broken down into 36 sub components. Each of these sub components is then rated on a scale of one to six. Number one represents the need for urgent attention, and six indicates that there is not a need for immediate improvement in this area. The average score for each sub component indicates the stage of development for each of the seven main criteria areas. The four stages of organizational development, as rated by the average of each seven criteria for the OCA tool are:

1. Nascent: the NGO is in the earliest stages of development. All the components measured by the OCAT are either in a rudimentary form or non-existent.
2. Emerging: the NGO is developing some capacity in structures for governance, management practices, human resources, financial resources, and services.
3. Expanding: the NGO has a track record of achievement with its work being recognized by its constituency, the government, the business sector, and other NGOs.

4. Mature: the NGO is fully functioning and sensible with a diversified resource base and a partnership relationship with national and international networks.

The final result of an organizational capacity assessment for an individual NGO is a better understanding of the developmental stage of their organization. Looking at each component separately, assessors can evaluate which organizational topics are in the need of greatest attention for each individual NGO. For example, an NGO might have a nascent financial resource capacity, but an expanding ability to deal with human resources. Interventions on behalf of that NGO should, therefore, focus on financial issues, rather than staff concerns.

Evaluating the development stages of the Ethiopian NGOs as a group is also important as it reveals trends in organizational strengths and weaknesses across the NGO sector as a whole. In terms of the Re-OCA, this information provides important insight into the overall improvements to the NGO sector.

III. Undertaking the Organisational Capacity Assessment-OCA

SC/USA's Ethiopia Field Office has submitted a formal request to Pact to conduct an Organisational Capacity Assessment of its headquarters in Addis Ababa and selected field offices. This ToR is therefore prepared in response to the request.

1. Task: SCF/USA is interested in undertaking an Organisational Capacity Assessment (OCA) of,
 - o its headquarters based in Addis Ababa and its urban RH programme,
 - o child survival impact areas of Negelle, Liben District,
 - o refugee programme in Jijiga, and
 - o counterpart government offices in Negelle. SC is undertaking a child survival programme here with an objective of building the capacity of district offices.
2. Duration: It is estimated that it would take two months to complete the OCA and produce the report along with the computerised charts.
3. Required Human Resources: Two trained and experienced OCATers will undertake the OCA that Pact Ethiopia will assign.
4. Logistics: SC needs to facilitate logistical support like transportation, arranging hotel accommodation, etc.
5. Meetings: SC should, in agreement with the assigned OCATers, schedule meetings and facilitate all related matters like gathering relevant documents etc. In fact, a responsible person/s should be assigned at all the sites to be OCATED so that work is efficiently carried out.
6. Report: The OCA as a tool has distinct processes, after whose completion a draft report will be submitted to SC. On receiving feedback and reaching a consensus, the report will be finalised and submitted along with the computerised charts of the OCA Tool.

7. **Participation:** One of the essential requirements of the OCA process is its requirement for multi-stakeholder involvement and participation in all aspects. Therefore, in conjunction with the persons assigned to undertake the OCA, every attempt will be made to get the full participation of all stakeholders. Towards this end, a joint planning will be undertaken with concerned staff and subsequently an orientation will be held for relevant persons to be involved before the start of the assessment.

(E) CS-13 FINAL AND CS-17 BASELINE KPC SURVEY – SUMMARY REPORT

Prepared by: EFO Monitoring and Evaluation Unit

1. Introduction

A baseline Knowledge, Practice and Coverage (KPC) Survey was carried out for CS-13 in August 1997, prior to project start-up in October. In July/August 2001, another KPC Survey was conducted. This survey served as final survey for CS-13 and baseline for the follow-on CS-17 project, and focused on the following areas:

1. Maternal and newborn care:

- Births attended by trained personnel
- Use prenatal care services
- Knowledge of pregnancy-related danger signs

2. Diarrhea case management:

- Household care, including oral rehydration therapy (ORT)
- Care seeking for diarrhea

3. Pneumonia Case management:

- Caretakers' knowledge of the signs and symptoms of pneumonia
- Care seeking for pneumonia

4. Malaria control:

- Caretakers' knowledge about signs and symptoms of malaria
- Care seeking for malaria
- Compliance with treatment for malaria

5. Immunization

6. Family Planning

7. Child Nutrition

2. Survey Methods

2.1 Development of Survey Instruments

The Rapid KPC survey questionnaire developed by the Johns Hopkins University, School of Hygiene and Public Health, PVO Child Survival Support Program that was used during the baseline was the survey instrument adapted and used in the final survey as well. SC modified some questions to reflect the local prevailing conditions and to measure specific project interventions and indicators. In the same manner, some questions that do not apply to the project interventions in the impact area were eliminated.

The questions include topics in maternal care, diarrhea, pneumonia, malaria, child nutrition, immunization, water, and health services. Basic background population characteristics such as ethnic group, sex, age, marital status, education, and economic activities were also included. During the survey instrument development, comments and feedback were received from SC's Home Office. In addition, before implementation of the first survey in 1997, pre-testing of the questionnaire in actual field conditions was conducted and the necessary changes were made.

2.2 Sampling Design

The sampling design employed was two-stage cluster sampling using probability proportional to size (PPS). At the first stage the primary sampling units, clusters or pastoralist associations (PAs) were selected randomly from a list of PAs. At the second stage, selection of a constant number of elementary sampling units or households from each of the selected cluster was undertaken from both rural and urban areas. A total sample size of 360 households, which is roughly the same size as the 1997 survey, was taken from rural and urban areas with 24 clusters from rural and six from urban locations. The selection of elementary sampling units in both urban and rural areas was done based on WHO/UNICEF EPI random walk methods.

2.3 Training of Field Staff (Enumerators and Supervisors)

A two-day (July 23-24) intensive training was given in Negelle for ten enumerators and two supervisors. The training focused on the objectives of the survey, sample selection procedures, interviewing techniques, and ethical considerations.

2.4 Field Organization and Survey Operation

The survey was conducted with two teams. Each team consisted of five enumerators and a supervisor. The actual implementation of the survey started on July 25, 2001 and ended on August 2, 2001. As expected in all surveys, the first few days were critical in that the enumerators had to adapt and familiarize themselves with the questionnaire.

2.5 Analysis

The data were entered using Integrated Software for Statistical Analysis (ISSA), then exported to SPSS application software for analysis. Results such as frequencies of major variables and cross-tabulations of subgroups by background variables such as sex, residence, ethnic group, and religion are presented.

3. 2001 Survey Results

3.1 Sample Description

The total sample size was 360 mothers with children under two. Most of these mothers (66%) are young, aged between 15 and 30.

Number of Mothers by Age Group

Age Group	Number	Percent
15-19	30	8.3
20-24	112	31.1
25-29	97	26.9
30-34	57	15.8
35-39	35	9.7
40-44	29	8.1
Total	360	100.0

The sex ratio of the surveyed children was around 103. The Guji ethnic group composed 41% of the sample, followed by Borana (25%), Arsi (15%), Somali (8%) and Others (10%).

Number of Mothers by Ethnic Group and Residence

Ethnic Group	Urban		Rural		Total	
	Number	Percent	Number	Percent	Number	Percent
Guji	1	0.7	148	99.3	149	41
Borana	14	15.4	77	84.6	91	25
Arsi	11	20.0	44	80.0	55	15
Somali	14	48.3	15	51.7	29	8
Others	32	88.9	4	11.1	36	10
Total	72	20.0	288	80.0	360	100

80% of the total sample were rural residents. Almost all Gujis (99%) live in rural areas, as do 85% of Boranas. The majority of ethnic groups classified as “Other”, live in urban areas, and Somalis are split fairly evenly between urban and rural areas.

