FARTA CHILD SURVIVAL PROJECT

Amhara National State,South Gondar Administrative Zone, Farta Woreda, Ethiopia

Final Evaluation

May 27 – June 11, 2007
Donald T. Whitson, MD, MPH
Evaluator

DATE OF SUBMISSION: December 2007

Cooperative Agreement No: HFP-A-00-02-0004600
October 1, 2002 - September 30, 2007This report was prepared by:

Donald T. Whitson, MD, MPH
24/41 Sukhumvit Soi 18
Domus Condominium 18, 12th floor
Khlong Toey, Bangkok 10110
Thailand

Tel: +66-86-315-3454
E-mail: ***dtwhitson@gmail.com***

ACRONYMS, ABBREVIATIONS AND DEFINITIONS

AFP	Acute flaccid paralysis
ANC	Antenatal care
ARI	Acute respiratory infection (pneumonia)
BCC	Behavior change communication
CHW / CHA	Community health worker / agent
COPE	"Client-oriented provider-efficient": methodology for improving quality of health care delivery through special training and ongoing supportive supervision
CORE	Group of US-based NGOs with Child Survival projects; involved in polio-eradication programs
CRP	Community resource person
CS	Child survival
DHS	Demographic and Health Survey
DIP	Detailed implementation plan
DPPO	Disaster Prevention and Preparedness Office (the designated government liaison office for NGOs)
DT	Debre Tabor (capital of Farta Woreda)
DTP	Diphtheria, tetanus and pertussis vaccine. In Ethiopia, pentavalent vaccine is being used (DTP + Hepatitis B + *Hemophilus influenza B*)
EOC	Ethiopian Orthodox Church
EPI	Expanded program for immunization
FCSP	Farta Woreda Child Survival Project
FGD	Focus group discussion
FWHO	Farta Woreda Health Office
GM	Growth monitoring (not "genetically modified"---we're not doing GM children yet!)
HC	Health center
Health promoter	Includes all community health workers (mother facilitators, EOC religious leaders, TBAs, CRPs, and others)
HEARTH	The HEARTH Nutrition model, a child nutrition methodology developed by Save the Children Federation using a positive deviance approach.
HFS	Health facility survey
HIS	Health information system
HIV/AIDS	Human immunodeficiency virus / Acquired immunodeficiency syndrome
HP	Health Post
IFA	Iron and folic acid (tablets, supplement during pregnancy)

IMCI	Integrated management of childhood illness
IMNCI	Integrated management of childhood and newborn illness (newer protocol than IMCI)
Kebele	A political sub-division of the Woreda (district). Labelled as "Peasant association" or "PA" in some earlier project documents.
KPC	Knowledge, practice and coverage (survey)
LQAS	Lot Quality Assurance Sampling (a sampling method for surveys)
MCH	Maternal and Child Health
MOH	Ministry of Health
MTE	Mid-term evaluation
MTMSG	Mother to mother support group
NNT	Neonatal tetanus
OPV	Oral polio vaccine
ORS	Oral rehydration solution (salts in packet)
ORT	Oral rehydration therapy (salts and/or other appropriate home fluids)
RDF	Rotating drug fund
ToT	Training of trainers
VCHW	Volunteer community health worker
WHO	Woreda health office
Woreda	A political sub-division of the region (South Gondar). Sometimes labeled as "District" in earlier SC documents. The Woreda is, in turn, subdivided into "kebeles".

Table of Contents

Contents **Pages**

Attachments:

A. Summary

The Farta Woreda Child Survival Project is a five-year Child Survival Project implemented by CARE Ethiopia (October 1, 2002 to September 30, 2007). The project aims to improve the health of children under five and women of childbearing age by focusing on the following interventions: Nutrition (35%), Pneumonia Case Management (25%) and Control of Diarrheal Disease (20%).

The project is located in a highland region of northwestern Ethiopia in a rural district with over 2400 villages and a population of about 278,000 people. The project focuses on children under five and women of childbearing age, and has the following objectives:

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

The FCSP adopted three principal strategies to achieve these objectives: BCC and community mobilization, skill development and improvement of access to quality health services. The project achieved an impressive degree of behavior change, including an increase in exclusive breastfeeding from 0-6 months from 73% to 95% and the proportion of children receiving complementary feeding from 6-9 months from 38% to 98%. Appropriate care-seeking for fast and difficult breathing rose from 27% to 84%, appropriate disposal of children's feces from 6% to 94%, and full immunization coverage (DTP, OPV, measales and BCG) in children 12-23 months of age from 19% to 61%.

Communities and partners have noted the improvements in their children's health, including notably fewer child deaths (and funerals), the absence of measles and whooping cough, and that children are larger and more active. Behaviors have been adopted as the "norm", and are therefore sustainable. At the same time, IMCI protocols are now being consistently applied in health facilities, and the Woreda Health Office has adopted systematic supportive supervision to improve health service quality.

Communities now have sustainable mothers' groups, who meet monthly, and whose facilitators participate in monthly coordination meetings with trained local church leaders, MOH health workers, local administration and volunteer health workers. These meetings are being held regularly in every kebele without external support. In addition, key partners hold quarterly coordination meetings, including the Woreda Health Office, EOC office, woreda administration and Woreda Education Office. These meetings are held for review and planning, and also do not depend on the presence of CARE or on the

project's financial support. The EOC is very enthusiastic about their new role in the communities.

The most important conclusions from the project are the following:

- A high degree of involvement and ownership by stakeholders and partners from the outset will maximize impact, improve project "stability" in the face of modifications and constraints, and maximize sustainability
- CARE served as a facilitator more than an implementer. Whenever possible, local resources were used for training, and capacity-building for future training was built into all training (capacity for partners to continue training in the future)
- Aside from training allowances, no external incentives were paid to community volunteers or partner staff. This avoids the problem of how to sustain external subsidies in the future.
- The BCC strategy took maximum advantage of the presence of the EOC. The EOC's pervasiveness and high degree of authority led to almost one-hundred percent coverage of BCC messages with high credibility.
- The project created a self-reinforcing network of community structures, including the MTMSGs, health posts (and HEAs), kebele administration and EOC leaders.
- The project concentrated on a limited number of high-impact BCC messages, and delivered them in a coordinated fashion through multiple simultaneous channels that achieved one-hundred percent coverage.
- Training is important, but not sufficient to improve services. Follow-up training, on-the-job training and intensive supportive supervision are all essential if services are to be improved.
- The FCSP worked *within* existing systems whenever possible. This is evident in the structure of the rotating drug fund, where the existing woreda administrative structures were used to support the fund, which has led to a high degree of sustainability.
- A long-term plan for phase out that was developed together with partners has helped ease the transition and maximized sustainability.

The project's achievements show indications of a high degree of sustainability due to a high degree of ownership by partners and communities and the fact that all of those involved have directly observed the outcomes that were achieved through the project.

B. Assessment of Results and Impact of the program

1. *Results: Summary Chart*

In some cases, the indicators have been reworded slightly (e.g. from "proportion of mothers who discarded colostrum" to "proportion of mothers who gave colostrum"), but retain the same meaning. This was done for ease and consistency of interpretation. Indicators in *italics* were not included in the DIP results framework, but are available and provide additional useful supporting information.

A word of caution in interpreting data from the Health Facility Assessments is in order. At the time of the baseline, health posts provided curative services. As such, a total of 20 health facilities including 13 health posts were assessed, and 38 of 87 cases observed and exit interviews were done in health posts. By the time of the final Health Facility Assessment, health posts were not performing curative care, and nine health posts had been redesignated as "developing health centers". Only the 12 health facilities that provide both curative and preventive services were included in the assessment (1 hospital, 1 health center, and 9 developing health centers). This may tend to skew the results toward the positive, as no health posts were included in the final HFS. For data to be strictly comparable, the baseline data should be reanalyzed, to exclude data from the health posts.

Finally, only an incomplete draft of the final health facility survey was available for the final evaluation team. The final report was made available at the time of the preparation of this final report, and the information available was incorporated.

Table1- *Project Indicator Summery*

Indicator[1]	**Source**	**Target**	**Baseline**	**Final**	**Other sources**	**Notes**
To promote the practice of health behaviors, including seeking of appropriate medical care as needed, by caregivers of children under five years and women of reproductive age, especially pregnant and lactating mothers.						
Indicator	**Source**	**Target**	**Baseline Jan 2003**	**Final May 2007**	**Other sources**	**Notes**
Nutrition						
Proportion of mothers who initiated breastfeeding	KPC	60%	31%	77% (n=300)	DHS 2005 National 69.1%	

[1] Unless otherwise specified, "mothers" refers to mothers of children 0-23 months of age, as this is the age group interviewed in the KPC surveys.

Indicator[1]	Source	Target	Baseline	Final	Other sources	Notes
within one hour after birth					Ahmara 62.6%	
Proportion of mothers practicing exclusive breastfeeding for at least six months (KPC is "at 0-5 months")	KPC	90%	73%	95% (n=63)	DHS 2005, about 51%	
Proportion of mothers who give colostrums	KPC	90%	62%	92% (n=300)	DHS 2005 Amhara 44.8% National 45.3%	
Proportion of children 12-23 months who consume vegetables, fruits and foods rich in Vitamin A in previous 7 days from survey	KPC	45%	19%[2]	N/A	DHS 2005 Amhara 19% National 26%	See footnote "2" below
Proportion of children age 6-9 months who get complementary food.	KPC	60%	38%	98% (n=64)	DHS 2005 50% (national average)	"Energy dense" did not increase from 17%. "Semi-solid" increased from 36% to 71%
Proportion of mothers of children < 2 years who during their recent pregnancy received more than 100 IFA	KPC	40%	N/A	N/A		May have been met as 49% of all mothers reported 2 or more ANC consults.

[2] This number appears to be mis-interpreted in the DIP. The baseline KPC lists 18.9% for "fruits and vegetables" in the 9-11 month age range, not 12-23 months as per the indicator. What's more, animal sources of vitamin A are better sources than plant sources, so the indicator itself is of questionable usefulness. Suggest re-analysis of the raw data for both baseline and final KPC adding together yellow/orange vegetables (response "I") + yellow fruits (response "L") + meat/fish/eggs (response "M") on the KPC.

Indicator[1]	Source	Target	Baseline	Final	Other sources	Notes
tablets						
Proportion of women with children <2 years who received deworming during second or third trimester of pregnancy	KPC	50%	N/A	N/A		Not MOH policy now. Only iron/folate. There is also no malaria prophylaxis in Farta.
Proportion of children 6-23 months who received deworming medicine in the past 6 months	KPC	*N/A*	*3%*	*59%*		
Acute Respiratory Infection (ARI)						
Proportion of mothers who seek medical care from a qualified, trained provider (Hospital, Health Center, Pharmacists) when their child under five has signs of pneumonia (fast or difficult breathing). (last two weeks)[3]	KPC	40%	27%	84% (n=32)	DHS 2005 National 18.7% Amhara 14.7%	
Proportion of mothers who do not delay for more than three days before seeking ARI-care when their child has cough or difficult breathing (last two weeks).	KPC	90%	50%	90% (n=29)		This is mis-stated in the DIP, corrected here (DIP states "do not delay" then gives the converse target (50%->10%)

[3] The indicator is "fast or difficult breathing", but the KPC questionnaires (baseline and final) ask about "cough or fast breathing".

Indicator[1]	Source	Target	Baseline	Final	Other sources	Notes
Proportion of mothers who seek medical care from a qualified, trained provider (Hospital, Health Center, Pharmacists) within 24 hours when their child under five has signs of pneumonia (fast or difficult breathing).	KPC	N/A	8%	76%		
Control of Diarrhea Disease (CDD)						
Proportion of households disposing children's stool properly (in a latrine).[4]	KPC	25%	3% latrine 6% latrine or burial	58% latrine 94% latrine or burial		
Proportion of children who had diarrhea in the past two weeks who were given the same or more:						
a. Breastfeeding (among those still breast feeding).	KPC	80%	59%	96% (n= 79)		
b. Fluids	KPC	50%	23%	82% (n=79)	DHS 2005 National 27.3% Amhara 22.0%	
c. Food	KPC	50%	14%	77%	DHS	

[4] Only "latrine" was considered correct, to reinforce latrine-building intervention. Burying was not considered correct.

Indicator[1]	Source	Target	Baseline	Final	Other sources	Notes
(children 6-23 months)				(n=79)	2005 National 14.8% Amhara 17.7%	
Proportion of children who had diarrhea in the past two weeks who received recommended home fluids or ORS.	KPC	N/A	19%	80% (n=79)	DHS 2005 National 37.1% Amhara 32.9%	
Immunization						
Proportion of children aged 12-23 months who received measles vaccine (documented—no card=no immunization)	KPC	70%	25%	74% (n=127)	DHS 2005 National 22.2% Amhara 34.8%	
Proportion of children aged 12-23 months who received BCG, DPT3, OPV3 and measles vaccines	KPC	60%	19%	61% (n=127)	DHS 2005 National 20.4% Amhara 17.1%	
Proportion of drop-outs between DPT1 and DPT3	KPC	10%	17% 10%	N/A 3%[5] (12-23m)		Data for 0-23 months not available in final evaluation report.
Immunization access: proportion of children 12-23 months who received DPT1	*KPC*	*N/A*	*33%*	*72% (n=127)*	*DHS 2005 National 36.5% Amhara*	

[5] This number is not entirely accurate, as it was calculated using only the data from children 12-23 months of age. The proper calculation uses DPT1 and DPT3 for ALL children 0-23 months. The final KPC raw data from children 0-12 months were not available for the evaluation team at the time of the final evaluation. The corresponding figure for the baseline KPC using data only for 12-23 months is 10%.

Indicator[1]	Source	Target	Baseline	Final	Other sources	Notes
(documented)					*57.2%*	
Immunization access: proportion of children 12-23 months who received DPT3 (documented)	*KPC*	*60%*	*30%*	*69% (n=127)*	*DHS 2005 National 25.1% Amhara 31.5%*	
Other indicators (maternal health)						
Antenatal care coverage: proportion of mothers of children 0-23 months who had at least one antenatal care consult during the previous pregnancy	*KPC*	*N/A*	*23%*	*58% (n=300)*	*DHS 2005 National 27.6% Amhara 26.5%*	*85% of of these (or 49% of the total) reported 2 or more antenatal care consults.*
Institutional delivery: proportion of mothers of children 0-12 months who delivered in a health facility	*KPC*	*N/A*	*4%*	*9% (n=300)*	*DHS 2005 National 4.8% Amhara 3.5%*	
Knowledge of maternal danger signs: proportion of mothers who can name at least two danger signs in pregnancy, labor, delivery, or post-partum period.	*KPC*	*N/A*	*62%*	*97%*		
Process indicators						
Number of CHWs and service providers trained in breastfeeding counseling	Annual reports		2464 MTMSG facilitators, 527 religious leaders (74% active—see notes nutition), 153 kebele leaders, 269			

Indicator[1]	Source	Target	Baseline	Final	Other sources	Notes
			CRPs, 40 VCHWs, 92 health workers			
Number of target breastfeeding communication products and materials developed and disseminated	Annual report		2664 sets of counseling cards, 8300 posters, 500 t-shirts 2000 leaflets 30 cassettes			This does not separate out those for breastfeeding from the others.
Percentage of target audience exposed to IEC/BCC messages on breastfeeding	Qualitative assessment, evaluation visits		Entire community			BCC coverage probably 100%
BCC strategy developed	Annual report		Done and implemented			
Number of mother-to-mother support groups established	Project staff		2664 groups			

Indicator	Source	Target	Baseline	Final	Other sources	Notes
To increase sustainable access to health education, quality care, and essential medicines (from government institutions, private sources, and partner organizations).						
Indicator	**Source**	**Target**	**Baseline Jan 2003**	**Final May 2007**	**Other sources**	**Notes**
Nutrition						
Proportion of women who receive appropriate counseling on breastfeeding (during ill child consults)	HFS	50%	0%	Not available		This question is not included on the HFS form.
Proportion of women who receive appropriate nutritional counseling	HFS	60%	5.4%	90% (n=50)		

Indicator	Source	Target	Baseline	Final	Other sources	Notes
(during ill child consults)						
Proportion of children who received one dose of Vitamin A supplement in last six months.	KPC	90%	80%	87% (n=234)	DHS 2005 National 45.8% Amhara 43.2%	
Proportion of children aged 0-23 months whose weight is taken, plotted on the growth monitoring chart [in the past four months] and their mothers counseled. (card-confirmed)	KPC	40%	0%	39% (n=300)		Counseling cannot be verified by KPC. This indicator refers only to whether they were weighed and plotted.
Acute Respiratory Infection (ARI)						
Proportion of communities who have cotrimoxazol access for 10 of 12 months (from health facilities) [6]	HFS for facilities	60%	15% of facilities	83% of facilities (final HFA; day of survey)		Cotrimoxazol is available in all 9 health facilities with RDF (evaluation team observation) Not free of charge.
Proportion of communities who have cotrimoxazole access for 10 of	HFS for facilities	60%	0%	N/A See notes		Indicator no longer valid. Community pharmacies not implemented

[6] This should be redefined as "health facilities" and not "communities", which is too difficult to define. In addition, national health policy was not under the influence of the project.

Indicator	Source	Target	Baseline	Final	Other sources	Notes
12 months (from community pharmacies)						as they are not accepted by MOH policy.
Control of Diarrhea Disease (CDD)						
Proportion of CHAs and health posts that have ORS ten of twelve months	HFS	70%	30% of health facilities	66.7% (final HFA on day of survey)	HFS showed 94% of children with diarrhea received ORS in facilities.	ORS is not free of charge. Health posts not included in final HFS.
Immunization						
Proportion of health facilities with measles, DPT, BCG and OPV vaccines on the day of inspection.	HFS	75%	30%	DPT/OPV 83% Measles / BCG 75%	Visits during evaluation showed all facilities visited had vaccines.	Health posts not included in final HFS
Proportion of [mothers] women who have appropriate counseling and information on immunization	HFS	75%	N/A	Not asked on HFS	Final HFS showed 94% of ill children had immunization status checked during consult (n=60); 4% at baseline.	Cannot verify whether checking the card was followed by immunization counseling.
Process indicators						
Quality Assurance (QA) team established	Annual reports	Training in COPE for staff in all health facilities. No teams established.				
Number of TOT training on specific quality improvement	Training reports	1 (COPE)				

Indicator	Source	Target	Baseline	Final	Other sources	Notes
tools						
Number of service providers trained on child health COPE	Training reports			38		
Number of CHWs and Village Health Committees (VHCs) trained in quality care related issues	Training reports			N/A		CHWs are not providing health care according to MOH policy.

Indicator	Source	Target	Baseline	Final	Other sources	Notes
To ensure that quality health care is provided in areas of diarrhea, pneumonia, malnutrition and immunization by government health personnel, CHAs, CHWs (including CBRHAs and trained TBAs) and other service providers.						
Indicator	**Source**	**Target**	**Baseline Jan 2003**	**Final May 2007**	**Other sources**	**Notes**
Nutrition						
Proportion of health personnel/ CHWs who are able to counsel mothers about feeding a sick child	HFS	75%	N/A	90% (n=50)		Final indicator is proportion of sick children receiving nutrition counseling.
Proportion of health facilities with stock of essential drugs and supplies (Iron, Vitamin A, antihelminthics, scales and	HFS	80%	Vit A 35% Antihelm 70% Scale 60%	Vit A 67% Antihelm 92% Salter Scale 67% Baby scale 100%	Observation shows all facilities with RDF have drugs. All have equipment. No HPs have	MOH policy allows only health centers to have drugs.

Indicator	Source	Target	Baseline	Final	Other sources	Notes
related materials for growth monitoring and promotion) in the last month				Iron 25%	drugs.	
Acute Respiratory Infection (ARI)						
Proportion of CHAs and health facility staff who correctly diagnose and manage pneumonia cases according to protocol	HFS (quality)	70%	<15% assess correctly 82% manage correctly	90% assess correctly 100% managed correctly	Note that Health Posts are not providing ARI treatment, but do provide malaria treatment.	Indicator is % of cases of cough/difficult breathing correctly assessed and treated in **health facility.**
Proportion of children assessed by health workers for all three danger signs	HFS	60%	2.2%	68%.		This indicator probably reached target per evaluation observation.
Control of Diarrhea Disease (CDD)						
Proportion of children with diarrhea who receive appropriate case management in the health facility.	HFS (exit interview)	50%	25% correct assessment 72% ORS But 46% of simple diarrhea received antibiotic	89% correct assessment 94% ORS. But 17% of simple diarrhea received antibiotic		Assessment = pinch skin, look for sunken eyes. Note that health posts were not included in the HFS. The results apply only to health centers.

Indicator	Source	Target	Baseline	Final	Other sources	Notes
Proportion of CHAs who can correctly demonstrate preparation of ORS or appropriate home preparation	HFS (quality)	70%	Not tested	Not tested		CHAs are not included in MOH policy.
Proportion of CHAs who can practice proper standard case management of diarrhea according to MOH protocol.	HFS (quality)	70%	N/A	100% (mothers)	See KPC results for mothers. This is more important than CHAs.	CHAs are not included in MOH policy. Redefine as HEAs.
Process indicators						
Number of CHWs and service providers at health facility level trained in case management	Training and annual reports			33 health workers trained in IMCI		CHWs are not allowed to provide curative care according to MOH policy.
Number of people referred to the health facilities	Annual reports			Not available	Number of referrals is not large. Most health centers receiving fewer than 20 referrals per month according to interviews during final evaluation and maybe partially explained due to self referral of patients.	
Number of supervisory visit made to the	Supervision forms (CARE and	**Region:** 0 **Zone and district EOC**: 168 visits (>50% of churches) District Health office: 12 visits				

Indicator	Source	Target	Baseline	Final	Other sources	Notes
community and health facility by: a. Regional health bureau b. Zonal c. District (core CSP team)	FWHO)	to each facility **District Core Team Members:** 9 rounds to idirs, churches, kebele meetings, VCHWs, etc. **CARE Project staff:** >1500 visits to MTMSG, school clubs, religious leaders, health facilities, kebele admin, VCHWs, churches, idirs, CRPs, home visits, model mothers, and case studies				

Indicator	Source	Target	Baseline	Final	Other sources	Notes
To strengthen local and community-based institutions and partners and build capacity to support child survival activities on a sustainable cases						
Indicator	**Source**	**Target**	**Baseline Jan 2003**	**Final May 2007**	**Other sources**	**Notes**
Proportion of communities in peasant associations have established revolving drug funds (community pharmacies) and mechanisms for cost recovery for essential drugs including ORS	Administrative and program records review	60%	0	9 developing health centers + 1 health center		Only in health centers per MOH policy. Indicator changed at MTE.
Proportion of CHWs are involved in health education and community	Administrative and program records review	80%	Not known	100%		CHW definition now broadened

Indicator	Source	Target	Baseline	Final	Other sources	Notes
mobilization efforts						
Proportion of EOC leaders actively support child survival intervention	Rapid assessment survey.	50%	None	527 total trained 74% working regularly	Interviews during final evaluation show that many more are working informally.	
Advocacy strategy for use of antibiotics by CHAs Developed	Review of administrative and project records	N/A	N/A	N/A		Against MOH policy. Eliminated at MTE.
Nursing School and EOC staff provide ongoing training	Administrative and program records review	N/A	N/A	Nursing school is key to training		Nursing school is especially active in training.
Proportion of health facilities within the district provide IMCI services and receive referral cases from CHWs	Conduct facility assessment	90%	None	100% of HCs. HPs lack antibiotics.		Quality of IMCI generally good. Limited by lack of organized formal referral system and transportation.
Change in national/regional guidelines regarding use of antibiotics by CHAs	None	N/A	N/A	N/A	N/A	Against MOH policy. Eliminated at MTE.
Process indicators						
Number of CHWs trained in PHC	Annual reports	2464 MTMSG facilitators 527 religious leaders (61 in BCC)				

Indicator	Source	Target	Baseline	Final	Other sources	Notes
		153 kebele leaders / administrators 269 CRPs 40 VCHWs 118 existing CHAs				
Number of mother-to-mother support groups in place and active	Internal quarterly reports	2464 MTMSG active				
EOC BCC and C-HIS strategy in place	Supervision reports	25 data boards in place				
Number of health facility revolving drug funds and community pharmacies in place	Supervision reports	9 RDF in place per MOH policy (only health centers)				Community pharmacies eliminated at MTE.

2. ***Results: Technical Approach***

a. Brief overview of the project

The Farta Woreda Child Survival Project is a five-year Child Survival Project implemented by CARE Ethiopia (October 1, 2002 to September 30, 2007). The project aims to improve the health of children under five and women of childbearing age by focusing on the following interventions: Nutrition (35%), Pneumonia Case Management (25%) and Control of Diarrheal Disease (20%).

The project is located in Farta Woreda, an entirely rural district divided into 40 "kebeles" and with a total of over 2400 villages located in the highlands of northwestern Ethiopia. The total population is estimated at 278,851 people, 45,523 children under five and 66,859 women of childbearing age. The region is poor, with health indicators among Ethiopia's worst. Although the project office is based in the centrally located town of Debre Tabor, Farta Woreda occupies the "doughnut-shaped" rural area that surrounds but does not include the town. The area is highland, with an elevation varying between about 1100 and 2500 meters. The population is 95% Ethiopian Orthodox Christian.

Each village in Farta Woreda has an average of about 22 families. Each of the 40 kebeles has an average of five churches, 60 villages, one health facility (a health post or a "developing health center"), and a school. The entire woreda has 30 health posts, 9

developing health centers, 177 churches, 47 elementary schools and 57 local "idirs". Transportation is difficult, and some villages are not accessible by vehicle at all.

The Farta Woreda Child Survival Project was designed with the following objectives:

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

The project is implemented through three principal strategies: 1) community mobilization and BCC, 2) skill development and 3) quality assurance and improved access to quality health services.

One of the unique features of the project is CARE's role as coordinator and facilitator more than implementer. CARE Ethiopia has consistently worked with and through many different partners to achieve the project's objectives. These include the following most important partners:

Table 2- *Key Partners for Farta Child survival Project*

Level	***Government***	***Civil Society***
Woreda	Woreda Health Office Woreda DPPO Woreda Education Office Debre Tabor Nurse College Debre Tabor Hospital Debre Tabor Health Center	Woreda/Zonal Ethiopian Orthodox Church
Kebele and sub-kebele (40)	Kebele administration (4 members per kebele) Schools (47) Health facilities (30 health posts, 9 "developing health centers" 1 health center and DT hospital)	Volunteer community health workers (40) Churches and their leaders (177 churches, 527 priests) Idirs (soon to be 80)
Communities (>2400)		MTMSG (>2400) Community resource persons (40) Other health promoters (many)

The key strategy for achieving behavior change was the formation of Mother to Mother Support Groups (MTMSG) in every community. These meet monthly to discuss key Child Survival Messages. The key to achieving coverage and credibility of these groups

is the involvement of Church leaders, who reinforce the key messages and encourage mothers to attend the MTMSG meetings. The entire BCC strategy is coordinated through regular meetings between CARE, the FWHO, the EOC and community members at each level.

At the same time, the project has worked to support improved quality of services at health facilities through in-service training, the introduction of supportive supervision and provision of key equipment and supplies. Almost all training was done through local partners, including the Debre Tabor Nursing College. In this way, training programs are institutionalized locally and can be repeated in the future.

Other supportive strategies used to overcome obstacles include the establishment of a rotating drug fund for essential IMCI medications and capitalization of idirs to reduce the barrier of the cost of emergency health care for families. Other strategies adopted by the project are school health clubs and school gardens, in collaboration with the department of education.

The project was carefully monitored through a participatory health information system supplemented by a series of special evaluations and surveys, including baseline and final KPC surveys, LQAS surveys, qualitative survey, baseline and final health facility assessment, and others.

In the technical sections that follow for each intervention, first there is a discussion on strategies used by CARE to achieve the CS objectives, followed by results, positive and negative factors influencing the outcomes, and special outcomes and lessons learned.

b. Nutrition (35%)

The nutrition intervention received the most attention among the various interventions, and potentially had the greatest overall impact on child health. It is also probably the most sustainable of the interventions as it relies almost exclusively on home behaviors. The project focused on Essential Nutrition Actions, encouraging early and exclusive breastfeeding to six months of age, introduction of appropriate weaning foods, continued breastfeeding to two years of age, and feeding during illness. Micronutrients were a relatively minor focus. Some attention was given to vitamin A (gardens and supplementation). CARE did not emphasize either iron or iodine in the nutrition intervention (see constraints).

BCC and nutrition counseling

The principal project activities and strategies for achieving behavior change, community mobilization and capacity-building are discussed in the appropriate sections on cross-cutting activities (BCC, training and community-mobilization, capacity-building, and training), as these apply to all of the interventions. For changing household behaviors, the BCC strategy was crucial, and the MTMSG, model mothers, and the EOC leaders proved to be the most important. For this intervention, strengthening of the health system through capacity building, management and logistical support and training played a

secondary role, supporting growth monitoring, nutrition counseling during ill child consults, and micronutrient supplementation. The following project activities are specific to the nutrition intervention.

Growth monitoring

One special area of support to the health system was in the area of growth monitoring. This is a notoriously difficult activity, as it is complex, and requires a sustained effort with high coverage and quality in order to achieve any impact at all. In fact, it was the repeated disappointing performance of growth monitoring in many child survival programs that led to the development of alternative approaches to improving child nutrition, such as HEARTH. CARE provided training for health workers and health promoters in growth monitoring, as well as supportive supervision using COPE methods.

Positive deviant mothers

Positive deviant mothers are discussed further in the section on BCC below. The identification and "publicizing" of mothers who exemplified the desired CS behaviors in each community was mentioned by community leaders, VCHWs and MTMSG facilitators as important in convincing mothers to adopt appropriate breastfeeding and feeding practices. This approach is supported as formal policy by the Regional Health Office as part of the MOH's "model mothers" program as part of the "Health Extension Package".

HEARTH

Although the use of the HEARTH model is discussed in the DIP, the CARE team chose not to implement it. This decision was supported by the MTE, and this consultant agrees with the decision. The HEARTH model is highly labor-intensive and would have been impossible to implement properly in over 2400 villages given the human resources available. CARE correctly chose to intensify its BCC activities through the MTMSG and other channels, and adopt the positive deviance approach through the MOH "model mothers" program.

Home gardens

Home and school gardens are mentioned several times in the DIP as a means to increase vitamin A consumption and improve household food security. As of the MTE, little had been done aside from some training for agricultural extension agents and working with other CARE projects. School gardens are mentioned as a possible future strategy in the MTE. By the time of the final annual report, food demonstrations had been done in collaboration with the Woreda Agriculture Office in seven kebeles, and several school and home garden initiatives were underway. By the final evaluation, there were school gardens in twenty kebeles. The schools were given seeds for food diversification and income-generation. They planted cabbage, tomatoes, carrots and beets. These gardens were not inspected during the final evaluation.

Curiously, in the sustainability report, gardens are cited as one of the most sustainable activities, and community members cited these as important. Nonetheless, the garden

initiative remained in the realm of a "pilot" and was not scaled up. It had little overall impact on child nutrition.

Vitamin A and other micronutrient supplementation and deworming

Vitamin A distribution and deworming were carried out during immunization activities, usually during campaigns. Whereas these interventions rightly belong in the section on nutrition, the factors affecting success and the constraints are the same as those discussed in the section on immunization that follows. CARE provided training in planning and management and supportive supervision, supported quarterly partners review meetings and monthly kebele review meetings, as well as providing logistical support for campaigns. Iron supplementation during pregnancy received only minor attention during the project, though it was included in the MOH antenatal care training curriculum and is included in maternal health supervision checklists. This is in spite of the fact that antenatal iron supplementation is effective in reducing iron-deficiency anemia in infants.

Feeding during and after illness

Feeding during and after illness are important messages for both management of childhood illness and infant and child nutrition. One reason is the high frequency of minor illnesses such as diarrhea and ARI in young children: in the KPC, 26% of mothers reported that their children had diarrhea in the previous two weeks, and 11% had ARI in the previous two weeks. This translates to six episodes of diarrhea and three episodes of ARI in the first two years of life. This is significant, but actually lower than is found in similar surveys in other developing countries. During illness, children may lose a significant amount of weight very rapidly due to refusal of food, increased metabolic demand, and loss of nutrients (in diarrhea). Therefore, inclusion of a single message to increase feeding *for the weeks after* an illness is important, as increasing caloric intake during the illness may not be possible due to the child's refusal of food. Whereas a message to increase food, liquids and breastfeeding *during* illness was included in the BCC package, increasing feeding *after* illness was not. This is a common oversight in many CS projects.

i) Results baseline to final

The achievements of the FCSP in the area of nutrition are nothing short of outstanding. All of the nutrition targets for the FCSP were met or exceeded, as can be seen in the results summary table above.

Nutrition is a very complex intervention, including changing household infant and child feeding behavior and health-seeking behavior, improving access to and quality of health services, micronutrient supplementation, growth monitoring, antenatal care, and gardens, among other strategies. This report contains various comments and suggestions on how the various components may have been improved. These are not meant to undermine the overall success of the project, but rather, to make suggestions on how future projects may be improved further. However, all too often, Child Survival projects become bogged down in the less-important interventions and lose sight of the essentials. This cannot be

said of the FCSP, which concentrated on the most critical interventions, that is, early and exclusive breastfeeding and appropriate complementary feeding.

The final LQAS survey (December 2006) found a prevalence of weight for age of -2 SD of or more in children 0-23 months of age of 26%. Although comparable baseline data for the project zone are not available, the 2005 Ethiopia DHS found a prevalence of low weight for age (below -2 SD) in children under five of 38.4% nationwide and 48.9% for Amhara region. The CARE South Gondar Household Livlihood Assessment in 2000 found a 59.2% prevalence of underweight among children 0-5 years of age. This is strong evidence for an improvement in child nutrition in the project zone that is directly attributable to project interventions.
–
In addition to the nutrition survey, qualitative comments by community members provide strong supporting evidence for improved nutrition during the life of the project. One male health promoter in one village commented: “with better feeding, my younger child is bigger and stronger than my older child”. Finally, there is strong indirect evidence from proxy behavioral indicators that would indicate that behavioral practices regarding breastfeeding and complementary feeding of infants and children improved significantly.

Infant and child feeding practices (household behaviors)

All targets for nutrition were either met or exceeded (note: vitamin A supplementation reached 87% with a target of 90%, which are technically equal). What is perhaps even more impressive are the levels reached are *far* above the national average for exclusive breastfeeding, giving colostrums and complementary feeding. Exclusive breastfeeding to six months has risen from a baseline of 73% to 95% in the project zone, but the national average is only 51% (DHS 2005).

There was similar improvement in the indicators for complementary feeding. It is curious that the problems identified with infant feeding in the project zone at baseline were the opposite of those found in most other countries; that is, in the project zone women exclusively breasted for too long, and delayed the introduction of complementary foods.

Although complementary feeding improved overall, there is less evidence that the *quality* of the complementary feeding improved greatly. For example, whereas in the 6-8 month age group feeding semi-solid foods increased from 36% to 71%, feeding of energy dense foods did not increase (16% at baseline, 17% at final). In the 9-11 month olds, feeding energy-dense foods rose from 19% to 47%, but animal foods rose only slightly, from 38% to 48%. There is no objective information on the frequency of feeding, but several mothers commented during the evaluation that it had not changed.

There was anecdotal and qualitative evidence from both CARE staff and mothers during the final evaluation that messages encouraging pregnant women to eat one extra meal per day and to reduce their workload were understood and put into practice. However,

systematic investigation of the magnitude of this behavior change was not carried out during the evaluation, and these questions were not included in the KPC surveys.

One message that was heard in nearly all focus groups with mothers was that the adoption of early, exclusive, and appropriate feeding had become the "community norm", that is, it was *expected* that mothers would exclusively breastfeed to six months, and then introduce complementary foods. Any deviation from this was considered "abnormal". In addition, the evaluation team heard numerous comments from mothers, men, and leaders that they had witnessed their children's improved nutrition and growth once the new nutrition practices were in place. This is evidence that the behavior change is likely to be sustainable.

Improvement in health services and micronutrient supplementation

Most of the gains in infant and child nutrition are the result of improvements in household feeding practices. However, improvements in health services, specifically micronutrient supplementation (child vitamin A and antenatal iron), deworming, growth monitoring and nutrition counseling, nutrition counseling during sick child consults, and antenatal care certainly contributed somewhat. Deworming during pregnancy is not MOH policy and was not done.

The coverage for vitamin A supplementation was already high at baseline (80%) and rose only slightly to 87%. However, deworming rose from 3% to 59%. The increase is impressive, but the reasons why deworming did not reach the same coverage as vitamin A, which is administered in the same way (during campaigns) though to a slightly different age group (vitamin A to 6-59 months, deworming 12-59 months). is not clear. It is perhaps due to the fact that once children are immunized, mothers are less likely to bring them during campaigns. The CARE team also suspects that there may have been problems with the way the questions were asked during the KPC survey. In addition, there were reportedly some stockouts of antihelminthics.

The indicator on iron supplementation in pregnancy is, "the proportion of mothers of children under two who received at least 100 iron/folic acid tablets during pregnancy"., Unfortunately, questions to verify coverage for this indicator were not included in the KPC surveys as bednet distribution was still ongoing. Antenatal care (at least one visit) increased from 23% at baseline to 58% at the final, and, of these, 85% (or, 49% of all women) said they attended two or more consults. As iron/folic acid tablets were present in all health centers visited, it is likely that the target of 40% coverage for "100 iron/folic acid tablets" was met. Note that only health centers perform antenatal care, so pregnant women may have to walk two to four hours for a consult.

Although both the DIP and MTE mention iodine supplementation, there were no targets set and use was not assessed by the KPC surveys. According to CARE staff and MOH documents, iodization of salt is government policy, but implementation has met with

technical and administrative difficulties which are being addressed by the MOH. Messages were included in the project, but access to iodized salt is poor.

Nutrition counseling and growth monitoring

The proportion of children who were observed receiving nutrition counseling during sick-child visits in the final HFS increased from negligible at baseline to 90% (in health centers only). This is in agreement with observations during the final evaluation and is likely the result of IMCI training together with supportive supervision.

The proportion of children with weight plotted on a growth monitoring card in the last four months improved from negligible at baseline to 39% at the final KPC survey, and fully 55% of children had a child health card. It is not possible to determine the proportion of these who received adequate nutrition counseling during growth monitoring, and growth monitoring activities were not observed during the final evaluation. However, judging from the counseling that was observed to be occurring during sick child consults both in the final qualitative survey and during the final evaluation, it is reasonable to assume that at least some counseling is occurring. Note that growth monitoring was one of the principal activities of the Health Extension Agents, which were introduced in 2006.

The *total number* of home and school gardens that were started was not well documented in the project reports, and targets were not set. Although there was some discussion of this intervention during the final evaluation, it was clear that this intervention never moved beyond the pilot stage. Anecdotal reports suggest that the activity was popular, especially for school gardens, and was cited by community members as one of the more sustainable aspects of the project. Comments in the project documents correctly admonish project staff to pay more attention to the selection of the plants in order to maximize their vitamin A content (cabbage, for example, has little nutritional value).

ii) Factors affecting achievement of program objectives

The most important factor in achieving the project's objectives was CARE's focus on the most important interventions and messages, namely, early and exclusive breastfeeding, appropriate complementary feeding among home behaviors, and improved nutrition counseling and vitamin A supplementation for health services. All other activities and interventions were rightfully secondary (growth monitoring, other micronutrients, gardens, etc.). A common shortcoming of many projects is to try to do everything, and to end up doing nothing well.

The impressive improvement in appropriate breastfeeding and complementary feeding was due primarily to the BCC strategy, which combined a series of very focused and coordinated messages with a multiplicity of delivery modes. Mother to mother support groups and involvement of EOC leaders, priests and confessors were the most effective strategies. The behavior change strategy is discussed more in depth in the section on BCC below.

Nutritional improvements were widespread, visible and present long enough in the community for the community to take notice. Numerous comments were heard from mothers and health promoters during the final evaluation indicating that community members were convinced that the new breastfeeding and feeding practices had improved their children's health, This factor is important in the sustainability of the behaviors.

The improvement in the coverage of growth monitoring is easily attributable to the MOHs policy of recruiting HEAs to staff health posts. CARE staff supported training and supervision of these health workers, whose primary responsibility is outreach from health posts, especially for immunization and growth monitoring. Growth monitoring coverage rose from 0% at baseline to 25% in March 2006, to 40% in December 2006 and did not increase further. The increase during 2006 corresponds to the arrival of the HEAs and the intensification of outreach services. In addition, CARE assigned one non-CARE VCHW to coordinate each outreach session with oversight and coordination from the kebele VCHWs. This factor was important in community mobilization for outreach activities. Growth monitoring was not mentioned in focus groups with mothers as a "norm" activity—that is, unlike immunization and breastfeeding, it was not in the forefront of community opinion as a factor that had changed infant nutrition.

Another factor that positively affected the nutrition intervention was CARE's support for IMCI training and COPE supervision for health workers. The training and supervision included improving nutrition counseling during ill-child consults (observed in the qualitative evaluation and final evaluation). Health workers have a high degree of credibility, and counseling messages are often heeded.

iii) Contributing factors for objectives not fully achieved (constraints)

At the risk of detracting from the tremendous nutritional gains achieved in the FCSP, this section discusses some issues that would have made the nutrition intervention even better than it was. Some of the suggestions, such as iron and iodine, were not included in the original project design, but would be beneficial in future projects in this zone and elsewhere in Ethiopia.

As per the recommendations of the CARE 2006 consultant report, observations in the field, and the results of the KPC, more specific messages on child feeding would be beneficial, including density, frequency, and diversity as well as active feeding (see the recommendations in the nutrition paper at the end of last annual report). The qualitative study on infant feeding practices recommended in the consultant report was not carried out.

Growth Monitoring

According to observations in the field, the recommendation to include moderate malnutrition on community data boards was also not done. This recommendation should

be modified to say “faltering growth”, as GM does not measure “malnutrition” in the strictest sense (which requires height), but rather, identifies faltering growth. Recording this indicator on community data boards could be used as an early warning system for an imminent food security crisis, which is a recurrent problem in the project zone and would therefore be worth exploring. Finally, whereas all health posts reportedly have some sort of appropriate infant weighing scales, according to the HFS, not all health centers have them (one health center was observed during the final evaluation to have only an adult scale). As with immunization, health centers do not perform outreach, and children’s weight may not be plotted on a growth chart during an ill-child visit to a health center.

Gardens

Gardens usually require a significant sustained effort and technical expertise and collaboration in BCC, nutrition and agriculture if they are to lead to meaningful sustained improvements in child health. Garden initiatives usually have one of three main purposes: i) increase consumption of beta-carotene; ii) serve as a source of cash for the purchase of nutritious foods (such as animal products); or iii) serve as a focus for discussion and demonstration of new dietary practices (usually related to vitamin A). For the first two to be effective, scaling up becomes a problem when the target population is large, as was the case with the FCSP. In order to be effective, the objectives of the garden activities must be explicit at the outset.

In order to increase consumption of beta carotene, it is necessary to carefully select the plants to be grown, provide technical assistance in how to cultivate these new plants, and then change eating habits instead of selling the food. In the local setting, carrots, orange sweet potatoes and dark green leafy vegetables would perhaps have been the best choices. Perhaps a better option would be to investigate and encourage feeding of selected available vitamin A-rich animal products to young children (such as eggs), which are required in only small amounts due to their high vitamin A content.

Iodine

Iodine is mentioned only once in all the CARE documentation for the project, in the DIP under the list of priority nutrition activities for CC/H-IMCI. There is a single passing mention of iodine in the DIP: “adequate intake of iron and iodized salt will be encouraged”. There is no other mention of iodine in any of the child survival documents. In spite of this, clinical goiter is common among mothers in the region, as was observed during the final evaluation. In addition, according to FCSP staff, communities in this landlocked and mountainous region often consume locally-produced salt and consume little seafood. This is borne out by the 2005 DHS survey that found that nationwide only 20% of households used adequately iodized salt, and in Amhara, only 15% do. Nonetheless, questioning of both mothers and FCSP staff during the final evaluation did not reveal evidence of widespread clinical effects in children (deafness, mental retardation or spasticity). A rapid goiter survey and salt survey could assess the need for iodine supplementation in future projects, and Helen Keller International provides a rapid

assessment methodology that may be used in future projects. As mentioned above, iodization of salt is official MOH policy, and the MOH is working to increase access, which remains poor.

Iron

The 2005 DHS found the prevalence of moderate to severe anemia to be 32% in children 6-59 months in Amhara Region (national average 32.1%). As even moderate anemia can lead to permanent cognitive impairment over a relatively short period of time, it may be advantageous to address this problem more in depth in the region in future projects. Iron supplementation is mentioned several times in the DIP, but neither detection of anemia nor appropriate nutrition messages were included in the FCSP, as routine iron supplementation it is not MOH policy (except for iron supplementation in pregnant women), though improved sanitation and systematic deworming would be expected to reduce the prevalence of anemia where hookworm is common. As mentioned earlier, iron supplementation during pregnancy probably increased significantly during the life of the FCSP, but this would be expected to only benefit infants up to about six months of age when their natural neonatal iron stores are depleted.

iv) Special outcomes and unexpected successes

There were no unexpected outcomes that have not been thoroughly discussed above. At the risk of being repetitive, the general community perception that children are now bigger and healthier than before is of critical importance to the adoption of the new behaviors as "the norm", which then reinforces the sustainability of the behaviors through social pressure.

c. Acute Respiratory Infection (25%)

Acute respiratory infection is the number one cause of death among young children in high-altitude environments such as the FCSP project zone. The key strategies used by the project to reduce mortality due to ARI include the following:

Community-based strategies

- Improved household recognition of the symptoms and signs that require immediate attention at a health facility. This was achieved through the various channels of BCC, especially including mother-to-mother support groups and positive deviant modeling.
- A community-based referral system to health facilities,
- Community mobilization to support case-recognition and referral
- Idirs to overcome cost barriers
- Community health information system and regular review

Strengthening the quality of health services

- IMCI training of health workers to improve diagnosis and treatment at health facilities

- Supportive supervision of health workers in IMCI through COPE training and logistical support
- Improved availability of key drugs through the establishment of a rotating drug fund at health centers and training in logistics management
- Improved planning and management through multi-sector planning and review (quarterly partner review meetings and monthly kebele level meetings)

Reducing child mortality from ARI is a relatively straightforward intervention: children with fast and/or difficult breathing should quickly seek out a trained caregiver that has appropriate antibiotics available. It is more complex than it appears, however, as pneumonia kills children very quickly, often within less than 48 hours from the onset of symptoms and the signs and symptoms are relatively subtle (high respiratory rate, chest indrawing, inability to feed). Successfully reducing infant and child mortality from ARI requires a high degree of alertness on the part of caregivers, very well-trained health workers, and almost no stockouts of medicine. There is no known effective home care action that can prevent an illness from progressing to pneumonia, though good infant and child nutrition, immunization against pertussis and measles, and reduction of smoke in houses (through the use of smokeless stoves, for example) are known to contribute to reducing the incidence of pneumonia overall. This is the reason for the importance of prompt household and community case-recognition and care seeking, and high quality care at health facilities.

Reducing household smoke was not an explicit message in the FCSP, and is not mentioned in any of the project documentation. However, smokeless stoves are being promoted by the FWHO as a part of the Health Extension Package, and are included in the criteria for certification as a "model mother". The FCSP is indirectly supporting this initiative.

i). Results baseline to final

The results of the key indicators are listed in the results summary table above. The increase in care-seeking for fast and/or difficult breathing is nothing short of spectacular (27% to 84%), especially considering that there are only nine health centers in the 40 kebeles, and many villages are from two to four hours walk from a health center where medicines are available. Fully 76% of mothers who had sought care said they had done so within 24 hours after the onset of symptoms. Most of the increase in maternal knowledge of danger signs and increase in care-seeking occurred before the March 2006 LQAS survey. This was after IMCI training for most health workers, but before the institution of the rotating drug fund. Most of the MTMSGs were functioning by the time of the March 2006 survey, but the BCC counseling cards were not yet available.

Health workers also showed significant improvements in their ability to assess and treat ARI, with correct assessment rising from under 15% to over 90% according to the health facility survey. Management of pneumonia once it is diagnosed was already high at baseline (82%), and improved to 100% in the final HFS. Although health workers were not using clinical IMCI forms at the time of the final evaluation, the IMCI protocols were

in evidence in the examining rooms, and health workers were knowledgeable about the protocols and diagnostic criteria for ARI. Unfortunately, only 42% of health facilities were found to have a timing device (final HFS). Health workers were observed to lift the child's shirt and check for rapid breathing during the final evaluation observations. During the final evaluation, observations, diagnoses and treatment were correctly being noted in the patient registries.

Likewise, whereas at baseline only 15% of health facilities had stocks of cotrimoxazole, the rotating drug fund has reduced stockouts to almost zero *in health centers.* Only health centers are permitted to have medicines, according to MOH policy, and the plan to advocate for a change of national policy to allow for community pharmacies as described in the DIP was (correctly) scrapped at the mid-term evaluation.

The community-to-health facility referral system received significant attention during the final year of the project. An early version of the referral system, based on paper forms, was little used. CARE and the FWHO trained EOC leaders, VCHWs, HEAs and MTMSG facilitators in a new referral system using color-coded chips indicating the reason for referral (yellow, blue and red depending on the disease). Chips were distributed to these workers, and collected in health facilities. As of the final evaluation, all health facilities that were visited were aware of the system and could show their box of chips for the current month. None had more than five chips in the box. Health workers uniformly reported that they receive several per week, but no more, and that referred patients are treated in the same way as any other patient. This agrees with observations by mothers who were interviewed during the final evaluation focus groups.

ii). Factors affecting achievement of program objectives

Once again, the dense, self-reinforcing, coordinated network of BCC messages with nearly 100% coverage was crucial to changing household knowledge and behavior. This is discussed more fully in the section below on BCC and community mobilization. For ARI, the MTMSG and EOC leaders were the most important sources of information for caretakers. As the care-seeking behavior changed before the arrival of BCC counseling cards and EOC booklets, one must draw the conclusion that these had only a marginal effect on the results achieved. During focus group discussion with mothers, they agreed that "everybody" knows the danger signs for child illness, and that, if their child is ill, they are willing to walk to the health center, even if it is three hours distant.

Improved diagnosis of ARI at health centers using IMCI protocols was the major reason for improved case management. This improvement was the result of training and supportive supervision for health workers. The availability of training manuals for health workers was cited by the evaluation team as a contributing factor.

The evaluation team also felt that the MOH decentralization policy was important in improving case management, as staffing and equipment at "developing health centers" improved access to health services. In addition, the MOH's "Health Extension Package"

was a positive factor, as the newly trained HEAs may identify and refer ARI cases, as well as identifying model mothers who can be relied upon to assist mothers with doubts.

The Rotating Drug Fund that guaranteed essential medicines in health centers virtually eliminated the problem of repeated stockouts of essential medications. However, neither the routine MOH medication supply nor the RDF supplies medicines free of charge (though the government system drugs are somewhat cheaper). The RDF is discussed in more detail in a subsequent section.

CARE attempted to mitigate the impact of the cost of health care through expanded idirs, which lend money for child health emergencies. This was an attempt to prevent families from being forced to borrow money from high-interest lenders or sell assets at a discount. The idir initiative was mostly successful where it was implemented, although the coverage of the idir initiative was limited (fewer than one-third of households in the project zone were covered as of the final evaluation). Idirs are discussed in more detail in a subsequent section.

iii). Contributing factors for objectives not fully achieved (constraints)

By far the most important constraint to achieving even greater reductions in child mortality due to ARI is MOH policy. These include:

- Prohibition of the use of essential antibiotics for ARI at the community level or in health posts. This caused mothers to have to walk up to three hours to reach a health center or hospital where life-saving antibiotics were available.
- Fees for essential life-saving medicines, and a cumbersome "poverty-certification" policy to waive fees for medicines. The waiver was reportedly so difficult for families to obtain that, according to both mothers and FWHO workers, very few are given.

In addition to the policy issues above, the evaluation team noted that the frequent changes in MOH policy hampered project implementation. Also, the shortage of human resources in health facilities and high MOH staff turnover (and transference) presented other barriers to project implementation. It is noted that the FWHO director was changed several times during the life of the project, and that the current FWHO director, an active supporter of the FCSP, will be leaving the project zone very soon.

During one focus group with a MTMSG, mothers agreed that "everybody knows the danger signs. If a mother doesn't take her child to a health center when he is ill, it's not for lack of knowledge, but due to the cost." Everyone agreed that the distance to the health center, while long, was not an insurmountable hurdle. However, the cost of care was a significant barrier. In areas where an idir was not available, mothers stated that they borrowed money from "rich people" at very high interest rates in order to pay for care for their children. This is the same response quoted in the final qualitative evaluation: "Before [the idir] system they were not having other alternatives, we borrow from rich people with high interest otherwise we lose our children. If they don't get this

money the only alternative is death of their children, or they go to traditional healers." Clearly the cost of health care poses a significant barrier to care-seeking.

The community-to-health facility referral system was not much utilized due to the overwhelming success of self-referral. In addition, caretakers saw no significant advantage from being referred, as everyone is treated the same way whether they are referred or not.

Finally, there is no transportation or communication between communities and health facilities, nor between health centers and the hospital in Debre Tabor. Mobile phone coverage is very poor outside the town of Debre Tabor, and no health facilities have radios. There are no ambulances in the area, and even if there were, many health facilities are difficult to reach by road, especially during the rainy season. Patients are carried long distances on litters by other community members. Under these circumstances, it makes sense to put essential life-saving services, such as antibiotics for ARI, as close to the communities as possible, but this runs counter to MOH policy.

iv). Special outcomes and unexpected successes

Mothers are willing to walk long distances to seek care for their children if they are confident that the care is needed and that, on arrival, they will be well-received and medicines will be available. Mothers are even willing to overcome the barrier of the cost of the medicines if they know that their trip will not be in vain. This highlights the importance of having well-trained health workers always present with *no* medicine stockouts. Mothers learn quickly that walking long distances is a waste of time if there is no health worker or medicine when they arrive. Regaining their trust afterward is a difficult task.

d. Control of Diarrheal Diseases (20%)

Diarrhea is the second most common cause of infant and child mortality in high-altitude regions like Farta Woreda. The diarrhea intervention is more complex that that for ARI, as it includes all of the elements of the ARI intervention plus prevention, home management and care-seeking, but it less dependent on the health system overall.

The strategies and activities used by CARE are the same as those described in the previous section on ARI, plus the following:

Community-based strategies

- Improved household management of diarrhea, including continued breastfeeding, increasing liquids and continued feeding.
- Improved community prevention of diarrhea, including latrine construction through the Health Extension Package and model mothers, and special involvement of kebele administrative leaders

- Encouraging hand washing before handling food, after defecation and after handling chlldren's feces; proper disposal of children's feces. The FCSP encourages disposal of children's feces either by burial or in a latrine, though the latrine was more strongly encouraged.

Strengthening the quality of health services

- Establishment of ORT corners in health facilities. All nine health centers and another nine health posts received equipment, training and supervision for this.
- Training in IMCI to recognize diarrhea with blood (dysentery) and to treat appropriately with antibiotics according to IMCI protocols.

As can be seen from the list above, control of diarrheal disease includes a wider range of household prevention and management behaviors than the ARI intervention. One area that is often included in the diarrhea intervention but was not included in the FCSP is management of severely dehydrated children at more advanced health facilities using intravenous treatment (or nasogastric treatment where intravenous treatment is not available). "Developing health centers" in the Farta district are not equipped to provide intravenous treatment. This is available only at the hospital and at the health center in Debre Tabor.

i) Results baseline to final

The results summary table shows that all project objectives and targets for the diarrhea intervention were far exceeded. The number of health posts that can mix and administer ORS could not be verified during the final evaluation.

There were no indicators relating to hand washing and latrine construction in the DIP. However, the following were noted:

Table 3-*Hand Washing Practices*

Indicator	Baseline	Final	Notes
Maternal Hand-washing Before Food Preparation	95%	97%	
Maternal Hand-washing Before Infant/ Child Feeding	41%	98%	
Maternal Hand-washing After Defecation	68%	99%	
Use soap or ash to wash hands	7%	35%	Note: baseline asked only "soap", final asked "soap or ash"
Dispose of human waste in a pit latrine	3%	59%	

Source: baseline and final KPC surveys

Community resource persons ("CRP") and kebele administrators were engaged in water and sanitation activities. According to the CARE final annual report, the CRPs were involved in the facilitation of pit latrine construction for 4580 households and maintaining the sanitation of 304 locally protected springs. The total number of latrines and protected water sources at the end of the project was not discussed during the final evaluation, and targets were not set for the FCSP. The MOH Health Extension Package and model mother program were instrumental to this effort, as they provided models for "proper" latrine construction, including covering the hole and providing a place for washing hands just outside the latrine. The "Model Mother Program" is discussed in somewhat more detail in the next section on "factors affecting achievement of program objectives", as it had a significant impact on community hygiene.

Only 67% of hospitals and "developing" health centers had ORS in stock the day of the final HFS, an improvement over the 30% at baseline, but not yet ideal. As the HFS did not investigate health posts, it is not known whether they have regular stocks of ORS or not. Those health posts that were visited during the final evaluation had ORS in stock. Unlike antibiotics, the MOH allows health posts to treat dehydrated children with ORS.

During the final evaluation, the number of cases of diarrhea that had ORS administered in the health facilities ("Plan B") was not available. During interviews with health workers during the final evaluation, most stated that they use the ORT equipment "several times

each week". According to CARE staff, all health posts have ORT corners as well, but this was not objectively verifiable by the final evaluation team.

ii) Factors affecting achievement of program objectives

Most of the factors already discussed above in the section on ARI are also applicable to the diarrhea intervention, including the very dense nature of the BCC activities (especially involvement of the EOC), the MOH's Health Extension Package, the project's Rotating Drug Fund, idirs, and training and supportive supervision for health workers by the FWHO and FCSP team.

The MOH's Health Extension Package Model Mother Program merits some further discussion at this point, as it was especially important to the diarrhea intervention. This program fit neatly into the plans of the FCSP to use positive deviance as an approach to behavior change. Through the "Model Mother Program", mothers whose households exhibit exemplary practices drawn from a standardized list are awarded a certificate of "Model Mother". Among these practices are included a latrine with a cover, a place near the latrine to wash hands (with soap or ash), a dry garbage pit, a water runoff seepage pit, an open window for ventilation, shelves in the home for storage of food and other items, a smokeless stove, water containers with lids and mosquito nets, among other things. All of these directly reinforce the prevention messages of the diarrhea intervention and thus reinforced key BCC messages through modeling.

As with the other behavior change interventions, mothers said that they had seen the positive results of the new ways to manage diarrhea at home. "Before, we gave hard foods when the child had diarrhea. Now we give liquids to replace the liquid that is lost", was heard from *several* mothers in different settings during the final evaluation. Also, "when my child has diarrhea, I try to manage it at home with liquids and feeding, and only go to the health center if it isn't working". As with the other interventions, the desired Child Survival behaviors have been in place long enough for the community to see the results and to adopt these behaviors as their own "norm".

iii) Contributing factors for objectives not fully achieved (constraints)

The same factors that negatively affected the ARI intervention also affected the diarrhea intervention, namely, FWHO staff shortages, high staff turnover, frequent changes in MOH policy, charging for essential medicines (including ORS), and the bureaucratic process for certification of poverty and waiving fees. MOH policy *does* allow for ORS to be dispensed (sold) in health posts, but not by community health workers.

The Child Survival message to give children extra food for a time after illness did not receive attention in the FCSP, although it is potentially an important message. This was discussed in more detail in the section on the nutrition intervention above.

The activities of the Community Resource Persons and kebele leaders in construction of pit latrines and the encouragement of hand washing and other hygiene behaviors

produced impressive results, with a significant increase in the number of families using latrines even though project financial investment was negligible.

iv) Special outcomes and unexpected successes

No other results were noted other than those discussed in the previous sections. Both the ARI and diarrhea interventions could easily be replicated and scaled up in other regions of Ethiopia that have similar characteristics without significant changes. See the section on sustainability below for a full discussion on scaling up and sustainability issues.

e.Immunization (20%)

In the FARTA Child Survival Project, immunization represents the intervention that requires the broadest range activities and changes in order to achieve results. As with ARI and malaria, reducing morbidity and mortality from vaccine-preventable diseases requires changes in both household and community-behaviors as well as improvements in health worker performance, but this intervention places an extra burden on health systems management due to the need to reliably supply and stock a wide range of supplies, from vaccines to syringes, cold-chain maintenance, the need for the health system to closely coordinate with communities, a complex system of "drug" administration (injection), and a complex information system.

The most important activities carried out by the FCSP in order to achieve the objectives are described in more detail in the sections on cross-cutting measures below, and the general activities will not be repeated here in order to avoid repetition. FCSP activities specific to immunization included:

- Donation of 16 refrigerators to health facilities (first semester 2005), 36 megaphones, tote bags, and some spare parts for refrigerators and kerosene.
- Intensive BCC in support of key immunization messages, including a counseling card depicting immunization as well as inclusion of immunization messages in other BCC materials (EOC booklet, pamphlets and others).
- Support for individual tracking and follow-up of immunization defaulters by health promoters.
- Logistical support to national immunization days as well as to routine vaccination and supportive supervision visits
- Training in EPI, cold chain maintenance for health workers and managers; training and refresher training for all health workers and health promoters in vaccine preventable diseases and immunization, and surveillance.
- Surveillance for vaccine-preventable diseases. The FCSP supported training for all FWHO staff as well as selected health promoters (emphasis on MTMSG facilitators and EOC leaders) in active surveillance and reporting for acute flaccid paralysis, measles and neonatal tetanus (with technical support from CORE group).
- Support for quarterly partner review and planning meetings (see section on capacity-building for more on this).

- Training and follow-up (as well as direct participation in) in supportive supervision using the COPE methodology for FWHO and health facility staff.

i) Results baseline to final

The most compelling evidence for impact of the immunization intervention came from comments by mothers, church leaders and health extension agents during focus groups and key informant interviews during the final evaluation. Repeated comments were heard that stated that common vaccine-preventable diseases no longer plagued the communities, with whooping cough and measles being specifically mentioned. Mothers are no longer afraid to have their children immunized. The fact that illness and death had been sufficiently reduced in a short enough time to be evident to the population in general is evidence of a significant change. In addition, consistent comments attest to the fact mothers that take children for immunization are the "norm", and not having one's children immunized is unacceptable behavior.

It is unfortunate that neither data on surveillance for vaccine-preventable diseases nor proportional mortality data were available from official sources during the final evaluation, but it is almost certain that they would have supported the conclusions below if they were available. Fortunately, the project trained focal surveillance persons at the kebele and church levels with support from CORE Ethiopia. In 2005 these agents reported four cases of measles and one of AFP. In 2006, they reported one case AFP and in 2007 two cases of AFP. The steady number of AFP cases implies that the system is working properly (the number of AFP cases should be relatively steady in a given population). Therefore, the reduction of measles from four cases to zero is almost certainly real, and not due to under-reporting.

Coverage and counseling

A reduction in vaccine-preventable morbidity and mortality as measured by disease incidence and proportional mortality is the most important indicator of the immunization intervention, as it is the end result of all of the various components of the entire effort. As this is difficult to measure directly, immunization coverage normally serves as the next-best proxy-indicator, given the assumption that records are accurate and vaccines have been properly handled and applied by health workers. All other indicators merely serve to help identify specific weakness in the overall program if coverage is low and/or incidence is not reduced.

The coverage results from the baseline and final surveys are described in the results framework table above. All The LQAS surveys and interviews with communities and health workers support the final KPC survey results. However, in spite of the fact that all targets set for the FCSP were met or exceeded, full immunization coverage for children 12-23 months of age, at 61%, is still not optimal.

The indicator "Proportion of [mothers] women who have appropriate counseling and information on immunization" was not verified systematically. However, verification of "checking the immunization status" was included in the final HFS, where 80% of

children's cards were verified by health workers during sick child consults. Counseling was not recorded. Checking the card was observed in only 4% of cases during the baseline HFS. In those consults observed during the final evaluation, all children had their immunization status verified.

Unexplained anomaly

Curiously, data from the FWHO on doses of vaccine applied do not support large improvements in coverage during the period 2004-2006, as the following table illustrates:

Doses of Vaccine/Year	2004	2005	2006 + 8% (does not include December)
DTP3	6135	6059	6989
BCG	6234	6049	7093
Polio3	6250	5894	6790
Measles	4351	3872	4149

Source: Farta Woreda Health Office. Note: the table did not specify age group, but by inference these must represent doses applied in the 0-11 month age group.

One explanation for this apparent discrepancy is that the gains in immunization coverage may have occurred early in the project, primarily in the period 2003-2004, and improved more slowly thereafter. The baseline KPC in January 2003 and the March 2006 LQAS surveys show a large increase in immunization coverage between the outset of the project and March 2006 (DTP3: 19% to 71%) and only incremental or no change between March 2006 and the final KPC (DTP3: 71% to 69%).

If the principal gains in immunization coverage indeed occurred during the first years of the project (2002-2004), this implies that the main factors in improving immunization coverage included support to the health system (supply side), and very few of the gains are attributable to BCC and widespread community mobilization (demand side), which were only consolidated during the second half of the project.

It was not possible to investigate this curiosity in more depth during the evaluation, as it arose only on in-depth analysis of the data after the end of the group analysis. However, it may be worth further investigation by CARE national staff or even headquarters (as it may provide insights valuable to other CARE projects.

Commodities and cold chain

The final HFS found that all facilities had working refrigerators and cold boxes, but that vaccines were present in between 75%-83% of facilities, an improvement over baseline (30%), but not ideal. It must be kept in mind that the final HFS did not include health posts, which are important to immunization under the current MOH policy, so a complete objective picture is not be available. During the final evaluation, FWHO and CARE staff report that many health posts do not have permanent cold chain equipment and vaccines. During the evaluation, all health centers and all but two health post that were visited had working cold chain equipment. All had records of regular inspection of temperature

(though the HFS found 83% of health facilities had a temperature chart), there were no outdated vaccines and all essential commodities were present (including needle disposal). In one health post, the kerosene refrigerator had recently broken down, and could not be repaired due to a shortage of spare parts in the region (the glass flues must be imported, and the regional health office had none). The health post continued to immunize by seeking vaccines in cold boxes from the nearest health center during outreach days. The other health posts had vaccines, commodities and a functioning cold chain.

All facilities at all levels that were visited had up-to-date graphs with coverage estimates, and all staff were knowledgeable about proper immunization practices. CARE staff, FWHO management and health workers reported that there are still some health posts without working cold chain, and that there had been only occasional stockouts of vaccines from the central level to the FWHO, especially for DPT. There were also reportedly some short-term stockouts in distant health facilities during the rainy season. This is a far cry from the situation reported in the baseline health facility survey, where only half of facilities had a working cold chain, 30% had any vaccines, and only 15% had OPV.

Epidemiologic Surveillance

With support from the CORE Group (an organization of US-based NGOs in Child Survival with a grant to support polio eradication activities), CARE supported training for FWHO staff, health workers, EOC leaders and VCHWs and MTMSGs in surveillance for acute flaccid paralysis, measles and neonatal tetanus. Each kebele and health facility has a focal point for reporting, and reports are filed each week with the FWHO.

ii) Factors affecting achievement of program objectives

The FCSP addressed both the supply side of immunization as well as the demand side. This combination resulted in improvements in both. General strategies including BCC, community mobilization, health worker and health promoter training, and health systems strengthening are addressed below in the discussions of cross-cutting strategies and will not be repeated here.

It may be interesting to note here an observation made during a visit to the Debre Tabor Health Center in the urban area of the town. This health center received project support for training and some equipment, but the primary catchment area of the health center is the urban area of Debre Tabor, not included in the FCSP. A wall graph illustrating immunization coverage in the urban area showed that coverage was between 10% and 25% for each vaccines. The health worker in the health center then went on to explain that “coverage wouldn’t even be as high as it is if it weren’t for the children vaccinated by the FCSP that overlap and get counted here” It seems clear that the FCSP was responsible for the excellent immunization coverage in the rural areas, and not some overall secular trend in MOH policy.

Factors specific to the immunization intervention that helped achieve the improved coverage include the following:

Demand
The FCSP took advantage of the existence of community registries of children, including immunization status. The project then trained HEAs and VCHWs to identify defaulters from these registries and refer them to EOC leaders and MTMSG facilitators for follow-up action and home visits.

The FCSP team investigated specific barriers for immunization, including the temporary malaise and fever cause by vaccines. They then provided specific training for all health promoters in countering these perceptions. In interviews with health promoters and mothers, this is no longer a barrier to immunization.

Finally, in order to effectively mobilize communities, CARE and partners held quarterly review meetings, and health promoters and leaders held monthly kebele meetings during which plans for immunization activities were disseminated to villages. In this way, community-level health promoters (MTMSG facilitators and EOC leaders, for example) were able to effectively mobilize communities for outreach immunization activities.

Supply
The supply side of immunization received quite a lot of attention. Significant effort went into planning immunization activities with partners. In addition, CARE mobilized VCHWs to coordinate outreach immunization sessions, and then trained non-CARE VCHWs (later in the project) in order that each one could support the HEA with outreach by assisting in community mobilization.

The MOH reorganization of the health system in 2005, re-designation of health posts as sites for prevention activities, and staffing health posts with HEAs realigned the emphasis of health posts toward preventive activities and away from curative activities. This policy provided the opportunity for intensified immunization activities through regular scheduled outreach sessions from health posts.

iii) Contributing factors for objectives not fully achieved (constraints)

Missed opportunities for immunization are the most important barrier to improving immunization coverage. The FWHO has an open vial policy that does not allow immunization of small groups of children. In addition, some health posts refuse to immunize except during outreach sessions, even though an unimmunized child, vaccines and idle health workers are all present. Similarly, some health centers were observed to check the immunization status of an ill child, and then *refer* the child to the next immunization session rather than immunizing the child on the spot. Finally, some health centers do not provide any outreach, even though they may have time and human resources to do so. CARE staff also report that health facilities that perform deliveries do not usually immunize newborns, but rather refer them to immunization sessions.

Reducing missed opportunities will be necessary if coverage is to rise beyond the 60-70% level. This opportunity exists and should not be missed now that care-seeking for illness has improved greatly.

In addition, many health posts still lack equipment for storage of vaccines, and HEAs must walk long distances (2-3 hours each way) to fetch vaccines from health centers. Health workers state that outreach sessions would be better-attended if the planned outreach shelters were constructed, as mothers are reluctant to take their children outside in inclement weather for fear of illness. CARE staff also report that there are still some weaknesses in health workers' ability to maintain cold chain equipment in some facilities. These will require refresher training and intensified supervision.

There was disagreement between CARE staff and FWHO staff as to the adequacy and frequency of EPI supervision. Both agreed, however, that the most remote facilities may not be receiving regular quarterly supervision. Unfortunately, this problem will likely worsen when CARE withdraws logistical support at the end of the project (see section on sustainability below).

The change in MOH policy from DTP to the newer pentavalent vaccine caused stockouts during the first months of 2007, though this problem is reportedly resolved. Another technical problem cited above relates to the difficulty in acquiring spare parts for certain models of kerosene refrigerators. Availability of spare parts should be included in the terms of reference for future equipment purchases.

Finally, FWHO staff could be trained to use LQAS to identify under-performing kebeles in order to target and intensify immunization activities in these areas.

iv) Special outcomes and unexpected successes

Immunization is a well-documented standardized intervention that does not usually generate "unexpected outcomes". However, it is notable that during the evaluation community members repeatedly and spontaneously noted the great reduction in the number of cases of measles, whooping cough and polio in their communities since the beginning of the project, and they commented on the changed attitude of mothers with respect to vaccines. As with the other behavior interventions already discussed, the high coverage of BCC activities and the interconnection of the web of community resources created a resilient framework for community learning and behavior change. Immunizing children has effectively become the "normal and expected" behavior in communities, and not something imposed from outside. If the health system can uphold the supply side, it is likely that the demand side will be sustainable once the project ends.

f.Other interventions

Integrated Management of Childhood Illness

The FSCP used IMCI as a framework for both improving the quality and access to institutional health services, but also adapted "Community IMCI" as a basis for improving household behaviors and appropriate care seeking.

A total of 33 health workers (including some CARE staff) received training in clinical IMCI, and 269 community resource persons completed training in C-IMCI during the second-last year of the project. Originally, the FCSP was to train community health workers in basic case management, but this proved impossible as this cadre of worker was eliminated from official MOH policy. As C-IMCI focuses primarily on household behavior and community mobilization, the analysis of the effectiveness is discussed in the appropriate technical sections above and in the BCC/IEC/Community Mobilization section that follows.

Most of the issues regarding IMCI are discussed in the sections above on immunization, ARI and diarrhea and will not be repeated. The health facility assessment noted that in all health centers that were assessed, workers correctly assess children for ARI 90% of the time, and treat correctly according to guidelines 100% of the time. During visits to health facilities during the final evaluation, IMCI reference materials and guidelines were available in all examination rooms (on paper, and in most cases, also on the wall). Health workers did indeed assess and treat correctly, although not rigorously following all of the steps required by IMCI and not using pre-printed flow-chart forms as is sometimes done. It was also noted during the evaluation that the typical caseload for health workers is fewer than 20 sick children per day, which allows adequate time for diagnosis and treatment using the time-consuming protocols.

One factor that facilitated the introduction of IMCI and improved the quality of care was the regional MOH's flexibility. According to MOH policy, only health centers hospitals are allowed to treat illness and dispense medication (except ORS and malaria medicines, which may be dispensed in health posts). However, there is only one hospital and one full-fledged health center in the entire region, both in town in Debre Tabor. Farta Woreda has nine larger and better equipped health "clinics" which will eventually be upgraded to full health centers. The regional MOH office allowed these to be designated as "developing health centers", and allowed them to be staffed by nurses and to dispense medicines. None of these "developing health centers" have inpatient facilities or can do deliveries, however. These facilities are located strategically to be centered in the area of three to four kebeles. According to the FWHO, no village is more than about three hours walk from a developing health center. In addition, the total number of health workers in the woreda increased during the life of the project.

Other facilitating factors for implementing clinical IMCI included regular structured supportive supervision and the rotating drug fund. Some constraints that have already been discussed include high staff turnover and frequent transfers both within the woreda and between woredas. Finally, the lack of transportation and communication from

villages to health facilities and from developing health centers to the Debre Tabor Hospital reduced the potential impact of IMCI when children are severely ill.

Malaria

Although malaria was not explicitly included as an intervention, the FCSP could not avoid including some activities, as malaria is one of the most important causes of morbidity and mortality in the region. In fact, malaria was originally to be part of the project, but as other resources became available for malaria, CARE decided to substitute it with immunization. Of the 40 target kebeles, malaria is endemic in 26, but the others are subject to sporadic epidemics in spite of being at high altitude. Malaria diagnosis and case management are included in the IMCI protocols. In addition, the MOH provides antimalarials to both health centers and health posts, so HEAs must also be trained in their use (52 health workers initially received malaria training, and later, 21 new HEAs received malaria training). During the third year of the project CARE assisted in the distribution of 69,000 long-lasting insecticide-treated bednets donated by the Carter Center. The LQAS surveys found that bed net ownership increased from 1% in early March 2006 to 13% in December 2006, in spite of the fact that the former was done during "mosquito season" and the latter was done in the "winter".

Water and sanitation (kebele administration, CRPs)

During the life of the project the number of families reporting latrine use rose from 3% to 59%, an impressive increase. This was due to both MOH efforts as well as those of community workers trained in community-IMCI. Community resource persons (CRPs) trained during the final two years of the project were instrumental in implementing water and sanitation projects, and model mothers demonstrated the desired behaviors. The last annual report mentions that CRPs were instrumental in facilitating the construction of 4580 pit latrines and protection of 304 water springs. Handwashing and disposal of children's feces were discussed above with the diarrhea intervention.

Maternal Health: antenatal care, tetanus toxoid and institutional deliveries

The coverage for some of the key indicators for maternal care are included in the results framework above. Coverage for antenatal care increased from 23% to 58%, probably due primarily to a combination of designation of "developing health centers" and an increase in trained human resources. This is double the average for Amhara region of 26.2% cited in the 2005 DHS. Other indicators attest to improved coverage for antenatal care. Tetanus toxoid coverage (two or more doses card-confirmed) rose from 57% to 71%, and the proportion of mothers who are aware of danger signs in pregnancy, labor, delivery and post-partum period showed a similar increase (62% at baseline, 97% at the final KPC survey). Whereas this knowledge is a prerequisite for reducing maternal mortality, only by coupling this knowledge with appropriate referral for institutional deliveries by trained personnel can maternal mortality be significantly reduced.