The overall illiteracy rate was generally high (77%), though it was much higher for rural women (90%) than for their urban counter parts (26%).

Mothers' Educational Status by Place of Residence

Educational Status	Urban		Rural		Total	
	Number	Percent	Number	Percent	Number	Percent
Illiterate	19	26.4	259	89.9	278	77.2
Informal Education	4	5.6	9	3.1	13	3.6
Grade 1-6	11	15.3	11	3.8	22	6.1
Grade 7-12	33	45.8	0	0.0	33	9.2
Above Grade 12	5	6.9	0	0.0	5	1.4
Not Stated	0	0.0	9	3.1	9	2.5
Total	72	100	288	100	360	100.0

Islam is the dominant religion, accounting for 59% of the total. Christianity followed with a percentage share of 25%. Waaqeefatta (traditional) took the third position (13%). The rest were insignificant (0.3%).

Number of Mothers by Religion and Residence

Religion	Urban		Rural		Total	
	Number	Percent	Number	Percent	Number	Percent
Muslim	41	56.9	173	60.1	214	59.4
Waaqeefatta	1	1.4	47	16.3	48	13.3
Christian	30	41.7	61	21.2	91	25.3
Others	0	0.0	1	0.3	1	0.3
Not Stated	0	0.0	6	2.1	6	1.7
Total	72	100.0	288	100.0	360	100.0

Islam is found equally in urban and rural areas while Waaqaafetta is concentrated in rural areas and Christianity in urban areas. All Somalis are Muslim. Almost all (96%) Arsi are Muslim. Among the Borana, Waaqeefatta and Islam are the leading religions. Ethnic groups classified under “Other” accounted for about 10% of the total sample size. These groups are predominantly Christian (69%) and the majority reside in urban areas (89%).

Number of Mothers by Religion and Ethnic Group

Ethnic Group	Entry Designation	Religion					
		Muslim	Waaqeefatta	Christian	Others	Not Stated	Total
Guji	Number	85	10	51	1	2	149
	Percent	57.0	6.7	34.2	0.7	1.3	100.0
Borana	Number	36	38	14	0	3	91
	Percent	39.6	41.8	15.4	0.0	3.3	100.0
Arsi	Number	53	0	1	0	1	55
	Percent	96.4	0.0	1.8	0.0	1.8	100.0
Somali	Number	29	0	0	0		29
	Percent	100.0	0.0	0.0	0.0	0.0	100.0
Others	Number	11	0	25	0	0	36
	Percent	30.6	0.0	69.4	0.0	0.0	100.0
Total	Number	214	48	91	1	6	360
	Percent	59.4	13.3	25.3	0.3	1.7	100.0

Urban and rural mothers were engaged in different economic activities. Most urban mothers (79%) were housewives, while only 37% of rural mothers were housewives. 42% of rural mothers were pastoralists or agro-pastoralists. The second major economic activity of urban mothers was trade/retail (10%).

Economic Activities of Mothers by Residence

Economic Activity	Urban		Rural		Total	
	Number	Percent	Number	Percent	Number	Percent
Pastoralist	0	0.0	13	4.5	13	3.6
Agro-Pastoralist	0	0.0	108	37.5	108	30.0
Farmer	2	2.8	47	16.3	49	13.6
Trader/Retailer	7	9.7	2	0.7	9	2.5
Housewife	57	79.2	107	37.2	164	45.6
Student	0	0.0	1	0.3	1	0.3
Government Employee	3	4.2	0	0.0	3	0.8
Others	3	4.2	0	0.0	3	0.8
Not Stated	0	0.0	10	3.5	10	2.8
Total	72	100.0	288	100.0	360	100.0

Over half (62%) of the surveyed mothers worked away from home. 42% of women took their children with them when they were away from home to work. 25% of urban mothers and 24% of rural mothers stated that older siblings take care of the youngest child when they are away from home to work.

Childcare Provider while Mother is working Away from Home by Residence

Care Provider	Urban		Rural		Total	
	Number	Percent	Number	Percent	Number	Percent
Mother take child with her	4	33.3	90	42.7	94	42.2
Husband/partner	1	8.3	20	9.5	21	9.4
Older children	3	25.0	50	23.7	53	23.8
Relatives	2	16.7	32	15.2	34	15.2
Neighbors/friends	1	8.3	18	8.5	19	8.5
Maid	1	8.3	0	0.0	1	0.4
Not stated	0	0.0	1	0.5	1	0.4
Total	12	100.0	211	100.0	223	100.0

3.2 Child Birth and Death

The average number of live births a mother had was 4.9 for rural and 3.0 for urban areas. In line with this, 26% of rural mothers reported that they have experienced one or more deaths of children under five; it was 17% for their urban counterparts. The average number of live births a woman had had was high for Guji mothers (5.0) compared with that of Borana (4.4), Arsi (4.6), Somali (4.4) and “Others” (2.5).

3.3 Maternal and Newborn Care

42% of urban mothers had a maternal health card, while only 17% of rural mothers had them. In addition to this, 33% of urban mothers and 19% rural mothers had the card but lost it. Mothers were asked when a woman should visit a health facility for the first time during pregnancy. 40% responded 4-6 months of pregnancy and 26% 1-3 months of pregnancy. 19% did not know when to go and 3% reported that they do not see the necessity of visiting health institutions during pregnancy.

During pregnancy more urban mothers visit health institutions than rural mothers. 85% of urban mothers visited hospitals, health centers, health posts, and/or drug vendors at least once when they were pregnant with their youngest child, while only 44% of rural women sought prenatal care in health institutions at least once.

Tiredness (42%) and severe headache (12%) were the most cited danger signs related to pregnancy; 21% of rural mothers responded that they did not know any danger, as did 26% of urban mothers.

Mothers' Knowledge of Pregnancy Danger Signs by Place of Residence

Danger Signs	Urban		Rural		Total	
	Number	Percent	Number	Percent	Number	Percent
Vaginal bleeding	1	1.4	12	4.2	13	3.6
Sever headache	7	9.7	36	12.5	43	11.9
Sever vomiting	9	12.5	5	1.7	14	3.9
Convulsions	0	0.0	13	4.5	13	3.6
Tiredness	23	31.9	127	44.1	150	41.7
Pallor	0	0.0	6	2.1	6	1.7
Unusual swelling	12	16.7	29	10.1	41	11.4
Joint ache	3	4.2	28	9.7	31	8.6
Stomach ache	2	2.8	32	11.1	34	9.4
Others	38	52.8	120	41.7	158	43.9
Do not know	19	26.4	61	21.2	80	22.2

45% of mothers stated that meat is one of the foods that prevents anemia during pregnancy. Other foods reported were milk (40%), fruits (40%), vegetables (32%), macaroni/pasta (14%), eggs (12%), and butter (10%). Other responses such as liver, injera (the traditional bread), rice, fat/oil and red beets together accounted for 28%.

Delivery: Untrained Cheretis (Traditional Birth Attendants) delivered more than one-fourth (29%) of the mothers' most recent pregnancies.