Coverage for institutional delivery did not rise significantly (4% to 9%), and continues to reflect the very low rate overall in Ethiopia (4.8% nationally, DHS 2005). The reason for this low coverage is not difficult to discern, as only the only facility that performs

deliveries in the woreda is the hospital in Debre Tabor. The hospital is able to perform Cesearean deliveries and emergency blood transfusions (with immediate donors), but the facility is very old and poorly equipped. Only about five deliveries per day are performed there. There is no transportation available for emergency referral. The FCSP did not provide specific training or supervision for maternal care aside from the nutrition messages and a general admonition for mothers to attend antenatal care.

Maternal care and institutional delivery would be next-step high-priority interventions for the FSCP, though coverage for institutional deliveries cannot be expected to rise significantly until the construction and equipment of the new health centers is completed so they may perform deliveries as well. Maternal waiting centers near the health centers and hospital may prove to be an effective means to increase coverage.

HIV/AIDS

HIV/AIDS was not explicitly included in the FCSP as an intervention, although questions were included in the baseline and final KPC surveys. The survey demonstrated a large increase in maternal knowledge regarding ways to avoid transmission (40% rose to 86%) and knowledge of vertical transmission (22% to 92%). The reasons for these increases were not discussed during the final evaluation, so it is not possible to ascertain the relative contribution of the FCSP and other external sources of information. It is logical to assume, however, that the communication channels created during the FCSP (MTMSG meetings, EOC leaders, etc.) likely contributed to improved greater knowledge.

g. New tools or approaches

Model mothers: positive deviance approach

The use of a positive deviance approach was originally discussed in the DIP in the context of using the Hearth nutrition model for improving infant and child nutrition. And, although Hearth was not implemented (as appropriately recommended in the mid-term evaluation), the concept of positive deviance was applied during the FCSP.

MTMSG facilitators were selected, in part based on their model behaviors. Kebele administrators were instructed to recommend mothers that exhibited the desired Child Survival behaviors, including exclusive breastfeeding, appropriate infant feeding, children who are immunized, and latrine use, among others. In fact, some kebele administrations reportedly did not follow these instructions, and in some cases MTMSGs insisted on replacing the indicated mothers with others that are better role models.

The second instance of using positive deviance was discussed above. The MOH's Health Extension Package includes guidelines for a "model mothers" program through which mothers who demonstrate eleven desired health behaviors are publically rewarded with a certificate as a "model mother". Mothers in groups were aware of the program, and the one model mother that was visited during the final evaluation was very proud of her certificate, and proudly showed off the improvements in her home and the health of her family.

Community Data Boards

Community data boards were another innovative approach used to increase community participation, analytical thinking and information use. The use of the data boards was described briefly in the DIP, but was only implemented as a pilot later in the project after the mid-term evaluation. A total of 25 data boards were in existence at the time of the final evaluation.

The data boards are located at churches, and are administered by a committee consisting of the HEA, EOC leaders and VCHW. Each group decides on the data that will be displayed, but typically the information comes from the nearby health post. In both cases that were observed during the evaluation, the information largely came from the epidemiologic surveillance system, and included the number of severely malnourished children, vaccine-preventable disease cases, and cases of ARI and diarrhea in children. The boards are updated quarterly. In focus groups with MTMSGs and MTMSG facilitators, mothers were aware of their data boards and the information contained on them, and said that the EOC leaders use the data boards during their health talks after church services. Religious leaders and HEAs who were interviewed were also enthusiastic about the data boards, and felt that they encouraged community involvement in health.

It was clear to the evaluation team that the data boards help communities become more aware of and involved in the health of their children. However, coverage of the data boards is still low, with only about 25% of villages having regular access to one. CARE planned to expand the number of data boards to all kebeles before the end of the project.

It may be useful in the future to suggest an expansion of the data to include both indicators that change rapidly and others that do not. In addition, focusing on positive as well as negative indicators may be useful. Interesting and informative indicators may include the percentage of children fully immunized and number of homes with latrines. However, collection of this information would be more difficult than the current information, which is drawn from existing health facility reports.

Idirs

Idirs are a traditional Ethiopian institution aimed at helping families cope with the cost of funerals. Typically, they are membership organizations covering one or several villages, and members contribute in-kind with food or other materials to help a member family through the funeral.

The cost of health care is a major barrier to care seeking, as even essential medicines such as ORS are not free of charge, and although there is a system in place to waive fees for health care for poor families, the system is reportedly cumbersome and little-used. During the final evaluation, in focus groups with mothers and others, the cost of health care was frequently cited as the most important barrier to seeking health care, outweighing even long distances in importance. This observation is in agreement with

other studies, including the qualitative survey, the idir study performed in 2006 and the rapid rural appraisal.

The DIP mentions exploring idirs as a possible means to overcoming the cost barrier to care seeking, but as of the mid-term evaluation, the FCSP had only begun very tentative activities, having signed only three memoranda of understanding with pilot idirs. The MTE recommended following through with this pilot. As of the last annual report, a total of 10 pilot idirs had been strengthened, and the effort was thought to be successful enough to expand. As of the final evaluation, the project currently has provided training in financial management and record-keeping and seed money of about US$50 to 57 idirs. The team planned to extend to about 80 by the end of the project. The FCSP team is aware of 211 idirs in Farta Woreda.

Idirs were initially selected based on the following criteria:

- Organizational level of idir: and existence of written bylaws
- Number of members and under 5 children
- Prevalence of childhood illnesses in their kebele
- Motivation of volunteerism

An assessment of the original ten pilot idirs was done in 2006 which found wide variation in their use. All had been in existence for over ten years (one was founded over 60 years ago, and in several cases members couldn't remember when it was founded). Most had no capital other than the seed money given by the FCSP, though two did have funds. These two charged members a monthly fee. Some others had small stores of in-kind materials and funeral supplies. Initially, idir bylaws restricted loan conditions to those for child health emergencies. In February 2007, the FCSP instructed all participating idirs to begin allowing loans for obstructed labor. Most bylaws allow for loans of about US$5 for child health emergencies and about $15 for referrals, with conditions for repayment for 2-3 months and interest of one to three percent.

Among the ten idirs assessed, two had made over 20 loans, one had fourteen, four idirs had made between five and ten loans, two had made only one loan, and one idir had made no loans. A total of 94 loans had been made by the ten idirs in a period of about six months. Those that were making few loans were discovered to have administrative problems, in that the person that controlled the funds was often unavailable. Most loans were being repaid, eight loans had been delayed but paid, and eight had not been repaid at all (and would not be paid). A total of 22 loans were still outstanding (but within the time frame) at the time of the assessment. Of the 72 loans that had completed their repayment period and whose repayment status was known, eight (eleven percent) had defaulted.

In focus groups both in the qualitative assessment and during the final evaluation, community members agreed that the idirs were very useful when community members could access them. Alternatives to borrowing from the idirs were either to sell assets, to borrow at high interest from "rich people", or to seek out traditional healers. The primary

complaint about idirs was that coverage is still poor. Although almost all mothers who were interviewed during the final evaluation were aware of the existence of idirs that give loans for child health emergencies, *none* of the villages visited during the final evaluation had access to these idirs seeded for care seeking.

It is clear that idirs can be an effective means to lessen the cost barrier to appropriate care-seeking. However, coverage is still insufficient for the idirs to have an overall impact on child morbidity and mortality in the population. In addition, there are wide discrepancies in idir performance, and there are doubts about sustainability if eleven percent of loans are not repaid, but interest charged is only between one and three percent. It would be very interesting if the FCSP were able to perform a follow-up assessment on the larger number of idirs that are now making loans in order to verify their performance.

Rotating drug fund

The rotating drug fund (RDF) was established as a means to overcome recurrent stockouts of essential medicines in the MOH drug system. These stockouts were beyond the ability of CARE and the FWHO to solve locally, and therefore a parallel RDF was established.

The project originally was designed to include a rotating drug fund at both facility and community levels. The community pharmacy idea was scrapped at the mid-term evaluation as it was counter to MOH policy. Nevertheless, after the MOH designated the health clinics as "developing health centers", thus allowing them to dispense medicines, the FCSP proceeded with plans to support the RDF in those nine facilities. In addition, the FCSP supported a separate rotating drug fund at the Debre Tabor health center. A separate fund was necessary as the Debre Tabor health center falls in the Debre Tabor Woreda, and is thus under a different administration from the facilities in Farta Woreda. In addition, as a full-fledged health center, it manages its own separate account.

The establishment of the rotating drug fund required negotiation with the woreda government, as woreda administration uses a pooled funding arrangement for all sectors of government (education, health, infrastructure, etc.). CARE and the FWHO reached an agreement that allowed for the opening of a separate account for management of the drug fund. According to the FWHO director, it is the woreda's pooled funding arrangement that is the main reason for the problems with the central drug system, as many signatures are required to release funds, making agile administration difficult. In addition, many MOH drugs are donated in-kind, making it impossible to control the type, quality and validity of the drugs. These problems lead to frequent stockouts.

Under the Rotating Drug Fund, the Farta Woreda Administration pharmacist procures drugs at commercial pharmacies in Bahir Dar using data from the nine participating health facilities. The health workers in these facilities travel to Debre Tabor, deposit their money in the administration's special RDF account, then request drugs based on their consumption. The local FWHO has a ledger for each health facility RDF. Each facility

maintains a cash ledger, but not an RDF itself; rather, they function as extensions of the central district fund due to lack of administrative skills. The Farta Woreda financial administration monitors the accounts.

The drugs that are included in the system are amoxicillin, erythromycin, chloramphenicol (oral and injectable), a topical anti-fungal, paracetamol, and chloroquine (for vivax malaria). Co-Artem for falciparum malaria and ORS are provided by the MOH system, and stocks are reportedly quite regular. Drugs from the MOH system are somewhat cheaper than the RDF drugs, and fees can be waived in cases of poverty, but supply is irregular. RDF drugs cannot be given free of charge.

The simplicity of the system is one of the reasons for the RDF's success, as record-keeping at the facility level is kept to a minimum. Drugs are sold at a markup in order to increase the fund and compensate for drug expiry. According to the FWHO director, the RDF's capital is growing, as deposits have been correct. In those developing health centers that were visited during the evaluation, RDF drugs were kept in a separate room from the MOH drugs. Ledgers were up-to-date and drugs were in stock. In one facility, when asked how they decide between RDF and MOH drugs when both are in stock, the health worker immediately replied, "according to the expiration date". The FWHO director explained that in the future, once health posts are able to dispense essential drugs, they will be stocked as extensions of the developing health centers in their respective areas. Also, once the developing health centers are fully constructed, equipped and staffed, they will become full health centers and each will have a separate account with the Farta Woreda administration.

It is clear that the key to maintaining a functioning RDF is continuing education and tight supervision. The greatest threats to any RDF are stock "leakage" and poor administration leading to high levels of drug expiry, either of which could quickly deplete the RDF's working capital. Thus far, neither of these appears to be happening on a scale large enough to threaten the fund. Excellent administration and supervision will be increasingly important if the system expands to include health posts in the future. Focus groups with mothers and community members and interviews with health workers all praised the RDF, and all said that essential medicines are now always available at health centers.

3. Cross-cutting approaches / Project Strategies

This section follows the FCSP framework of three primary strategies: 1) community mobilization and BCC, 2) skill development and 3) improving access and availability to quality services. In addition, it includes sections at the end on capacity-building of CARE and partners.

a) Behavior Change Communication and Community mobilization

In the FCSP behavior change communication and community mobilization are so interrelated that they cannot be treated separately. The strategies used for achieving improved household behaviors for child health are probably the most interesting and successful aspect of the FCSP. CARE and its partners successfully created an

interlocking self-reinforcing network of communication, support and supervision that allowed effective communication of key messages to every human being in the project zone. All of the behavior change objectives described in the DIP were met or exceeded, as the previous sections of the report have demonstrated. What is most remarkable is that this was accomplished without any use of modern mass communications. As will be described here, the FCSP took full advantage of some unique characteristics of the local social structure to achieve its objectives.

A written BCC strategy was developed together with partners after an initial training of trainers in how do develop a BCC strategy was carried out by other trained CARE Ethiopia staff. The document was finalized during year three. Materials development lagged well behind training, however, and most of the BCC materials were not produced until late in year three. These included the following:

- key maternal and child health cassette recorded messages were produced. The cassettes were distributed in 10 Kebeles as pilot before scale up. The ten Kebeles started organizing tape listening sessions.
- more than 3000 leaflets were developed based on action plan of the BCC strategy. The leaflets were designed in local languages. These leaflets were disseminated for all health promoters in all kebeles, including trained religious leaders and MTMSG facilitators
- counseling cards, posters and T-shirts were piloted and pretested before scale up and production of these materials for the large group was done in late fourth year.
- initially, booklet was not identified as BCC material but it was identified as an important materials in late fourth year of the project.

The two cornerstones of the effective BCC and community mobilization component were the establishment of mother-to-mother support groups and the active engagement of the Ethiopian Orthodox Church in the BCC activities. These were reinforced by the involvement of other players, including MOH health workers, kebele administration and various cadres of volunteer community health workers and school clubs.

i) Strategy

Mother to Mother Support Groups

Mother-to-mother support groups were the most important vehicle for transmitting messages. A total of 2464 groups were formed, one for each village. According to focus group discussions and key informant interviews, *all* mothers in each village participated in their respective MTMSGs. Each group meeting was led by an MTMSG facilitator, and was typically attended by about 15-20 mothers. In most cases, women who were not mothers of young children did not normally attend meetings (that is, unmarried women or grandmothers). Most groups reported meeting once each month, though some met twice. Mothers also said that their meetings were also occasionally attended by EOC leaders, VCHWs and HEAs, though this was not the rule.

MTMSG facilitators were selected early in the project using “model mother” criteria. These women were selected with the assistance of kebele administrators and in some

cases, the MTMSG members themselves, as mothers who demonstrated desired health behaviors. In addition to simply demonstrating the desired behaviors through their day-to-day lives, MTMSG facilitators received initial and refresher training on key project messages, communication, and on how to conduct meetings. They also reported performing home visits, especially to pregnant and lactating women and women with doubts or resistance to adopting the new behaviors. MTMSG facilitators also attended the monthly kebele coordination meetings together with other community health workers. During these meetings, facilitators were refreshed on messages, techniques, and the "theme" for the upcoming month, which was decided and scheduled during quarterly partner coordination meetings. The theme for each month was uniform for all communication channels, including MTMSG meetings, across the entire woreda.

Coordination of these meetings was an important aspect. Meetings were scheduled well in advance, and VCHWs, HEAs, health facility workers, kebele administrators, FWHO officials and CARE staff were aware of the date and time of each village-level MTMSG meeting that was scheduled. During the final evaluation, MTMSG schedules for each village were visible on the walls of health facilities that were visited.

Ethiopian Orthodox Church

The second most important aspect of the BCC strategy was the engagement of the Ethiopian Orthodox Church (EOC). A total of 527 religious leaders including church leaders, priests (with a higher level of education) and Farta Woreda EOC office leaders received training, supervision and materials.

Church leaders performed three important roles in the BCC strategy. They transmitted messages in special educational talks after each church service, they performed routine home visits for follow-up and educational purposes, targeting pregnant and lactating mothers, and they followed up with home visits to mothers who missed MTMSG meetings, and those who were "resistant" to adopting the desired household health behaviors (e.g. did not exclusively breastfeed or did not have their children immunized). If a trained EOC leader was not successful in "correcting" a mother's behavior, the family's assigned confessor could be called in to provide even more persuasion. These confessors are a staple of the EOC, each responsible for between 15-40 families. Even if the confessor was not among those who received Child Survival training, the intimate relationship with the family lent them great credibility. Their arguments could be persuasive, often including creative linkages of child survival messages to lessons drawn from the Bible. According to FWHO staff, CARE staff and MTMSG focus groups, in exceptional cases the EOC leaders could even threaten to withhold important religious services such as communion or baptism for the most resistant families.

The pervasive nature of the EOC was one of the most important factors in achieving excellent coverage and attendance in MTMSG meetings, as mothers who were absent soon received home visits by EOC leaders. EOC leaders also participated on the committees that maintained the 25 community data boards, occasionally attended MTMSG meetings in their areas, and attended the monthly kebele coordination meetings.

School Clubs

Farta Woreda has 47 functioning elementary schools. In district schools, school clubs that are centered around specific themes are common. For example, many schools now have clubs for trachoma (supported by the Carter Center), hygiene and sanitation (supported by the CARE Millenium Water Project), and HIV/AIDS. CARE first negotiated with the Farta Woreda Education Office and gained official permission to organize Child Survival school clubs. Then, CARE provided training for teachers to lead Child Survival school clubs, first in the ten pilot kebeles, and later, during the fourth and fifth year, expanded to training more teachers and student leaders. Student leaders were trained in order to lessen the impact of frequent teacher transfers on continuity. Clubs meet outside of school hours (morning session students meet in the afternoon and vice-versa), and teachers receive no extra compensation for their participation.

During the final evaluation, two clubs were visited. One club had 94 members, the other 36 (in schools with over 1000 students each). Club members were knowledgeable and enthusiastic about child survival messages. The clubs' principal activities center around regular meetings 1-2 times each month during which they discuss Child Survival messages. They also perform skits and plays based on key messages for the community on special occasions. The students said that, in addition to their regular organized activities, they help teach their parents and siblings about child health messages at home. One girl said that when her sister became pregnant, she convinced the family to lighten her workload and let her rest more. Another said she taught her mother to breastfeed exclusively and to take her baby brother for immunization.

During MTMSG focus groups, many mothers said they had seen a play or skit about Child Survival messages, though most said they had seen only one. Many were completely unaware of the existence of the school clubs. It is clear that the clubs are not having a widespread effect on message dissemination and behavior throughout the community, but that these children apparently do affect behaviors within their own families and will be future parents. The future impact of their participation in school cannot be objectively assessed.

Other community workers

A number of other community level workers received training in CS messages, including Volunteer Community Health Workers, Community Resource Persons (last years of the project, 269 trained), non-CARE CHWs, (118 trained) and kebele administration officials (153 trained; 4 per kebele). All of these play supporting roles in message dissemination and behavior change.

VCHWs

Although the VCHWs are not central in message transmission, they play a vital role in community mobilization. These volunteer workers, one per kebele, were carefully chosen and received more in-depth training than the other cadres of community health workers. They provide a "bridging" role between the various other workers, and between the

health facilities and community workers. VCHWs collect reports, attend monthly kebele coordination meetings, attend some MTMSG meetings, meet with EOC leaders, and have regular contact with FCSP and FWHO staff. Their role now overlaps somewhat with the newly hired Health Extension Agents, as either or both may coordinate the monthly kebele coordination meetings..

MOH health workers

Health Extension Agents (52 trained) are a new cadre of worker introduced by the MOH to provide extension services. Their health services role will be discussed in more detail in the section below on quality and access to services. CARE also provided them with training in counseling and CS messages, as well as on how to conduct effective monthly kebele coordination meetings. HEAs, who are all female, have assumed the responsibility for chairing the monthly kebele coordination meetings, where they reinforce the month's messages with EOC leaders and MTMSG facilitators as well as with other CHWs and kebele officials who attend.

The 30 health workers in the nine developing health centers provide counseling during sick-child consults. That this counseling is actually occurring was documented in the final qualitative survey as well as by direct observation during the final evaluation.

BCC materials and means of communication

In addition to training of community volunteers, MOH workers, school clubs and EOC leaders in message dissemination, the FCSP provided them with supporting materials, although these were not produced until the fourth year of the project.

The FCSP purchased megaphones, tape recorders and cassettes, batteries, and posters and message cards for health posts. In addition, FCSP purchased a television and videocassette player for the Debre Tabor Health Center.

CARE produced the following BCC materials:

- 26,640 counseling cards (10 types) -two thirds of them were distributed.
- 8300 posters
- 500 t-shirts with printed messages
- More than 2000 pamphlets
- 900 booklets for EOC leaders
- 30 tape players and cassettes with "radio dramas" recorded.

Counseling cards: CARE produced a set of ten cards with original drawings depicting key Child Survival messages. The cards have written explanations on the back. The drawings were thoroughly tested prior to being reproduced, and the cards are in color and are plastified. They were produced in large quantities (2,664 sets) for MTMSG facilitators, VCHWs and HEAs who were trained in their use. During the evaluation, these cards were seen in use in all meetings where MTMSG facilitators were present, including the monthly coordination meeting that was attended during the final evaluation. They were also visible in the health posts that were visited.

Booklets: The booklets containing key messages were distributed to EOC religious leaders. They were primarily used to guide them in their talks after the church service, and during home visits and individual counseling. They were particularly well-suited to use by the religious leaders, as they look quite similar to small Bibles (though they are thinner), and therefore, give the appearance of containing important messages. EOC leaders took to the books naturally, and the books were seen to be in use during the after-church talks that were attended during the final evaluation.

Tapes: The FCSP team produced three different radio plays that contain key messages. HEAs received training in their use, and each health post received a cassette player, batteries and tapes to be used during outreach sessions. During the evaluation, many mothers said they had heard the cassette tape messages one or more times, and HEAs were able to show them and said they were in use during outreach sessions. No sessions were observed during the final evaluation.

ii) Effectiveness

The evaluation team performed an exercise to rank the various channels of communication and support materials in terms of relative coverage and impact in order to help determine which strategies were most responsible for the observed behavior changes.

Table 4- *IEC material, quantity Coverage and effectiveness*

Material	Quantity and coverage	Effectiveness
Counseling Cards	2466 MTMSG, VCHW, HEA coverage: 1	1
Posters	8300 coverge 1	1
T-shirts	500; coverge 3	2
Stickers	2000: coverage 3	
EOC booklet	Coverage. 1; about 1000 for EOC / Religious Leaders	1
Cassettes	3 stories on each of 30 cassettes HEA, Schools. Coverage: 2	2
Pamphlets	1 X 2000. Coverage:	3
Megaphones	45 coverage ?	Mobilization
Data board	25 distrib. Coverage: 2	
Umbrella	40 coverage: 3	3
Gown	40 coverage 3	3
Billboard	18 coverage 3 Kebele	3
Handouts	MANY (EVERY training) Coverage: 2	1

BCC materials: 1=high; 2=middle; 3=low

As can be seen in the above table, the most effective media were the counseling cards and EOC booklets. However, it should be noted that for most of the interventions, the greatest amount of behavior change occurred *before* the production of any of these materials (according to the LQAS surveys in March 2006 and December 2006.). This was true for infant complementary feeding, appropriate care seeking and knowledge of danger signs in a sick child. The greatest changes occurred between the baseline KPC and the March 2006 LQAS survey, with only marginal improvement thereafter. From this one may infer that much of the behavior change was due to interpersonal communication, irrespective of supporting BCC materials.
The evaluation team also attempted to rank the various communication channels according to coverage and effectiveness in the following table:

Table 5- *Effectiveness of communication channels*

Communication Channel	Estimated coverage (number of people reached)	Effectiveness
Counseling during MTMSG meetings	1	1
Home visits—MTMSG		
Religious Leaders	1	1
VCHW	1	1
CRP	3 (10 kebeles)	3 (project)
HEA	2	1
Counseling / outreach by HEAs	1	1
Sunday teaching	1	1
Data board teaching (25)	2	2
School club (presentations)	1	2-3
Cassette	3	3
Drama dialogue	3	2
Monthly kebele review meeting	1	1

1=high; 2=middle; 3=low

iii) Lessons learned

The following are among the lessons learned that were highlighted by the final evaluation team:

- Multiple simultaneous communication streams are most effective in having an impact on behaviors (MTMSG, EOC, VCHW, HEA).
- Selection of key BCC messages through different and multiple BCC materials was effective. The messages were limited in number and very clearly defined.
- Coordinated delivery is most effective. That is, the focus is kept on a single message for one month, saturating the population.

- Monthly review meetings were important to coordinate messages, teach techniques, review strategies, and clarify doubts.
- Identification and use of positive deviant mothers works well for message communication at the base level, especially in concretely demonstrating behaviors that are discussed in meetings.
- Extensive and intensive training is critical for all persons delivering messages, and not just in message content, but in how they must be delivered.
- The use of respected institutional authorities is an effective means to teach messages to convince mothers to practice behavior and to reduce dropout (especially the religious leaders)
- MOH Health Extension Package supported the FCSP messages which served as reinforcement. This was a fortunate coincidence that led to increased impact.
- BCC materials must be appropriate for communication and message delivery (size, durability, prayer book, plastification). The materials should be made appropriate to the person that has to deliver the messages.
- BCC materials must reflect the community and must be useful for literate and non-literate mothers alike. Materials must be durable (laminated)
- Partnerships are key for BCC due to continual reinforcement of messages and also to make sustainability
- The relatively high population density, the homogeneous nature of the population (all rural, almost all are farmers, almost all Ethiopian Orthodox), and high stability of the population made it possible to reach everyone with a single strategy. The rural society is highly cohesive, so social pressure is highly effective to encourage appropriate behaviors.
- The Ethiopian Orthodox Church is highly pervasive and has very high credibility. Their engagement was key to "enforcing" behavior change. In addition, there are many religious holidays and fasting days when working in the fields is prohibited. This allows for enough free time for meetings and gatherings when messages can be disseminated.

The following barriers to good coverage of BCC were also noted:

- The first trained religious leaders met resistance from their peers. The Woreda EOC was required to intervene to overcome the resistance. Coordination at a high level and inclusion of high-level supervisors from the start was essential to success.
- BCC materials took a long time to prepare. This was partly due to high staff turnover among CARE project staff (there were 5 BCC leaders in project before the materials were finally prepared).
- The woreda is extensive, and there are only five community facilitators in CARE, each responsible for eight kebeles. The area is too expansive to cover well.

iv) Demand for continued activities

Demand for BCC activities continues to be high. MTMSGs will continue to meet as before, as their meetings do not depend on the FCSP in any significant way. Likewise, messages preached during church services will continue to be popular.

One interesting comment was made by Woreda EOC leaders in an interview during the final evaluation. They stated that their involvement in the project had given them a new calling. That is, they now have a mission to improve health instead of only remaining in the spiritual realm, and that this has given them a more active and concrete role in the community. They were excited about this expanded role, and were anxious to become involved in other "social" issues, such as education.

v) Plans for sustainability

The evaluation team deemed the behavior changes to be highly sustainable, as they have been in place long enough to have been adopted as the community "norm" and have led to noticeable improvements in the health of children. This was discussed in the sections above on the individual interventions. Likewise, the BCC activities at the community level are highly sustainable (church services, MTMSG meetings, and school clubs) because they do not depend on the FCSP for their continuation. Only post-consult counseling at health facilities may decline as health workers are transferred out of the area and replaced with others, or if MOH supervision declines in intensity due to lack of transportation.

The following factors were noted by the evaluation team:

- Because there has been behavior change in a high percentage of the population, people have already seen the benefits of the new practices in reduced child morbidity and mortality, and therefore they believe in the new practices.
- MTMSG and EOC leaders will continue because the system has been internalized in the community
- Monthly review meetings have been incorporated into the HEA role and even when HEA is not present, the VCHW presides
- The EOC sustainability is due to giving them a new role in the present structure, and the EOC has observed a decrease in child deaths in their congregations (there used to be 40 deaths per church in May and June each year, now there are very few)
- CARE conducted a phase-out workshop with different partners one year prior to the end of the project. Handover of duties and responsibilities has been developed and detailed.

Sustainability of the behavior change is virtually guaranteed, but the replicability of the results in other circumstances is not as certain. The set of circumstances that led to the spectacular results in behavior change were in many ways unique to the region. It may be difficult to reproduce these results in urban areas, for example, as social cohesion is much

lower and people have less free time for meetings. Likewise, the results may not be replicable in areas where religious institutions are not as pervasive or are more varied.

B. Skill Development

Skill development formed the second important strategy of the FCSP. This strategy overlaps greatly with "training" and "health worker performance" sections below (as required by the Child Survival Final Evaluation Report guidelines). Every effort will be made to avoid repetition. Skill development as described in project documents focuses primarily on training for health workers and managers, key partners and community-level workers. Issues relating to supervision and specifically to COPE supervision will be discussed in the next section on "increasing access to and availability of quality health services".

The FCSP included a great deal of training, and the strategies that the project used for this training were important to its success. An inventory of trainings carried out in the first half of the project was included in the mid-term evaluation report and will not be repeated here. The trainings carried out in the second half of the project are summarized in the table on the next pages. Unfortunately, the name of the training institution was not available for all trainings at the time of the evaluation.

i). Training strategy

What is striking is the number of training sessions (29) and the number of people trained. The mid-term evaluation lists 23 training sessions, but only five had more than 100 participants, and the largest was for 235 participants. It is clear that training accelerated during the second half of the project as activities and coverage were scaled-up.

The evaluation team listed the following as key elements that led to the success of the training strategy:

- All training materials were adapted to local needs together with local partners before being used.
- All training manuals and materials were extensively pre-tested before being used. They were often tested in a pilot approach before being scaled up.
- Trainings were offered based on feedback from supervision visits and gap analysis with partners.
- All training was followed up with on-the-job orientation and facilitative supervision.
- Almost all trainings were facilitated by local partners in order to maximize sustainability and ownership and to build local capacity.
- When outside expertise was necessary for training, the process followed was to first train local trainers, followed by replication with the ultimate target group. In this way local capacity for training was developed.
- When large numbers of people must be trained, this is done in cascade.
- The presence of the Debre Tabor Health College and its willingness to participate as a partner was instrumental to the training strategy's success.

- Whenever possible, training included practical application of the content (especially in cold chain management, malaria, essential nutrition actions, etc.)

Table 6- *Capacity building activities of Farta Child Survival Project*

Topic of Training	Category	Year	Training Participants			Trainers
			Male	Female	Total	
ToT on Community IMCI for partners and HWs	Partners and HWs	Year 3	3	16	19	
Workshop on orientation of Community IMCI	Partners	Year 3	75	20	95	
Training on Community IMCI for CRP	Community	Year 3	206	63	269	
Training on ENA and BCC for health workers	Health workers	Year 3	11	15	26	
Training on Rotating Drug Fund for district and health workers	Health workers and RDF management	Year	14	10	24	
Training on health information management for HWs	Health workers	Year 3	14	42	56	
Training for MTMSG facilitators	Community	Year 4	0	1717	1717	CARE staff + partners
Training for religious leaders	Religious leaders	Year 4	61		61	FWHO and Debre Tabor Health College
Training for merigitas and district leaders	RL, community	Year 4	18		18	FWHO and Debre Tabor Health College
Training for school club members	School	Year 4	15	11	26	Debre Tabor Health College
Training for Kebele leaders	Community	Year 4	115	39	154	District Women's Affairs, FWHO,

			Training Participants			
						DTH College
Training for existing community health workers	Community	Year 4	74	28	102	FWHO, DTH College
Training on ENA for health workers	Health workers	Year 4	2	26	28	Debre Tabor Health Center
RDF Training for health district staff and health workers	Health workers, RDF management	Year 4	9	5	14	
EPI modular training for extension agents	Health workers	Year 4	3	55	58	FWHO and Regional Health Bureau
ToT on COPE for district	MOH Managers	Year 4	13	3	16	Engender Health (CARE sponsored)
Training on COPE for health workers	Health workers	Year 4	13	25	38	FWHO, DTH College
Training on planning and management for core team	Managers	Year 4	11	0	11	Univ. of Gondar
Orientation workshop for idir leaders	Community	Year 4	46	0	46	
Refresher training for CRPs	Community	Year 5	152	48	200	
IMNCI training for health workers	Health Workers	Year 5	5	7	13	
Malaria training for health workers	Health Workers	Year 5	48	4	52	
EPI and cold chain maintenance training for new HEAs	Health workers	Year 5		23	23	FWHO and Regional Health Bureau
Refresher training for MTMSG facilitators	Community	Year 5	0	1300	1300	
Refresher training for religious leaders	Religious leaders	Year 5	279	0	279	

			Training Participants			
Refresher training for school club leaders	School	Year 5	33	19	52	DTH College
Malaria training for New HEAs	Health workers	Year 5	0	21	21	
Training community data boards	Community	Year 5	38	2	40	
Orientation workshop for Idirs	Community	Year 5	48	0	48	

ii). Effectiveness of approach

The training objectives outlined after the mid-term evaluation were met and exceeded, as additional unplanned training needs became evident with the evolution of the project. These included the need to train the newly-hired Health Extension Agents, the need to expand the number of idirs beyond the pilot, the new referral system, and growth monitoring. Also, training for existing community health workers had not been planned.

The best pieces of evidence of the effectiveness of the training approach are the good results of the health facility assessment showing effective implementation of IMCI, good management of the rotating drug fund, and the effectiveness of the BCC interventions. In addition, both the FWHO and the Debre Tabor Health College are confident that they can repeat the trainings as needed as long as financial resources are available.

iii). Lessons learned

The evaluation team identified the following lessons learned for skill development:

- Trainings are the key tools to improve skills that change behavior and provide quality services
- Training materials must be adapted based on the capacity of the trainees and must be adapted locally prior to their use.
- The trainings were offered based on the former capacity and skills/knowledge of trainees and not on standardized curricula.
- The training arrangement (round table), learning method (role play and experience sharing) and categorization based on the level skills trainees have and social status/peers are most effective.
- Whenever possible, projects should identify local resources to carry out all training and then facilitate it together with partners. This will maximize sustainability.

iv). Sustainability of training

The skills acquired by community workers, health workers, religious leaders and managers are likely to be sustained after the end of the project as long as supportive supervision and periodic refresher training are available. However, there are some doubts about the sustainability and intensity of future supervision in the absence of adequate transportation for supervisors.

The evaluation team identified the following factors that will maximize sustainability of the improved skills:

- Trained health workers will continue to train the community health promoters at grass root level.
- District health office staff will continue whole site trainings and refresher trainings for health workers, as they performed the initial training and participated in materials development
- There is strong interest in continuing supportive supervision, though lack of transportation may limit the frequency and intensity
- All lists of trainees and training manuals will be kept in FWHO for further reference and training.
- Partnership with ToT trained partners will be one strategy for further training.
- The FWHO is planning to use future RDF profits to fill gaps in the training. This may prove to be overly optimistic, as the amount of profit that the RDF is generating is limited.

c. Increase access to and availability of quality health services

The third key strategy in the FCSP design is to increase the access and availability to quality health services. This is mostly related to improvements in woreda level MOH services and is less under the control of the FCSP than community-based aspects.

i) Key strategies

A number of the key strategies used to improve access have already been discussed, including:

- Idirs to overcome cost barriers
- Referral system to overcome reluctance to seek care and improve care seeking
- Rotating drug fund to improve access to essential medicines

At the same time, changes in MOH policy that have been discussed negatively affected project plans to improve access to quality services:

- Reclassification of health clinics as health posts and prohibition of health posts from providing curative care services. This made access to curative health services worsen, but in the long run, improved access to some preventive services.
- Prohibition of medication distribution at the community level

Some other MOH policies improved access to services, however, including:

- Designation of nine future health centers as “developing health centers”, thus allowing them to provide curative care and dispense medicines.
- Improved staffing for developing health centers
- Recruitment of 52 Health Extension Agents, all women, to staff health posts and provide preventive care and outreach. The HEAs all have completed secondary school and have a full year of specialized training.

- CARE successfully negotiated permission from the Regional Health Bureau to launch the rotating drug fund in health centers.

It should be noted that, aside from the flexible policy in establishing the "developing health centers" and permission to launch the rotating drug fund, other MOH policy modifications and barriers were outside the influence of CARE and the FCSP. It was these aspects that led to many of the planned project activities that were scrapped at the mid-term evaluation, such as community pharmacies.

FCSP also supported the baseline and final Health Facility Assessments which provided input into the plans for training of health workers and equipping health facilities, and the project supported a Health Service Assessment which focused primarily on essential equipment and supplies for IMCI.

Supportive supervision was the other pillar to improving access to *quality* health services. Although COPE training ("Client-Oriented Provider Efficient" supervision) was planned in the DIP, the first training of trainers did not occur until just after the mid-term evaluation. Thereafter, all health center workers received training in COPE. The COPE methodology is one that focuses on supportive standardized supervision and joint problem-solving between health workers and supervisors. Action plans are developed between the health worker and the supervisor for the next visit, and progress is reviewed during each supervision visit.

The degree to which all of the elements of COPE were implemented was beyond the scope of the final evaluation. However, in each case where a health facility was visited during the final evaluation, health workers were aware of the method and were able to show the written action plans they had developed during the previous supervision. Health workers praised the system and said it was helpful to them and more useful than previous supervision method. The FWHO also praised the COPE method of supervision and said it had been implemented throughout the district. It was not clear how much effect the COPE training had on supervision of CHWs or EOC leaders, and this was not discussed specifically with them during the evaluation.

Transportation proved to be one of the more important ways that the FCSP supported improvements in the quality of care, as the FWHO and EOC district office both stated explicitly that they didn't have enough of their own vehicles for supervision and outreach, and that CARE had provided that needed service.

The number of supervision visits made to health facilities rose significantly during the FCSP:

- FWHO made 12 supervision visits to each health facility.
- District Core Team Members made 9 rounds of visits to community-level organizations (idirs, kebele meetings, VCHWs, etc.)

- CARE project staff made over 1500 supervision visits to MTMSG, school clubs, religious leaders, health facilities, kebele administration, VCHWs, churches, idirs, CRPs, home visits, model mothers and to perform case studies.
- EOC leaders made 168 supervisory visits covering over half of all churches

Unfortunately, there were no visits by Regional Health Office to the District or lower levels.

This contrasts with the baseline which HFS found that only 15% of heath facilities had received a supervision visit in the prior six months, and only 20% had received a visit in the previous year. The final HFS found vast improvement, with 100% of health workers reporting a supervisory visit in the previous six months. According to both FCSP and FWHO staff, all but the most remote health facilities were receiving at least quarterly supervision visits during the final years of the project. It is clear that both frequency and quality of supervision of health facilities improved as a result of the FCSP, and according to health workers, that it led to improvements in service provision. Likewise, focus groups, key-informant interviews and improvements in coverage attest to the improvements in the quality of outreach services, including immunization and growth monitoring.

ii) Lessons learned

Few of the lessons learned regarding improvement in the quality of services that were cited by the evaluation team have not already been discussed in other sections above. They will be summarized here:

- Supportive supervision is more effective than "enforcement". COPE is one such methodology that may be able to be applied in other projects.
- Planning and budgeting for refresher training and on-the-job follow-up are critical to improving service quality. Especially important is "whole site" training, where all members of a facility health team receive retraining at once. This is also the principal means to overcome the barriers created by high turnover of health facility staff.
- Supporting the community health system while improving services can improve care-seeking

iii) Sustainability

The sustainability of the improvements in <u>access</u> are more certain than the sustainability of the <u>quality</u> of services. Most of the issues relating to maintaining access to services are unrelated to the FCSP:

- Access will continue to expand as the MOH continues with its Health Extension Package, including completion of construction and staffing of all "developing health centers" to become full-fledged health centers, and the expansion of the number of HEAs and health posts to the planned number of two per kebele.
- This expansion will possibly allow the RDF to be extended to health posts as well, at least for essential drugs such as cotrimoxazol. The principal barriers and

challenges to this expansion would be a lack of capital to increase the stock of drugs and a degradation in the quality of management if the RDF expands beyond the ability of the FWHO to provide adequate supervision.
- Planned improvements in regional infrastructure (including the new highway under construction and slow expansion of the mobile telephone network) will improve access to health services.

In addition, the project team plans to increase the number of idirs with loans for child care from 57 to 80 by the end of the FCSP project, which will provide some improved access to services.

Maintaining the quality of services will be more problematic. High staff turnover at health facilities coupled with a very limited number of vehicles available to the FWHO for supervision and retraining could quickly erode the gains in quality if creative solutions are not found. The FWHO assured the evaluation team that sufficient funds are available to support *per diems* and other costs of supervision if vehicles were available.

All health workers, including HEAs, have detailed job descriptions, and training curricula and capacity to train and retrain all workers is present in the FWHO and partner organizations (including the Debre Tabor Health College). However, funding for continued training is not guaranteed after the FCSP, and plans by the FWHO to use profits from the RDF to sustain continued training may prove to be unrealistic.

d. Capacity-building approach

This section overlaps significantly with those the sections above on cross-cutting approaches. The section will discuss CARE USA and some local partners. Capacity-building of health facilities, health workers and training have already been adequately discussed.

i) CARE USA (Atlanta)

Strengthening the Grantee Organization: The organization's capacities were built in many different areas and different measures, for example:

- CARE under CSHGP worked closely with a FBO for the first time – The EOC. This learning was at all levels. The field, the CI – Ethiopia office and CARE – Atlanta HQ's all benefited from this experience and is applying the lessons learnt in other projects, for example, the MITRA TB project in Indonesia.
- CARE also learnt to work with other 'newly incorporated' activities like the sanitation drive taken up by the CRP's. This drive was a movement in and of it itself and thousands of households benefited from it. Working with the WHO consultant in this area was helpful not only for the training of CRP's for IMCI, but for sanitation drives which resulted in the building and usage of latrines.
- CARE Atlanta participated in the COPE training exercise done in the field and greatly benefited from this application. Similar exercises, if needed, can be carried in the field with greater confidence.

- In 2007 CARE presented at the APHA Conference our work with the religious leaders in the FCSP.
- Lives saved calculator was used in Ethiopia by the CARE – Atlanta team and shared with the project team so that they got a quick feedback on the excellent results they accomplished. The Atlanta team is looking forward to using this tool for project design and advocacy in subsequent projects.
- Routine use of LQAS in the project increased CARE HQ's confidence in the use of the methodology and interpretation of results. This will allow optimum use of the LQAS methodology in the future. One of the key lessons learned and capacities built was how to turn around a project which was not doing well at the time of the MTE. This knowledge will greatly help CARE Atlanta to look at other 'weak' performing projects and help them reach and perform at their peak level.

ii) Local partner organizations

The FCSP worked with a large number of partner organizations, though with differing levels of intensity. One of the factors that led to the success of the FCSP was intensive partner engagement from the outset, especially at the regional and district levels. This high degree of networking, training and consensus-building were important in smoothing project implementation and guaranteeing the highest level of sustainability possible, as CARE assumed the role of facilitator more than implementer.

The project documents mention that the FCSP has over 20 project partners. The evaluation team attempted to prioritize these, and the following table illustrates the most important partners for each level of organization, and separates them between government and civil society:

Level	***Government***	***Civil Society***
Woreda	Woreda Health Office Woreda DPPO Woreda Education Office Debre Tabor Nurse College Debre Tabor Hospital Debre Tabor Health Center	Woreda/Zonal Ethiopian Orthodox Church
Kebele and sub-kebele	Kebele administration Schools Health facilities	Volunteer community health workers Churches and their leaders Idirs
Communities		MTMSG (>2400) Community resource persons Other health promoters

Although the FCSP team spent a significant amount of effort with regional/zonal government counterparts (health, education and the DPPO), these contacts and meetings

were mainly for coordination and cooperation. The project did not invest significantly in their strengthening. Note that the Farta Woreda EOC office is also the regional office.

In the table above, those partners that the evaluation team felt to be the primary focus of partner strengthening are listed in **bold/underline**. All partners in the table did receive some training and strengthening.

Health sector

The FWHO and Debre Tabor Woreda Health Office (Debre Tabor Health Center and Hospital) were the principal targets of institutional capacity building in the project. There were significant investments in technical and management training, on-the-job training and coordination. Aside from the significant investment in community-level resources, the FWHO was the primary institutional partner for the FCSP. The following were identified by the evaluation team as the principal strategies and their results:

Table 7- *FWHO and Debre Tabor WHO- Evidence for improved capacity and sustainability*

Strategy	Evidence
Training in COPE, IMCI, C-IMCI, IMNCI, EPI, cold chain, and ENA	Evidence: Improved health worker performance as evidenced by final HFS and final evaluation team, increased demand for services. Sustainability: medium/high. High staff turnover may erode gains if resources for refresher training are not available. Capacity for refresher training exists at DT Health College and FWHO.
Quarterly review meetings with all partners	Evidence: Improved coordination between Woreda Health Offices and other partners, including FCSP, EOC, kebele administration, Education Office and community-level resources. Led to improved coverage for interventions. Sustainability: high. All participants stated that the quarterly meetings will continue after the end of the project. Zonal participation in the meetings may wane as project support for transportation and per diem stops.
Joint supervision between FWHO (and sometimes DTWHO) and FCSP	Evidence: interviews with FCSP, WHO staff, health workers and community workers state that supervision was useful and improved coordination and service quality. Sustianability: Medium/low: Joint supervision with FCSP will end. FWHO states that they lack vehicles to continue with the same intensity.
Logistics support: immunization, supply distribution, campaigns	Evidence: Improved coverage for campaign-based services, few supply problems. Sustainability: Same as for supervision. WHO has limited number of vehicles. Campaigns will continue due to episodic use of non-health vehicles.
Equipment: computer, printer,	Evidence: not assessed objectively. Key-informant interviews state that the equipment is in use to support project activities and

Strategy	Evidence
photocopier, overhead projector	all are functional. Sustainability: continued use probable. Replacement likely with HEA.
LQAS TOT: WHO can now perform LQAS surveys on their own	Evidence: two LQAS surveys performed with FCSP and FWHO staff. Key informant interviews indicate that FWHO continues to have capacity. Information was utilized to guide the project (see information management section below). Sustainability: Medium/low as staff turnover erodes capacity. Funds to repeat survey will probably not be available.
Planning and MoUs	Evidence: Significant effort went into project coordination and planning. One example is documented in the MTE and DIP regarding planning. Also, handover planning. Key informant interviews indicate high level of ownership by partners and knowledge of next steps. Sustainability: High. Inter-agency collaboration through quarterly review meetings will continue. Staff turnover could erode this arrangement.

The Zonal Health Office also received some project investment in improved capacity, including:

- Training—C-IMCI, ENA
- Donated equipment: fax, photocopier
- Participation in quarterly key partners group meeting (FWHO, EOC, Zonal health office, CARE, Woreda Administration, DPPO) for project monitoring. Zonal participation will not continue after project ends as it was supported by per diems and transportation subsidies.
- Head of Zonal Health Office is providing training for district health workers in IMCI (in all of the woredas in the zone) with support from the MOH.

Of special mention are the quarterly review meetings, as these have not been discussed at length earlier in the report. These meetings were key to overall project coordination and monitoring. They were attended by the FCSP team, Woreda and Zonal Health Offices, Zonal/Woreda EOC office, DPPO, Farta Woreda Administration and Woreda Education Office. At these meetings the participants would review data from the health information system and progress toward achievement of targets and workplan activities, as well as lay out the work plan for the coming quarter. These plans would include upcoming campaigns, trainings needed based on gap analysis, decision on themes for BCC (monthly messages to be communicated by *all* channels), supervision schedule, and special events such as surveys.

Through these meetings the FCSP achieved a high degree of ownership by key partners, as the FCSP team played more of a coordination role rather than an implementation role. This served to maximize sustainability as capacity for project direction and management lay with partners rather than with the FCSP itself. Once again, however, sustainability

could be endangered by high staff turnover at the FWHO. During the life of the FCSP, the FWHO had three different directors, and the current director will be leaving the area shortly.

Ethiopian Orthodox Church

The strategic role of the EOC in the consolidation of the key behaviors at the community level has already been discussed in the report. It is interesting to note that the EOC was the partner that was probably the most "transformed" by participation as a partner in the FCSP, as the project introduced an entirely new focus (child health) and methodology (systematic communication of specific key messages) to their longstanding spiritual work. Both woreda level and church level EOC leaders stated repeatedly that the FCSP has allowed them to play a more active role in the community which, in turn, has strengthened their spiritual role.

The EOC was the target of capacity-building at both the zonal/woreda and church levels (note again that the EOC office in Debre Tabor is the woreda office for both Debre Tabor and Farta Woredas as well as the zonal office. The health office, is only the woreda office). The following strategies were used to improved EOC capacity:

Table 8- *Ethiopian Orthodox church- Evidence for improved capacity and Sustainability*

Strategy	Evidence
Church level	
Training: (church level only): key messages for IMCI, communication skills for BCC, BCC materials (booklets)	Evidence: Communication skills and knowledge were in evidence during visits to churches and after-service talks during the final evaluation. The booklets were in use. Focus groups with MTMSG and others described the active role of the church leaders in reinforcing key messages through after-service talks, home visits, and participation in MTMSG meetings and monthly kebele review meetings. Sustainability: High, as there is little turnover among church leaders. Also, church leaders were very enthusiastic about their new role.
Monthly kebele-level meetings	Evidence: attendance and active participation by EOC church leaders was seen. They stated that the meetings gave them greater involvement in the communities than before. Sustainability: high, as the church leaders are very enthusiastic about their new role.
Woreda / zonal office level	
Equipment for Office: computer, furniture typewriter, telephone line, megaphone	Evidence: According to EOC leaders and FCSP staff, the equipment allowed better coordination with the EOC office. Members of the evaluation visited the office, which was quite poor (the building itself is mud). The equipment and furniture were much needed and in use. Sustainability: high as long as the equipment lasts. Replacement

Strategy	Evidence
	is not guaranteed.
Transportation for supervision	Evidence: key-informant interviews with EOC leaders stated that they were previously unable to undertake supervision due to lack of transportation. With FCSP support, they have been able to visit half their churches. Sustainability: Poor due to lack of transportation.
Training in supportive supervision: "mini-COPE" (3 days), supervision checklists, with joint implementation between FCSP and EOC	Evidence: Key informant interviews with Woreda EOC leaders stated that this has been beneficial and that the checklists are now in use. They stated that this has improved the quality of communication of church leaders. Sustainability: there is high willingness to continue and much enthusiasm for the new "mission" to support child survival. Once again, transportation for supervision may be a limiting factor.
Management training: health systems management, monitoring, planning (12 days)	Evidence: the final evaluation did not systematically investigate evidence for impact of this training, although EOC leaders stated that overall their ability to manage their programs had improved. Sustainability: high, as there is low turnover of EOC staff.
Participation in quarterly partner review and planning meetings	Evidence: EOC leaders were regularly present and participated actively according to other participants. Sustainability: high, as quarterly meetings will continue.

In most churches, three leaders received training in messages and BCC, and another leader received training in surveillance and reporting for surveillance. At the church level, monthly meetings with mothers created an enabling environment that increased contact with the community. It also provided a forum for increased interaction between the church and the kebele administration. Church level EOC participation in the monthly kebele-level meetings will continue after the end of the FCSP.

EOC leaders also stated that the project structure allowed the creation of linkages between churches that didn't exist before. It also provided an opportunity for increased linkage between religious leaders and confessors. The religious leaders visit the confessors more often than before, and these in turn, visit with families more often than before.

Prior to the FCSP, the woreda EOC office had little consistent contact with their churches due to a lack of transportation. Their only means of reaching churches was on foot. Also, the office had difficulty coordinating with other partners due to lack of infrastructure (telephone and typewriter, for example). The woreda EOC leaders stated that "the project

gave us better structure to carry out our work", and "we want to expand this type of work to other sectors".

Public Administration

Woreda level

Farta Woreda authorities participated in project planning and through regular participation in the quarterly partner review meetings. The FCSP worked most closely with the offices of Communication, Women's Affairs and Capacity-building. In addition, the FCSP contributed a photocopier and computer to the woreda administration. It should also be noted that the woreda administration was responsible for the budget of the woreda health office as well as administration of the rotating drug fund.

During the life of the project the local government structure changed, and also suffered from high staff turnover. There were three different woreda administrators during the life of the FCSP. It is difficult to determine whether there was any lasting effect of the FCSP on woreda administrative capacity outside their ability to coordinate with the other partners and administer the drug fund. The final evaluation team did not meet with woreda level administration for interviews.

Kebele level

Kebele administrative offices are small, and their structure mirrors that of the woreda administration. The FCSP worked most closely with the kebele administration leader, and representatives of the offices of capacity-building, women's affairs, and communications/community mobilization.

Kebele administration staff from all kebeles received training in project messages, and those from the ten pilot kebeles also received formal C-IMCI training. They also attended monthly kebele review meetings, but not quarterly partner meetings at the woreda level. FCSP staff provided structured supervision using checklists to ascertain their regular participation in coordination meetings, dissemination of key messages during public events, and provision of feedback to community health promoters.

During the final evaluation, kebele administration staff were present during the kebele level meeting that was observed. The evaluation team noted that the level of participation and degree of strengthening in the project varied greatly from one kebele to the next. They noted that kebele administration is responsible for all sectors, and that there is no officer specifically assigned to health. Therefore, attention to health issues may vary between kebeles. Sustainability of ongoing structured supervision of kebele staff was not discussed during the final evaluation.

Education

The zonal and woreda education offices as well as the schools in the zone were another important partner, especially regarding the establishment of school child health clubs.

Early in the project the FCSP team spent considerable effort meeting with zonal and woreda education offices to gain their cooperation and participation in the FCSP.

The Zonal Education Office received training in BCC strategy development and BCC messages. They participated in quarterly partner review meetings. During the final evaluation, the Zonal Education Office representative stated that the Zonal Office is now better prepared to use school clubs of all types to transmit messages. This was not independently verified by the evaluation team.

The Woreda Education Office received the same training as the Zonal Education Office. In addition, they received a computer, typewriter, stationery, and registration books. They participated in the development of supervision checklists for school clubs, but actual supervision was done by the FCSP, HEAs and other health facility workers. The FCSP team plans to train school supervisors at woreda level to supervise school club activities as part of handover plan.

In each school, the FCSP trained a school club leader (a teacher), a school director, and two student school club members in key messages of the project. The clubs received stationery materials, BCC materials, t-shirts, equipment for gardens, watering materials, and seeds. The school clubs use these materials for their regular discussion meetings, and they perform skits for the public and education for their families at home. It is clear that the objective of forming Child Survival school clubs has been met, and that these are likely to be sustained after the end of the project, as message reinforcement for the clubs can come from various community sources, including health facilities, the Woreda Education Office and even MTMSGs and community health promoters.

Disaster Preparedness and Prevention Office

The DPPO is a desk within the Woreda Rural Development and Agriculture Office. It is charged not only with disaster prevention, but serves as the liaison office for all NGOs. As such, the DPPO was an important partner in the FCSP. The Zonal DPPO approves projects and participates in FCSP quarterly partner review meetings. The office recently established a Zonal NGO forum, which the DPPO coordinates.

The woreda level DPPO also participates in the quarterly partner review meetings. The FCSP purchased fuel and oil one time in order to allow the Farta Woreda DPPO to supervise the woreda level NGO activities.

The FCSP provided training on micronutrient diversification and home gardens; micronutrient food preparation campaign for 56 DPPO rural development agents in all 40 kebeles. The project also supported the agricultural development agents in promotion of home gardens through the model mothers and school gardens through school clubs, including the provision of seeds. The DPPO will continue to support this activity, as it forms part of the Health Extension Package and the DPPO program. The development agents also performed food preparation demonstrations using micronutrient-rich foods in

eleven kebeles. This shows that the DPPO has integrated some of the key nutrition messages about micronutrients into their activities.

Other strategies

CARE carried out a formal annual needs assessment of each of the partners every fiscal year using a questionnaire prepared according to the previous year's action plans. This was used to identify gaps in each partner office which would require support in the subsequent year. These gaps may include training needs, materials and supplies, or other support. The assessments were compiled and incorporated in the coming year's action plan by prioritizing activities and balancing available resources.

Lessons learned

The evaluation team cited the following as among the lessons learned and key principles regarding partner strengthening:

- Create mechanisms to benefit both sides
- Clearly define roles and responsibilities early in the project
- Supportive supervision is key to success
- Regular review and planning meetings, including review of activities achieved, developing action plan for the next time: micro-planning
- Creating linkages between partners (not just between CARE and partners) is important to sustainability

One partner noted during the evaluation: "With the CARE project, we were able to achieve our goals and plans faster than before; especially with the community participation"

iii) Health facilities

This has been adequately discussed above under cross-cutting measures (access, quality and skill development). The only point mentioned by the evaluation team that has not already been discussed above is the successful negotiation with the FWHO to prioritize essential IMCI drugs when drugs are purchased for the MOH drug system.

iv) Health worker performance

This has been adequately discussed above under cross-cutting measures (access, quality and skill development).

v) Training

This has been adequately discussed above under cross-cutting measures (access, quality and skill development).

e. Sustainability strategy

The sustainability strategy received considerable attention during the FCSP. A formal exit strategy document was prepared (it is annexed to the final annual report as well as

this report – Annex G). This was the result of meetings and negotiations with partners in a workshop held one year before the end of the project. The exit strategy includes specific actions and responsibilities, and led to the signing of formal memoranda of understanding with each partner outlining key actions and responsibilities. The exit strategy addresses training gaps, supervision, cost recovery (idirs and gardens---it curiously doesn't mention the RDF), data analysis and use, and maintenance of activities of community-level workers and MTMSGs.

The DIP included the following project objective relating to sustainability:
"To strengthen local and community-based institutions and partners and build capacity to support child survival activities on a sustainable [basis]."
Indicators for this objective can be grouped into three broad areas:

1) Indicators relating to various cadres of community workers and the EOC being able to sustainably transmit messages. These indicators were met and exceeded.
2) Indicators of the health system able to sustainably provide quality IMCI services. These indicators were met within the limitations of MOH policy. The project originally envisioned that all health posts and health centers would provide these services, but this was not feasible.
3) Indicators regarding the revolving drug fund and community pharmacies. Whereas the RDF was a success in health centers, MOH policy made it impossible to expand beyond this level into peripheral facilities and communities.

Given the five-year span of the FCSP, it is not surprising that the sustainability strategy would suffer significant modification as the project, its context and strategies have evolved and become more refined. The exit strategy is a detailed document based on the IMCI framework and as such follows the same structure as the rest of the project: skill development; community mobilization/BCC; and quality assurance, access and availability of services. It contains significant emphasis on ensuring that partners at all levels have the skills and materials necessary to continue with key activities including training, supervision and communication. It also mentions institutionalization of the cost-recovery strategies, specifically idirs and home gardens. Much emphasis is on follow-up training in key areas and handover of supportive supervision of the various cadres of institutional and community workers.

According to members of the final evaluation team, the handover plan activities are either on schedule or running ahead of schedule. The principal remaining activities include some selected refresher training and expansion of the idirs. The following table was developed by the evaluation team.

Table 9- *Status of the key sustainability activities*

Activity	1=on schedule, 2=late 3=not possible	Further Assistance Required
MTMSG support and supervision transferred	1	No assistance
Monthly Review Meeting - support and supervision transferred to HEAs/VCHWs	1	No assistance
Home Visits continuing	1	No assistance
Supportive supervision of each level in cascade	1	No assistance
Training and re-training needed: done by FCSP team members	1	No assistance
Institutionalized of all cost recovery systems (idirs, gardens)	1	No assistance
Expansion of data boards	1	Further materials and training—on schedule
Documentation of best experience	1	In process
System for Monitoring and Evaluation of counseling	1	No assistance
Report compile analysis	1	No assistance
Referral system	1	Requires consolidation
Develop checklist and follow-up of handover activities	1	No assistance

Not mentioned in the above table are the Rotating Drug Fund and the idir expansion. The RDF was probably not mentioned simply because it has been well managed by the Farta Woreda Administration for some time. It requires no further assistance. The idir expansion will simply require replication of the techniques already successfully applied in the existing idirs. As described above in the section on idirs, there is some variation in how well each of these functions, but in general they are achieving their goal. Also, as time is short, it may not be possible to provide the intensive supervision after training that the other idirs received. It is possible that this will affect the new idirs' performance.

Direct evidence exists that there is continued demand for community level activities, as the MTMSG meetings and monthly kebele review meetings continue to occur without project intervention. After-service messages are also continuing at all churches.

As was discussed under each technical intervention as well as in the BCC section above, the new behaviors, including child care and care-seeking, have been in place long enough that the community members and community organizations (including the EOC) have noticed the positive effect on health. This fact, together with the fact that behavior change has been pervasive have lead to the adoption of the new behaviors as the community "norm", thus leading to a high probably of future self-reinforcement and propagation even in the absence of external support.

One of the keys to sustainability was planning the transfer of responsibilities to low-level structures, especially structures at the community and health facility level. Project and woreda level support are not necessary for most project activities to continue. It should also be noted that the decision to not provide financial incentives to community volunteers, including MTMSG facilitators, EOC leaders and VCHWs has helped the FCSP avoid the dilemma faced by many CS projects at phase-out of how to sustain the supports in the future.

Finally, the HIS is now functioning at all levels without project support. See the section below on information management for details on information gathered, information flow and information use during the life of the project.

Some critical issues for sustainability identified during the final evaluation include:

- **Transportation**: this is the weakest link at the woreda-to-kebele level. All other levels below this are functional, as distances within kebeles allow for transportation on foot. The FWHO is the only woreda administration office with any vehicles at all, and it has only five vehicles for all activities. There are no vehicles designated for supervision, and the FWHO and EOC are seriously concerned about the sustainability of supervision. There are no plans for the FCSP to hand vehicles over to government or EOC entities.
- **Stationery**: This is a relatively minor issue, but eventually all forms for reporting at the community level will be exhausted, and there are no funds available to replace them. The MOH HIS will continue, as it receives financial support from the MOH.
- **Zonal participation** in quarterly partner review and planning meetings: the FCSP has been providing per diem support for zonal health office and DPPO participation in the quarterly meetings. The Farta Woreda EOC office is also the zonal office, so continued zonal level EOC participation is guaranteed. The per diem support will end, and it is not certain whether the zonal offices will continue to send representatives. However, their participation is not crucial to the continuation of project activities, and is most important in order to keep the zonal offices informed.

The evaluation team identified the following lessons learned about sustainability:

- The communities are able to successfully manage the monthly review meeting and community-based activities, as long as they are convinced of their usefulness

- It is important to identify all potential partners in the area, in this case including the religious leaders.
- The MTMSG successfully served as a base for a peer group approach to behavior change and community involvement; however, involvement of the EOC was probably essential to achieve the high level of ongoing participation in MTMSG meetings.
- The partnership approach to project implementation is most effective in achieving a high degree of sustainability. CARE implemented very few activities itself. In addition, the FCSP achieved a high degree of partnership between communities (MTMSG, VCHWs, and other health promoters), the health system (HEAs and health posts), religious institutions and civil government (kebeles)
- Focused and coordinated delivery of BCC message and use of appropriate BCC materials are critical to achieve behavior change that is pervasive enough to see concrete results and achieve sustained changes.
- Use of the positive deviance approach (role-model mothers) is effective in achieving behavior change
- Coordinated use of multiple communication channels is important to achieve behavior change
- LQAS proved to be a very useful tool to monitor the project and focus interventions (see information management section below)
- Use community data boards: information to community was a successful and sustainable example of community data use. It also successfully integrated health facilities (health posts) and community level organizations (EOC, MTMSG and kebele administrations).

C. Program Management

The mid-term evaluation report contains an extensive section discussing project management. The points discussed there will not be repeated in this report.

1. Planning

The extensive joint planning that was carried out as part of the DIP preparation and start-up phases of the project are well-described in the MTE report. It is worthwhile to mention that eventually, the quarterly partner review and planning meeting and the monthly kebele meetings became the cornerstones for project collaboration, planning and review. These meetings are now well-institutionalized and should not depend on the FCSP team for their continuation. The active involvement of partners in all phases of project planning and execution is one of the reasons for the excellent results and high degree of sustainability of project activities.

The original DIP workplan suffered significant changes through the life of the project, as would be expected over five years. The major changes were the result of alterations in MOH policy to which the plans had to be adapted (described in previous sections). The ongoing nature of the review and planning meetings allowed the team to take these changes in stride.

The evaluation team did not identify any specific alterations in the original project planning process or DIP preparation that they thought would have improved the process. There remains the observation that it is overly optimistic to expect that a district level project can assume that it will be able to alter national MOH policy (in the case of the FCSP, this is as regards the community pharmacies and plans to train community health workers to diagnose and treat common childhood illnesses). It is unwise to gamble the success of a project on the future ability to alter policy if the agency has not yet secured an agreement to that effect in writing prior to the project's implementation.

2. Staff training

Training of partner staff has been discussed in other sections above, and it is clear that workers have demonstrated improved skills. Of special mention for FWHO management is the implementation of supportive supervision using the COPE methodology which was lauded by FWHO managers and health workers alike.

The MTE report describes much of the training that the CARE team had attended up to that time. It is notable that CARE staff participated in all training when new skills were to be imparted. During the second half of the project CARE staff received training in IMNCI together with FWHO staff, LQAS survey methodology and COPE supervision. In all cases, a TOT was first done for CARE and FWHO staff alike, followed by training for the final target group. The final evaluation team and CARE staff cited the LQAS and COPE supervision as very important skills that they had learned and implemented. The

FWHO feels that they now have the skills to perform LQAS-based surveys without external assistance in the future if there are sufficient funds.

The evaluation team felt that adequate effort went into training of program staff, both CARE and partners. The most important lesson learned was to treat the NGO staff and partner staff equally. Both require training, and as partners, should develop the same skills. The inclusion of both CARE staff and partner staff in TOTs enhanced project sustainability.

3. Supervision of Program Staff

As before, staff supervision was discussed in the MTE report. CARE staff reported adequate supervision at all levels, including the Project Manager, who felt that supervision and support from both CARE Addis Ababa and CARE headquarters was sufficient for his needs. Staff performance evaluation is discussed in the following section. The supervision methodology for FWHO health facility workers and EOC leaders has been consolidated and is sustainable, using COPE supportive supervision. However, lack of transportation after the end of the FCSP may reduce the frequency of regular supervision visits.

4. Human Resources and Staff Management

CARE FCSP staff agreed that one of the better aspects of working for CARE is the clarity of policies and procedures for employees. Most had previously worked in the public sector, and they cited the contrast between the lack of such clarity in their previous positions and the clear communication of policies by CARE. FWHO policies and procedures are those of the MOH, and high staff turnover has hindered communication of these policies. The new HEAs may represent an exception, as they received formal induction training regarding their roles and responsibilities when they were integrated into the project. CARE staff performance is monitored using a regular staff performance monitoring system, which CARE staff confirmed is in use.

The MTE describes in detail many problems faced in filling the program management positions during the first half of the project. During the second half of the project, these problems continued. The Project Manager position was vacant almost continuously from November 2003 until December 2005 when the acting Project Manager was promoted to the Project Manager position. He has remained as Project Manager until the end of the project. The BCC facilitator was another position that proved difficult to fill. It was filled temporarily for four months, but is now vacant again. Of the current team, only one has been with the project since the beginning. Two began in 2003, one in 2004, and three in 2005. None have been with the project less than two years, and all previously worked in the public sector. The FCSP team meets monthly for discussion and planning, and all programs in the CARE Debre Tabor office meet every six months for a mid-year review. One shortfall noted by the team is the complete lack of women among the technical staff. This is also true of CARE's other projects in the Debre Tabor office. CARE Ethiopia worked hard to recruit women to the team, but was not successful. They explained that this is due to a lack of experienced women as well as the physical difficulty of the project

zone. However, it is interesting to note that *all* of the HEAs recruited and trained by the MOH are women, though they have a lower educational standard than project staff.

All staff agreed that the level of supervision and support that they have received from their immediate supervisor, from CARE Ethiopia and from CARE Headquarters has been adequate and supportive. The team received three visits from Dr. Khrist Roy from CARE Headquarters during the life of the project, and he provides regular technical support at a distance as well, sending reference materials and indicating useful websites. The team also received other technical visits from headquarters staff, including from Renee Charleston, who helped with preparation for the final evaluation. The team also cited the ongoing technical support they received from Mariana Stephens at CARE Headquarters.

The Project Manager also stated that he receives regular supervision visits by the Area Coordinator from Addis Ababa (at least quarterly). In addition, CARE sponsors bi-annual national coordination and review meetings in Addis Ababa. The staff agreed that the overall management style has been supportive, with general sharing of skills among the technical staff. They also agreed that staff cohesion and morale are generally good, and this agrees with observations during the final evaluation. In addition, CARE Ethiopia provides support in editing and distributing project proposals prepared by project staff.

The post-project transition is a source of anxiety among staff, as is the case for almost all projects that are closing. Some staff members have been offered other positions within CARE (one team member left for another CARE project during the evaluation). Others are still looking for employment, but most believe that they will not have great difficulty finding other employment after the end of their contracts. CARE will provide them with letters of recommendation on request.

It should be noted that in spite of turnover among project staff and FWHO staff, and the inability to consistently fill all project staff positions, the FCSP achieved and exceeded its objectives. This illustrates the importance of partnership in sharing responsibilities. As CARE was not responsible for the actual implementation of most project activities, vacancies were less important than they otherwise would have been.

5. Financial Management

As part of each CARE headquarters supervision visit, finances were analyzed at the CARE Ethiopia office and spending adjusted to meet project needs and improve financial flows. In addition, a detailed analysis was performed prior to completion, and an action plan developed and implemented in order to improve the burn rate of funds.

Prior to nine months of project completion, very detail financial analysis was made among PM(Nina), SRH Program Coordinator(Dr. Barbara) and Financial analyst (Alemaye). Action plan was agreed upon to improve the burn rate of the project by additional capacity building of partners at all levels.

Financial management staff in the Debre Tabor office said they were adequately trained and received support from CARE Addis Ababa as necessary. The FCSP team stated that they receive monthly financial updates on the status of expenditures. Project staff all said that they were paid on time, and that there were no problems with financial flows causing project delays. Project funds have been expended according to planned activities, and there were no significant rearrangements of funds. As of April 2007, the project had a pipeline of $290,000. This residual is already allocated to follow-up training that has been identified by the team and partners as necessary for sustainability, as well as seed money to expand the idirs according to the workplan. Up to the time of the evaluation, about 80% of the total field budget had been expended. There will be no funds left after the end of the project.

Partners are adequately prepared in financial management. The Farta Woreda Administration has a well-developed, if cumbersome financial management system. The Rotating Drug Fund has been operating well for some time now, and presents no significant problems. During the idir evaluation, there were no significant financial management problems identified, except for the fact that some idirs were not lending
No significant issues were raised. Financial management staff in the Debre Tabor office said they were adequately trained and received support from CARE Addis Ababa as necessary. The FCSP team stated that they receive monthly financial updates on the status of expenditures. Project staff all said that they were paid on time, and that there were no problems with financial flows causing project delays. Project funds have been expended according to planned activities, and there were no significant rearrangements of funds.

6. Logistics Management

The initial difficulties in procuring equipment had been largely overcome by the time of the mid-term evaluation. However the team cited the longer-than-expected time necessary to develop and procure the BCC materials. This was due to the process of materials preparation, however, and not due to CARE's procurement procedures. The transportation problems cited at the mid-term evaluation were resolved when the FCSP negotiated with the Debre Tabor office to assign one vehicle permanently to the FCSP. Prior to that time, all office vehicles had been in a pooled arrangement, which occasionally caused transportation bottlenecks. There are no future logistics issues for partners that should affect sustainability. The logistics for the Rotating Drug Fund are already being well-managed by the Farta Woreda administration.

7. Information Management

The evaluation team discussed information management at four levels: community, health facility, district and project.

Community level

At the community level the following forms are collected:

- CRPs registration and data collection forms
- Referral token material-'bonos'

- VCHWs registration book.
- Birth and death reporting forms
- Community data boards.

The information that is collected includes the following:

- The number of under five deaths and births
- The number of under-one defaulters for vaccination.
- The number of cases of measles, AFP and NNT.
- The number of malaria cases
- Community latrine coverage
- The number of attendees of kebele monthly meeting.
- The number of referrals made for ARI, diarrhea, malnutrition cases.
- The number of under-five, ARI, diarrhea, malnutrition cases and deaths
- The number of participants and topics of health education session
- The number of home visits for pregnant, lactating and other caretakers

This information is sent to health facilities some of which is included on community data boards. The surveillance information is aggregated weekly by HEAs and sent upwards to the FWHO. Other data are aggregated by VCHWs and the data board committee for inclusion in the data board. Surveillance is reported weekly, other data monthly. The data boards are updated quarterly. The numbers are also discussed during some MTMSG meetings and during monthly kebele level meetings. The data are used to trace and provide support and motivation for EPI defaulters, motivate communities for malaria prevention activities, follow up on AFP and neonatal tetanus cases (specimen collection), and to help identify topics for health education.

Health facility level

At the health facility level the following forms are collected:
Disease surveillance, immunization, under-five sick child visits and deaths, growth monitoring (0-3 years), antenatal and postnatal care, environmental sanitation and home visits.

The indicators collected at this level include the following:

- Number of immunized children for each antigen.
- Number defaulters.
- Number of sick children treated (ARI, diarrhea and malnutrition) and immunized.
- Number of deaths of each case (ARI, diarrhea and malnutrition).
- Number of children whose weight taken or monitored.
- Number of ANC, PNC and DS attendants.
- Number of local latrines, waste disposal pit, seepage pits constructed
- Number of people reached through health education, number of sessions and topics, number of home visits and counseling sessions
- Number of cases of AFP, measles and neonatal tetanus, malaria (epidemic). The number of malaria breeding sources reduced

This information is collected and aggregated at health facilities on MOH forms and sent to the FWHO and to the CRPs. Surveillance data are reported weekly, and the rest monthly. Much of the information is used locally in the same way as community level information. It is also used during quarterly review meetings by the FWHO to target underperforming kebeles and health facilities, and weekly to investigate disease outbreaks. Finally, it is used to identify education topics for the coming months.

District level

The FWHO collects information on immunization, under-five morbidity and mortality, growth monitoring, malaria prevention and control, maternal care, environmental sanitation, health education and surveillance.

The indicators collected by the FWHO include the following:

- Number of immunized children for each antigen
- Number of sick children treated (ARI, diarrhea and malnutrition) and immunized
- Number of deaths of each case (ARI, diarrhea and malnutrition)
- Number of children whose weight taken or monitored
- Number of ANC, PNC and DS attendants
- Number of local latrines, waste disposal pit, seepage pits constructed
- Number of people attending health education talks, number of sessions, and topics
- Number AFP, measles and neonatal tetanus, malaria (epidemic). The number of malaria breeding sources reduced

It is interesting to note that the indicators analyzed at the district level are fewer than those at the health facility level. This is appropriate, as the most detailed information is needed at the most local level.

This information is aggregated by FWHO staff and sent to the zonal health office as well as the Woreda Administration and the FCSP office. It is reviewed quarterly during the quarterly partner review meetings. It is used for monitoring and on the job orientation and facilitative supervision, for ranking to create competitive environment among health facilities to encourage improvement in performance, to address stockouts of essential medicines, for resource mobilization, provision of feedback and early preparedness and planning. It is also used to update the plans of actions and compensation measure to improve performance and coverage as well as to identify problematic areas for intensified intervention.

One important note is the key role of the VCHWs in the information system, especially at the community level. The VCHWs collect the reporting forms from MTMSG, CRPs and others and take them to the relevant authorities, including health facilities and kebele administrations. More recently, the HEAs, which were not foreseen in the original project, have been assuming some of this function for MTMSG and health facility data, though the VCHWs continue to fulfill the primary liaison role between the kebele administration and CRPs.

Project Level

The FCSP gathers the following information for use to measure progress toward achievement of its objectives:

- Internal regular review of project activities/project + FO.
- Mid-term review
- Quarterly review of project DIP/annual operational plan
- LQAS KPC surveys—two completed

The FCSP team cited LQAS as being a particularly useful tool for monitoring, as it was fast and inexpensive. It provided information not only about project outcome indicators, but also about the relative performance of individual supervision areas. This allowed the team to focus its efforts and resources to support specific geographic and programmatic areas that were lagging. This was done through consultation with partners to identify possible strategies to improve performance, joint development of an action plan, and intensified activities such as training in growth monitoring for VCHWs, and greater attention to BCC messages in growth monitoring.

For those who are skeptical of the LQAS sampling method, note that the results of the KPC cluster survey agreed very closely with the results of the LQAS surveys, as would be expected if the sampling methods are both valid. However, although the overall cost of the two methods is similar for the first rounds, LQAS has two significant advantages over cluster sampling: 1) the recurrent cost of data collection using LQAS falls significantly if data collection can be coordinated with supervision and 2) LQAS can provide data at the sub-district level, whereas cluster sampling cannot.

The FCSP also performed the following special studies:

- Baseline and final KPC surveys
- Health Services Delivery Assessment (baseline and final)
- Preliminary potential partners assessment (baseline)
- Health Information Gap Assessment
- Census Survey on EPI and Environmental Sanitation
- FGDs on Maternal and Child Health Problems
- FGDs on BCC Messages and Materials
- FGDs on Effectiveness of Tape Listening
- FGDs on effectiveness of Idirs and community data boards.
- BCC Strategy (FGDs, etc) and for materials development

These surveys led, for example, to the procurement of IMCI equipment for health facilities (HFS), an action plan for training and resources (capacity building activities) required to work with potential community level partners, and the identification of gaps in the health information system and training arranged for health workers and materials provided.

It also led to the institution of targeted identification and follow-up of EPI defaulters, and an evaluation of EPI and environmental sanitation. The studies were also used to identify priorities for preparation of a follow-on proposal for expanded impact of Child Survival (not funded), allowed the testing of BCC messages, led to the expansion of idirs, improvement and of the tape listening activities and data boards and their subsequent scale-up.