Mothers' Response for Last Pregnancy Birth Attendant by Residence

Birth Attendant	Urban		Rural		Total	
	Number	Percent	Number	Percent	Number	Percent
Myself	0	0.0	29	10.1	29	8.1
Family member	2	2.8	58	20.1	60	16.7
Neighbors/friends	2	2.8	35	12.2	37	10.3
Chereti (TBA)	10	13.9	94	32.6	104	29.0
TTBA	22	30.6	67	23.3	89	24.8
Health professional	34	47.2	5	1.7	39	10.9
Others	1	1.4	0	0.0	1	0.3
Does not know	1	1.4	0	0.0	1	0.3
Total	72	100.0	288	100.0	359	100.0

Delivery by untrained Cheretis ranked first in all the major ethnic groups except Arsi and others. Among Arsi women, Trained Traditional Birth Attendants were the most common birth attendants. Overall, Trained Traditional Birth Attendants (TTBA) attended 25% of the total deliveries. Generally, the contribution of health professionals was minimal; they accounted for only 11% of the total deliveries. Among Somalis, however, health professionals were equally important with Cheretis.

Birth Attendant for Last Pregnancy by Mothers' Ethnicity

Birth Attendant	Guji		Borana		Arsi		Somali		Others		Total	
	no.	%	no.	%	no.	%	no.	%	no.	%	no.	%
Myself	25	16.8	2	2.2	1	1.8	1	3.4	0	0.0	29	8.1
Family member	37	24.8	10	11.0	7	12.7	3	10.3	3	8.3	60	16.7
Neighbors/friends	18	12.1	12	13.2	1	1.8	5	17.2	1	2.8	37	10.3
Chereti (TBA)	39	26.2	35	38.5	19	34.5	7	24.1	4	11.1	104	28.9
TTBA	25	16.8	24	26.4	23	41.8	6	20.7	11	30.6	89	24.7
Health professional	5	3.4	8	8.8	4	7.3	7	24.1	15	41.7	39	10.8
Others	0	0.0	0	0.0	0	0.0	0	0.0	1	2.8	1	0.3
Does not know	0	0.0	0	0.0	0	0.0	0	0.0	1	2.8	1	0.3
Total	149	100	91	100	55	100	29	100	36	100	360	100.0

3.4 Diarrhea

Of the total 360 children under two years of age, 80 (22%) had diarrhea in the two weeks prior to the survey. The percentage of children with diarrhea in urban and rural areas was the same.

Children with Reported Diarrhea During the Two Weeks Prior to the Survey

Child with Diarrhea	Urban		Rural		Total	
	Number	Percent	Number	Percent	Number	Percent
Yes	16	22.2	64	22.2	80	22.2
No	56	77.8	223	77.4	279	77.5
Does not know	0	0.0	1	0.3	1	0.3
Total	72	100.0	288	100.0	360	100.0

Most mothers (64%) breastfed their children as usual at the time of the diarrhea episode (50% for urban and 67% for rural), while 14% reported breastfeeding less than usual during illness and 8% stopped completely during the diarrhea. Only 9% of mothers reported to have breastfed their child more than usual at the time of illness.

Breastfeeding Pattern Among Children Reported Diarrhea by Residence

Pattern	Urban		Rural		Total	
	Number	Percent	Number	Percent	Number	Percent
More than usual	2	12.5	5	7.8	7	8.8
As usual	8	50.0	43	67.2	51	63.8
Less than usual	3	18.8	8	12.5	11	13.8
Stopped completely	2	12.5	4	6.3	6	7.5
Child not breastfed	1	6.3	4	6.3	5	6.3
Total	16	100.0	64	100.0	80	100.0

Anti-diarrhea medicine ranked first in mothers' preference of treating diarrhea (48%), and rural women (50%) were more likely to choose it than their urban counterparts (38%). Oral rehydration solution (ORS) sachets were more widely used in urban areas (31%) than in rural areas (11%). Only one rural woman used cereal based ORT to treat diarrhea. Overall, 28% of women (25% for urban and 28% for rural) did not use any kind of treatment.

Diarrhea Treatment by Place of Residence

Treatment	Urban		Rural		Total	
	Number	Percent	Number	Percent	Number	Percent
ORS sachet	5	31.3	7	10.9	12	15.0
Sugar salt solution	1	6.3	8	12.5	9	11.3
Cereal based ORT	0	0.0	1	1.6	1	1.3
Other home available fluids	1	6.3	7	10.9	8	10.0
Anti diarrhea medicine	6	37.5	32	50.0	38	47.5
Others	3	18.8	6	9.4	9	11.3
Nothing	4	25.0	18	28.1	22	27.5

Nearly two-thirds (64%) of mothers reported seeking treatment for diarrhea (56% urban women and 66% rural women). More treatment was sought for female children (75%) than for males (54%). Most women reported seeking treatment from health posts or clinics (63%). The second place that women sought treatment was Negelle Hospital (26%). Spatially, people living in or near Negelle sought treatment from Negelle Hospital. As the table below shows, very few mothers reported seeking treatment from drug vendors/pharmacies, Community Health Agents (CHA), or Cheretis.

Facilities at which Mothers Sought Treatment for Diarrhea

Facility	Urban		Rural		Total	
	Number	Percent	Number	Percent	Number	Percent
Hospital or health center	4	44.4	9	21.4	13	25.5
Health station/post	0	0.0	13	31.0	13	25.5
Private clinic	4	44.4	15	35.7	19	37.3
Drug vendor or pharmacy	1	11.1	1	2.4	2	3.9
Community health agents (CHA)	0	0.0	1	2.4	1	2.0
Cheretis	0	0.0	3	7.1	3	5.9
Total	9	100.0	42	100.0	51	100.0

Most of the mothers (63% of the total; 78% urban and 60% rural) reported that fever is the sign that causes them to seek treatment for diarrheal disease. A “decrease in urine output”, and “blood in stool” are the lowest ranked danger signs of diarrhea. When asked about the action they should take if their child is ill with diarrhea, more than three-fourths (76%) of mothers responded that they should take the child to health facilities (68% urban and 78% rural residents). ORS ranked second with a percentage response of 13%.

Recommended Home Care for Children with Diarrhea

Recommended Home Care	Urban		Rural		Total	
	no.	%	no.	%	no.	%
Initiate fluids rapidly	15	20.8	20	6.9	35	9.7
Give the child more to drink than usual	5	6.9	33	11.5	38	10.6
Give the child smaller more frequent meals	7	9.7	14	4.9	21	5.8
Proper mixing and administration of ORS	21	29.2	25	8.7	46	12.8
Take the child to health facility	48	66.7	224	77.8	272	75.6
Feed more after diarrhea episode so that the child regain	5	6.9	3	1.0	8	2.2
Do not give fluids	1	1.4	7	2.4	8	2.2
Do not give foods	0	0.0	8	2.8	8	2.2
Others	5	6.9	50	17.4	55	15.3
Does not know	1	1.4	7	16.7	8	2.2

31% of women recommended giving more food to a child recovering from diarrhea. Giving the child smaller more frequent meals ranked second for urban mothers, while rural women preferred to give food on the request of the child.

Recommended Home Care for Children Recovering from Diarrhea

Recommended Home Care	Urban		Rural		Total	
	Number	Percent	Number	Percent	Number	Percent
Give the child smaller more frequent meals	22	30.6	61	21.2	83	23.1
Give the child more food than usual	24	33.3	86	29.9	110	30.6
Give food on the request of the child	18	25.0	72	25.0	90	25.0
Give foods with high caloric content	16	22.2	63	21.9	79	21.9
Extra daily meal or feeding for about a week	14	19.4	36	12.5	50	13.9
Others	11		54		65	18.1
Does not know	3	4.2	8	19.0	11	3.1

3.5 Pneumonia

16% of all children, and 73% of those with a cough, were reported to have been ill with cough and fast or difficult breathing in the two weeks prior to the survey.