The project supported community-based data use through

- training of VCHWs and EOC leaders (and eventually HEAs) in basic health information systems and community data boards
- provision of registries and other materials (data boards, chalk, formats, etc.)
- quarterly reviews and technical support through on-the-job orientation

The evaluation team cited the following points as evidence for the long-term sustainability of the various information systems implemented by the project:

- The FWHO leads the quarterly partner review and planning meetings using data from the various information systems
- DPPO uses the data for resource allocation
- The Regional Health Office uses project information for planning
- All of the information systems are functioning essentially without project intervention except for their dependence of the community level systems on the FCSP to fund stationery (registries and forms).

Key partners use the various information systems as well. The MOH will soon be implementing a new HIS. CARE will back this effort through support for training and follow-up if the new system is implemented before the end of the FCSP. In addition, the FCSP is developing a system to compile and analyze information from supervision checklists in order to provide a better objective measure of service quality at all levels. Aside from use by partners for adjusting their activities, use of CS data outside the project was not discussed during the evaluation.

8. Technical and Administrative Support

The mid-term evaluation provides a detailed discussion of the technical support provided during the first half of the project.

The following table was taken from the mid-term evaluation report listing recommendations for future technical assistance.

Table 10- *Midterm evaluation for future technical assistance and its outcomes*

Topic	**Suggested Source (mid-term evaluation)**	**Outcome (final evaluation)**
COPE implementation	Planned in Oct/Nov 2005 by Engender Health, CARE Ethiopia	Engender health provided TOT in August 2005.
Qualitative Methodologies: Key Informant Interviews, Focus Group Discussions	CARE Ethiopia- This is expected to be done before December 2005	CARE headquarters provided training in PRA and qualitative methodologies including focus group discussions.
Systems Analysis for improving logistics	UNICEF, JSI-DELIVER	Not done due to coordination problems with partners and a shortage of qualified local technical assistance.
C-IMCI	Currently being conducted by central MOH and WHO staff, Regional Health Bureau, and pilot C-IMCI woredas in Amhara region	Done. Facilitated by MOH as a pilot. This was replicated for all health workers and community health workers.
LQAS	CORE-Ethiopia in mid September	Done, and two LQAS studies were done, and the action plan that resulted from the first LQAS was implemented. This allowed the team to focus on underperforming areas.

Other TA received included the following:

- CARE headquarters; Khrist Roy and Renee; August 2006. Purpose: phase out plan, preparation for final evaluation, reinforce ENA.
- Linkages Ethiopia provided 6-day TOT for project staff and partners on ENA.

The FCSP team felt that the technical assistance received was generally adequate. The only suggestion they had for further technical assistance was in the area of using computers more effectively.

9. Mission Support

The project received a visit from USAID Washington in 2002 and one from the USAID Ethiopia mission in 2006 (to visit both the FCSP and water projects). The FCSP collaborated with the USAID Mission in the distribution of bednets, as well as with Vitamin A distribution campaigns. CARE staff provided the USAID mission with annual project updates, and communicated regularly with the mission by email and telephone as necessary. There are no plans for continued mission support to the CS project after the

end of the project. It was not possible to arrange a meeting with the USAID mission at the end of the CS final evaluation, as the representative was not present in country at that time.

10. Management Lessons Learned

Overall, the FCSP was a very well-managed project functioning in a relatively difficult environment. The project office is in a town with poor infrastructure and poor access to commodities (for example, there is a single petrol station in the town, and shortages are common). Telephone and internet communication connections are tenuous, and cell phone coverage is limited to the urban area. The physical and cultural characteristics made recruitment of competent staff difficult for CARE and partners alike. Nevertheless, project management did not present a significant hurdle to the experienced CARE office, and overall, the project ran well and on-time.

Close partner collaboration from the beginning was perhaps the key to the project's success. As has been stated many times already, CARE's role was more of a facilitator rather than an implementer. Planning, implementation and monitoring and evaluation were collaborative efforts at all stages, with partners (including communities) playing the most active role in implementation. Ongoing capacity-building was an integral part of project implementation.

These characteristics made it possible to overcome high staff turnover in both CARE and the FWHO (there was much less staff turnover in the EOC). The lesson learned is that a well-designed project with adequate involvement of partners is quite resilient and sustainable.

D. Other Issues Identified

No significant other issues were raised by staff or the evaluation team.

E. Conclusions and Recommendations

The overall conclusion of the evaluation team is that the FCSP achieved and surpassed all of its objectives.

Those few areas where planned activities were not implemented were outside the influence of the project, as they ran counter to MOH policy. These include community pharmacies and community management of common childhood illnesses.

The most significant achievements of the project were in the area of behavior change for child nutrition, where improvements in breastfeeding and child feeding practices were large. Immunization and care-seeking also improved significantly, in spite of large distances to health facilities. There is also evidence that the quality of health services improved. The rotating drug fund has improved reliable access to essential medicines. The behavior change was significant enough that there was a noticeable improvement in child health and a reduction in child deaths. The behavior change was so pervasive and

the results so convincing and visible, that community have adopted the new behaviors as "their own", thus leading to a high degree of sustainability.

The most important constraints to achieving the greatest impact are some MOH policies restricting medication distribution and curative care to a few health centers as well as high staff turnover in the MOH. In addition, there was little or no verifiable change in the *quality* of infant feeding as regards energy density and frequency of feedings. Finally, sustainability may be hampered by a lack of transportation for supervision in the future.

Some of the best practices and lessons learned from the project include the following:

- A high degree of involvement and ownership by stakeholders and partners from the outset will maximize impact, improve project "stability" in the face of modifications and constraints, and maximize sustainability
- CARE served as a facilitator more than an implementer. Whenever possible, local resources were used for training, and capacity-building for future training was built into all training (capacity for partners to continue training in the future)
- Aside from training allowances, no external incentives were paid to community volunteers or partner staff. This avoids the problem of how to sustain external subsidies in the future.
- The BCC strategy took maximum advantage of the presence of the EOC. The EOC's pervasiveness and high degree of authority led to almost one-hundred percent coverage of BCC messages with high credibility.
- The project created a self-reinforcing network of community structures, including the MTMSGs, health posts (and HEAs), kebele administration and EOC leaders.
- The project concentrated on a limited number of high-impact BCC messages, and delivered them in a coordinated fashion through multiple simultaneous channels that achieved one-hundred percent coverage.
- Training is important, but not sufficient to improve services. Follow-up training, on-the-job training and intensive supportive supervision are all essential if services are to be improved.
- The FCSP worked *within* existing systems whenever possible. This is evident in the structure of the rotating drug fund, where the existing woreda administrative structures were used to support the fund, which has led to a high degree of sustainability.
- A long-term plan for phase out that was developed together with partners has helped ease the transition and maximized sustainability.

The behavior changes observed in the project have a high probability of sustainability for reasons discussed repeatedly above. Improvements in service quality will be more vulnerable to erosion, as they may suffer from high staff turnover, lack of funds for retraining and lack of transportation for adequate supervision. The rotating drug fund and idirs have a high chance of sustainability, as they took advantage of long-standing existing structures.

A documentary was produced in Amharic and English. Best practices and lessons learned will be presented at American Public Health Association Conference in Washington in November and are submitted as abstract to Global Health Council Conference in Washington in May 2008. The project and its Amharic Documentation will be presented at the NGO Fare in Addis Ababa in December 2007.

CARE Atlanta has taken the following steps to share the lessons learned to the broader development community

- A presentation on role of EOC religious leaders was done in the GHC conference in 2007.
- A similar presentation was done in CHC on *iddirs.*
- Within CARE a brownbag presentation on the same topic was done in 2007 both in the annual CS workshop and the CARE – Atlanta HQs.
- Efforts are being made to publish this paper in a peer reviewed journal.
- To tap the existing structure of the *idirs* benefited the project greatly. CARE looks forward to seeking for similar secular structures where it will do other projects and seek their participation.
- Most of CARE's MG in Ethiopia did not have a saving and loan group orientation, this might be one reason why the knowledge, interest and behavior of MG members was fixated on health and health alone. CARE in the future would like to observe other similar groups with a savings and loan orientation..
- Work with the *kebele* officials was found to be very effective in getting MG to be formed quickly, CARE will take this lesson in asking sub district level leadership elsewhere in its project to take lead on this aspect of quick MG formation.

Scale-up and replication are two interesting aspects that were much discussed by the evaluation team. The entire team agreed that the results of the project could be scaled up and replicated in other geographic areas with similar cultural characteristics, that is, high-density rural population based on agriculture, and where the EOC is pervasive. The results could be obtained at lower cost than the original project, as some aspects, such as the school clubs and gardens, may be omitted with little negative effect. However, the evaluation team was less optimistic about replicability in geographic areas or countries where the EOC is not strongly present, or where the population is of mixed religion. Also, the team was doubtful about whether the same results could be achieved in urban areas where there is less social cohesion, mothers and communities have less free time to meet, and volunteerism is less common.

Recommendations for promising future projects include the following:

- Addition of a maternal health component in the existing project zone: this would be quite easy and inexpensive, as it would take advantage of existing structures. However, as maternal health relies on timely emergency referral and transportation for obstetrical emergencies, it may be more timely once the developing health centers are complete and delivery services are available at more

decentralized health facilities. Other components that could be easily added to the existing project include neonatal care and quality of child feeding.

- Replication of the existing methodology in the adjacent rural area which has similar characteristics. A different suggestion involved a trial in a heavily Muslim area, where a similar degree of involvement of religious leaders could be attained.
- A trial of the same methodology in the urban area of Debre Tabor. This would be relatively inexpensive, as transportation costs would be greatly reduced, and the effort would be interesting as it would help identify the aspects of the rural project that were most critical to its success. It should be noted that infant and child health in the urban area is no better than in the rural areas.

One final recommendation for CARE is to make every effort to identify and retain the key staff that were responsible for the success of this project. The institutional memory for CARE is important to future project efforts, as the lessons learned in this project could be applied to projects in many different sectors.

F. Results Highlight

The CARE Ethiopia Farta Woreda Child Survival Project faced a tremendous challenge in working in a remote rural setting with very poor health indicators. The challenge was how to achieve high coverage and credibility for BCC activities in the face of poor coverage and outreach of the health care system and no mass media. The solution found was the active engagement of the Ethiopian Orthodox Church as an agent for community mobilization, transmission of key BCC messages and enhancement of credibility of the messages and behaviors.

The Ethiopian Orthodox Church in the project zone plays a huge role in day-to-day life in this region where 95% of the population is Orthodox. Nearly half of all days have some religious significance, and the population has regular contact with the church and religious leaders. Church leaders are assigned to oversee between 15-40 families each, and they provide regular home visits for spiritual counseling and advice. CARE engaged these religious leaders, providing training in key CS messages, providing them with BCC materials, and an active role in encouraging mothers to attend regular mothers group meetings and to adopt key C-IMCI behaviors. The church leaders also transmitted messages after Sunday sermons and during monthly coordination meetings.

This systematic support guaranteed that *all* mothers in the target zone attended regular mothers' groups meetings, heard messages from a credible source, and adopted the desired practices. As a result, appropriate complementary feeding rose from 38% to 98% in children 6-9 months of age, appropriate care-seeking for signs of pneumonia rose from 27% to 84%, and full childhood immunization in children 12-23 months of age rose from 19% to 61%.

What is more important is that these gains appear to be sustainable, as the EOC's involvement and mother's group meetings are not dependent on project support. Furthermore, the EOC itself has embraced its new role. Key informant interviews with

regional EOC leaders indicated that they are grateful for their expanded role in the community. They have indicated that they now feel much closer to the communities they serve, as they have a mission that goes beyond their traditional spiritual role, and that now they are able to benefit their communities in a tangible way though teaching the key C-IMCI behaviors. Early coordination with regional church leaders was key to obtaining the active participation of individual churches and church leaders.

Whether this model can be used in other regions of Ethiopia that are more religiously heterogeneous, or even in other countries remains to be seen, Nevertheless, the prominent role of religious institutions in the lives of rural people is a resource that should be explored in other settings.

Attachment A: Team members and their titles

Name	Organization	Position	Notes
Donald Whitson	Consultant	Evaluation facilitator	
Firesibhat Geze	Zone EOC	Liaison for Zonal EOC	
Tilahun Demissie	Zone DPPO	Expert	
Messeret Bahiru	Farta Woreda Education office	Section head	
Gobeze Ayalew	Farta Woreda health office	Head of FWHO	
Girma Goneshie	Farta Woreda Health Office	MCH Head	
Lakemariam Desta	EOC	Deacon, Liaison for EOC	
Nina Negash	CARE Ethiopia	FSCP Project Manager	
Zemene Mengistie	CARE Ethiopia	FSCP Project Officer	Left evaluation team Monday, June 4
Berihanie Aragie	CARE Ethiopia	FSCP Community Facilitator	
Tibebu Getachew	CARE Ethiopia	FSCP Community Facilitator	
Nebiyou Esayias	CARE Ethiopia	FCSP Community Facilitator	
Tefera Mekonnen	CARE Ethiopia	FCSP M&E officer	
Bethann Cotrell	Care Headquarters	Team Leader Child Health and Nutrition	

Attachment B*: Final KPC Report*

Please find report seperately

Attachment C*: Assessment methodology*

The final evaluation was undertaken using a participatory methodology that involved all of the major stakeholders. CARE Headquarters and Ethiopia thoroughly prepared for the evaluation by ensuring that the final KPC survey and health facility assessment were completed (though the reports were not yet finalized). In addition, CARE sponsored a qualitative assessment of the project that also provided input into the evaluation.

The evaluation team was composed of the CARE Ethiopia CS team, the Farta Woreda Health Office (director and deputy director), Zone EOC office, Farta Woreda Education Office, and the DPPO. In addition, CARE Headquarters Team Leader for Child Health and Nutrition participated. CARE Addis Ababa also provided input during the consultant's and HQ representative's arrival and departure and via telephone.

The evaluation consultant was briefed on project progress and then prepared guides for focus groups discussions and key informant interviews (attached) and the evaluation team was oriented as to their use. The evaluation team was divided into three teams for field visits over three days according to the schedule that follows.

Focus Group Discussions:
MTMSGs: 6
School groups: 2
Monthly kebele coordination meeting: 1

Key informant interviews:
Model mother: 1
EOC leaders: 3 (including 1 church service and after-church
Community Data Boards: 2
Zonal EOC office
Debre Tabor Nursing College
Debre Tabor Woreda Health Office
Health facilities: 6
Health Extension Agents: 4
Idirs: 2
VCHW: 2

In addition to the above, the participation of the FWHO director and deputy, as well as representatives of the EOC and Education office were instrumental in understanding the various roles.

After each day's field visits, the team met to debrief the other teams on their findings. The consultant prepared discussion and analysis guides for the final evaluation that conform to each of the major sections of the evaluation report: one each for the technical interventions, one each for each major strategy (cross-cutting issues), sustainability, management and information management. The evaluation team again divided into three teams for discussion and analysis of the information available, including reports, field

visits and personal experience. After the discussions, the teams presentated their findings, evidence and conclusions to the plenary group for discussion. These presentations and discussions served as the basis for the evaluation report.

Evaluation Schedule

Date	Activity	Notes
Sun 27 May	Consultant arrival Addis, briefing meeting with Barbara Pose, (CARE Addis Ababa) and Bethann Cotrell (CARE HQ).	
Mon 28 May	Document review, debrief with Barbara Pose (CARE Addis Ababa)	Local holiday
Tue 29 May	Presentation of project by Project Manager	
Wed 30 May	Elaborate evaluation schedule, draft instruments.	
Thur 31 May	Briefing meeting for partners, finalize schedule, finalize instruments	
Fri 1 Jun	Field visit to Worken (FGD: MTMSG, school group) Field visit to Askuma (FGD: MTMSG, school group) Field visit: Debre Tabor hospital, Debre Tabor health center, interviews with Debre Tabor Vice Director of Hospital, and Debre Tabor Woreda Director of Health.	Three teams (Don, Bethann, Barbara)
Sat 2 Jun	Document review, review of first field day, initial preparation for final presentation and report.	National immunization day (polio campaign) makes field activities impossible
Sun 3 Jun	Field visit to Ivaniva (Kidanemiret) (EOC leaders and Community Data Board); Qolaydengors (FGD: Model Mother) Field visit to Maynet (FGD: religious leaders, EOC Church service MTMSG)	Two teams (Don, Bethann)
Mon 4 Jun	Field visit to Kimir Dingay Developing Health Center; Cassay Developing Health Center; Sahirna Health Post, Religious Leaders, Data Board and VCHW.	Two teams (Don, Bethann)
Tue 5 Jun	Orientation to team; Analysis. Group analysis immunization, nutrition, ARI/diarrhea	Three teams (Don, Bethann, Nina)
Wed 6 Jun	Field visit to Simina—Kebele monthly meeting; FGD religious leaders, FGD VCHWs and HEA.	Two teams (Don, Bethann)
Thu 7 Jun	Group analysis: capacity building, BCC / community mobilization, information management. Bethann departs for US (afternoon).	Three teams (Don, Bethann, Nina)
Fri 8 Jun	Group analysis: sustainability, training, access and quality improvement. Interview with CARE team about project management. Preparation of presentation.	Three teams (Don, Nina, Tefara)
Sat 9 Jun	Debriefing with local partners	Large meeting
Sun 10 Jun	Travel to Addis	
Mon 11 Jun	Debriefing with USAID and partners, CARE Ethiopia Departure of consultant	Large meeting

Attachment D*: List of persons interviewed and contacted*

The following is a list of individual contacts that were not part of the evaluation team itself. Names and positions of all health workers, church leaders, community workers and mothers groups interviewed were not recorded during the evaluation:

Name	**Position**
Yibabie Tesfaye	Deputy Director of Debre Tabor Training Center
Dr. Abiy	Medical Director of Debre Tabor Hospital
Haile-Eyesus Dagnew	Debre Tabor Woreda Health Officer
Teje Mekonen	Head of MCH DT Health Center
Abebo Tafera	Head of DT Health Center
Dr. Barbara Pose	CARE Ethiopia SRH Program Coordinator

Attachment F*: Documents Reviewed*

CARE Ethiopia, "Baseline KPC Survey", January 2003.

CARE Ethiopia, "Child –E Child Health Initiatives for Lasting Development in Ethiopia. Farta Woreda Amhara Region Ethiopia Draft Detailed Implementation Plan Submission to USAID Child Survival and Health Grants Program CSXVIII. April 30, 2007

CARE Ethiopia. "Final Health Facility Assessment Evaluation Report". June 2007.

CARE Ethiopia. "Farta Child Survival Project (FCSP) Farta Woreda, South Gondar Administrative Zone, Amhara National Regional State (ANRS) Ethiopia Annual Report October 2005 – September 2006 (FY'06)" October 2006. NB: this includes final LQAS survey report as an annex.

CARE Ethiopia "LQAS Monitoring Survey Report". March 2006.

Charleston, Renee. "Consultant Trip Report" Nutrition consultant report. August 2006.

"Coverage, Achievements, Changes, Impacts, Lessons Learnt and Best Practices", Consultant report, CARE Ethiopia, September 2007. Qualitative study of best practices and lessons-learned.

Dejene, Amare *et al*. "Draft Report of Coverage, Achievements,Changes Impact, Lesson Learnt and Best Practices of the Child Survival Project at Farta District in South Gondar of Amahara Region". April 2007

Eshete, Berhanu. "CARE Ethiopia South Gondar Child Survival Project. Health Facility Survey of Child Health Services, Draft Report", March 2003.

Eshete, Berhanu. "Participatory Community Needs Assessment" Draft Report. March, 2003

ORC Macro, Central Statistical Agency Addis Ababa Ethiopia. "Ethiopia Demographic and Health Survey 2005" September 2006.

Seid, Endris. "Draft Report on Knowledge, Practice and Coverage (KPC) In South Gondar". May 2007.
Sustainability report

ANNEX G: Exit strategy

CARE South Gondar
Farta Child Survival Project

Exit Strategy

The project has developed partners with which it has been implementing the project's activities for the last four years. The project capacitated various government institutions and community volunteers. The government partners and community volunteers have been implementing most of the activities of the project.

The exit strategy plan of the project comprises the following key activities:

- The priority activity will be capacity building for community volunteers and government partners to maintain sustainability.
- Ensure transfer of responsibilities for key partners and community volunteers that require efforts after the project will end its inputs. These include the Kebele monthly meetings, Sunday congregation, school skit performances, home visits, etc.
- Establish a system for effective supervision for the community and institutions.
- Ensure the existing community networks to be sustainable and continual.
- Conduct orientation and communication with stakeholders, partners and community members on the phase out of the project.
- Transferring of project assets for key partners.
- Developing a general guideline on the strategies, community mobilization, etc. with problem solving approaches and communication among networks for support.
- Provision of supplies required for maintaining sustainability.
- System or mechanism for follow up and modifications of phase out plan
- Stakeholder communication
    - Community – beneficiaries
    - Community volunteer workers such as religious leaders, VCHWs, MTMSGs, CRPs
    - Government partners at zonal, district and Kebele levels such as district partners, Kebele administrations, health facilities, schools, development agents.
- Development of memorandum of understanding among key partners of the project and transfer of responsibilities to be undertaken after the phase out
- Developing action plans for the continuation of sustainable activities
- Documentation of best experiences and dissemination to others (district and others).

Transfer of Responsibilities Action Plan

Sustainable Activities	**Who would be responsible**	**What resources do they need**	**Where/how would they obtain the resources**	**When wil they assu responsib**
MTMSG support and supervision	HEAs, HWs, religious leaders, VCHWs and CRPs	Stationery materials	From project and WHO	Onwards, They are conductin the activit The hand will be do starting fr now.
MRM support and supervision	WHO	Formats and per diem for supervisors	Project for supplies and WHO for regular supervision	Starting fr now jointl with the project an independe after June 2007.
Home Visits	HEAs, HWs, religious leaders, VCHWs and CRPs	Reporting formats. Refresher training	Project for supplies and WHO for refresher training	Onwards: They are doing now
Supervision/Support HF staff Religious leaders MTMSG Facilitators VCHWs School clubs/teachers Agricultural extensionists	WHO WHO & EOC HWs and HEAs HWs and HEAs Wereda Education Wereda Agriculture			Starting fr now jointl with the project an independe after June 2007.
Training/re-training	Project	Required resources for the trainings	From the project	Based on schedule o the annual work plan
Institutionalization of all cost recovery systems (Edirs, Home Gardens)	WHO, Idir leaders, Kebele leaders and	Seed money and supplies like stationery,	The project will provide the supplies and seed	Onwards f Idirs and o January fo home gard

	school leaders	vegetable seeds and formats	money.	
Expansion of Data Board	Project	Resources required for the expansion of data boards	From the project	November 2006
Documentation of best experiences and disseminating to others	Project			Starting fr November 2006
System for monitoring and evaluation of Quality of Services especially counseling	WHO and Project	COPE training	From COPE trained personnel	December 2006
Reporting; Compile, analyze, interpret and use the data for decision making	Church trained religious leaders. VCHWs and HWs			Starting fr December 2006
Referral System	HFs, WHO and Project	Referrals materials	From the project	November 2006
Develop checklist and follow up to ensure sustained activities	Project			Starting fr November 2006

Attachment H: HFA

Acknowledgement

Endris Seid, the consultant, is deeply grateful to the CARE Ethiopia Country Office for its valuable contributions towards this report and for offering him the opportunity to conduct this evaluation on Health Facility Assessment in South Gondar Child Survival Project. Special acknowledgements are due to Dr.Barbara Pose, Sexual Reproductive Health Program Coordinator and Ato Nina Negash, Project Coordinator for their unlimited contributions in reviewing the questionnaire and draft report, and providing constructive comments.

The consultant also extends his deep appreciation to Ato Tefera Mekonnen, Monitoring and Evaluation Officer; Ato Zemene Mengistu, Project Officer ; Ato Getachew Asradew, Community Facilitator, and other CARE South Gondar Child Survival Project staff members for their support in coordinating and facilitating the fieldwork during the survey.

The consultant is very much indebted to the data collectors and supervisors for their diligent effort in filling out the questionnaire, and the additional information and views they have provided.

Last but not least, the consultant commends all the respondents who participated in the assessment, and who provided their time and information during the pre-test and the actual survey.

List of Acronyms

BCG: Bacillus Calmete Guarien
BL: Baseline Survey
CHAs: Community Health Agents
CHWs: Community Health Workers
CIMCI: Community Integrated Management Child Illness
CS: Child Survival
DPT: Diphtheria- Pertusis- Tetanus
EPI: Expanded Programs on Immunization
EV: Evaluation
HFA: Health Facility Assessment
IMCI: Integrated Management Child Illness
KPC : Knowledge-Practice-Coverage
MoH: Ministry of Health
NGOs: Non-Government Organizations
OPV: Oral Polio Vaccine
ORS: Oral Rehydration Salt
SPSS: Statistical Package for Social Science
TBAs: Traditional Birth Attendants

Table of Contents

Page

List of Tables

Page

Executive Summary

The CARE Ethiopian Child Survival Project was launched in October 2002 with the objectives of improving the health status of children under five and of women of reproductive age in Farta district of South Gondar Zone in Amhara National Regional State. The project has been implemented in partnership with South Gondar Zone Health Bureau.

The main objective of this study is to conduct the health facility assessment which evaluates the case management and preventive services for children less than five years of age and to obtain information on key indicators for health facility of the child health services in the project district. Besides, the findings of the assessment serve to compare with the baseline results (March 2003) in order to check whether the project achieved its initial set indicators on the services.

The evaluation was conducted in May 2007 and it involved cases of sick child observation, exit interview and health workers interview. The evaluation employed quantitative data design and the data analysis was performed using SPSS/statistical software package version 12.0.

The evaluation was based on the indicators employed in the baseline survey. The findings of the health facility survey generally showed that the CARE Child Survival projects are effective in meeting all of its program objectives target indicators. These include achievements in health care of child health services, knowledge and practices of health workers regarding the assessment and integrated case management of sick children, drug management , supervision of the health facility , counseling, caretakers' understanding of home treatment for their sick child were the major success of the project.

When compared with the baseline, the following achievements were recorded:

The study revealed that all of the health workers know at least three signs when to refer a child, which increased from 42.8 % in the baseline to 100% in the evaluation. Early detection of severity of illness among sick children and who should be referred to higher health care providers using the designed danger signs was conducted properly and adequately. In this regard, most (78.3%) of the children seen by health workers, checked for all three risk factors or danger signs.

Similar achievement was also observed in the major assessment tasks that counting respiratory rate and looking for chest in-drawing were performed for 90.9% and 95.6% children, respectively. Appropriate and correct treatment for malaria, pneumonia and diarrhea (100.0 %, 100.0% and 94.4 % of the cases, respectively) were also conducted.

The level of knowledge and practice among caretakers regarding to immediate health care seeking behavior when the child develops the major signs was found to be highly encouraging, on average within one and half days take their sick children to the health facility. Similarly, the level of supervision had been made in all of the health facilities; every facility received one visit within the last six months. Likewise, the linkage between the health facilities and the communities in terms of providing outreach program and operational plan including community based work was found to be significant.

In conclusion, the planned project interventions were carried out effectively and met the set objectives.

CARE ETHIOPIA

DEBRE- TABOR CHILD SURVIVAL PROGRAM

FINAL HFA

EVALUATION REPORT

D. JUNE 2007

ADDIS ABABA

I. Background and Introduction

1.1 Introduction

The CARE Ethiopian Child Survival Project was launched in October 2002 with the objectives of improving the health status of children under five and of women of reproductive age in Farta district of South Gondar Zone in Amhara National Regional State. The project has been implemented in partnership with South Gondar Zone Health Bureau. The Child Survival project tried to achieve its objectives within the framework of Community Integrated Management Child Illness (CIMCI) in the intervention areas of Nutrition, Acute Respiratory Infection, Control of Diarrheal Diseases and Immunization through improving major components: case management skills of the health care staff, the overall health system (logistics and supplies) and family and community health care practices.

The project has already been in the final year (fifth) of its life time and is on the way of finalizing its implementation phase designed to address the leading causes of child morbidity and major contributors to maternal and newborn mortality and to improve the health system as the project area's health care service was limited. As a result, the Child Survival project had integrated interventions.

The integrated interventions are meant for creating skill development for health workers, core staff of partner organizations, community health workers, volunteer health workers, community leaders, school clubs and women's associations, mobilizing community, promoting healthy practices at the community, family and individual level through behavior change communication, and improving access and availability of services and supplies to formal and

private sector systems.

1.2. Background

Farta district is situated in Amhara Regional State about 667 km north of Addis Ababa.

It was reported in the baseline that the main killing diseases in under- five children were pneumonia, diarrhea, malaria, measles and malnutrition in the country and the prevalence of fever in children under five years of age in the two weeks prior to the survey was 30.3% and of these children, only three children were taken to a health care service provider.

The baseline study has revealed that the health facilities in 40 Farta district Kebeles are extremely limited. There is only 1 hospital, 1 health center and 10 health stations to serve a population of over 2 million. It was estimated that only 40 % of the population are within two hours distance from health facility by locally available means of transportation. Only 14.3% of the health workers were reported to have received trainings related to child health care according to the baseline report.

EPI rates were low; out of 35.6% of the cases the vaccination status of the child checked; only in 4.6 % of the cases the cards were available. The baseline survey has also shown that the most common diseases among under five children reported in the project area include respiratory tract infection, diarrhea and fever. However, only 27.3% of the caretakers reported to give home care for their sick child and 14.8% sought care elsewhere before seeking care at the facility.

Realizing the aforementioned problems the five -year project was initiated through Child Survival project in Farta district since October 2002.

The CS Project objectives include:

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

This assessment is part of the Child survival project implementation.

1.3. Objectives of the Health Facility Assessment

The main purpose of conducting health facility assessment is to assess the case management and preventive services for children less than five years of age and to obtain information on key indicators for health facility services in the district. The findings of the health facility assessment findings are to compare with the baseline results (March 2003) in order to check whether the project achieved its initial set indicators on the services.

Specific Objectives of Health Facility Assessment

The specific objectives of the health facility assessment are:

- To assess and determine quality of health care delivered to sick children at out patient health facilities,
- To assess and determine availability of key health system supports that are required for the implementation of sick child services, such as drugs and vaccines, equipment and supervision,

- To assess and determine effectiveness of integrated case-management for sick children,
- To assess and determine quality of counseling given at outpatient health facilities and caretakers' understanding of home treatment for their sick child,
- To assess and determine knowledge and practices of health workers at outpatient clinics regarding the assessment and management of sick children,
- To assess the effectiveness of the referral services within and among the health facilities for sick children.
- To assess and determine effectiveness of case-management practices and adequacy of training and supervision of the health workers, and
- To make comparisons between the baseline and survey findings.

II. Methods

Study Area

The health facility assessment was carried out in Farta District (40 Kebeles), South Gondar, where the Child Survival project has been implemented.

Study design and population

The survey used a cross-sectional design. The source populations were the health workers, head of the health facilities and the caretakers of children under five years of age coming to health facilities during the day of the survey.

Sample and sampling procedure

The assessment employed census of health facilities and it involved sick child observation, exit interview and health workers interview. Cases of sick children under five years were included and observed in the surveyed health

facilities.

All 12 health facilities in the project district which have been engaged both in clinical and preventive serves were assessed. This included 1 hospital, 1 health center and 10 health stations and namely Debre Tabor hospital, Debre Tabor health center and the remaining 10 health stations were Teraroch, Askuma , Maderemariam, Hamuze wonze, Mynet, Qualaha, Genamechawech, Addeder, Kimir Dingay and Gassay health station.

A total of 60 children under five years from all 12 surveyed health facilities (five cases of sick children from each facility) were observed. The criteria for selecting eligible children a) age (0- 59 months) and b) illness (malaria, fever, diarrhea, respiratory problems). In addition, 60 caretakers of the child in Exit Interviews and 12 health workers were interviewed.

Survey Instruments

The instruments used and administer for health facility assessment has five individual survey forms which include:

- Observation checklist (observation of clinical care for sick children)
- Exit interview (caretakers of the child)
- Checklist for health workers interview
- Equipment and supplies checklist
- Checklist for community links

Recruitment and training

Recruitment of the interviewers was carried out by CARE Field office at Farta district. The consultant conducted the training. The interviewers were Farta district MOH staffs and Nursing training college. Overall, participants included 6 CARE staffs and 14 Farta district health office and Nursing training college staffs. They were adequately trained for three days on the objective of the survey and how to collect the data. Standard guideline was prepared with detail information

on the procedure of data collection. Interviewers were also given copies of the questionnaire to be used for the mock-interviews and as a reference during discussion.

Efforts were made to make the training interactive and participatory where all participants were encouraged to take part actively and share their experience. A number of rehearsal interviews were held and discussions were initiated and conducted among the interviewers to have a common understanding in the application of each question.

Data Analysis

Data cleaning was made both at field level and in the office before the data entry. Data was edited and coded for entry. Data entry processing done made using SPSS/statistical software package version 12.0. Frequency distributions were made to check data consistency and entry problem. Descriptive and comparative analysis mainly cross-tabulations, frequency percentages and averages was used for data analysis

Ethical considerations

During the interview, maximum effort was made to keep privacy of respondents and explain to them the purpose of the survey to give us their opinion what they feel. Data was collected on prior approval of the respondents.

III. Results

3.1. General/ background information

As all 12 health facilities provide clinical and preventive services both were surveyed, no sampling was required; rather a census was taken of all eligible facilities found in the project Woreda. Categories included 1 hospital, 1 health center and 10 health stations. All of the health facilities assessed were found to be government owned ones. In general, 60 forms of observation checklist (five

eligible cases of sick children from each health facility), 60 exit interviews, 12 health workers interviews, 12 equipment and supply checklists and 12 health facility community- link questionnaires were undertaken and completed.

A total of 84 health workers were assigned in the surveyed health facilities (see Table 1). Of eighty-four health workers, 54 were assigned in hospital, 22 in the health stations and 8 were in health centers.

Of the twelve health workers included in the survey 3 senior nurses, 3 junior nurses and the remaining 6 frontline health workers were interviewed. Majority (75.0%) of the interviewed health workers reported having received child health care training.

Table 1. Distribution Health workers and Health facilities surveyed in the Woreda

Type of Health Facility(n=12)	No of Health Facility	No of Health Worker by Category							
		MD	PHO	S.Nurse	J.Nurse	HA	FLW	Total	Average Health worker
Hospital	1	5	0	28	8	13	0	54	-
H/Center	1	0	1	5	2	0	0	8	-
H/Station	10	**0**	0	5	5	3	9	22	2.2
Total	**12**	**5**	**1**	**38**	**15**	**18**	**9**	**84**	**7.0**

N.B. PHO =Public health officer

FLW = Frontline workers

Table 2. Distribution of health workers with child case management

Category (n=12 health facilities)	Category of Health workers to child interviewed	Trained in child health (IMCI)

		Frequency	%
Physician			
PHO	-		
Senior Nurse	3	1	3.3
Junior Nurse	3	3	100.0
Health assistant	-		
Frontline health workers	6	5	83.3
Total	**12**	9	75.0

3.2. Child and Caretakers' Characteristics

As shown in Table 3, a total of 60 children 0-59 months were included in this health assessment. Majority (60.0%) of the children were found in the age group 12-59 months, followed by age group 2-11months (35.0%) while the remaining 5.0% were found under the age of two months. More than half (53.3%) of the children observed were males while the remaining (46.7%) were females. The result of the assessment also revealed majority (86.7%) of the caretakers were females and most (96.2%) of them were the biological mothers of the children.

Table 3. Child and Caretakers Characteristics

Characteristics	**Frequency**	**Percent (n=60)**
Age of child in months (Mean age=13.1months)		
< 2	3	5.0

2-11	21	35.0
12-59	36	60.0
Sex of child		
Male	35	58.3
Female	25	41.7
Type of caretaker (n=60)		
Mother	50	83.3
Father	8	13.3
Other/Relative	2	3.3

Table 4. Case distribution by type of health facilities and categories of health workers attended.

Characteristics	N0. of cases	% Average case seen per facility and HW
Type of Health Facility		
Hospital	5	8.3
H/Center	5	8.3
H/Station	50	83.3
Category of Health Worker		
Senior Nurse	3	25.0
Junior Nurse	3	25.0
Frontline Health workers	6	50.0

3.3. Child Case Management in the Health Facilities surveyed

3.3.1. Assessment

The data presented in this section comes from the observations made while 60 children under five of age were being cared for by health workers in 12 health facilities. It was found out that the median time of consultation for entire 60

children seen by health workers was 15 minutes (ranging between 5-64 minutes).

As shown in Table 5 below, reasonably high proportion of danger signs for which IMCI is designed to detect, was adequately investigated. Majority (78.3%) of the children seen by health workers, were checked for all three risk factors or danger signs.

When the analysis is made by each of the indicator or danger signs, 54 (90.0 %), 53 (88.3%) and 51 (85.0%) of children were assessed by the health workers for fever, cough or difficult breathing and diarrhea, respectively. A further examination of Table 5 revealed that nutrition assessment tasks were undertaken for the majority of the cases. 56 (93.3%) of the children were weighed and 39 (65.0%) among those children whose weight was measured, was plotted on growth chart. The findings of this assessment further showed that 49 (81.7 %), 42 (70.0%) and 40(66.6 %) of children were checked for wasting, palmar pallor' and edema, respectively.

According to the major assessment task classification made by the health workers, 22 children were categorized as having cough or difficult breathing; of the total assessed cases, counting respiratory rate and looking for chest in drawing were performed for 90.0% and 95.6% children, respectively. Similarly, of 18 children being classified with diarrhea, 88.9% of the cases were assessed for pinching skin of the abdomen and 83.3 % of them were checked with looking for sunken eyes.

As indicated in Table 5, the level of vaccination status of children and their caretakers checked by the health workers was found to be high. Out of 60 children seen by the health workers, most 56 (93.3%) of the children and majority 48 (80.0%) of the caretakers were checked for their vaccination status.

Table 5. Proportion of sick children assessed for key indicators

Characteristics	N0. of cases	%
For all children (n=60)		

Health worker determined/asked if the child had		
Cough or difficult breathing		
Diarrhea	53	88.3
Fever	51	85.0
Child checked for three	54	90.0
Of the above symptoms	47	78.3
Health worker determined/asked if the child had:		
Convulsions	45	75.0
Was lethargic or unconscious	48	80.0
was unable to drink or breast feed	57	95.0
Vomited every thing	46	76.7
Child checked for three of the above danger signs checked	41	68.3
Health worker assessed the nutritional status:		
Weighing the child	56	93.3
Child weight checked against a growth chart	39	65.0
Checking for edema of both feet	40	66.6
Checking for palmar pallor	42	70.0
Checking for severe wasting	49	81.7
For children with cough or difficult breathing (n=22):		
Counted respiratory rate	20	90.9
Looked for chest in drawing	21	95.6
For children with diarrhea (n=18):		
Pinched skin of the abdomen	16	88.9
Looked for sunken eyes	15	83.3
Vaccination status/card of the child checked (n=60)	60	100.0
Vaccination card available	56	93.3
Vaccination status/card of the caretaker checked (n=60)	48	98.3
Median time of consultation (n=83)	9 minutes	Range 2-68 minutes

3.3.2. Classification/Diagnosis and Treatment

According to the assessment of the health workers, a total of 63 classifications were made from all 60 children (Table 6). About 20.0% of the

children were diagnosed to have simple diarrhea, followed by pneumonia, cough or cold and malaria 16.7%, 15.0 % and 10.0%, respectively. Consequently, the treatment provided for the children with respect to the classification given by the health workers, was generally found to be appropriate. All of the children with pneumonia and malaria cases received correct treatment. Most children were treated appropriately in 94.4 % of diarrhea cases and 12.7% simple diarrhea cases who were in need of medication have got antibiotic while the remaining(93.3%) of the cases were not given any antibiotic since unnecessary use of antibiotic could result in drug resistance.

Table 6. Proportion of Classifications made by the health workers

Indicators (n=60)	**Cases**	**%**
Simple diarrhea	12	20.0
Pneumonia	10	16.7
Cough or cold	9	15.0
Malaria/Fever	6	10.0
Fever other cause	7	11.7
Some dehydration	6	10.0
Severe pneumonia	1	1.7
Severe persistent diarrhea	1	1.7
Dysentery	5	8.3
Dehydration	3	5.0
Persistent diarrhea	1	1.7
Severe dehydration	2	3.3
Total	**63**	

Table 7. Proportion of sick children correctly treated and managed

Indicators	Cases	%
Children treated appropriately according to the classification made by the health worker		
a. Children with pneumonia correctly treated (n=10)	10	100.0
b. Children with cough or cold correctly treated (n=9)	9	100.0
c. Children with diarrhea has got ORS (n=18)	17	94.4
d. Children with simple diarrhea correctly treated (n= 12)	12	100.0
e. Children with fever/malaria correctly managed and Treated (n=6)	6	100.0
f. Children needing referral correctly referred (n=3)	2	66.7

3.2.3. Communication/Counseling

Health and nutrition counseling service is one of the strategies advocated, evaluated and implemented in advising and providing guidance to caretakers how to administer the prescribed drugs or treatment and how to provide nutrition care for their children. The result in Table 6 revealed that high proportion 48 (96.0%) of the caretakers were properly advised how to administer the prescribed ORS/ drugs for their children. Majority (82.0%) of the caretakers were asked open ended questions to check their comprehension how to administer ORS/oral medications. This assessment has also shown that over three-fourth (78.0%) of the caretakers have taken advice to give extra fluids and continue feeding for their children during illness. Moreover, most (90.0%) of the caretakers received appropriate nutrition counseling and 81.7% of the caretakers

were given advice when to return immediately if the health of the child does not get improved.

Table 8. Proportion of caretaker/children counseled correctly

Indicators (n=50)	Cases	%
Children prescribed oral medication/ORS whose Caretaker advised on how to administer	48	96.00
Comprehension how to administer oral medications or ORS Checked	41	82.0
Caretakers advised to give extra fluids and continue Feeding during illness	39	78.0
Caretakers receive correct nutritional counseling	45	90.0
Caretaker advised when to return immediately if child gets sicker (n=60)	49	81.7

3.3. Caretakers Knowledge, Satisfaction, Homecare and Care seeking

To measure the level of knowledge on the symptoms that required immediately seeking care outside of the home and how to take the prescribed oral drugs/ORS, respondents were asked to mention all the symptoms they think are needed as indicative means for immediate care seeking behavior of the caretakers. Generally, caretakers' knowledge on immediately seeking care outside of the home was found to be significant as most (96.7 %) of the caretakers reported that when child develops fever as danger signs to seek immediate care. Likewise, 85.0%, 78.3% and 76.7 % of the caretakers cited, respectively, for child unable to eat, to drink /breast feed and children with difficult breathing /pneumonia, as major danger signs for seeking care. About 46.7% of the caretakers reported to seek immediate care when the child is with convulsion.

The assessment findings presented in Table 9 indicated that the largest proportion of the caretakers (80.0 %) do have a basic knowledge on how to give the prescribed oral treatment/ORS. The finding further revealed that caretakers who gave any types of homecare for sick before coming to the facility were found to be significant (81.7%).

Furthermore, the health seeking practices is high among the caretakers to bring their sick children to the health facility following the commencement of the symptoms. The average time lapsed was one and half days and about 75.0% of the caretakers confirmed that the child was seriously sick before seeking care.

Information was also collected regarding the waiting time (the time lapsed before child observed by the health worker) and child health services in the facilities, majority(61.7%) of the caretakers said short waiting time and 30.0 % of them rated as acceptable while only 8.3 % of the caretakers claimed as long waiting time.

Quality of services was found to be quite satisfactory; majority (78.3 %) of caretakers reported that the child health service is good and 15.0% said it is fair while very small proportion (6.7%) of the respondents mentioned the service is poor.

Table 9. Caretakers' knowledge

Indicators	Cases	%
A. On danger signs (n=60)		
Child develops fever	58	96.7
Child unable to eat	51	85.0
Child has difficult breathing/pneumonia	46	76.7
Child not able to drink or breastfeed	47	78.3
Child has convulsion	28	46.7
B. How to give prescribed drugs/ORS (n=50)	40	80.0

Table 10. Home care and care seeking behavior

Indicators (n=60)	Cases	%
Median time/days between onset of symptoms and Bringing children to health facility	one and half days	(Range 1-5 days)
Proportion of caretakers who gave home care	49	81.7
Proportion of caretakers who knows two aspects of home case management	59	98.3
Proportion who sought care elsewhere before coming to the facility	36	60.0
Proportion of caretaker who thought child was seriously ill	45	75.0

Table 11. Client satisfaction

Indicators (n=81)	Cases	%
Time lapsed before the child was seen/ Waiting time		
Long	5	8.3
Acceptable	18	30.0
Short	37	61.7
Opinions about child health services at the facility		
Good	47	78.3
Fair	9	15.0
Not - good	4	6.7
Average amount (in Birr) spent on consultation and treatment (n=60)	12.5 Birr	--

3.4. Assessment of the Health worker and Health Facility Capacity

3.4.1. Health workers knowledge, supervision and documentation

The assessment finding presented in Table 12 shows that there is a high level of knowledge on child health care among interviewed health workers that 11 (91.7%) know correctly about EPI vaccination schedule. Regarding knowledge on danger signs, interestingly, all of the health workers know at least three signs when to refer a child. Similarly, majority (83.3 %) of the health workers were correctly able to interpret a growth chart and make appropriate recommendations.

Information on the existence and systems of supervision for the health facilities was collected through the questionnaire (Table 13). All of the health facilities included in the assessment were supervised in the last one year in connection to care of observation, reviewing of records and other related activities on management of sick children. Additionally, the surveyed health facilities were found to have adequately equipped with the essential monthly reporting formats, immunization records, and patient examination cards, counseling card and flip charts was reported in more than 91 % of the health facilities.

Table 12. Health workers' knowledge

Indicators (n=12)	Frequency	%
Time lapsed before the child observed/ Waiting time		
Health workers with correct knowledge of EPI vaccination schedule	11	91.7
Health workers with correct knowledge of at least three signs of when to refer a child	12	100.0

Health workers who can correctly interpret growth chart and make appropriate recommendation	10	88.3

Table. 13. Supervision and documentation

Indicators (n=12)	No of Facility	%
Have regular supervisory visit	12	100.0
Supervisory visit in the last 6 months	12	100.0
Supervisory visit in the last 12 months	12	100.0
All essential monthly reporting formats	12	100.0
Immunization tally sheet	11	91.7
Immunization register	12	100.0
Patient examination card/forms	12	100.0
Counseling card	11	91.7
Flip chart	12	100.0

3.4.2. Drugs and supplies

Drug supply at health facilities included in this assessment was generally found to be good at the day of the survey; over 90 % of the health facilities were having essential antibiotic medicines. Vitamin A and ORS were found in three-fourth of the health facilities. Similarly, EPI vaccines (BCG, measles) were available in three-fourth and (DPT, OPV) in 83.3% of the health facilities. Functional refrigerators and cold boxes were found in all of the health facilities at the time of the survey. However, many health facilities encountered with transport problems on the day of the survey. Only 8.3 % and 16.7 % of the health facilities had vehicle and motorcycle, respectively.

Table 14. Availability of Drugs and other supplies on the day of the survey

Indicators (n=12)	No of Facility	%
Ampi/amoxicillin tablets/syrups	11	91.7
Penicillin tablets/syrups	11	91.7
Cotrimoxazole tablets/syrups	10	83.3
Nalidixic acid tablets	1	8.3
Chloroquine tablets/syrups	10	83.3
Fansidar	1	8.3
ORS	8	66.7
Vitamin A	8	66.7
DPT	10	83.3
OPV	10	83.3
BCG	9	75.0
Measles	9	75.0
Mebendazole	11	91.7
Paracetamol	15	100.0
Iron tabs	5	25
Aspirin	12	60
Needles	9	75.0
Syringes	7	48.3
*Injectable quinine	12	100.0
Injectable penicillin	12	100.0
*Injectable chloramphenicol	5	41.7
*IV solution for severe dehydration	7	58.3

Table 15. IMCI, nutrition and other materials present and functional on the day of the survey

Indicators (n=12)	No of Facility	%
Vehicle	1	8.3
Motorcycle	2	16.7
Adult weighing scale	12	100.0
Baby weighing scale	12	100.0
Salter scale	8	66.7
Timing device	5	41.7
Steam sterilizer	9	75.0
Measuring and mixing utensils	12	100.0
Refrigerator	12	100.0
Working thermometer inside	12	100.0
Temperature chart	10	83.3
Cold box with good condition	12	100.0
Tongue depressor	12	100.0

3.4.3 Identified Major Barriers to Effective Practice

Shortage of transport is very common among health facilities in the project area where three-fourth of the surveyed health facilities reported transport as major problems due to lack of vehicle and motorcycle. Shortage of staffs was reported by about (58.3%), followed by poor working environment (50.0%), lack of motivation (41.7%) were identified as main problems to carry out their routine activities.

Table 16. Identified problems at health facilities

Indicators (n=12)	No of Facility	%
Lack of feedback on performance	2	16.7
Lack of training	1	8.3
Lack of regular supervision	1	8.3
Lack of motivation	5	41.7
Poor working environment (health facility, housing)	6	50.0
Staff shortage	3	25.0

3.5. Health Facility Community Links

As shown in Table 12 it was found out that all of the health facilities provide out reach services to their surrounding communities. The median time of providing outreach service was 7.5 times in the last three months prior to the survey. This assessment also revealed that most (91.7%) of the health facilities have an operational plan that include community work. In the same manner, 91.7% of health facilities had formal working agreement with the community based organization though 8.3% of them carried out need assessment in the catchments areas in the past years.

Table 17. Health facility - community links

Indicators (n=12	No of Facility	%
Facilities with outreach to the community	12	100.0
Frequency (Mean) of outreach activities in the last three months	4.5	
Facilities with an operational plan that include community based organizations	11	91.7
Facilities with at least one need assessment/ community diagnosis	1	8.3

IV. Comparison of Baseline and End project Results

4.1. Summary of key findings of outcome indicators

Major findings of the objectives/outcome indicators of the project were evaluated against the findings of the baseline survey (see Table18). The findings of the survey clearly revealed that almost all planned objectives during the project life were successfully achieved. The key outcomes of the project accomplished during the life of the project are shown in the following sub-sections.

4.1.1. Case assessment, management and classification

Danger signs

The health facility assessment confirms that using the designed danger signs the health workers conducted properly and adequately an inquiry to detect the severity of illness among sick children and who should be referred to higher health care providers. Interestingly, all of the health workers know at least three signs when to refer a child (BL 42.8 %vs. 100.0%).This finding suggests that there is high opportunity for the sick children to be detected and to get appropriate care and treatment.

Regarding the assessment and management of sick children, of 22 children being identified with cough or difficult breathing, the major assessment tasks (counting respiratory rate and looking for chest in-drawing) were performed for 90.9% and 95.6% children, respectively i.e. (BL 2.3 vs. EV 90.9; BL 6.9 %vs.95.6 %).This finding indicated a better diagnosis capability among health workers in the CARE Ethiopia targeted communities. This can largely be attributed to the outcome of good quality of trainings provided for health workers on integrated management of childhood illnesses.

Growth monitoring

Growth monitoring is one of the important components of the child survival project and the health facility assessment result indicated that it is reasonably effective in achievement of planned objective. In this regard, most 56 (93.3%) of the children were weighed and majority 39 (65.0%) of the measured weight was plotted on the growth chart (BL36.7 % vs. EV 65.0%). Furthermore, other nutritional investigation tasks like assessing for edema, Palma pallor and severe wasting were done in more than 66 % of the cases.

In regard to interpretation and making use of the growth chart, a significant proportion (83.3 %) of the health workers were correctly able to interpret a growth chart and make appropriate recommendations (BL 0%vs. 88.3.0 %)

Treatment

According to the result of the health facility assessment the quality of health care in terms of making correct diagnosis and prescribing the proper drugs was found to be encouraging. Correct treatment for malaria, pneumonia and diarrhea was 100.0 %, 100.0% and 94.4 % of the cases. Antibiotics was given only for 16.7 % of simple diarrhea cases while the majority (93.3%) of the cases were not give any antibiotics and this treatment is appropriate for the diagnosis of simple diarrhea, since unnecessary use of antibiotics could result in drug resistance.

4.1.2. Communication/Counseling

The finding of this assessment revealed that the quality of services regarding provisions of counseling services and advice how the caretakers should give the prescribed drugs and other needed home treatments like importance of continued feeding and fluids as well as counseling about when to return to the facility, is good. Most *48 (96. %) of the caretakers received advice on how to* administer the prescribed oral medication/ORS for children (BL 10.8 vs. (96.0%). About 82.0% of the caretakers were asked open-ended questions to check if they had comprehended how *to* administer oral medications or ORS

(BL 4.0% vs. 82.0%). Over three-fourth (78.0 %) of the caretakers of the child had taken appropriate advice to give extra fluids and continue feeding during illness (BL13.5% vs. EV 78.0 %), and correct nutritional counseling (BL 5.4 & vs. EV 90.0%). Majority of the caretakers were also given advice when to return immediately if the health of the child does not get improved (BL 27.6% vs. 81. 7%).

As data presented in brackets indicate all these rates in this evaluation are much higher than at baseline this implies that there has been an effective case management intervention in the project area which improved communication skills of the health workers and case management skills.

Table 18 Comparison of Baseline and End project Results

Variables	Baseline (%)	Evaluation(%)	% Achieved
Health workers with correct knowledge of at least three signs when to refer a child	42.8	100.0	56.2
Health workers who can correctly interpret growth chart and make appropriate recommendation	0 .0	88.3	88.3
Counted respiratory rate	2.3	90.9	88.6
Looked for chest in drawing	6.9	95.6	88.7
Child weight checked against a growth chart	36.7	65.0	28.3
Checking for edema of both feet	1.2	66.6	65.4
Checking for palmar pallor	1.2	70.0	68.8
Children with pneumonia correctly treated	81.8	100.0	18.2
Children with diarrhea correctly treated	72.4	94.4	22.0
Children with fever/malaria correctly managed and treated	61.5	100.0	38.5
Children prescribed oral medication/ORS whose Caretaker advised on how to administer	10.8	96.0	85.2
Comprehension how to administer oral medications or ORS Checked	4.0	82.0	78.0
Caretakers advised to give extra fluids and continue Feeding during illness	13.5	78.0	64.5
Caretakers receive correct nutritional counseling	5.4	90.0	84.6

Caretaker advised when to return immediately if a child gets sicker	27.6	81.7	54.1

4.1.3. Caretakers' knowledge, home management behavior and care seeking behavior practice

The health facility assessment on care seeking behavior revealed that the median time bringing children to health facility following onset of symptoms was one and half days (ranging 1-5 days). Besides, during the baseline survey, only 27.2% of the caretakers in the project area reported that they gave home care/ treatment to their sick children. During the evaluation this proportion increased to 81.7 %. The survey further indicated most 59 (98.3%) of the caretakers know two aspects of home care management. This proportion is higher compared to baseline (67.9%). It was also found out that caretakers of the child were satisfied with existing health care services that majority (61.7%) of the caretakers said short waiting time and 30.0 % of them rated as acceptable while only 8.3 % of the caretakers claimed as long waiting time. Moreover, most (78.3 %) caretakers reported that the child health service is good and 15.0% said it is fair while very small proportion (6.7%) of the respondents mentioned the service is poor. Still this figure is very small as compared to prior to the intervention, that is

4.1.4. Drugs, equipments and medical supplies

The drug supply at surveyed health facilities was relatively good, with more than 90.0 % of health facilities having essential antibiotic medicines. Vitamin A and ORS were found in three-fourth of the health facilities. Similarly, EPI vaccines (BCG, measles) and (DPT, OPV) were available in three-fourth 83.3% of the health facilities, respectively. Functional refrigerators and cold boxes were found in all of the health facilities at the time of the survey.

4.1.5. supervision and Training

The survey revealed that the supervision of health facilities has generally been implemented in an effective way to ensure and enhance the performance of the health workers in the project district. All of the surveyed 12 health facilities had received a visit in the last six months though lack of regular supervision mentioned as a problem in one of the health facilities. The types of supervision included observation of care, review of records and provision of feedback. This assessment also showed that the training has been carried out satisfactorily; of the 12 health workers interviewed, 9 (75.0%) of them had been trained related to child health care.

4.1.6. Facility community link

The involvement of the health workers in community based works through out reach program was found to be high. The health facility assessment revealed that all of the health facilities provide outreach services to their surrounding communities and most (91.7%) of the health facilities have an operational plan that include community work. Similarly, 91.7% of health facilities had formal working agreement with the community based organization. Therefore, effective achievements of community link activities have been observed in satisfactory way in this regard.

V. Discussion, Conclusion and Recommendations

5.1. Discussion

The CARE Child Survival Project interventions with improving the health status of children under five and of women of reproductive in Farta Woreda were carried out in general satisfactorily and met the set objectives when compared to the original targets. The findings of this evaluation showed that much progress was made on the key issues such case management, treatment, communication/counseling, caretakers' knowledge and care -seeking behavior.

The finding of this HFA revealed that most of the factors which are designed to identify severely sick children who should be referred to higher health centers were adequately asked. Most (78.3%) of the children seen by health workers, checked for all three risk factors or danger signs. Such appropriateinvestigation in deed, is an indication for highest level of knowledge on child health care or at least three danger signs among health workers which was proved in the evaluation survey (56.2% increase, compared to baseline survey).

Regarding the major assessment tasks for the children with cough or difficult breathing, counting respiratory rate and looking for chest in drawing to detect the severity of acute respiratory infections, were used in most cases for 90.0% and 95.6% children, respectively. This implies that the assessment task could be an easy task for most of the health workers and this was largely attributed to adequate and proper health education provided for the health workers.

The quality of health services was found to be very satisfactory, as measured by the health workers' performance indicators such as making correct diagnosis or classification and treatment of diseases with appropriate drugs. The treatment was appropriate to diagnosis for pneumonia, malaria and diarrhea in 100%, 100% and 94.4% of cases, respectively. In this case, case management for sick children was made properly. For instance, correct treatment for diarrhea (antibiotic) was prescribed in 12.7% simple diarrhea cases who were in need of medication. Successful provision of correct treatment or antibiotics for sick children not only decreases the risk of treatment failure but also decreases the development of drug resistance and this also implies that the health workers clearly understand on the problems of drug resistance resulting from unnecessary use of antibiotics.

Counseling was also quite effective; almost all (96.0%) of the caretakers were properly advised how to administer the medication prescribed ORS/drugs for their children. Most (80.0%) of the caretakers were able to explain how to correctly administer all medication given. The findings from KPC report confirmed the practice of appropriate nutritional care for children with diarrhea, such as continued breastfeeding during diarrhea and giving more fluids and foods in addition to breast milk for CARE project communities is effective. The mothers whose children were sick with diarrhea in the two weeks preceding the survey continued breastfeeding their children the same amount or more than usual in the project baseline was 76.0% and increased to 96.2% in the KPC final evaluation. This obviously indicates that communication and counseling skills are high among health workers as well as the knowledge of the caretakers was quite satisfactory in the project area and this is due to the quality of health education and credibility of the health promoters (see KPC survey).

The level of knowledge and practice among caretakers regarding to immediate health care seeking behavior when the child develops the major signs was found to be highly encouraging, on average within one and half days take their sick children to the health facility. This finding complements the KPC survey in which children with acute respiratory infections, most (89.7%) proportion of the children were taken to a modern health facility for treatment within the first three days on commencement of the illness.

5.2. Conclusion

In general, the project was found successful and has achieved its activities in line with the project activities. As discussed in the previous section of the report, encouraging and successful achievements were recorded concerning on provision of quality health care services including case management, drug management, counseling and health education programs were the major success of the project and the project met all of its objectives as set out in the original activity plan .

5.4. Recommendations

Base on the findings of the study the following recommendations are made:

- At this stage, attempts should be made to further familiarize this successful project's modality /strategy of implementation of the intervention to relevant woreda and kebele offices and leaders of the community organizations so as to enhance awareness and understanding and create ownership about project among those relevant bodies.
- Disseminate the project strategies as means of promoting other concerned government institutions or NGOs to adopt the concept and modality of the project.

VI. Annexes

References

1. Debre-Tabor Child Survival Program Project Proposal , CARE Ethiopia 2002
2. Debre-Tabor Child Survival Program Project Baseline Health Facility Survey of Child Health Services , CARE Ethiopia 2003

Questionnaire

Care Ethiopia Child Survival Project
South Gondar Zone / Farta Woreda
Health Facility Survey
Form 1. Observation Checklist (Child 2 months - 5 years)

Zone: _____Woreda:_____ Date_____/_____/____
Facility Name_____ Facility Type_____ Facility Status_____
Surveyor ID: ___ ___

Health Worker Category (1) MD (2)PHO (3)Senior Nurse
(4)Junior Nurse (5) HA (6)Other
Sex: (1) M (2)F

Child's Name_____ Birth date: ____/____/____
Child's Age (months) _____
Sex: (1) M (2)F

Begin Timing the Observation Now. Time:_____
If consultation is interrupted note time at beginning of interruption. Time:_____
When resuming consultation. Time:_____

ASSESSMENT MODULE

Record what you hear or see. DO NOT intervene.

1. What reason does the caretaker give for bringing the child to the health facility? (Check all that apply.)

1.a. Diarrhea	(1)Yes	(2) No
1.b. vomiting	(1)Yes	(2) No
1.c. Fever/malaria	(1)Yes	(2) No
1.d. Fast / difficulty breathing/cough/pneumonia	(1)Yes	(2) No
1.e. Ear problem	(1)Yes	(2) No

1. f. Other(specify)_____

2. Does the health worker ask the age of the child or have the age available?
(1)Yes (2) No

3. Is the child weighed?	(1)Yes	(2) No
4. Is the child's weight plotted on a growth chart?	(1)Yes	(2) No
5. Is the child's temperature checked?	(1)Yes	(2) No

Does the health worker ASK about (or does the caretaker REPORT) -	Does the health worker perform these EXAMINATION tasks-
6. Danger signs: 6. a. Not able to drink or breast feed?	11. Look for lethargy or consciousness? (1)Yes (2) No

(1)Yes (2) No 6.b. Vomits everything? (1)Yes (2) No 6.c. Convulsions? (1)Yes (2) No 7. Change in consciousness/ lethargic/sleepy? (1)Yes (2) No	
8. a. Diarrhea? (1)Yes (2) No 8.b. For how long? _____ days 8.c. Is there blood in the stool? (1)Yes (2) No	12. Observe drinking or breastfeeding? (1)Yes (2) No 13. Pinch the skin on abdomen? (1)Yes (2) No 14. Look for sunken eyes? (1)Yes (2) No
9. a Cough or difficult breathing? (1)Yes (2) No 9.b. For how long?_____ days	15. Raise the shirt? (1)Yes (2) No 16. Count breaths/minute? (1)Yes (2) No 17. Look for chest in drawing? (1)Yes (2) No
10. a. Fever? (1)Yes (2) No 10.b. For how long? _____ days	18. Look or feel for stiff neck? (1)Yes (2) No 19. Look for generalized rash? (1)Yes (2) No 20. Look for runny nose or red eyes? (1)Yes (2) No
21. Ear problem? 21.a. Ear pain? (1)Yes (2) No 21. b. Ear discharge? (1)Yes (2) No 21. c. If YES, for how long?_____ days	Malnutrition: 24. Undress and look for wasting? (1)Yes (2) No 25. Look for palmar or conjunctival pallor? (1)Yes (2) No

22. Look for pus from ear? (1)Yes (2) No 23. Feel for swelling behind ear? (1)Yes (2) No	26. Look for edema of both feet? (1)Yes (2) No

Immunization and screening

27.a. Does the health worker ask for the child's immunization card? (1)Yes (2) No
If NO, go to question 29.

27. b. If YES, does the child have the card? (1)Yes (2) No

27. c Is the child referred for vaccination? (1)Yes (2) No
1. Today (1)Yes (2) No
2. Another day (1)Yes (2) No
3. Not referred (1)Yes (2) No
4. Up to date (1)Yes (2) No

28. a. Does the health worker ask for the caretaker's vaccination card?
(1)Yes (2) No (99) Does not apply
If NO or N/A, go to question 29.

28.b. If YES, does the caretaker have the card?
(1)Yes (2) No

28.c. Is the caretaker referred for vaccination?
1. Today (1)Yes (2) No
2.Another day (1)Yes (2) No
3. Not referred (1)Yes (2) No
4. Up to date (1)Yes (2) No

DIAGNOSIS MODULE

How does the health worker classify the child?

29. Simple diarrhea (1)Yes (2) No

30. Severe dehydration (1)Yes (2) No

31. Some dehydration (1)Yes (2) No

32. No dehydration (1)Yes (2) No

33. Dysentery (1)Yes (2) No

34. Severe persistent diarrhea (1)Yes (2) No

35. Persistent diarrhea (1)Yes (2) No

36. Severe pneumonia (1)Yes (2) No

37. Pneumonia (1)Yes (2) No

38. Upper respiratory infection(cough or cold) (1)Yes (2) No

39. Very severe febrile disease (1)Yes (2) No

40. Malaria (1)Yes (2) No

41. Severe complicated measles (1)Yes (2) No

42. Complicated measles (1)Yes (2) No

43. Measles (1)Yes (2) No

44. Fever, other cause (1)Yes (2) No

45. Mastoiditis (1)Yes (2) No

46. Acute ear infection (1)Yes (2) No

47. Chronic ear infection (1)Yes (2) No

48. No diagnosis (1)Yes (2)No

Care Ethiopia Child Survival Project
South Gondar Zone / Farta Woreda
Health Facility Survey

Form 2. EXIT INTERVIEW (2 months-5 years)

Zone: _____Woreda:_____ Date_____/_____/____
Facility Name_____Facility Type_____Facility Status_____
Surveyor ID ___ ___

Child's Name_____ Sex: (1) M (2) F Child's Age (month)_____
Birth date:____/____/____

Care taker: Sex (1) M (2) F Relationship to child (1) Mother (2) Father
(3) Relative (4) Other

Greet the caretaker and say that you would like to ask some questions about his/her visit to the health facility today.

TREATMENT + GENERAL INFORMATION MODULE

73. Did the health worker give you or prescribe any oral medicines for the child at the health facility today?
(1)Yes (2) No (88) does not know
If NO, go to question 80-.
If YES, compare the caretaker's medications with the samples for identification of the oral medicines.

Complete the table below for the listed oral medications. Fill in the information in the table below.
If the caretaker's answer is-
"As required," write AR in the appropriate cell.
"Until completed," write UC in the appropriate cell.
"I don't know," write DK in the appropriate cell.

Medicine	a)How Much Each Time?	b)How Many Times/Day?	c)How Many Days?	d)All Correct ? (Y or N)
74. Chloroquine tablets/syrup				
74a chloroquine				
74b Fansider				

74c Quinine				
74 d Cortem				
75. Antibiotic tablets/syrup Name:_____ Dose/tablets:_____				
76. Aspirin tablets/syrup OR Paracetamol tablets/syrup Dose/tablets:_____				
77. ORS/RHF				
78. other:_____			„	

79. Caretaker knows how to give ALL essential medications correctly? (1)Yes (2) No (99) Does not apply

80. What will you do for your child when you return home? (Check all that apply.)
(1) Continue feeding or breastfeeding the child
(2) Give the same quantity or more fluids to the child
(3) Complete course of medications/ORS/RHF
(4) Bring the child back if he/she doesn't get better or gets worse (5) Other (specify): _____
(88) Doesn't know

81. Caretaker knows at least two aspects of home case management? (1)Yes (2) No

82. How will you know if the child becomes worse at home? (Check all that apply).
(1) Fever begins or doesn't go away
(2) Child unable to eat
(3) Diarrhea continues
(4) Child has chest indrawing
(5) Vomiting begins or continues
(6) Child unable to drink
(7) Child has convulsions
(8) Child has difficulty breathing
(9) Blood in stool
(10)Other (specify):____ (88) Doesn't know

83. Which diseases will be prevented by the immunizations you or your child has received? (Check all that apply.)
(1) Diphtheria
(2) Tetanus
(4) Measles
(5) Tuberculosis

(3) Whooping cough
(6) Polio
(7) Other (specify):_____
(88) Doesn't know

84a. Do you know what might happen as a side effect after the immunization?. (1)Yes (2) No

84b. If YES, what do you know? (Check all that apply.)
(1) Fever
(2) Irritability/crying
(3) Pain at injection site
(4) Swelling
(5) Other (specify):_____

85. How many vaccination visits does a child need in the first year of life to complete the series of vaccinations? _____
(1) Correct (2) Incorrect (88) Doesn't know

86a. Did your child receive an immunization today? (1)Yes (2) No
86 b. If No, was your child referred for vaccination another day? (Prompted question. Check a single response.)
(1) Referred for vaccination another day
(2)Not referred for vaccination
(3)Up to date

87. Do you have your child's vaccination card?

(1) Yes (3)Never received
(2) Lost (4)Left at home

88. If the caretaker has the card :

Birth date:____/____/____
Age:_____Months

Immunization Received

a. Polio-0 (birth) (1)Yes (2) No
b. BCG (1)Yes (2) No
c. DPT-1 (1)Yes (2) No
d. Polio-1 (1)Yes (2) No
e. DPT-2 (1)Yes (2) No
f. DPT-3 (1)Yes (2) No
g. Polio-2 (1)Yes (2) No
g. Polio-3 (1)Yes (2) No
h. Measles (1)Yes (2) No

89. Child is up to date? (1)Yes (2) No

89. Do you have your own vaccination card?
(1) Yes (2) Lost (3)Never received
(4)Left at home (99) Does not apply

91. If YES, copy the caretaker's tetanus toxoid vaccinations in the table at right.

Immunization	Received
a. TT-1	(1)Yes (2) No

If the caretaker's TT doses are recorded on the child's vaccination card, copy them here also.	b. TT-2	(1)Yes (2) No
	c. TT-3	(1)Yes (2) No
	d. TT-4	(1)Yes (2) No
	e. TT-5	(1)Yes (2) No

92a. Caretaker has received at least TT-2? (1)Yes (2) No

92b if the caretaker has received TT-5 , date received _____

93 a. Did you receive a tetanus vaccination today?(1) Yes (2) No

.b If NO, were you referred for vaccination another day? (Prompted question. Check a single response.)

(1)Referred for vaccination another day
(2) Not referred for vaccination because received TT-5
(3) Not referred for vaccination for another day
(3)Up to date

94 a Were you prescribed any oral medication at your last visit? (1)Yes (2) No

B If YES, were you able to get your medication? (1)Yes (2) No

If YES, where did you get your medication?
c (1) This health facility from regular stock
(2) This health facility from essential drug store/ IMNI
(3) Private pharmacy
(4 Another health facility/hospital
(5) Drug vendor
(5) Other (specify):_____

d. If NO, why could you not get the medication?
(1) No drugs available
(2) No money/could not afford
(3)Other (specify):_____

CLIENT SATISFACTION MODULE

95. How did you get the facility today?
1.Walking
2.Animal or animal-pulled vehicle
3. Bicycle
4. Own motorized vehicle

5. Rented vehicle
6. Other, specify_____

96. How long did it take you to get to the facility?_____ minutes(88)does not know)
97. How long did you wait to have your child seen today? __ minutes(88) does not know
98. How do you feel about the time you had to wait today before receiving attention for your child? Do not prompt.
1. Definitely too long
2. Long
3. Acceptable
4. Short
(88). Does not know
99. What do you think of services for sick children at this facility? Do not prompt.
1. Good as they are
2. Should improve, explain what should improve
_____
_____
(88) Does not know
100. Have you brought children to this facility before?
(1) Yes
(2) No Skip to question 102
(88) Does not know Skip to question 102

101. How money times have you brought children to this facility in the last six months? _____ times
< use (88) if does not know>

102. How much money did you have to spend for?
(1) Transportation _____ Birr
(2) Consultation _____ Birr
(3) Medication _____ Birr
(4) Lab work _____ Birr
(5) Lump sum _____ Birr
(6) Other expenses, specify ____ Birr
103. Please add up the total(1-6) _____ Birr

HOME CARE AND CARE SEEKING MODULE

104. How long ago did you first notice that <CHILD> was sick? _____ days
105. Did you do any thing at home to <CHILD> before seeking help?
(1) Yes
(2) No Skip to 107
(88) Does not know Skip to 107
106. What did you do at home? Circ le all that apply
1. gave home remedies, specify_____
2. gave medicine, specify _____
3. gave ORS
4. holy water
5. Other, specify _____
107. During the present illness did you believe that <CHILD> was very seriously ill?
(1) Yes
(2) No
(88) Does not know
108. How many days ago did you believe that < CHILD> was seriously ill?
_____ days
109. Before coming to this facility did you go anywhere else outside of your home for help?

(1) Yes
(2) No Skip to 111
(88) Does not know Skip to 111

110. Where did you go?(Circle the one to which they went first)
1. relative or friend
2. traditional healer
3. church
4. pharmacy, drug seller
5. trained community-based health worker
6. private nurse or doctor
7. hospital
8. another provider, specify_____

111. What was done for the child? Circle all that apply
1. gave a massage
2. herbal medicine
3. extraction
4. obtain medication/drugs
5. Other, specify _____

112. During this illness how would you feed <CHILD>? Prompt.
1. same as before
2. give more
3. give less

Care Ethiopia Child Survival Project
South Gondar Zone / Farta Woreda
Health Facility Survey
Form –3 Health Worker Interview

Zone: _____ Woreda: _____ Date_____/_____/____
Facility Name_____ Facility Type_____Facility Status_____
Surveyor ID: ___ ___

113. Health worker Name:_____ Sex: (1) M (2)F
114. Health Worker Category (1) MD (2)PHO (3)Senior Nurse
(4)Junior Nurse (5) HA (6)Other
115 Trained in Child Health in the last two years? (1) Yes (2) No
116. If yes, check all that apply(1) IRT (2) IMCI (3) Malaria (4) EPI (5) Other

Introduce yourself to the health worker. Tell him/her that you would like to ask some general questions about the health facility, followed by some questions about his/her job.

117. Where does the health facility usually get medications and supplies?
(Check a single response.)
(1) Government supplier
(2) Essential drug store
(3) Private pharmacy supplier
(4) NGO/Mission
(5) Other (specify):_____

118. How are the supplies usually received? (Check a single response.)
(1) Delivered to facility
(2) Picked up from the supplier
(3) NGO/Mission
(4) Other (specify):_____

119. What is the most common cause of a delay in delivery of supplies?
(Check a single response.)
(1) Inadequate transport
(2) Administrative difficulties
(3) Financial problems
(4) Insufficient fuel
(5) Insufficient staff
(6) Rupture of stock at the central store
(7) Other (specify):_____

120. Do you have a regular supervisor? (1)Yes (2) No
If NO, go to question 125.
121. Do you have a schedule for supervisory visits? (1)Yes (2) No
122 How many times have you had a visit from a supervisor-
1. In the last 6 months. ____ (number of times)
2. In the last 12 months ____ (number of times)
3. Supervisor works here and sees worker daily ____

123. What did your supervisor do the last time he/she supervised you?
(Check all that apply.)
(1) Delivered supplies (fuel, medicines, etc.)
(2) Observed immunization technique

(3) Observed management of sick children
(4) Reviewed reports prepared by health worker
(5) Updated health worker on current information
(6) Discussed problems with supplies and equipment
(7) Other (specify): _____

124a. Did you receive feedback from that supervisory session?
(1)Yes (2) No

124b. If YES, in what form?
(1) Supervisory register
(2) Oral report
(3) Written report
(4) Other (specify):_____

125. What are the most difficult problems that you face in doing your job?
(Check all that apply.)
(1) Lack of training
(2) Caretakers don't bring children to clinic
(3) Lack of time
(4) Staff shortages
(5) Lack of supplies and/or stock
(6) Lack of supervision
(7) Lack of feedback on performance
(8) Inadequate transport
(9) Lack of motivation
(10) Poor working environment health facility, housing)
(11) Other (specify):_____

126. Have you discussed these problems with your supervisor? (1)Yes (2) No (99) Does not apply

127. How many child-health-related training sessions have you received in the last 12 months? _____

If no training received, go to question 130.

128. What type of training was it?_____

129. Did your last training involve clinical practice? (1)Yes (2) No

130. In this health facility, at what ages do you give?(Age in WEEKS but in MONTHS for measles only)
a. First b. Second c. Third d. Fourth

131. DPT

132. Polio

133. BCG

134. Measles

134.1 In this health facility, at what ages do you give Vitamin A?

135. EPI vaccination schedule all correct? (1)Yes (2) No

136. To whom do you give tetanus toxoid? (Check all that apply.)
(1) Pregnant women
(2) Women of childbearing age (15-49)
(88) Doesn't know

137a. On what occasion would you give tetanus toxoid? (Check all that the apply.)
(1) Antenatal clinic visit
(2) Visit for curative services of mother
(3) Visit with child for immunization or treatment

137b. To whom do you give Vitamin A ?
1. Children
2. Mother during later pregnancy
3 Post natal
4. Other (specify) _____

137a. To whom do you give Vitamin A ?
A . Mother 1. Yes 2. No
B. Children 1Yes 2. No
137c. If A is Yes , On what occasion , would you give Vitamin A
1. During late Pregnancy
2. Postnatal till day 42.
3. Other (specify) _____
137d if B is Yes, On what occasion would you give vitamin A ?
1. During immunization
2. During measles epidemic
3. In malnutrition of any age group
4. Any chronic disease
5. Other (specify)_____
137e. On what occasion would you give antihelmenthi as prophylaxis to children 2 years - 5 years old .
1. Growth monitoring
2. Visit to curative service (OPD) for children
3. Vaccination
4. Other (specify) _____
137f. Choose the malaria drug from the list to adequately treat in the column presented case?