Children with Cough Who Experienced Fast or Difficult Breathing

	Urban		Rural		Total	
	Number	Percent	Number	Percent	Number	Percent
Yes	9	60.0	48	76.2	57	73.1
No	4	26.7	15	23.8	19	24.4
Does not know	2	13.3	0	0.0	2	2.6
Total	15	100.0	63	100.0	78	100.0

Mothers reported seeking care more frequently for female children who showed signs of respiratory illness than for males (71% vs. 58%). In urban areas most mothers reported seeking care in Negelle Hospital, and in rural areas most mothers reported seeking care in health posts/clinics. Very few mothers reported seeking care from drug vendors/pharmacies and Cheretis.

Facilities at which Mothers Sought Treatment for Cough and Fast or Difficult Breathing

Facility	Urban		Rural		Total	
	Number	Percent	Number	Percent	Number	Percent
Hospital or health center	5	62.5	7	25.0	12	33.3
Health station/post	0	0.0	10	35.7	10	27.8
Private clinic	3	37.5	8	28.6	11	30.6
Drug vendor or pharmacy	0	0.0	1	3.6	1	2.8
Cheretis	0	0.0	1	3.6	1	2.8
Others	0	0.0	1	3.6	1	2.8
Total	8	100.0	28	100.0	36	100.0

Fifty percent of women reported cough as a sign that would prompt care seeking, while 44% reported fever, 20% reported fast breathing, and 23% reported chest in drawing as signs that prompt care seeking.

Sign of Possible Respiratory Illness that would Prompt Care-Seeking

Sign	Urban		Rural		Total	
	Number	Percent	Number	Percent	Number	Percent
Fast or difficult breathing	10	13.9	65	22.6	75	20.8
Chest in-drawing	14	19.4	70	24.3	84	23.3
Loss of appetite	17	23.6	30	10.4	47	13.1
Fever	35	48.6	122	42.4	157	43.6
Cough	42	58.3	139	48.3	181	50.3
Vomiting	5	6.9	26	9.0	31	8.6
Diarrhea	4	5.6	22	7.6	26	7.2
Tiredness	5	6.9	23	8.0	28	7.8
Others	19	26.4	94	32.6	113	31.4
Does not know	7	9.7	18	6.3	25	6.9

3.6 Malaria

Out of the total children surveyed, 9% were reported ill with malaria in the two weeks prior to the survey date. As in the case of diarrhea and pneumonia, there is gender disparity in seeking malaria treatment. Caretakers reported seeking treatment for 80% of malaria ill females and for 58% for males. All of the mothers classified in the “Other” ethnic group reported seeking care for malaria, 86% of Borana mothers, 60% of Somali mothers, 33% of Arsi mothers, and 25% of Guji mothers reported seeking care.

Regarding signs that prompt care seeking, 83% of mothers reported fever, followed by shivering (65%). Sweating was the third with a percentage share of 39%. These symptoms have the same ranking order in both urban and rural areas.

Sign Prompted Care Seeking for Suspected Malaria

Sign	Urban		Rural		Total	
	Number	Percent	Number	Percent	Number	Percent
Fever	8	88.9	11	78.6	19	82.6
Sweating	3	33.3	6	42.9	9	39.1
Shivering	5	55.6	10	71.4	15	65.2
Joint ache	1	11.1	1	7.1	2	8.7
Headache	2	22.2	3	21.4	5	21.7
Diarrhea and vomiting	2	22.2	3	21.4	5	21.7
Loss of appetite	3	33.3	5	35.7	8	34.8
Others	2	22.2	0	0.0	2	8.7

Regarding signs of severe malaria, fever (79%) is the most reported, followed by convulsions (30%), and loss of consciousness (22%). 70% of the women whose child was ill with malaria reported seeking treatment from health posts or private clinics. The remaining 30% sought treatment from Negelle Hospital.

Sign of Severe Malaria

Sign	Urban		Rural		Total	
	Number	Percent	Number	Percent	Number	Percent
Fever	50	69.4	232	80.6	282	78.3
Convulsions	18	25.0	88	30.6	106	29.4
Loss of consciousness	21	29.2	58	20.1	79	21.9
Others	28	38.9	97	33.7	125	34.7
I do not know	12	16.7	30	10.4	42	11.7

3.7 Breastfeeding and Nutrition

Nearly four out of five mothers (79%) were breastfeeding at the time of the survey, ranging from 97% for infants less than two months old to 34% for children aged 22-24 months. The percentage of Arsi mothers who were currently breastfeeding was 94%, for “Others” it was 83%, for Borana it was 78%, for Somalis 76%, and for Gujis 72%.

83% initiated breastfeeding during the first few hours after the birth of their last child, 5% after six hours, 4% after a day, 8% after two days, 1% after a week, and 0.3% after two weeks. More Gujis (93%) initiated breastfeeding in the first few hours than any other ethnic group (Arsi 80%, Borana 78%, Somali 70%) (Annex Table 24). Breastfeeding is not exclusive; 90% of children 3 to 5 months old were given water, tea, or milk in the 24 hours prior to the survey.

Initiation of Breastfeeding after Delivery

Initiation of Breastfeeding After Delivery	Guji		Borana		Arsi		Somali		Others		Total	
	no.	%	no.	%	no.	%	no.	%	no.	%	no.	%
During the first few hours	137	93.2	71	78.0	44	80.0	19	70.4	23	63.9	294	82.6
More than six hours	1	0.7	4	4.4	5	9.1	1	3.7	5	13.9	16	4.5
After one day	3	2.0	7	7.7	1	1.8	2	7.4	1	2.8	14	3.9
After two days	4	2.7	8	8.8	5	9.1	5	18.5	7	19.4	29	8.1
After a week	1	0.7	1	1.1	0	0.0	0	0.0	0	0.0	2	0.6
After two weeks	1	0.7	0	0.0	0	0.0	0	0.0	0	0.0	1	0.3
Total	147	100.0	91	100.0	55	100.0	27	100.0	36	100.0	356	100.0

3.8 Family Planning

At the time of the survey, 9% of the women reported that they were pregnant. Of the total women who were not pregnant, 51% expressed their interest to have more children in the coming

two years. 56% of the total women who did not want to have more children in the coming two years, would like to use modern contraceptives, but only 45% were actually using contraceptives to avoid or postpone pregnancy. 44% of the women who did not want to have more children in the coming two years reported that their husbands are not interested in using modern contraceptives.

3.9 Immunization

Of the total children aged 12 to 24 months, 43% had an immunization card at the time of the survey. More rural children (44%) had an EPI card than urban children (38%). More urban mothers had lost their children's EPI cards (50%) than rural mothers (35%). In general, 89% of urban children and 77% of rural children had been vaccinated at least once, and 19% of children from 12-23 months old were fully immunized. There was little change from 1997 to 2001 in immunization coverage for children or pregnant women.

4. Comparison of 1997 and 2001 Survey Results

4.1 Maternal and Newborn Care

4.1.1 Birth Attended by Trained Personnel

As Table 1.1 shows, the percent of births attended by trained personnel (TTBA and professional) has increased from 16% in 1997 to 36% in 2001. In addition, births attended by Cheretis (untrained TBAs) have increased from 13% in 1997 to 29% in 2001. Part of this increase may have resulted from respondents misreporting Trained Traditional Birth Attendants (TTBAs) as untrained TBAs.

A primary activity of CS-13 was training TBAs in safe delivery practices and maternal and newborn care. Accordingly, the percentage of deliveries by TTBAs has tripled over the life of the project. The contribution of health professionals is still minimal, largely due to limited access to health facilities and cultural preferences. As the use of trained attendants has increased, the percentage of births attended by family members has dramatically declined during the project.