	Chloroquine	Fanside	Coartem	Quinine	Other	If other specify
Pregnant mother prophylaxis						
Pregnant mother treatment						
Children 2- 5 years						
Children > 5 years						
Adult						

138. On what days are immunizations given? (Circle days.)
a) 1.M 2. T 3. W 4. Th 5. F 6. Sa b) Total Number of immunization days/week____
139a.Does the health facility have an antenatal clinic?
(1)Yes (2) No
b. If YES, on what days is the clinic held? (Circle days.)
1) 1. M 2. T 3. W 4. Th 5.F 6. Sa
2) Number of clinic days/week____
c. If NO, why are antenatal clinics not held? (Check all that apply.)
(1) No staff
(2) No supplies
(3) No training
(4) No space available
(5) Other (specify):_____
(88) Doesn't know
140.What are the signs that would make you refer a child to the next level of health facility? (Check all that apply.)
(1) Child is lethargic/abnormally sleepy/unconscious

(2) Child has not responded to usual treatment
(3) Child is not eating or drinking
(4) Child has severe dehydration
(5) Child has severe malnutrition/anemia
(6) Child has had convulsions
(7) Child looks very unwell
(8) Child has a very high fever
(9) Child vomits everything
(10) Child has severe pneumonia
(health facility, housing)
(11)Other (specify):_____

141. Health worker knows at least three signs for referral?
(1)Yes (2) No

142a.Have you ever wanted to refer a child to the next level of health facility but have not been able to do so?. (1)Yes (2) No

142b. If NO, go to question 144.

143 If YES, why could you not refer the child? (Check all that apply.)
(1) No fuel available
(2) No transport available
(3) Caretaker/parents refused to go
(4) Parents didn't have enough money
(5) Next level of health facility too far
(6) Other (specify):_____

144. What do you see as your role in communicating with caretakers when they bring their child to the health facility? (Check all that apply.)
(1) Giving information on danger signs to watch for
(2) Giving information on what to do at home
(3) Giving information on how to give medicine at home
(4) Finding out what caretakers have done at home and what are the symptoms of the child's illness
(5) Giving information on how to prevent illness
(6(Telling caretakers when to come back to the health facility
(7) Ensuring that caretakers understand what to do at home
(8) Giving group talks
(9) Other (specify):_____

145. What prevents you from communicating with caretakers when they bring their children to the health facility? (Check all that apply.)
(1) Someone else does it
(2) They don't listen
(3) No time
(4) It isn't important
(5) It isn't really my role
(6) I don't have any education materials
(7) language barriers prevent effective

communication

9.Other (specify)
(88) I do not know

END OF HEALTH WORKER INTERVIEW

Thank the health worker for his/her cooperation and answer any questions that he/she may have about the

correct recommendations for immunizations or management of sick children.

Care Ethiopia Child Survival Project
South Gondar Zone / Farta Woreda
Health Facility Survey

Form-4 EQUIPMENT AND SUPPLIES CHECKLIST

Zone: _____Woreda:_____ Date_____/_____/____

Facility Name_____ Facility Type_____ Facility Status_____

Surveyor ID: ___ ___

Discuss with the head of facility to determine the number of health staff with child case management responsibilities (curative and preventive).

146 Category	1. Number Assigned to the Facility	2. Number Present the Day of the Survey	1. Total Number Assigned to the Facility
a. Physician			
b. Health officer			
c. Senior Nurse			
d. Junior Nurse			
e Health assistant			
f. Other			

147. Patient and Worker Accommodation module

. a. Is there adequate seating for patients? (1)Yes (2) No

. b. Is there a covered waiting area? (1)Yes (2) No

. c. Is there potable water? (1)Yes (2) No

. d. Is there a functional toilet or latrine? (1)Yes (2) No

. e. Is there a functional waste disposal area/pit? (1)Yes (2) No

F1. Are health information posters displayed? (1)Yes (2) No

. F2. If YES, are they written in the local language? (1)Yes (2) No

. g. Is an ORT corner present and being used? (1)Yes 2) No

Equipment and Supplies module

Are the following equipment and supplies present in the health facility?

148. Transportation

A1. Vehicle (1)Yes (record number available ___) (2) No

A2. If YES, in working order? (1)Yes (record number available ___) (2) No

B1. Motorcycle (1)Yes (record number available ___) (2) No

B2. If YES, in working order? (1)Yes (record number available ___) (2) No

C1. Bicycle. (1)Yes (record number available ___) (2) No

C2. If YES, in working order? (1)Yes (record number available ___) (2) No

149. . Social mobilization equipment

A1. Megaphone. (1)Yes (record number available ___) (2) No

A2. If YES, in working order? (1)Yes(record number available ___) (2) No

B1. Flip-chart. (1)Yes (2) No

C1. Counseling cards/pamphlets (1)Yes (2) No

(1)Yes (2) No

150. Weighing equipment

A1. Adult weight scale (1)Yes (record number available ___) (2) No

A2.If YES, in working order? (1)Yes (record number available ___) (2) No

B1. Baby weight scale (1)Yes(record number available _____) (2) No

B2. If YES, in working order? (1)Yes(record number available _____) (2) No

C1. Salter (1)Yes (record number available _____) (2) No

C2. If YES, in working order? (1)Yes (record number available _____) (2) No

151. Medical Supplies

.

A1. Thermometer (1)Yes (record number available _____) (2) No

A2. If YES, in working order?
(1)Yes (record number available_____) (2) No

. Stethoscope

B1. - Regular . (1)Yes (2) No

B2. If YES, in working order?
(1)Yes (2) No

C1. Obstetrical (1)Yes (2) No

C2. If YES, in working order?
(1)Yes (2) No

.

D1. Otoscope. (1)Yes (2) No

D2. If YES, in working order?
(1)Yes (2) No

F1. Tongue depressor (1)Yes (record number available ____) (2) No

E2. If YES, in working order?
(1)Yes (record number available ____) (2) No

. Watch with a second hand or other

G1. Timing device (1)Yes record number available ____) (2) No

g2. If YES, in working order?
(1)Yes (record number available _____) (2) No

H1. Steam sterilizer (1)Yes (record number available _____) (2) No

h2. If YES, in working order?
(1)Yes (record number available ____) (2) No

I1. Cooker or stove (1)Yes (record number available ____) (2) No

I2. . If YES, in working order?
(1)Yes (2) No

K1. Measuring and mixing utensils (1)Yes (2) No

L1. Cups and spoons (1)Yes (2) No

M1. Refrigerator (1)Yes (record number available _____)
(2) No
If No, go to question 151 N1.

If YES

M1a. Type:
(1)Electric
(2)Kerosene
(3)Gas
(4) Solar (5) Mixed (6)Nonfunctional

M1b. Condition (1) Good (2) Fair (3) Poor
M1c. Freeze-watch indicator? (1)Yes (2) No
M1d. Working thermometer inside? (1)Yes (record number available ____) (2) No

M1e. Temperature chart? (1)Yes (record number available _____) (2) No
If No, go to question 151 N1.
M1f. In the last 30 days, temperature record up to date ?
(1)Yes (2) No
N1. Ice packs.
(1)Yes (2) No
O1. Cold boxes
(1)Yes (2) No
O1a. Condition: (1) Good (2)Fair (3) Poor (4) Nonfunctional

Availability of Drugs and Other Supplies the Day of the Survey
(Circle Y or N for each item.)

152. Supplies- Available

Drugs for pneumonia:

A1. Penicillin tablets/syrup
(1)Yes (2) No (3) N/A
A1.1 if yes 1. from regular store and number -------- 2. from essential drug store and number ----------

A2. Ampi/amoxicillin tablets/syrup
(1)Yes (2) No (3) N/A
A2.1 if yes, 1. From regular store and number ----------
2. from essential drug store and number ----------

Drugs for Shigella:

B1. . Cotrimoxazole tablets/syrup.
(1)Yes (2) NO (3) NA
B1.1 A1.1 if yes 1. from regular store and number -------- 2. from essential drug store and number ----------

B2. Nalidixic acid . (1) Yes (2)No
(3) N/A
B2.1 if yes 1. from regular store and number ---------- 2. from essential drug store and number ----------

Drugs for malaria:

C1. Chloroquine (1)Yes. (2) No
(3.) N/A

C1.1 if yes, 1. From regular store and number -------- 2. from essential drug store and number ----------

C2Fansider (1) Yes (2) No.
3.N/A.
C2.1 if yes,1. from regular store and number -------- 2. from essential drug store and number ----------

C3 Quinine tablets (1)Yes. (2) No
(3.) N/A

If yes C3.1 1. From regular store and number -------- 2. from essential drug store and number ----------

C4.Coarten for children 3mnth -2 years 1) Yes (2) No. 3.N/A.
If yes C4.1 From regular store and number -------- 2. from essential drug store and number ----------

C5 Coartem for children 3mnth - 7 years 1) Yes (2) No.
3.N/A.

C5.1 If yes, . From regular store and number -------- 2. from essential drug store and number ----------

C6 Coartem for children 8-10 years 1) Yes (2) No.
3.N/A.
If yes C6.1. From regular store and number -------- 2. from essential drug store and number ----------

C7 coartem for children > 10 years 1) Yes (2) No.
3.N/A.

If yes C7.1. From regular store and number -------- 2. from essential drug store and number ----------

C8. Injectable quinine (1) Yes If yes C8. From regular store and number -------- 2. from essential drug store and number ---------- (2) No (3)N/A

d. Injectable penicillin . . . . . 1.Y If yes. 1From regular store and number -------- 2. from essential drug store and number ---------- 2.N 3. N/A

e. Injectable chloramphenicol . . . . . 1.Y If yes. 1From regular store and number -------- 2. from essential drug store and number ---------- 2.N 3. N/A

f. Paracetamol . . . . . 1.Y 2 If yes. 1From regular store and number -------- 2. From essential drug store and number ---------- .N 3. N/A

g. Aspirin . . . . . 1.Y If yes. 1From regular store and number -------- 2. From essential drug store and number ---------- 2 .N 3. N/A

h. Tetracycline eye ointment . . . . . 1.Y If yes. 1From regular store and number -------- 2. From essential drug store and number ---------- 2.N 3. N/A

i. Gentian violet . . . . . 1.Y If yes. 1From regular store and number -------- 2. From essential drug store and number ---------- 2.N 3. N/A

j. Iron . . . . . 1.Y If yes. 1From regular store and number -------- 2. From essential drug store and number ---------- 2.N 3. N/A

k. Vitamin A . . . . . 1.Y Y If yes. 1From regular store and number -------- 2. From essential drug store and number ---------- 2.N 3. N/A

l. Mebendazole . . . . . 1. If yes. 1From regular store and number -------- 2. From essential drug store and number ---------- Y 2.N 3. N/A

m. Sterile water for injection . . . . . 1.Y If yes. 1From regular

store and number --------
2. From essential drug store and number ----------
-- 2.N 3. N/A

n. ORS . . . . . 1.Y Y If yes. 1From regular store and number -------- 2. From essential drug store and number --- --------- 2.N 3. N/A

o. IV solution for severe dehydration. . . . . 1.Y If yes. 1From regular store and number -------- 2. From essential drug store and number ---------- -- 2.N 3. N/A

p. Needles . . . . . 1.Y If yes. 1From regular store and number -------- 2. From essential drug store and number ---------- -- 2.N 3. N/A

q. Syringes . . . . . 1.Y If yes. 1From regular store and number -------- 2. From essential drug store and number--- 2.N 3. N/A

r. Are expired drugs in the health facility? . . . . . 1.Y If yes. 1From regular store and number -------- 2. From essential drug store and number 2.N 3. N/A

s. If YES, which ones? 1_____ 2 _____ 3_____

Vaccines- Available

t. BCG .. . . . . 1.Y If yes. 1From regular store and number - ------- 2. From essential drug store and number--- 2.N 3. N/A

u. OPV . . . . . 1.Y If yes. 1From regular store and number --- ----- 2. From essential drug store and number--- 2.N 3. N/A

v. DPT . . . . . 1.Y If yes. 1From regular store and number -- ------ 2. From essential drug store and number-- 2.N 3. N/A

w. Measles . . . . . 1.Y If yes. 1From regular store and number -- ------ 2. From essential drug store and number-- 2.N 3. N/A

x. Tetanus toxoid . . . . . 1.Y If yes. 1From regular store and number --- ----- 2. From essential drug store and number-- 2.N 3. N/A

y. Are expired vaccines in the refrigerator?. . 1. Y 2.N 3. N/A

z. If YES, which ones?1 _____ 2 _____3_____

Are frozen vials of DPT or TT in the refrigerator? 1.Y 2.N 3. N/A

Rupture of stock in the last 30 days? . . . . . 1.Y 2.N 3. N/A

If YES-

Item	Number of Days of Stock-Outs/Last 30 Days
a. Vaccines	
b. Syringes/needles	
c. ORS	
d. Essential drugs	
e. Cards/forms	

Are drugs and other supplies adequately organized and appropriately stored?. . . . . 1.Y 2.N 3. N/A

Documentation and Record Keeping module
Are the following items present in the health facility?

a.Immunization a.register. . . . . 1.Y 2.N 3. N/A

b. If YES, is it up to date? . . . . . 1.Y 2.N 3. N/A

Immunization tally sheets. . . . 1.Y 2.N 3. N/A

Stock of vaccination/child health cards. . 1.Y 2.N 3. N/A

Stock of TT/maternal health cards. . . . . 1.Y 2.N 3. N/A

Stock of essential drugs cards. . . .. 1.Y 2.N 3. N/A

Notifiable disease report forms. . . . . 1.Y 2.N 3. N/A

All essential monthly reporting forms. . . 1.Y 2.N 3. N/A

If YES, are they up to date?. . . . . 1.Y 2.N 3. N/A

Is a patient register
(a)kept?. . . . . 1.Y 2.N 3. N/A

(b)If YES, is it up to date?. 1.Y 2.N

Number of patients seen in last month: _____

Number of patients 0-4 years of age seen in last month: _____

Average number of patients seen per day: _____

END OF EQUIPMENT AND SUPPLIES CHECKLIST

Care Ethiopia Child Survival Project
South Gondar Zone / Farta Woreda
Health Facility Survey
Form 5. Health Facility-Community Links

Zone: _____Woreda:_____ Date_____/_____/____
Facility Name_____ Facility Type_____ Facility Status_____
Surveyor ID: ___ ___ The

167. Does the health facility have outreach to the community?
(1)Yes
(2) No Skip to question 168
(88) Does not know Skip to question 168

167 a. What kind of outreach is provided by the facility?
1. Vaccination 2. Nutrition 3. Malaria
4. Family planning 5. The new Water and Sanitation
6. School health 7. General MCH 8.Home visits
9.Other, specify_____

167 b. How many times have staffs done out reach activities in the last three months? _____ times

168. Does the facility have an operational plan that includes community work? (1)Yes (2) No

169. Does the facility work with any sort of community based worker?
(1)Yes (2) No

170. Does the facility have any formal agreements with any community based organizations in the catchment area?
(1)Yes (2) No

171. Has any one in the facility conducted a needs assessment/community diagnosis in the catchment area in the last two years? (1)Yes (2) No

172. if Q 170 yes

Name of CBOs	Services/ types of agreement
1.	
2.	
3.	

Attachment I: LQAS 2006

Attachment J: Instruments used

1) CARE Ethiopia: Farta Child Survival Project Final Evaluation 2007

Interview with group or individual:
Volunteer Community Health Worker (vCHW)

Date: _____ Interviewer: _____

Village:_____ Kebele: _____

Distance to Health Facility (on foot, in minutes):_____minutes

Number of vCHWs being interviewed: _____vCHWs

How long have you been working with the project? _____

1. What do you do to support improved health in women and children? (Describe activities).

2. About how much time to you spend on this work each week?

3. What meetings do you attend regularly (MTMSG, Kebele meetings, school groups, others)? How often? What is your contribution?

4. Who do you receive reports from, and what do you do with the information?

5. Many mothers have changed their health behaviors during this project. What do you think contributed most to those changes and how?

	What is the contribution of each of these to the behaviors?	How important was this group relative to the others?
Religious leaders		
Mothers groups		
School clubs		
Community leaders (CRPs, vCHWs)		
Health facility workers (HEAs, nurses)		
Others		

7. Supervision and support:
Who supervises your work? How often do you receive supervision? How have you found this supervision useful?

8. Who supports you when you have doubts or have a family health problem that you do not know how to solve?

9. How has your participation in this health program affected your own life and work?

10. CARE's participation in the project will end in a few months. Do you think you will continue to do your work as before? How?

2) IMMUNIZATION (include Vitamin A supplementation) (20% of the project)
Indicators in the Detailed Implementation Plan (DIP)

1. To promote the practice of health behaviors, including seeking of appropriate medical care as needed, by caregivers of children under five years and women of reproductive age, especially pregnant and lactating mothers.
    - Proportion of children aged 12-23 months who received measles vaccine (documented—no card=no immunization)
    - Proportion of children aged 12-23 months who received BCG, DPT3, OPV3 and measles vaccines
    - Proportion of drop-outs between DPT1 and DPT3
    - Proportion of children who received one dose of Vitamin A supplement in last six months.
    - *Immunization access: proportion of children 12-23 months who received DPT1 (documented)*
    - *Immunization access: proportion of children 12-23 months who received DPT3 (documented)*
2. To increase sustainable access to health education, quality care, and essential medicines (from government institutions, private sources, and partner organizations).
    - Proportion of health facilities with measles, DPT, BCG and OPV vaccines on the day of inspection.
    - Proportion of [mothers] women who have appropriate counseling and information on immunization
3. To ensure that quality health care is provided in areas of diarrhea, pneumonia, malnutrition and immunization by government health personnel, CHAs, CHWs (including CBRHAs and trained TBAs) and other service providers.

Other indicators

- Doses of vaccine administered and estimated coverage from FWHO: BCG, Polio 1 and 3; DTP 1 and 3, measles, vitamin A in children
- Completeness of cold chain, frequency of outreach, stockouts (between DTP and pentavalent), training done.

DISCUSS

- Results, comparing baseline and final.
- Other supporting data:
    - Data from the FWHO: doses applied, consults, etc.
    - Data from the FCSP; other sources of data?
    - Comments from focus groups and interviews

- What were the principal strategies that the project used to achieve its objectives. (in this case, support through donation of refrigerators, training, mobilization, supervision?) Cite evidence for your statements.
- Discuss factors that positively and netagively affected the results---support with data.

- Discuss successes and lessons learned
- Would it be possible to increase the scale of the activities? How?

NUTRITION (35% of the project)

Indicators fromt the Detailed Implementation Plan (DIP)

1. promote the practice of health behaviors, including seeking of appropriate medical care as needed, by caregivers of children under five years and women of reproductive age, especially pregnant and lactating mothers.

- Proportion of mothers who initiated breastfeeding within one hour after birth
- Proportion of mothers practicing exclusive breastfeeding for at least six months (KPC is "at 0-5 months")
- Proportion of mothers who give colostrum
- Proportion of children 12-23 months who consume vegetables, fruits and foods rich in Vitamin A in previous 7 days from survey
- Proportion of children age 6-9 months who get complementary food.
- Proportion of women with children <2 years who received deworming during second or third trimester of pregnancy
- Proportion of children 6-23 months who received deworming medicine in the past 6 months*)*

2. To increase sustainable access to health education, quality care, and essential medicines (from government institutions, private sources, and partner organizations).

- Proportion of women who receive appropriate counseling on breastfeeding (during ill child consults)
- Proportion of women who receive appropriate nutritional counseling (during ill child consults)
- Proportion of children aged 0-23 months whose weight is taken, plotted on the growth monitoring chart and their mothers counseled. (card-confirmed)

3. To ensure that quality health care is provided in areas of diarrhea, pneumonia, malnutrition and immunization by government health

- Proportion of health personnel/ CHWs who are able to counsel mothers about feeding a sick child
- Proportion of health facilities with stock of essential drugs and supplies (Iron, Vitamin A, antihelminthics, scales and related materials for growth monitoring and promotion) in the last month

Process indicators

- Number of CHWs and service providers trained in breastfeeding counseling
- Number of target breastfeeding communication products and materials developed and disseminated
- Percentage of target audience exposed to IEC/BCC messages on breastfeeding

DISCUSS

- Results comparing baseline to final
- Other supporting data from other sources
    - Data from the FWHO (including therapeuting feeding center)
    - Data from the FCSP
    - Comments from focus groups and interviews
    - Other sources of data

- Were the objectives and targets achieved? What is the evidence?
- What were the principal strategies used by the project to achieve the objecives? Were the strategies successful? What is the evidence? What strategies contributed the most?
- Discuss factors that affected the results positively and/or negatively---support with evidence.
- Discuss successes and lessons learned
- Would it be possible and feasible to increase the scale of these activities? How?

ACUTE RESPIRATORY INFECTION (25%) AND DIARRHEAL DISEASE (20%)

Indicators fromt the Detailed Implementation Plan (DIP)

1. promote the practice of health behaviors, including seeking of appropriate medical care as needed, by caregivers of children under five years and women of reproductive age, especially pregnant and lactating mothers.

- Proportion of mothers who seek medical care from a qualified, trained provider (Hospital, Health Center, Pharmacists) when their child under five has signs of pneumonia (fast or difficult breathing). (last two weeks)
- Proportion of mothers who do not delay for more than three days before seeking ARI-care when their child has cough or difficult breathing (last two weeks).
- Proportion of mothers who seek medical care from a qualified, trained provider (Hospital, Health Center, Pharmacists) within 24 hours when their child under five has signs of pneumonia (fast or difficult breathing).
- Proportion of households disposing children's stool properly (in a latrine).
- Proportion of children who had diarrhea in the past two weeks who were given the same or more:
    - Breastfeeding (among those still breast feeding).
    - Fluids
    - Food (children 6-23 months)
- Proportion of children who had diarrhea in the past two weeks who received recommended home fluids or ORS.

2. To increase sustainable access to health education, quality care, and essential medicines (from government institutions, private sources, and partner organizations).

- Proportion of communities who have cotrimoxazol access for 10 of 12 months (from health facilities)
- Proportion of communities who have cotrimoxazole access for 10 of 12 months (from community pharmacies)
- Proportion of CHAs and health posts that have ORS ten of twelve months

3. To ensure that quality health care is provided in areas of diarrhea, pneumonia, malnutrition and immunization by government health

- Proportion of CHAs and health facility staff who correctly diagnose and manage pneumonia cases according to protocol
- Proportion of children assessed by health workers for all three danger signs
- Proportion of children with diarrhea who receive appropriate case management in the health facility.
- Proportion of CHAs who can correctly demonstrate preparation of ORS or appropriate home preparation
- Proportion of CHAs who can practice proper standard case management of diarrhea according to MOH protocol.

Process indicators

- Number of CHWs and service providers at health facility level trained in case management
- Number of people referred to the health facilities
- Number of supervisory visit made to the community and health facility by:
    - a. Regional health bureau

- b. Zonal
- c. District (core CSP team)

DISCUSS

- Results comparing baseline to final
- Other supporting data from other sources
    - Data from the FWHO (including therapeuting feeding center)
    - Data from the FCSP
    - Comments from focus groups and interviews
    - Other sources of data
- Were the objectives and targets achieved? What is the evidence?
- What were the principal strategies used by the project to achieve the objecives? Were the strategies successful? What is the evidence? What strategies contributed the most?
- Discuss factors that affected the results positively and/or negatively---support with evidence.
- Discuss successes and lessons learned
- Would it be possible and feasible to increase the scale of these activities? How?

3) BCC AND COMMUNITY MOBILIZATION

PLEASE MAKE A COPY OF THE BCC STRATEGY AVAILABLE (SOFT COPY IF POSSIBLE)

1. What were the key strategies for changing behaviors and mobilizing communites? [don't forget COPE training for health facility workers]

2. To what extent was the BCC plan successfully implemented?

2. List all the key messages that the project transmitted

a. Breastfeed immediately after birth
b. Give colostrum…..
c. etc.

3. List the means of communication, and discuss coverage and probably effectiveness in changing behavior *in this project* (not theoretical ability to change behavior):

Means of communication and target audience	**Coverage (percent of target audience that heard the messges) (1=high > 70%, 2=medium 30-69%, 1=low <30%)**	**Effectiveness at changing behaviors (1=high, 2=medium, 3=low)**
a.Counseling cards during meetings		
b. House to house visits		
c. Counseling during health facility consults		
Etc….		

4. List all the BCC materials produced, who received, estimated effectiveness

Material (description, messages, target)	**Quantity produced and who received**	**Estimated effectiveness in achieving the results in the project**
a. Counseling cards; mothers and communities; all key messages		
b. Tapes and cassettes for mothers, communities…		
c. Etc….		

5. What were the principal barriers and difficulties encountered in changing behaviors and mobilizing communities, and how were these addressed?
6. What were lessons learned?
7. How will the behavior changes be sustained after the project ends, and how realistic are these plans?

CAPACITY-BUILDING OF PARTNERS

Discuss the capacity-building approach---how did the project improve the capacity of partners.

1. Partner organizations (EOC, FWHO, civil administration, others?):

a. How have the organizational capacities of partner organizations changed since the beginning of the project?
b. What were the principal strategies used to achieve these changes (include donations of equipment and supplies, logistics support, financial support, technical/training support, etc.)
b. What are the best practices and lessons learned in capacity-building of local partners?
c. How will the improvements be sustained?

2. Health facility strengthening

a. What were the principal strategies used to improve management of health services at health facilities? (example: health facility assessment. Include any donations of equipment and supplies, logistics and transportation support, training and management support, etc.)
b. Discuss factors that facilitated and/or were barriers to improvement in health facility management.
c. How effective was the strategy to improve the management of health services? (give examples)
d. What were the lessons learned?
e. What are the plans for sustaining these improvements? Are they realistic?
f. Discuss linkages between health facilities and communities.

3. Health worker performance

a. How effective was the strategy for strengthening health worker performance?
b. Did services improve as planned? (how do you know? Give examples)
c. What were the best practices and lessons learned?
d. What are the plans for sustaining health worker performance once the project closes?
e. Are the sustainability plans realistic?

INFORMATION MANAGEMENT

1. Describe the information management system
    a. What information does each level collect and report---provide examples of forms and indicators?
    b. Where does the information go, who aggregates it?
    c. How (how often?, when?) is it used by each level?

2. What information was used by the project staff and partners to measure progress towards project objectives?
3. How effective was the system to measure progress towards project objectives?
    a. Cite examples of how project data was used to make management or technical decisions.
4. Did the project do any special studies or surveys Besides the KPC, LQAS and health facility surveys, did the project conduct or use special assessments, mini survey focus groups, etc. Give examples and how the information was used.
5. Did the project strengthen information collection and use at the community level, EOC or FWHO? Give examples.
6. Are these infromation systems sustainable? (how do you know?)
7. How have the project's data been used outside this Child Survival project? Give examples.

4) TRAINING STRATEGY

1. Please provide an inventory of training in the FSCP since the mid-term evaluation (see the table at the end of this guide---complete it for the rest of the period.) Include training for CARE Ethiopia staff.

2. How effective was the training strategy? How do you know?
3. Was the training plan outlined for the period after the mid-term evaluation met?
4. What is the evidence that the training change the way things are done or increased knowledge and skills of the participants---give examples (especially examples that can be documented from observations during the evaluation visits)
5. What are the best practices and lessons learned for training?
6. What are plans for sustaining training activities after the end of the project?

5) DISCUSSION GUIDES: MANAGEMENT

1. Planning

a. How inclusive was the project planning process and what effect did this have on the implementation process?
b. To what extent was the DIP work plan practical? Based on the grantee's and its partner's experience with this project, what could be added to the DIP preparation and review process that would have strengthened implementation?
c. What were the gaps in the DIP and how were they addressed by the project staff?

2. Staff Training

a. What change is there in the knowledge, skills and competencies of the project and partner's staff? Is there evidence that the staff has applied these skills both within the project and in another context?
b. Were adequate resources dedicated to staff training?
c. What are the overall lessons learned about building the capacity of project staff?

3. Supervision of Project Staff

a. Was the supervisory system adequate?
b. Is the supervisory system fully institutionalized and can it be maintained?
c. Is there evidence that the project's approach to strengthening supervisory systems has been adopted beyond the project?

4. Human Resources and Staff Management

a. Are essential personnel policies and procedures of the grantee and partner organizations in place, to continue project operations that are intended to be sustainable?
b. Describe the morale, cohesion and working relationships of project personnel and how this affected project implementation.
c. Describe the level of staff turnover throughout the life of the project, and the impact it has had on project implementation.
d. Have plans been developed to facilitate staff transition to other paying jobs at the end of the project?

5. Financial Management [to be completed with the field staff and lead evaluator]

a. Discuss the adequacy of the grantee's and partners' financial management and accountability for project finances and budgeting. If the project budget was adjusted, explain why. Do the project implementers have adequate budgeting skills to be able to accurately estimate costs and elaborate on budgets for future programming?
b. Are adequate resources in place to finance operations and activities that are intended to be sustained beyond this cooperative agreement?
c. Was there sufficient outside technical assistance available to assist the grantee and its partners to develop financial plans for sustainability?

6. Logistics

a. What impact has logistics (procurement and distribution of equipment, supplies, vehicles, etc.) had on the implementation of the project?

b. Is the logistics system sufficiently strong to support operations and activities that are intended to be sustained?

CARE Ethiopia: Farta Child Survival Project
Final Evaluation 2007

Interview with group of
Mothers to Mothers Support Group

Date: _____ Interviewer: _____

Village:_____ Kebele: _____

Distance to Health Facility (on foot, in minutes):_____minutes

Number of mothers in the group being interviewed: _____mothers

When did this club start? _____
How many mothers are members? _____
1. Is the number of mothers that participate
Growing? Same/stable? Shrinking?

2. Who comes to your meetings? (young mothers? Older women non-mothers?)

3. How do you encourage new mothers to participate in your group?

4. How often do you meet? _____

5. What do you do in your meetings? What topics do you discuss? How? (are there things they talk about besides mother and child health?)

6. Has your group done out any special activities or events? Describe (fairs, theaters, demonstrations, etc.)

7. I know that you are all very busy at home. Why do spend the time to come to these meetings?

8. Who performs home visits to in your community to check on the health of women and children?

9. How are the families selected for the visits and why? Has anyone visited YOUR home to check on your health or your children's health in the past few months?

10. Are there people who are not mothers who visit your community regularly for health? Elaborate: (Who? How often? What do they do?) [prompt: Health facility workers, religious leaders, CARE staff, Kebele administsrators?]

11. <u>Health seeking</u>
a. When you or your children are ill, do you go to a health facility (health post or health center)?

b. How are you received? Are they able to help with most problems?

c. Do you receive medicine at the health facility? If so, is it expensive?

d. Those that don't go to the health facility, why not?

e. If expense is a barrier, what options do families have for getting money for payment?

<u>12. Non-participants</u>
a. How many women in the village do not participate in the mothers group?

b. Why do you think they don't participate?

c. If there are mothers that do not want to change the way they feed and take care of their children, what is done?

d. Who is most effective to convince them to change? (other mothers, religious leaders, community/kebele leaders?)

13. Other community resources

a. Does your community have a school club? How is this important to children's and mothers' health?

b. Does your area have a community data board? How is it important? Do you know the results?

c. Does your area have an idir for health care loans? Is anyone here a member? Has anyone used it? Describe:

d. Is there a health post near this village? What do the Health Extension Agents do in your village?

e. Some health facilities have cassette tapes with plays or there are theater groups. Have any of you heard these cassettes or seen the theater groups? (About how many women?, Discuss---how many times, messages, did the cassettes help?)

LEADER OF MOTHER TO MOTHERS GROUP

1. What meetings do you attend at the kebele (health facility)?

2. How do these meetings help you or your mothers group or your village?

3. Many mothers have changed their health behaviors during this project. What do you think contributed most to those changes and how?

	What is the contribution of each of these to the behaviors?	How important was this group relative to the others?
Religious leaders		
Mothers groups		
School clubs		
Community leaders (CRPs, vCHWs)		
Health facility workers (HEAs, nurses)		
Others		

4. Who supports you the most in your work? How?

5. When you have a doubt or don't know how to deal with a problem, who helps you? How?

6. How has your participation in this health program affected your own life and work?

CARE Ethiopia: Farta Child Survival Project
Final Evaluation 2007

Interview with group of
<u>Religious leaders</u>

Date: _____ Interviewer: _____

Village:_____ Kebele: _____

Distance to Health Facility (on foot, in minutes):_____minutes

Number of religious leaders being interviewed: _____leaders

How long have you been working with the project? _____
How many families are you responsible for? _____

1. What do you do to support improved health in women and children?

2. How much time to you spend on Sunday health messages?

3. How much time to you spend on meetings and home visits for health every week?

4. How do you select the homes you will visit? (routine? Selected by mothers group? Community leaders?, requested by mother?)

5. If families do not want to follow your advice, how do you manage this situation?

6. Many mothers have changed their health behaviors during this project. What do you think contributed most to those changes and how?

	What is the contribution of each of these to the behaviors?	How important was this group relative to the others?
Religious leaders		
Mothers groups		
School clubs		
Community leaders (CRPs, vCHWs)		
Health facility workers (HEAs, nurses)		
Others		

7. Supervision and support:
Who supervises your work? How often do you receive supervision? How have you found this supervision useful?

8. Who supports you when you have doubts or have a family health problem that you do not know how to solve?

9. What health-related meetings do you attend? (mothers meetings, monthly kebele/health facility meetings, others?

a. How do they help you do your work? (specify by type of meeting).

10. How has your participation in this health program affected your own life and work?

CARE Ethiopia: Farta Child Survival Project
Final Evaluation 2007

Interview with group of
<u>School health clubs</u>

Date: _____ Interviewer: _____

Village:_____ Kebele: _____

Distance to Health Facility (on foot, in minutes):_____minutes

Number of people being interviewed _____students _____ teachers

How long ago was this club organized? _____
How many students are members? _____
How many students are there in the school? _____

1. Is the number of students that participate
Growing? Same/stable? Shrinking?

2. How do you encourage new students to participate in your group?

3. How often do you meet? _____

4. What do you do in your meetings? What topics do you discuss?

5. What does your group do to support improved health in women and children?

6. How much time to (each of) you spend on these activities each month?

7. Who do you ask when there is a problem or question that you cannot answer? Who supervises you? How often? How?

8. Many mothers have changed their health behaviors during this project. What do you think contributed most to those changes and how?

	What is the contribution of each of these to the behaviors?	How important was this group relative to the others?
Religious leaders		
Mothers groups		
School clubs		
Community leaders (CRPs, vCHWs)		
Health facility workers (HEAs, nurses)		
Others		

FOR CHILDREN IN THE SCHOOL GROUP

1. What changes have you seen in your house from the information that you take home? (ask students to stand and tell their story).

2. What do you like about the school club?

3. **What do you do in your meetings? (ask this question of students if the leaders answered the first time).**

CARE Ethiopia: Farta Child Survival Project
Final Evaluation 2007

Interview with leader/administrator of
<u>Community Data Board</u>

Date: _____ Interviewer: _____

Village:_____ Kebele: _____

Distance to Health Facility (on foot, in minutes):_____minutes

Number of people being interviewed: _____people
Position/title:

1. When was this community data board established? _____

2. What information is on the data board? (TAKE PHOTOGRAPH IF POSSIBLE). What is the area that the information represents, and what pieces of data are present.

3. Where does this information come from? How often is it up-dated?

4. How is the information used? Has anything happened as a direct result of the information on this data board? Describe what has happened.

CARE Ethiopia: Farta Child Survival Project
Final Evaluation 2007

Interview with
Health worker in health facility

Date: _____ **Interviewer: _____**

Community: _____ Kebele: _____

Description of Health Facility:
Post _____ Dev. Center_____ Beds for inpatients_____
Deliveries per month_____ Beds for obstetrics_____
General description (rooms, state, water, electricity):_____
_____

Number of workers:

Number of workers	Nurses	OB nurses	Auxiliary	Lab	Auxiliar Pharmacy
At facility					
Interviewed					

Turnover?:

Activities at the health facility

Activity	Days of week and times	Estimate no. Of patients per month	Material and equipment (stockouts?)	Comments
IMCI / ill children				
Care for ill adults				
EPI				

Activity	Days of week and times	Estimate no. Of patients per month	Material and equipment (stockouts?)	Comments
Antenatal care				
Growth monitoring				
Others				

Improvements in the past 2 years

_____

_____

_____

_____

What still needs to be improved:

_____

_____

_____

_____

<u>Health education:</u>
Material in use? Frequency of talks, post-consult? How is it done? Who does it?

_____

_____

_____

_____

_____

_____

Material and equipment :

	Now?	Stockouts in the past?
Medicications:		
Cotrimoxazol		
Ferrous sulfate / folic acid		
Antimalarials		
Antipyretics		
Vitamina A		
ORS and equipment		
Mother and child health cards		
IMCI cards		
Vaccines, syringes, disposal		
Others		

Trainings received in the past 2 years:

Subject	Who was trained (number of people, level)	When, days, who gave course	Was it put to use
IMCI			
Antenatal care			
Emergency obstetrics			
Malaria			

Subject	Who was trained (number of people, level)	When, days, who gave course	Was it put to use
Growth monitoring and nutrition			
EPI			
Others			

Obs: about training:

_____

_____

_____

Supervision:

Describe the type and areas of supervision, frequency, who does it, method (is there a standardized instrument?) last time, usefulness, result (changes?):

_____

_____

_____

_____

_____

For those workerst that carry out extension work:
Describe by type, frequency, impact, trends (increased during project?), what's still lacking, sustainability:

_____

_____

_____

_____

_____

Mothers groups and church leaders:
Describe interaction, type, competence, usefulness, impact, opinion about impact, sustainability?

_____

_____

_____

_____

_____

Referrals to higher levels: (communication, transportation, type, registry?)

_____

_____

_____

_____

Referrals from community: (describe frequency, type, function?)

_____

_____

_____

_____

Religious leaders:
Contacts? Number? Strength of ties? Impact? Sustainability?

_____

_____

_____

Mother to mother support groups:
Number in the area? Do you know them? Strength of ties? Impact? Sustainability?
_____

_____

_____

_____

_____

School health groups:
Number? Do you know them? Strength of ties? Impact? Sustainability?
_____

_____

_____

vCHWs, CRPs, etc.