Table 1.1. Birth Attendance

Birth attended by	1997		2001	
	No.	Percent	No.	Percent
Mother herself	17	4.6	29	8.1
Family member	181	49.1	60	16.7
Neighbors	64	17.3	37	10.3
Chereti (TBA)	46	12.5	104	28.9
Trained TBA	25	6.8	89	24.7
Health professional	35	9.5	39	10.8
Others	0	0.0	1	0.3
Does not know	1	0.3	1	0.3
Total	369	100.0	360	100.0

4.1.2. Use of Prenatal Health Services

As indicated in Table 1.2 below, the percent of mothers who had antenatal cards at the time of the survey increased from 4% in 1997 to 22% in 2001. In the 2001 survey, 19% of the surveyed women reported they had lost their cards. Based on this self-reporting, 41% of women utilized ANC services at least once.

Table 1.2. Use to Prenatal Care Service

Mothers with card	1997		2001	
	No.	Percent	No.	Percent
Yes	13	3.6	80	22.2
No	329	89.9	211	58.6
Lost it	24	6.6	69	19.2
Total	366	100.0	360	100.0

4.1.3. Knowledge of Pregnancy Related Danger Signs

One of the project objectives was to increase the number of women who are aware of three or more pregnancy danger signs. As Table 1.3 indicates, the percentage of women who know some danger signs has increased between 1997 and 2001, but only 3% of women knew three or more signs, and the signs in general that women listed were not accurate or similar to each other. This seems to indicate that the BCC messages and methods used by CHWs in this area have been unclear. SC plans to revise and pretest the messages regarding pregnancy danger signs during CS-17. It should be noted that the CS-13 final evaluators found that Trained TBAs knew pregnancy danger signs and when to refer clients to health facilities very well.

Table 1.3. Knowledge of pregnancy related danger signs

Danger signs	1997		2001	
	No.	Percent	No.	Percent
Vaginal bleeding	37	10.0	13	3.6
Sever headache	16	4.3	43	11.9
Sever vomiting	10	2.7	14	3.9
Convulsions	15	4.1	13	3.6
Tiredness	0	0.0	150	41.7
Pallor	1	0.3	6	1.7
Unusual swelling	11	3.0	41	11.4
Joint ache	0	0.0	31	8.6
Stomach ache	0	0.0	34	9.4
Labor > 18 hours	5	1.4	0	0.0
Drawing in chest	0	0.0	15	4.2
Loss of appetite	0	0.0	19	5.3
Pain on kidney	0	0.0	9	2.5
3+ signs	1	0.3	?	3
Others	0	0.0	158	43.9
Does not know	288	78.0	80	22.2

4.2 Diarrhea Case Management

Table 2.1. Prevalence of Childhood Diarrhea

Children with diarrheal disease	1997		2001	
	No.	Percent	No.	Percent
Yes	111	30.1	80	22.3
No	258	69.9	279	77.7
Does not know	0	0.0	1	0.3
Total	369	100.0	359	100.0

4.2.2. Preferred Treatment and Care Seeking for Diarrhea

The changes in treatment given for diarrheal disease between 1997 and 2001 show mixed results. The number of women who gave no treatment has decreased by more than half, but the treatments that have increased the most are not the most preferable according to the CDD guidelines. The percentage of caregivers using ORS sachets to treat diarrhea has declined from 17% in 1997 to 15% in 2001, which might in part be due to short supplies of ORS at health facilities. The percentage of children treated with home available fluids or cereal based ORT has increased and reached 11% during the final survey. The percentage of sugar/salt solution (SSS) users has increased from 0 to 11%, though BCC messages were supposed to have stopped advocating the use of SSS after the first year of the project. The percentage of caretakers giving anti diarrhea medicine increased from 25% in 1997 to 48% in 2001.

Table 2.2. Diarrhea Treatment

Treatment	1997		2001	
	No.	Percent	No.	Percent
ORS sachet	19	17.1	12	15.0
Sugar salt solution	0	0.0	9	11.3
Cereal based ORT	0	0.0	1	1.3
Other home available fluids	1	0.9	8	10.0
Anti diarrhea medicine	28	25.2	38	47.5
Others	4	3.6	9	11.3
Nothing	59	53.2	22	27.5

In 1997, out of the total children reported ill with diarrhea, care was sought for 44% of the children. At the time of the 2001 survey, care was sought for 63% of children with diarrhea (Table 2.3).

Table 2.3. Number of Children for Whom Care has Been Sought for Diarrhea

Care sought	1997		2001	
	No.	Percent	No.	Percent
Yes	48	43.6	51	63.8
No	62	56.4	29	36.3
Total	110	100.0	80	100.0

Mothers who reported seeking treatment for diarrhea from hospitals/health centers increased from 15% to 26% during the project implementation period. The percent of mothers who sought treatment at lower level health facilities was similar in both surveys, as was the percent of mothers who used Cheretis (untrained TBAs). The use of drug vendors has declined.

Table 2.4. Facilities at which mothers sought treatment for diarrhea

Facility	1997		2001	
	No.	Percent	No.	Percent
Hospital or health center	7	14.6	13	25.5
Health post/station/clinics	31	64.6	32	62.7
Drug vendors	7	14.6	2	3.9
Cheretis	3	6.3	4	7.8
Total	48	100.0	51	100.0

The results of the care seeking and treatment questions suggest a lack of clarity of BCC messages regarding management of diarrheal disease. CS-17 plans to revise and pretest BCC messages, and retrain CHWs in this area. In addition, discussions are underway with the District Health Office to make ORS more widely available at the community level.

4.3. Pneumonia Case Management

4.3.1. Care Seeking for Pneumonia

The percentage of caretakers who reported seeking treatment for a child with likely pneumonia doubled during the project implementation period, from 30% in 1997 to 63% in 2001. Four times more mothers reported seeking care at hospitals/health centers in 2001 than in 1997. The percentage of caretakers who reported seeking care at health posts remained about the same. Caretakers reported seeking care at drug vendors at much higher levels in 1997 (32%) than in 2001 (3%).

Table 3.2. Reported Care Seeking for Cough and Fast or Difficult Breathing

Facility	1997		2001	
	No.	Percent	No.	Percent
Hospital or health center	2	8.0	12	33.3
Health post/station/clinic	14	56.0	21	58.3
Drug vendor	8	32.0	1	2.8
Chereti	1	4.0	1	2.8
Others	0	0.0	1	2.8
Total	25	100.0	36	100.0

4.4. Malaria Control

4.4.1 Prevalence of Likely Childhood Malaria

Table 4.1. Prevalence of Likely Childhood Malaria

Ill with malaria	1997		2001	
	No.	Percent	No.	Percent
Yes	50	13.6	34	9.4
No	319	86.4	326	90.6
Total	369	100.0	360	100.0

4.4.2. Care Seeking for Malaria

The percentage of caretakers who reported seeking treatment for children with possible malaria increased from 28% in 1997 to 68% in 2001. Caretakers who reported seeking treatment at health posts or clinics increased from 43% in 1997 to 70% in 2001, while reported care seeking at drug vendors decreased from 14% to 0%. See Tables 4.2 and 4.3 below.

Table 4.2. Care seeking for Malaria Ill Children

Care sought	1997		2001	
	No.	Percent	No.	Percent
Yes	14	28.0	23	67.6
No	36	72.0	11	32.4
Total	50	100.0	34	100.0

Table 4.3. Facilities at Which Mothers Sought Treatment for Malaria

Facility	1997		2001	
	No.	Percent	No.	Percent
Hospital or health center	5	35.7	7	30.4
Health post/station/clinics	6	42.9	16	69.6
Drug vendors	2	14.3	0	0.0
Others	1	7.1	0	0.0
Total	14	100	23	100.0

4.5 Immunization

Table 4.5: Card Verified Immunization Coverage by Antigen for All Children 12-23 Months

Antigen	1997(N=193)		2001 (N=162)	
	N	%	N	%
BCG	70	36%	73	45%
OPV1	70	36%	73	45%
OPV2	59	31%	60	37%
OPV3	47	24%	42	26%
DPT1	70	36%	73	45%
DPT2	60	31%	64	40%
DPT3	45	23%	45	28%
Measles	44	23%	52	32%
Fully Immunized	34	18%	30	19%

Under the DAP, monthly outreach was conducted in collaboration with facility-based health workers. Antenatal care was provided at the same outreach sessions, when possible. The DAP provided fuel, transportation, and per diems for health staff. Vaccines and cold chain equipment was supplied by health facilities. KPC survey data measured card-only vaccination coverage and are therefore likely to underestimate total coverage. It should be noted, however, that the principal method for administering vaccinations in the district is through monthly outreach - at these sessions the policy is to give all children a vaccination card if they do not have one at the time of the outreach visit. Coverage data show marginal increases in coverage for BCG, OPV1, DPT1 and measles - although these are quite limited. The proportion of children receiving OPV3 and DPT3, and the proportion fully vaccinated is unchanged from 1997. Drop-out rates between OPV1 and OPV3, and between DPT1 and DPT3 remain unchanged. Data from the health facility assessment indicate that health workers are checking the vaccination status of children and their mothers more frequently. A very low proportion of children needing vaccination, however, are given that vaccination or referred for it. Outreach appears to have held coverage steady, although it has not resulted in any significant increases in coverage. Coverage rates for key antigens are still relatively low.

Annex 3. Agreements

Child Survival -17 Program Implementation Agreement Between SAVE THE CHILDREN, USA, Liben, and the Liben District Health Office (DHO) February 18, 2002

General

This agreement is signed between the SC/USA-Liben Project, hereafter called the Project, and the Liben District Health Office, hereafter called the District Health Office (DHO).

Purpose

The purpose of this agreement is to formally recognize the collaboration and partnership that exists between Save the Children/US-Liben and the Liben District Health Office. This agreement specifies the roles and responsibilities of the two parties with regard to the planning, implementation, and evaluation of CHILD SURVIVAL -17 (CS-17) from its inception to the end of the project.

Background Information

Both parties being cognized of the fact that:

1. There is poor access to and limited availability of essential health services in Liben District.
2. Based on recent surveys, there is a high rate of malnutrition: underweight (34%), wasting (11%), and stunting (42%).
3. The high prevalence of malaria, diarrhea, and other childhood illnesses contribute to high mortality of children under 5 similar to the national figure 173/1,000.
4. Poor access to obstetric care and low contraceptive prevalence cause high maternal mortality.
5. HIV/AIDS has not been a focus of Save the Children programming in Liben district, except that CHWs have received some training on HIV/AIDS BCC through the DAP.

Both parties, realizing the necessity of changing this situation, will continue to work together to design, plan, implement, monitor, and evaluate the Child Survival cost extension CS-17 project.

Location of the Project

The Child Survival-17 impact area includes all of Liben District in Borana Zone of Oromia State in Southern Ethiopia, administratively divided into 37 PAs and 5 urban Kebeles.

Duration of the CS-17 Project

The CS-17 will last for Five Year (2001-2006).

Program Beneficiaries

Out of an estimated total population of 138,310, there are an estimated 25,836 children under 5 years of age and 31,673 women between the age of 15 and 49 years. Thus, the total beneficiaries include **57,509** children and women of reproductive ages. (These figures are based on DHO estimates.)

Roles and Responsibilities of the Two Parties

This agreement highlights the roles and responsibilities of the Save the Children Negelle project and Liben District Health Office in implementing CS-17 program activities.

Roles and Responsibilities of SC/US - Liben Project

Save the Children will:

- Provide funds for the CS-17 project.
- Play an important role in the formation and functioning of District Health Management Team (DHMT), and the District HIV/AIDS and District Health Information Management sub committees.
- Conduct formative HIV research, baseline, and other necessary assessments, and surveys.
- Develop /revise training and BCC curricula and materials.
- Provide training and support to MOH staff at different levels.
- Train community health workers (TBAs, BHTs and HACs).
- Sponsor the training of three Community Midwives at Negelle Nursing School.
- Monitor health information system performance and health workers performance, and based on the data, give feedback.
- Support immunization and ANC by providing fuel and per diem to MOH staff.
- Conduct immunization/ANC/DAP outreach sessions together with MOH health facility staff.
- Plan and manage the community IMCI Revolving Drug Funds.
- Ensure compliance with donor requirements and Government of Ethiopia policies.

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Responsibilities of Liben District Health Office (DHO)

Liben District Health Office (DHO) will:

- Provide technical and management support for implementation of the CS-17 project.
- Chair the DHMT, District HIV/AIDS, and District HIM sub committees.
- Participate in formative HIV research, other surveys, and assessments.
- Give technical support for the development and revision of training and BCC curricula and materials.
- Give technical support for the training of health facility staff and Community Health Workers (CHWs, TBAs, BHTs, HACs).
- Provide EPI and MCH services.
- Lead the monitoring of health information systems and health worker performance, based on regularly collected data, and provide feedback to improve the district health management system.
- Provide available essential supplies and equipment to facilities and outreach sites.
- Provide guidance and support for community based IMCI revolving drug fund institution and management.
- Assign available staff at all levels to support the implementation and regular monitoring of CS-17.
- Support policy, information, and activity coordination both at community and government levels.

On Behalf of Save the Children
Liben Project Office

On Behalf of Liben District
Health Office

Name_____

Name_____

Signature⁴_____

Signature³_____

⁴ This document was signed in Negelle on February 18th, 2002, by Mr. Abrahma Bongassie, SC/Liben Program Manager, and by Dr. Taye Tolera, Liben District Health Officer and Medical Director, Negelle Hospital. Signed hard copies are available upon request from SC in Negelle and from Eric Starbuck (phone: 203-221-4151, e-mail: estarbuck@savechildren.org) in Westport.

Annex 4. Resumes/CVs of Key Personnel at HQ and in the Field

CURRICULUM VITAE-Tedbabe Degeffie Haile-Gebreil

Work Experience:

Senior Health Advisor, SCF/US, Ethiopia

2001-Present

Advise and guide the implementation of all Ethiopian Field Office (EFO) health activities, ensure that all program activities are satisfactorily implemented, and are meeting established standards, prepare annual workplan for the implementation of health activities in the EFO, initiate and develop new project ideas as well as manage assessment missions, propose strategic direction for the EFO health program.

Pediatrician, Brook Private Clinic, Ethiopia

March-Nov. 2001

Practiced general pediatrics in private clinic, including the diagnosis and treatment of a range of illnesses and conditions for infants, children and youth.

Independent Consultant, Medical Missionaries of Mary, Ethiopia

May-July 2001

Evaluated Medical Missionaries of Mary's HIV/AIDS counseling and social support program, providing input and recommendations regarding the enhancement of service delivery.

Pediatrician/Medical Co-Coordinator,

Gode Emergency Feeding Program, SCF/US, Ethiopia

May-Dec 2000

evaluated the therapeutic feeding program and developed simplified guidelines according to international protocols. Trained medical and paramedical staff on recommended guidelines to ensure that the therapeutic feeding center ran effectively. Participated in a comprehensive 30-cluster nutritional survey, which assessed the nutritional situation among children under five and adults, coverage of selective feeding programs and retrospective mortality. Initiated mobile clinics, which served ten villages of Gode district, and trained and supervised staff.

Pediatrician, BRASS MCH Center, Ethiopia

Sept.-May 1999

Managed all aspects of in- and out-patient care and provided immediate newborn evaluation.

Pediatrician, Yirgalem Hospital, Southern Nations and

Nationalities Peoples State (SNNP), Ethiopia

July 1997-Aug. 1999

Developed treatment protocol, taught and supervised staff in both in-patient and outpatient departments. Participated in collaborative research between Yirgalem Hospital and Heidelberg Children's Hospital.

General Practitioner, Yirgalem Hospital (SNNPS), Ethiopia

Jan. 1988-Sept. 1993

Responsible for both the medical and pediatric wards for the first year of my assignment and for the next four years, I was responsible for pediatric in-patient and outpatient care. Successfully completed on-the-job training in ultrasound examination and then provided this service independently and with a radiologist.

**Pediatric Residency; Ethio-Swedish Children’s Hospital,
Addis Ababa, Ethiopia**

Sept. 1993-Mar.1997

Successfully completed a three-year postgraduate training which included in-patient and out-patient management, provision of care with consultants in different specialty clinics, present seminars, grand rounds discussions, teaching and supervising nursing students and interns.

**Rotating Internship; Tikur Anbessa and St.Paul’s Hospitals,
Addis Ababa, Ethiopia**

Sept.1987-Sept.1988

A one-year internship in the two hospitals rotating between the four major departments of medical, surgical, pediatrics, and gynecology and obstetrics.

Education:

- Pediatric Specialization, Addis Ababa University Graduate School, Sept.1993-Mar.1996.
- Medical Doctor, Addis Ababa University Faculty of Medicine, Sept.1982-Dec.1988.

Research:

Participated in research conducted as a joint project of the Yirgalem Hospital and the Children’s Hospital of the University of Heidelberg, Germany. I was responsible in-patient enrollment in the study, reviewing, treating, data collection and follow-up of patients. I was also involved in the preliminary analysis of the second study.

Feb.1998-Jul 1999 “*Development of clinical criteria for diagnosis of Tuberculosis in malnourished and immuncompromised children-HIV/AIDS*”.

Apr. 1996-Mar.1999, “*The role of antioxidants in the management of severe protein energy malnutrition*”.

Jan.1998, Presented the preliminary report on the proceeding research to a three-day conference on the Tropical Pediatrics in Wuzberg, Germany.

Feb.-Mar 1996 “*A retrospective analysis of diarrheal cases study completed in fulfillment of pediatric specialty requirements, Ethio-Swedish Children’s Hospital Addis Ababa*”.

Teaching:

Taught Pediatrics to nursing students for three consecutive years (sixteen week segments, six hours/week) at the Yirgalem School of Nursing. Teaching included both theoretical and practical sessions.

Membership:

Member of Pediatrics Society and Ethiopian Public Health Association.

CURRICULUM VITAE-Tsegaye Sonto Ticha

Work Experience:

Child Survival Project Coordinator, Save the Children/US, Ethiopia Feb.2001-Present
Responsible for the oversight of health activities for SC in Liben District. Supervise SC health staff in the Liben impact area; in cooperation with the Training Coordinator, ensures that all health program staff receive regular skills training; provides reports for internal and government use on SC health programming in the impact area; facilitates program cooperation with the MOH at all levels; and works with Addis Ababa-based SC staff to develop new plans for health programming in the Liben impact area.

Head, Training Team, Oromia Health Bureau, Ethiopia Feb. 1993-Jan. 2001
Conducted needs assessments for programs, organized/conducted teaching methodology and refresher courses in regional training centers. Coordinate training at the Asela and Jima health regional training centers. Taught methodology to teachers in health schools. Incorporated family planning course into the curricula for nurses and health assistants; prepared a reproductive health manual and workshop.

Curriculum Expert, Training Department, MOH, Ethiopia 1988-1993
Worked on various curricula by preparing, implementing and evaluating the curricula.

Acting Division Head of Training Institutions, MOH, Ethiopia 1985-1988
Led, managed and coordinated all training institutions under the MOH. Acquired materials (teaching aids, equipment) for health schools. Organized various workshops to ensure conducive environment for teaching/learning.

Head Technician, Training Section, MOH, Ethiopia 1984-1985
Led and participated in the preparation of the program. Managed all training school technicians. Responsible for short- and long-term training conducted abroad and within Ethiopia. Managed all health profession training institutions in Oromia; supervised trainers and trainees. Evaluated the training program and graduates. Promoted the expansion and strengthening of training institutions and increased faculty capacity. Prepared project proposals to secure funding for training. Planned human resources development needs on a short- and long-term basis.

Assistant Expert, Training Section, MOH, Ethiopia 1981-1984
Evaluated health training curricula.

Administrative Manager, Addis Ababa Health Department, Ethiopia 1980-1981
Manager of personnel, budget, finance and general property allotted for regional health care services.

Head Nurse, Alert Hospital, Ethiopia 1978-1980
Managed the ward through planning, organizing, and evaluating staff service. Increased staff capacity through training. Developed and implemented a program for staff to teach patients how to care for themselves and their immediate environment.

**Staff Nurse, Dessie Hospital, Amanual Hospital,
Minilik Hospital, Ethiopia**

1969-1978

Provided comprehensive nursing care to patients, managed wards and taught health personnel environmental hygiene, health education, nutrition, care of their families to patients. 1969 – 1978

Education:

- Certificate; Trainer Facilitator, South-East Oromia Regional Training Center in Health, Oromia Health Bureau, 1999.
- Certificate in Training of Trainers, Ethiopian Management Institute, 1998.
- Certificate of achievement in advanced TOT, USAID, ESHE Project, 1997.
- Certificate, Advanced TOT, Western Consortium for Public Health, USA, 1997.
- MA, Health Personnel Education, 1974-1981, University of New South Wales, Australia.
- B.A., Economics and Political Science, 1974-1980, Addis Ababa University.
- RN, 1966-1969, Taffari Makonnen Hospital School of Nursing, Ethiopia.

Languages: Oromia, Amharic, and English

Annex 6. Response to Application Debriefing

Copies of the application’s summary score sheet and external reviewer comments were distributed and discussed during the CS-17 DIP workshop in Negelle. (Please see the summary score sheet and external reviewer comments attached below.) We believe that we are trying to address most of the weaknesses noted, as described below.

Weaknesses identified in the external reviewer comments to be addressed through CS-17

1. In the DIP, we have tried to be concise, while responding to the DIP guidelines. We agree that the DIP could be much more practical/usable for those involved in implementing the project if it were more concise (and more focused on the CS-17 interventions). While we have tried to improve our clarity in results, objectives, and description of activities, the way some of the goals (which are not measure) and strategies are worded may remain imprecise.
2. We are also concerned about the “thin spread of project efforts over a wide range of interventions,” a topic of much detailed discussion during the DIP workshop. Criteria for deciding which interventions and strategies to include in CS-17 were reviewed and debated,⁵

⁵ The criteria developed during the initial CS-17 design workshop in Negelle in September 2000 (first set, below), and more recently for CS-18 in Tajikistan (second set), were presented and discussed.

CS-17:

- Will value added through this CS-17 intervention/strategy likely contribute to a substantial reduction in under-five and/or maternal mortality?
- Can we do it well?
- Is there an opportunity for innovation and uptake beyond Liben District?
- Is there a strategic opportunity to build SC, DHO, and/or ZHD capacity in an important area?
- To what extent will it build capacity at the household and/or community-level?
- To what extent will it involve and support BHTs, HACs, TBAs, and/or other CS-13/DAP-supported community-level structures?
- Will it complement planned future DAP-supported food supplementation and/or other activities? (Opportunity for synergy with future DAP-funded activities?)
- To what extent will it meet community needs?
- Is it sustainable?
- Is it cost-effective?
- Is it consistent with national MOH plans and with USAID Ethiopia Mission SOs?

CS-18:

- Will value added through this CS-18 intervention/strategy likely contribute to a substantial reduction in under-five and/or maternal mortality?
- Can we do it well?
- To what extent will it meet community needs and/or build capacity at household and/or community-level?
- To what extent will it build capacity of rural health facilities?
- Are there opportunities for synergy with USDA-supported activities or with those of other donors/programs?
- Is it cost-effective and potentially sustainable?
- Is there an opportunity for innovation and uptake beyond the CS-18 site?
- Is it consistent with national MOH plans and with USAID/Tajikistan Mission SOs?

but workshop participants decided against dropping ongoing intervention work (MNC, ARI, malaria, CDD, and EPI), and against not introducing work in HIV through CS-17.

- Workshop participants discussed and defined what “functioning” will mean (how it will be measured) for the revised CS-17 objectives presented in the DIP related to the DHMT, BHTs, and HACs:

Objectives Related to “Functioning” DHMT, BHTs, and HACs, in the CS-17 Application

Result/Intermed. Result	#	End of Program Target/Indicator	Method	Interv
R-1: Improved Liben DHO capacity to effectively support community health services & activities.	1	Functioning District Health Management Team.	Final Eval.	All
	3	60% of HAC quarterly meetings attended by MOH staff.	HAC records	All
R-2: Improved capacity of BHTs & HACs in Liben to effectively address priority health needs of mothers & children under 5.	6	80% of rural PAs have trained & functioning BHTs.	“	All
	7	80% of rural PAs have functioning HAC.	“	All

Objectives Related to Functioning DHMT, BHTs, and HACs, in the CS-17 DIP

Result / IR	#	Indicator	Method	Basel.	Target	Interv.
R-1: Improved Liben District capacity to effectively support community health services & activities.	1	District Health Management Team has met 3 or more times in last year & has used data to plan activities.	Minutes MTE & FE	No	By MTE & FE	All
	2	District HIV/AIDS Council meets regularly, plans, & monitors HIV/AIDS activities in Liben.	Final eval.	No	Yes	HIV
	3a	% of PAs from which three or more HAC members have participated in three or more meetings with MOH staff over the previous year.	Health facility records	NA	80%	All
R-2: Improved community capacity in Liben to effectively address priority health needs of mothers & children under 5.	3b	% of PAs from which three or more HAC members have participated in three or more meetings with MOH staff over the previous year.	Health facility records	NA	80%	All
	6	% of BHTs which in the last 6 months have conducted 1 or more community education activity for each CS-17 intervention & turned in 4 or more monthly reports to HACs.	BHT forms at health facilities	NA	80%	All
	7	% of HACs which in the last 6 months have reviewed BHT, TBA, or CMW reports, & have sent reports to health facility.	BHT forms at health facilities	NA	80%	All

Weaknesses identified in the summary score sheet to be addressed through CS-17 include:

- In the revised CS-17 budget submitted to the USAID Office of Procurement in August 2001 (reflecting SC’s current indirect cost rate of 16.98%), direct HQ costs (\$207,294) represent 13.9% of total direct costs (\$1,486,034).

5. At the time the CS-17 application was submitted, only limited information was available regarding changes during the course of CS-13 in behavior and project results. These issues are discussed in depth in the final evaluation of CS-13.⁶ Copies of the CS-13 final evaluation were distributed, and findings, conclusions, and recommendations presented and discussed in detail, during the CS-17 DIP workshop in Negelle. SC has attempted to incorporate CS-13 lessons learned into the revised CS-17 design, as described in this DIP.
6. BHTs will not implement C-IMCI, but continue health education activities. The ability of Case Management Workers to do case management of childhood malaria, pneumonia, and diarrhea will be tested through CS-17 on a pilot basis, if MOH approval is obtained. The ability of CHWs to do case management has been documented in other settings, particularly with regard to pneumonia.^{7,8}
7. SC believes that supplementary feeding, supported through the DAP, may have contributed to childhood nutrition status not deteriorating, as could have been expected during the substantial drought in Liben District.
8. Use of TBAs and skilled providers is discussed in DIP Section III.F.
9. Breastfeeding will be addressed through the PLI/DAP/Title II program (please see DIP Section I.F, CS-17 Synergies, Nutrition).
10. A CDD objective has been added in the CS-17 results framework.
11. Most capacity building at field level is to be supported by SC's Ethiopia Field Office, rather than from SC in Westport.
12. After SC funding to post Senior Program Assistants at health facilities is no longer available, these SPAs may be hired by the MOH/DHO in Liben, but are more likely to move from these facilities to other jobs. SPAs will focus on building community capacity to address key MCH needs and facility capacity to support these community activities on a less intensive scale following the withdrawal of SC staff and improvements in community capacity. SC is helping to build the capacity of facility-based health services in Liben District in a sustainable way by constructing, equipping, and supplying new facilities (through the DAP) which are then taken over and staffed by the DHO, by training local women as Community Midwives who are then posted to local facilities and paid by the DHO, and through joint efforts to build DHO capacity to support health facilities in the district.
13. The scheduling of the midterm evaluation has been moved up to Year 2, in July 2003.

⁶ In December 2001, in response to questions from DCHA/PVC, SC submitted written suggestions to DCHA/PVC regarding the PVO CS Grants Program. One of these was that, final evaluation should be "due at the end of Year 4, to allow the project to address findings during the last year, and to aid in the PVO/project design, and PVC review, of a cost extension application."

⁷ Case Management of Acute Respiratory Infections in Children: Intervention Studies. Report of a Meeting. WHO, 1988 (WHO/ARI/88.2). "The experience in the studies indicates that Community Health Workers can be trained to responsibly dispense antimicrobials for pneumonia according to a simple classification of ARI."

⁸ Sazawal, S., and R. E. Black. "Meta-Analysis of Intervention Trials on Case-Management of Pneumonia in Community Settings." *Lancet* (1992; 340): 528–33.

Annex 7. Maps, SC CS-17 Organizational Chart, & CS-17 Forms

- Map of Ethiopia
- Map of Liben District
- SC CS-17 Organizational Chart
- BHT Tally Sheet
- TBA Tally Sheet
- HB-LSS Indicator Tracking Form

Annex 8. Ethiopia IMCI Strategies, Schedules, & CDD Protocols

Selected sections of the following documents are included in this Annex:⁹

- Department of Family Health, MOH, *National and Regional IMCI Plan of Action 1994 EFY (2001-2002)*, pages 1 and 3-9.
- Federal Ministry of Health, *Implementation Strategy for the Household and Community Component of Integrated Management of Childhood Illness (IMCI) in Ethiopia. 2001-2004*, pages 1-5 and 16.
- The cover/table of contents and CDD-related pages of the Ethiopia MOH/WHO/UNICEF 35-page chart booklet, *Management of Childhood Illness*, containing outpatient case management algorithms/ protocols for the sick young infant and for the sick child.

⁹ In keeping with DCHA/PVC guidance to “limit annexes to those essential to understand the program,” the entire contents of these documents have not been included in the DIP, but are available upon request from Tedbabe Degefi at SC’s Ethiopia Field Office, or from Eric Starbuck (phone: 203-221-4151, e-mail: estarbuck@savechildren.org) in Westport.