_____
Number, Do you know them? Strength of ties? Impact? Sustainability?

_____

_____

_____

Impact of the FCSP in general on your services and the community:

Sustainability of the project: what can CARE do in the coming months to make certain that the impacts are not lost?

CARE Ethiopia: Farta Child Survival Project
Final Evaluation 2007

Interview with leader/administrator of
<u>Idir</u>

Date: _____ Interviewer: _____

Village:_____ Kebele: _____

Distance to Health Facility (on foot, in minutes):_____minutes

Number of people being interviewed: _____people
Position/title:

When was this idir established? _____
When did the idir start making loans for sickness? _____

1. How many families are members of the idir? _____

2. How many loans have you made in the last 6 months?
(if the register is available, record number, amount, purpose for those related to health)

Funerals	
Health	

3. How much money is in your fund now?

4. What are the terms for the loans? (repayment time?, interest?, guarantees?)

5. Do you have many families who cannot pay back their loans? (howmany?, how often? what happens?)

6. How do families know that the idir can now provide loans for health care?

CARE Ethiopia: Farta Child Survival Project
Final Evaluation 2007

Interview with group of
Mothers to Mothers Support Group

Date: _____ Interviewer: _____

Village:_____ Kebele: _____

Distance to Health Facility (on foot, in minutes):_____minutes

Number of mothers in the group being interviewed: _____mothers

When did this club start? _____
How many mothers are members? _____
1. Is the number of mothers that participate
Growing? Same/stable? Shrinking?
_____
_____

2. How do you encourage new mothers to participate in your group?

3. How often do you meet? _____

4. Who comes to your meetings? (young mothers? Older women non-mothers?)

5. What do you do in your meetings? What topics do you discuss? How? (are there things they talk about outside
mother and child health?)

6. Have you done out any special activities or events? Describe (fairs, theaters, demonstrations, etc.)

7. I know you are all very busy at home. Why do spend the time to come to these meetings?

8. Who performs home visits in your community? How are the families selected and why? Has anyone visited YOUR home in the past few months?

9. Are there people who are not mothers who visit your community regularly for health? Elaborate: (Who? How often? What do they do?) [prompt: Health facility workers, religious leaders, CARE staff, Kebele administration?]

---

10. Do your group and groups in other villages meet from time to time? How is this useful?

11. <u>Health seeking</u>
a. When you or your children are ill, do you go to the health center?

b. How are you received? Are they able to help with most problems?

c. Do you receive medicine at the health facility? If so, is it expensive?

d. Those that don't go to the health facility, why not?

e. If expense is a barrier, what options do families have for getting money for payment?

11. Non-participants

a. How many women in the village do not participate in the mothers group?

b. Why don't they participate?

c. If there are mothers that do not want to change the way they feed and take care of their children, what is done?

d. Who is most effective to convince them? (other mothers, religious leaders, community/kebele leaders?)

12. Other community resources

a. Does your community have a school club? How is this important to children's and mothers' health?

b. Does your area have a community data board? How is it important? Do you know the results?

c. Does your area have an idir for health care? Is anyone here a member? Has anyone used it? Describe:

d. Is there a health post near this village? What do the Health Extension Agents do in your village?

LEADER OF MOTHER TO MOTHERS GROUP

1. What meetings do you attend at the kebele (health facility)?

2. How do these meetings help you or your mothers group or your village?

3. Many mothers have changed their health behaviors during this project. What do you think contributed most to those changes and how?

	Describe how? Relative contribution?
Religious leaders	
Mothers groups	
School clubs	
Community leaders (CRPs, vCHWs)	
Health facility workers (HEAs, nurses)	
Others	

4. Who supports you the most in your work? How?

5. When you have a doubt or don't know how to deal with a problem, who helps you?

6. How has your participation in this health program affected your own life and work?

3. Sabemos que as mães na comunidade aprenderam melhores maneiras de amamentar os seus filhos, dar comida às crianças e protegêlas de doenças. Onde é que vocês ouviram e aprenderam sobre amamentação, alimentos e malária? [NÃO ler inicialmente, mas explicitar se for necessários para discussão]

Visita de VCS (número de mães, frequência)	
Palestras (número de mães, quem deu, tipo, frequência)	
Líderes comunitários (número de mães, frequência, assuntos)	
Teatro (número de mães, frequência, assuntos)	
Centro ou Posto de Saúde (número de mães, frequência, assuntos)	
Rádio (número de mães, assuntos)	
Outros (descrever)	

4. Sabemos que quando os nossos filhos estão doentes, devemos levá-los para o Centro ou Posto de Saúde, porém, algumas mães não levam os seus filhos. Por quê elas não levam?

Tempo/distância	
Custo	
Qualidade de serviço, maus tratos, não vale a pena (não há medicamentos), horário	
Não percebe que a criança está doente	
Outros motivos (descrever)	

5. Nos últimos 3 meses, você ou um membro da sua família procurou assistência no Posto ou Centro de Saúde?
[*Quem, por quê, frequência*]

_____

_____

_____

_____

_____

6. Os VCS têm uma ficha de referência para o Posto ou Centro de Saúde. Você ou um membro da sua família usou alguma vez?
[*Descrever quem, circunstância, perguntar opinião sobre utilidade da referência se houve*]

_____

_____

7. [*Se tiver bicicleta ambulância*] Há uma bicicleta ambulância na sua comunidade. Você conhece alguém que utilizou no último ano?
[*Descrever quem, circunstância, perguntar opinião sobre utilidade se foi usado*]

_____

_____

_____

8. O VCS vendem redes mosquiteiras na comunidade, e algumas famílias compraram redes e utilizam para protegê-se da malária.
[LEER ESTAS PERGUNTAS]

a. A sua família tem rede mosquiteira? Usa a rede?	
b. Onde conseguiu as redes?	
c. Há outros lugares vendem redes aqui perto? Onde?	
d. Onde é que as pessoas vão conseguir redes após o fim do projecto?	

9. Algumas famílias não tem redes ou não usam redes mosquiteiras. Por quê é que não usam?

Custo (se for, perguntar sugestão de preço razoável)	
Falta de conhecimento / não é importante	
Não há redes para comprar na comunidade (se for rotura de estoque de VCS, descrever)	
Outros	

10. [*Se tiver grupo de mães na comunidade*] Sabemos que há um grupo de mães nesta comunidade. Por quê muitas mães, como vocês, não participam com o grupo de mães?

Desconhece	
Falta de tempo	
Horário inconveniente	
Problemas interpessoais	
Distância	
Outros motivos (descrever)	

Attachment K: Questionnaire and tools

Care Ethiopia Child Survival Project
South Gondar Zone / Farta Woreda
Health Facility Survey
Form 1. Observation Checklist (Child 2 months - 5 years)

Zone: _____Woreda:_____ Date_____/_____/____
Facility Name_____ Facility Type_____ Facility Status_____
Surveyor ID: ___ ___

Health Worker Category (1) MD (2)PHO (3)Senior Nurse
(4)Junior Nurse (5) HA (6)Other
Sex: (1) M (2)F

Child's Name_____ Birth date: ____/____/____
Child's Age (months) _____
Sex: (1) M (2)F

Begin Timing the Observation Now. Time:_____
If consultation is interrupted note time at beginning of interruption. Time:_____
When resuming consultation. Time:_____

ASSESSMENT MODULE

Record what you hear or see. DO NOT intervene.

1. What reason does the caretaker give for bringing the child to the health facility? (Check all that apply.)
1.a. Diarrhea (1)Yes (2) No
1.b. vomiting (1)Yes (2) No
1.c. Fever/malaria (1)Yes (2) No
1.d. Fast / difficulty breathing/cough/pneumonia (1)Yes (2) No
1.e. Ear problem (1)Yes (2) No
1. f. Other(specify)_____

2. Does the health worker ask the age of the child or have the age available?
(1)Yes (2) No
3. Is the child weighed? (1)Yes (2) No
4. Is the child's weight plotted on a growth chart? (1)Yes (2) No
5. Is the child's temperature checked? (1)Yes (2) No

Does the health worker ASK about (or does the caretaker REPORT) -	Does the health worker perform these EXAMINATION tasks-
6. Danger signs:	11. Look for lethargy or consciousness?

6. a. Not able to drink or breast feed? (1)Yes (2) No 6.b. Vomits everything? (1)Yes (2) No 6.c. Convulsions? (1)Yes (2) No 7. Change in consciousness/ lethargic/sleepy? (1)Yes (2) No	(1)Yes (2) No
8. a. Diarrhea? (1)Yes (2) No 8.b. For how long? _____ days 8.c. Is there blood in the stool? (1)Yes (2) No	12. Observe drinking or breastfeeding? (1)Yes (2) No 13. Pinch the skin on abdomen? (1)Yes (2) No 14. Look for sunken eyes? (1)Yes (2) No
9. a Cough or difficult breathing? (1)Yes (2) No 9.b. For how long?_____ days	15. Raise the shirt? (1)Yes (2) No 16. Count breaths/minute? (1)Yes (2) No 17. Look for chest in drawing? (1)Yes (2) No
10. a. Fever? (1)Yes (2) No 10.b. For how long? _____ days	18. Look or feel for stiff neck? (1)Yes (2) No 19. Look for generalized rash? (1)Yes (2) No 20. Look for runny nose or red eyes? (1)Yes (2) No
21. Ear problem? 21.a. Ear pain? (1)Yes (2) No 21. b. Ear discharge? (1)Yes (2) No 21. c. If YES, for how long?_____ days	Malnutrition: 24. Undress and look for wasting? (1)Yes (2) No 25. Look for palmar or conjunctival pallor? (1)Yes (2) No

22. Look for pus from ear? (1)Yes (2) No 23. Feel for swelling behind ear? (1)Yes (2) No	26. Look for edema of both feet? (1)Yes (2) No

Immunization and screening

27.a. Does the health worker ask for the child's immunization card? (1)Yes (2) No
If NO, go to question 29.

27. b. If YES, does the child have the card? (1)Yes (2) No

27. c Is the child referred for vaccination? (1)Yes (2) No
1. Today (1)Yes (2) No
2. Another day (1)Yes (2) No
3. Not referred (1)Yes (2) No
4. Up to date (1)Yes (2) No

28. a. Does the health worker ask for the caretaker's vaccination card?
(1)Yes (2) No (99) Does not apply
If NO or N/A, go to question 29.

28.b. If YES, does the caretaker have the card?
(1)Yes (2) No

28.c. Is the caretaker referred for vaccination?
1. Today (1)Yes (2) No
2.Another day (1)Yes (2) No
3. Not referred (1)Yes (2) No
4. Up to date (1)Yes (2) No

DIAGNOSIS MODULE

How does the health worker classify the child?

29. Simple diarrhea (1)Yes (2) No

30. Severe dehydration (1)Yes (2) No

31. Some dehydration (1)Yes (2) No

32. No dehydration (1)Yes (2) No

33. Dysentery (1)Yes (2) No

34. Severe persistent diarrhea (1)Yes (2) No

35. Persistent diarrhea (1)Yes (2) No

36. Severe pneumonia (1)Yes (2) No

37. Pneumonia (1)Yes (2) No

38. Upper respiratory infection(cough or cold) (1)Yes (2) No

39. Very severe febrile disease (1)Yes (2) No

40. Malaria (1)Yes (2) No

41. Severe complicated measles (1)Yes (2) No

42. Complicated measles (1)Yes (2) No

43. Measles (1)Yes (2) No

44. Fever, other cause (1)Yes (2) No

45. Mastoiditis (1)Yes (2) No

46. Acute ear infection (1)Yes (2) No

47. Chronic ear infection (1)Yes (2) No

48. No diagnosis (1)Yes (2)No

TREATMENT MODULE

What does the health worker administer or prescribe for the child?

49. Immediate referral?	(1)Yes	(2) No
50. Antimalarial injection	(1)Yes	(2) No
51. Antimalarial tablets/syrup	(1)Yes	(2) No
52. Paracetamol/aspirin	(1)Yes	(2) No
53. Tepid bath	(1)Yes	(2) No
54. Antibiotic injection	(1)Yes	(2) No
55. Antibiotic tablets/syrup	(1)Yes	(2) No
56. Vitamin A or vitamins	(1)Yes	(2) No
57. ORS	(1)Yes	(2) No
58. Antidiarrheal/antimotility	(1)Yes	(2) No
59. Metronidazole tablets/syrup	(1)Yes	(2) No
60. Tablets/syrup, unknown type	(1)Yes	(2) No
61. Injection, unknown type	(1)Yes	(2) No
62. None	(1)Yes	(2) No

63. Other Medication, (specify) _____

64a. Diarrhea case received appropriate medication? (1)Yes (2) No (99) Does not apply

64b. Pneumonia case received appropriate medication? (1)Yes (2) No (99) Does not apply

64c. Malaria case received appropriate medication? (1)Yes (2) No (99) Does not apply

COMMUNICATION MODULE

For all oral medications

65.a. Does the health worker explain how to administer medications/ORS? (1)Yes (2) No (99) Does not apply

65.b. Does the health worker demonstrate how to administer medications/ORS?

(1 Yes (2) No (99) Does not apply

65.c. Does the health worker ask an open-ended question to verify

the comprehension of how to administer medications/ORS?
(1)Yes (2) No (99) Does not apply

66. Does the health worker explain when to return for follow-up?
(1)Yes (2) No (99) Does not apply
67. Does the health worker explain the need to give more liquid at home?
(1)Yes (2) No (99) Does not apply

68. Does the health worker explain the need to continue feeding or breastfeeding at home? (1)Yes (2) No (99) Does not apply
69. Does the health worker tell the care taker to bring the child back for the following signs?
69.a. Child develops blood in the stool. (1)Yes (2) No (99) Does not apply
69.b. Change in consciousness/lethargic . (1)Yes (2) No (99) Does not apply
69.c. Child develops a fever. (1)Yes (2) No (99) Does not apply
69.d. Child is not able to drink or drinking poorly. (1)Yes (2) No (99) Does not apply
69.e. Child is not able to breastfeed/eat. (1)Yes (2) No (99) Does not apply
69.f. Child becomes sick. (1)Yes (2) No (99) Does not apply
69g. Child develops fast or difficult bleeding (1)Yes (2) No (99) Does not apply

70. Are at least three of the Q. 69 messages circled? (1)Yes (2) No

71. Does the health worker give the caretaker any advice on nutrition? (1)Yes (2) No
Check the time of the observation as the caretaker leaves: Time:_____
Duration of observation:_____ minutes

END OF OBSERVATION

Care Ethiopia Child Survival Project

South Gondar Zone / Farta Woreda

Health Facility Survey

Form 2. EXIT INTERVIEW (2 months-5 years)

Zone: _____Woreda:_____ Date_____/_____/____
Facility Name_____Facility Type_____Facility Status_____
Surveyor ID ___ ___

Child's Name_____ Sex: (1) M (2) F Child's Age (month)_____
Birth date:____/____/____

Care taker: Sex (1) M (2) F Relationship to child (1) Mother (2) Father
(3) Relative (4) Other

Greet the caretaker and say that you would like to ask some questions about his/her visit to the health facility today.

TREATMENT + GENERAL INFORMATION MODULE
73. Did the health worker give you or prescribe any oral medicines for the child at the health facility today?
(1)Yes (2) No (88) does not know

If NO, go to question 80-.
If YES, compare the caretaker's medications with the samples for identification of the oral medicines.

Complete the table below for the listed oral medications. Fill in the information in the table below.
If the caretaker's answer is-
"As required," write AR in the appropriate cell.
"Until completed," write UC in the appropriate cell.
"I don't know," write DK in the appropriate cell.

Medicine	a)How Much Each Time?	b)How Many Times/Day?	c)How Many Days?	d)All Correct? (Y or N)
74. Antimalarial drugs Name:_____ Dose/tablets:_____				
75. Antibiotic tablets/syrup Name:_____ Dose/tablets:_____				
76. Aspirin tablets/syrup OR Paracetamol tablets/syrup Dose/tablets:_____				
77. ORS/RHF				
78. other:_____			„	

79. Caretaker knows how to give ALL essential medications correctly? (1)Yes (2) No (99) Does not apply

80. What will you do for your child when you return home? (Check all that apply.)
(1) Continue feeding or breastfeeding the child
(2) Give the same quantity or more fluids to the child
(3) Complete course of medications/ORS/RHF
(4) Bring the child back if he/she doesn't get better or gets worse (5) Other (specify): _____
(88) Doesn't know

81. Caretaker knows at least two aspects of home case management? (1)Yes (2) No

82. How will you know if the child becomes worse at home? (Check all that apply).
(1) Fever begins or doesn't go away
(2) Child unable to eat
(6) Child unable to drink
(7) Child has convulsions
(8) Child has difficulty breathing

(3) Diarrhea continues
(4) Child has chest indrawing
(5) Vomiting begins or continues
(9) Blood in stool
(10)Other (specify):____ (88) Doesn't know

83. Which diseases will be prevented by the immunizations you or your child has received? (Check all that apply.)

(1) Diphtheria
(2) Tetanus
(3) Whooping cough
(4) Measles
(5) Tuberculosis
(6) Polio
(7) Other (specify):_____
(88) Doesn't know

84a. Do you know what might happen as a side effect after the immunization?. (1)Yes (2) No

84b. If YES, what do you know? (Check all that apply.)
(1) Fever
(2) Irritability/crying
(3) Pain at injection site
(4) Swelling
(5) Other (specify):_____

85. How many vaccination visits does a child need in the first year of life to complete the series of vaccinations? _____
(1) Correct (2) Incorrect (88) Doesn't know

86a. Did your child receive an immunization today? (1)Yes (2) No
86 b. If No, was your child referred for vaccination another day? (Prompted question. Check a single response.)
(1) Referred for vaccination another day
(2)Not referred for vaccination
(3)Up to date

87. Do you have your child's vaccination card?

(1) Yes (3)Never received
(2) Lost (4)Left at home

88. If the caretaker has the card :

Birth date:____/____/____
Age:_____Months

Immunization Received

a. Polio-0 (birth) (1)Yes (2) No
b. BCG (1)Yes (2) No
c. DPT-1 (1)Yes (2) No
d. Polio-1 (1)Yes (2) No
e. DPT-2 (1)Yes (2) No
f. DPT-3 (1)Yes (2) No
g. Polio-2 (1)Yes (2) No
g. Polio-3 (1)Yes (2) No
h. Measles (1)Yes (2) No

89. Child is up to date? (1)Yes (2) No

89. Do you have your own vaccination card?
(1) Yes (2) Lost (3)Never received
(4)Left at home (99) Does not apply

	Immunization	Received
91. If YES, copy the caretaker's tetanus toxoid vaccinations in the table at right. If the caretaker's TT doses are recorded on the child's vaccination card, copy them here also.	a. TT-1	(1)Yes (2) No
	b. TT-2	(1)Yes (2) No
	c. TT-3	(1)Yes (2) No
	d. TT-4	(1)Yes (2) No
	e. TT-5	(1)Yes (2) No

92a. Caretaker has received at least TT-2? (1)Yes (2) No

92b if the caretaker has received TT-5 , date received _____

93 a. Did you receive a tetanus vaccination today?(1) Yes (2) No

.b If NO, were you referred for vaccination another day? (Prompted question. Check a single response.)

(1)Referred for vaccination another day
(2) Not referred for vaccination because received TT-5
(3) Not referred for vaccination for another day
(3)Up to date

94 a Were you prescribed any oral medication at your last visit? (1)Yes (2) No

B If YES, were you able to get your medication? (1)Yes (2) No

If YES, where did you get your medication?
c (1) This health facility from regular stock
(2) This health facility from essential drug store/ IMNI=special pharmacy
(3) Private pharmacy
(4) Another health facility/hospital
(5) Drug vendor
(5) Other (specify):_____

d. If NO, why could you not get the medication?

(1) No drugs available
(2) No money/could not afford
(3)Other (specify):_____

CLIENT SATISFACTION MODULE

95. How did you get the facility today?
1.Walking
2.Animal or animal-pulled vehicle
3. Bicycle
4. Own motorized vehicle
5. Rented vehicle
6. Other, specify_____
96. How long did it take you to get to the facility?_____ minutes(88)does not know)
97. How long did you wait to have your child seen today? __ minutes(88) does not know
98. How do you feel about the time you had to wait today before receiving attention for your child? Do not prompt.
1. Definitely too long
2. Long
3. Acceptable
4. Short
(88). Does not know
99. What do you think of services for sick children at this facility? Do not prompt.
1. Good as they are
2. Should improve, explain what should improve
_____
_____
(88) Does not know
100. Have you brought children to this facility before?
(1) Yes
(2) No Skip to question 102
(88) Does not know Skip to question 102

101. How money times have you brought children to this facility in the last six months? _____ times < use (88) if does not know>

102. How much money did you have to spend for?
(1) Transportation _____ Birr
(2) Consultation _____ Birr
(3) Medication _____ Birr
(4) Lab work _____ Birr
(5) Lump sum _____ Birr
(6) Other expenses, specify ____ Birr
103. Please add up the total(1-6) _____ Birr

HOME CARE AND CARE SEEKING MODULE

104. How long ago did you first notice that <CHILD> was sick? _____ days

105. Did you do any thing at home to <CHILD> before seeking help?
(1) Yes
(2) No Skip to 107
(88) Does not know Skip to 107

106. What did you do at home? Circ le all that apply
1. gave home remedies, specify_____
2. gave medicine, specify _____
3. gave ORS
4. holy water
5. Other, specify _____

107. During the present illness did you believe that <CHILD> was very seriously ill?
(1) Yes
(2) No
(88) Does not know

108. How many days ago did you believe that < CHILD> was seriously ill?
_____ days

109. Before coming to this facility did you go anywhere else outside of your home for help?
(1) Yes
(2) No Skip to 111
(88) Does not know Skip to 111

110. Where did you go?(Circle the one to which they went first)
1. relative or friend
2. traditional healer
3. church
4. pharmacy, drug seller
5. trained community-based health worker
6. private nurse or doctor
7. hospital
8. another provider, specify_____

111. What was done for the child? Circle all that apply
1. gave a massage
2. herbal medicine
3. extraction
4. obtain medication/drugs
5. Other, specify _____

112. During this illness how would you feed <CHILD>? Prompt.
1. same as before
2. give more
3. give less

Care Ethiopia Child Survival Project
South Gondar Zone / Farta Woreda
Health Facility Survey
Form –3 Health Worker Interview

Zone: _____ Woreda: _____ Date_____/_____/____
Facility Name_____ Facility Type_____Facility Status_____
Surveyor ID: ___ ___

113. Health worker Name:_____ Sex: (1) M (2)F
114. Health Worker Category (1) MD (2)PHO (3)Senior Nurse
(4)Junior Nurse (5) HA (6)Other
115 Trained in Child Health in the last two years? (1) Yes (2) No
116. If yes, check all that apply(1) IRT (2) IMCI (3) Malaria (4) EPI (5) Other

Introduce yourself to the health worker. Tell him/her that you would like to ask some general questions about the health facility, followed by some questions about his/her job.

117. Where does the health facility usually get medications and supplies?
(Check a single response.)
(1) Government supplier
(2) Essential drug store
(3) Private pharmacy supplier
(4) NGO/Mission
(5) Other (specify):_____
118. How are the supplies usually received? (Check a single response.)
(1) Delivered to facility
(2) Picked up from the supplier
(3) NGO/Mission
(4) Other (specify):_____

119. What is the most common cause of a delay in delivery of supplies?
(Check a single response.)
(1) Inadequate transport
(2) Administrative difficulties
(3) Financial problems
(4) Insufficient fuel
(5) Insufficient staff
(6) Rupture of stock at the central store
(7) Other (specify):_____
120. Do you have a regular supervisor? (1)Yes (2) No
If NO, go to question 125.
121. Do you have a schedule for supervisory visits? (1)Yes (2) No
122 How many times have you had a visit from a supervisor-
1. In the last 6 months. ____ (number of times)

2. In the last 12 months ____ (number of times)
3. Supervisor works here and sees worker daily ____

123. What did your supervisor do the last time he/she supervised you? (Check all that apply.)
(1) Delivered supplies (fuel, medicines, etc.)
(2) Observed immunization technique
(3) Observed management of sick children
(4) Reviewed reports prepared by health worker
(5) Updated health worker on current information
(6) Discussed problems with supplies and equipment
(7) Other (specify): _____

124a. Did you receive feedback from that supervisory session?
(1)Yes (2) No

124b. If YES, in what form?
(1) Supervisory register
(2) Oral report
(3) Written report
(4) Other (specify):_____

125. What are the most difficult problems that you face in doing your job? (Check all that apply.)
(1) Lack of training
(2) Caretakers don't bring children to clinic
(3) Lack of time
(4) Staff shortages
(5) Lack of supplies and/or stock
(6) Lack of supervision
(7) Lack of feedback on performance
(8) Inadequate transport
(9) Lack of motivation
(10) Poor working environment health facility, housing)
(11) Other (specify):_____

126. Have you discussed these problems with your supervisor? (1)Yes (2) No (99) Does not apply

127. How many child-health-related training sessions have you received in the last 12 months? _____

If no training received, go to question 130.

128. What type of training was it?_____

129. Did your last training involve clinical practice? (1)Yes (2) No

130. In this health facility, at what ages do you give?(Age in WEEKS but in MONTHS for measles only)
a. First b. Second c. Third d. Fourth

131. DPT
132. Polio
133. BCG
134. Measles
134.1 In this health facility, at what ages do you give Vitamin A?

135. EPI vaccination schedule all correct? (1)Yes (2) No

136. To whom do you give tetanus toxoid? (Check all that apply.)
(1) Pregnant women
(2) Women of childbearing age (15-49)
(88) Doesn't know

137a. On what occasion would you give tetanus toxoid? (Check all that the apply.)
(1) Antenatal clinic visit
(2) Visit for curative services of mother

(3) Visit with child for immunization or treatment

137b. To whom do you give Vitamin A ?

A. Mother 1. Yes 2. No

B. Children 1. Yes 2. No

C. Other (specify) _____

137c. If (137b) A is Yes , On what occasion , would you give Vitamin A to mothers

1. During late Pregnancy
2. Postnatal till day 42.
3. Other (specify) _____

137d. If (137b) B is Yes, On what occasion would you give vitamin A to children?

1. During immunization
2. During measles epidemic
3. In malnutrition of any age group
4. Any chronic disease
5. Other (specify)_____

137e. On what occasion would you give antihelminthc drugs as prophylaxis to children 2 years - 5 years old?.

5. Growth monitoring
6. Visit to curative service (OPD) for children
7. Vaccination
8. Other (specify) _____

137f. Choose the malaria drug from the list to adequately treat the in column 1 presented case (tick) ?

	Chloroquine	Fansidar	Coartem	Quinine	Other	If other specify
Pregnant mother prophylaxis						
Pregnant mother treatment						
Children 2mth - 5 years						
Children > 5 years						
Adult						

138. On what days are immunizations given? (Circle days.)

a) 1.M 2. T 3. W 4. Th 5. F 6. Sa b) Total Number of immunization days/week____

139a.Does the health facility have an antenatal clinic?

(1)Yes (2) No

b. If YES, on what days is the clinic held? (Circle days.)

1) 1. M 2. T 3. W 4. Th 5.F 6. Sa
2) Number of clinic days/week____

c. If NO, why are antenatal clinics not held? (Check all that apply.)

(1) No staff
(2) No supplies
(3) No training
(4) No space available

(5) Other (specify):_____
(88) Doesn't know

140.What are the signs that would make you refer a child to the next level of health facility? (Check all that apply.)
(1) Child is lethargic/abnormally sleepy/unconscious
(2) Child has not responded to usual treatment
(3) Child is not eating or drinking
(4) Child has severe dehydration
(5) Child has severe malnutrition/anemia
(6) Child has had convulsions
(7) Child looks very unwell
(8) Child has a very high fever
(9) Child vomits everything
(10) Child has severe pneumonia
(health facility, housing)
(11)Other (specify):_____

141. Health worker knows at least three signs for referral?
(1)Yes (2) No

142a.Have you ever wanted to refer a child to the next level of health facility but have not been able to do so?.
(1)Yes (2) No

142b. If NO, go to question 144.

143 If YES, why could you not refer the child? (Check all that apply.)
(1) No fuel available
(2) No transport available
(3) Caretaker/parents refused to go
(4) Parents didn't have enough money
(5) Next level of health facility too far
(6) Other (specify):_____

144. What do you see as your role in communicating with caretakers when they bring their child to the health facility? (Check all that apply.)
(1) Giving information on danger signs to watch for
(2) Giving information on what to do at home
(3) Giving information on how to give medicine at home
(4) Finding out what caretakers have done at home and what are the symptoms of the child's illness
(5) Giving information on how to prevent illness
(6(Telling caretakers when to come back to the health facility
(7) Ensuring that caretakers understand what to do at home
(8) Giving group talks
(9) Other (specify):_____

145. What prevents you from communicating with caretakers when they bring their children to the health facility? (Check all that apply.)
(1) Someone else does it
(2) They don't listen
(3) No time
(4) It isn't important
(5) It isn't really my role
(6) I don't have any education materials
(7) language barriers prevent effective communication
(8) They don't understand/comprehend what we say
(9)Other (specify): _____
(88) I don't know how

145b. Standard /Guidelines and Job Aids

Are there the following standard/ guidelines available and easily accessible at health facility

	Available today			
	Yes	No	N/A	
	1	2	3	
a. Standard/guideline on family planning				
b. Job aids (quick references on FP)				
c. Standard/guideline on RTI/ STI/ HIV				
d. Standard/guideline on ANC and postpartum				
e. Standard/guideline on post abortion care				
f. Job aids/ wall chart on Infection prevention				
g. Checklist in Infection Prevention				
h. Standard/guideline on IMCI or IMNCI				
i. Job aids on IMCI or IMNCI				
j. Standard/guideline delivery				
k. Job aids on delivery				
l. Standard/guideline delivery				
m. Standard/guideline on immunization				
n. Job aids on immunization				
o. Standard/guideline=job aid on use of partograph				
p. Standard/guideline on checklist for infection prevention				

Checklist for local medicine / RDF

145c. Does this health facility help persons who cannot afford the costs of seeking or receiving treatment? 1. Yes 2. No

145d. if yes, please describe how? _____

_____

145e. Does this health facility use essential drug/RDF=special pharmacy? 12. Yes 2. No

145f. If yes, where does the health facility purchase medications and supplies for the use of revolving drug fund?

1. government suppliers
2. Essential drug store
3. Private pharmacy supplier
4. NGO /Mission
5. Other(specify)_____

145g. what percentage of funds for your facility is financed by users' fees? _____percentage

145h. Is there a functioning revolving drug fund committee at woreda level?

1. Yes 2. No

145i. Has this committee adapted the essential drug to fit local needs?

145j. Have members and leaders of revolving fund committee received any kind of trainings?

1.Yes 2.No

145k. If yes please describe the types of trainings offered, duration and number of people trained ?

No	Types of training	Duration	Number of people trained
1			

2			
3.			

145k. What are the most serious problems facing the members of the committee?

1. Lack of training
2. Financial problem
3. Administrative problem
4. Other (specify)

END OF HEALTH WORKER INTERVIEW

Thank the health worker for his/her cooperation and answer any questions that he/she may have about the correct recommendations for immunizations or management of sick children.

Care Ethiopia Child Survival Project
South Gondar Zone / Farta Woreda
Health Facility Survey

Form-4 EQUIPMENT AND SUPPLIES CHECKLIST

Zone: _____Woreda:_____ Date_____/_____/____

Facility Name_____ Facility Type_____ Facility Status_____

Surveyor ID: ___ ___

Discuss with the head of facility to determine the number of health staff with child case management responsibilities (curative and preventive).

146 Category	1. Number Assigned to the Facility	2. Number Present the Day of the Survey	1. Total Number Assigned to Facility
a. Physician			
b. Health officer			
c. Senior Nurse			
d. Junior Nurse			
e Health assistant			
f. Other			

147. Patient and Worker Accommodation module

. a. Is there adequate seating for patients? (1)Yes (2) No

. b. Is there a covered waiting area? (1)Yes (2) No

. c. Is there potable water? (1)Yes (2) No

. d. Is there a functional toilet or latrine? (1)Yes (2) No

. e. Is there a functional waste disposal area/pit? (1)Yes (2) No

F1. Are health information posters displayed? (1)Yes (2) No

. F2. If YES, are they written in the local language? (1)Yes (2) No

. g. Is an ORT corner present and being used? (1)Yes 2) No

Equipment and Supplies module

Are the following equipment and supplies present in the health facility?

148. Transportation

A1. Vehicle (1)Yes (2) No

A2. If YES, how many _____
A3. In working order?
(1)Yes (record number available ___) (2) No

B1. Motorcycle (1)Yes (2) No

B2. If YES, how many _____
B3. In working order?
(1)Yes (record number available ___) (2) No

C1. Bicycle. (1)Yes (2) No

C2. If YES, how many _____
C3. In working order?
(1)Yes (record number available ___) (2) No

149. . Social mobilization equipment

A1. Megaphone (1)Yes (2) No

A2. If YES, how many _____
A3. In working order?
(1)Yes (record number available ___) (2) No

B1. Flip-chart. (1)Yes (2) No

C1. Counseling cards/pamphlets (1)Yes (2) No

(1)Yes (2) No

150. Weighing equipment

A1. Adult weight scale (1)Yes (2) No

A2. If YES, how many _____
A3. In working order?
(1)Yes (record number available ___) (2) No

B1. Baby weight scale (1)Yes (2) No

B2. If YES, how many _____
B3. In working order?
(1)Yes (record number available ___) (2) No

C1. Salter (1)Yes (2) No

C2. If YES, how many _____
C3. In working order?
(1)Yes (record number available ___) (2) No

D1. Height scale (1)Yes (2) No

D2. If YES, how many _____
D3. In working order?
(1)Yes (record number available ___) (2) No

E1. Are there weighing records/ register?
1)Yes (2) No

F1 If yes, How often are children weighed?

1. Every two weeks
2. Every month
3. other specify _____

G1. Number of children under five of weighed in last month from the register?

Number _____

H1. Number of malnourished children under five from the register?

Number _____

151. Medical Supplies

A1. Thermometer (1)Yes No

A. If YES, how many _____
A. In working order?
(1)Yes (record number available ___) (2) No

. Stethoscope

B1. - Regular . (1)Yes (2) No

B2 If YES, how many _____
B3 In working order?
(1)Yes (record number available ___) (2) No

C1. Obstetrical (1)Yes (2) No

C2. If YES, how many _____
C3. In working order?
(1)Yes (record number available ___) (2) No

. D1. Otoscope. (1)Yes (2) No

D2 If YES, how many _____
D3. In working order?
(1)Yes (record number available ___) (2) No

F1. Tongue depressor (1)YES (2) No

F2. If YES, how many _____
F3. In working order?
(1)Yes (record number available ___) (2) No

. Watch with a second hand or other

G1. Timing device ((1)YES (2) No

G2. If YES, how many _____

CG3. In working order?
(1)Yes (record number available ___) (2) No

h2. If YES, in working order?
H1. Steam sterilizer (1)YES (2) No (1)Yes (record number available ____)
(2) No
I2. If YES, how many _____
I1. Cooker or stove (1)YES (2) No I3. In working order?
(1)Yes (record number available ___) (2) No
K1. Measuring and mixing utensils (1)Yes (2) No
L1. Cups and spoons (1)Yes (2) No
M2. If YES, how many _____
M1. Refrigerator M3. In working order?
(1)Yes (record number available ___) (2) No

If No, go to question 151 N1.

If YES

Ma. Type:
(1)Electric
(2)Kerosene
(3)Gas
(4) Solar (5) Mixed (6)Nonfunctional

M1b. Condition (1) Good (2) Fair (3) Poor
M1c. Freeze-watch indicator? (1)Yes (2) No
M1d. Working thermometer inside? (1)Yes (record number available ____) (2) No
M1e. Temperature chart? (1)Yes (record number available _____) (2) No
If No, go to question 151 N1.
M1f. In the last 30 days, temperature record up to date ?
(1)Yes (2) No
N1. Ice packs.
(1)Yes (2) No
O1. Cold boxes
(1)Yes (2) No
O1a. Condition: (1) Good (2)Fair (3) Poor (4) Nonfunctional

Availability of Drugs and Other Supplies the Day of the Survey
(Circle Y or N for each item.)

152. Supplies- Available

Drugs for pneumonia:

A1. Penicillin tablets/syrup
(1)Yes (2) No (3) N/A
A1.1 if yes 1. from regular store and number -------- 2. from essential drug store and number ----------

A2. Ampi/amoxicillin tablets/syrup
(1)Yes (2) No (3) N/A
A2.1 if yes, 1. From regular store and number ------ --
2. from essential drug store and number ----------

Drugs for Shigella:

B1. . Cotrimoxazole tablets/syrup.
(1)Yes (2) NO (3) NA
B1.1 A1.1 if yes 1. from regular

B2. Nalidixic acid . (1) Yes (2)No
(3) N/A
B2.1 if yes 1. from regular store and number -------

store and number -------- 2. from essential drug store and number ---- --------

Drugs for malaria:

C1. Chloroquine (1)Yes. (2) No (3.) N/A

C1.1 if yes, 1. From regular store and number -------- 2. from essential drug store and number ----------

C3 Quinine tablets (1)Yes. (2) No (3.) N/A

If yes C3.1 1. From regular store and number -------- 2. from essential drug store and number ----------

C5 Coartem for children 3mnth - 7 years 1) Yes (2) No. 3.N/A.

C5.1 If yes, . From regular store and number -------- 2. from essential drug store and number ----------

- 2. from essential drug store and number ----------

C2Fansider (1) Yes (2) No. 3.N/A.

C2.1 if yes,1. from regular store and number -------- 2. from essential drug store and number ----------

C4.Coarten for children 3mnth -2 years 1) Yes (2) No. 3.N/A.

If yes C4.1 From regular store and number -------- 2. from essential drug store and number ----------

C6 Coartem for children 8-10 years 1) Yes (2) No. 3.N/A.

If yes C6.1. From regular store and number -------- 2. from essential drug store and number ----------

C7 coartem for children > 10 years 1) Yes (2) No. 3.N/A.

If yes C7.1. From regular store and number -------- 2. from essential drug store and number ----------

C8. Injectable quinine (1) Yes If yes C8. From regular store and number -------- 2. from essential drug store and number ---------- (2) No (3)N/A

d. Injectable penicillin	1.Y If yes. 1From regular store and number -------- 2. from essential drug store and number ---------- 2.N 3. N/A
e. Injectable chloramphenicol	1.Y If yes. 1From regular store and number -------- 2. from essential drug store and number ---------- 2.N 3. N/A
f. Paracetamol	1.Y 2 If yes. 1From regular store and number -------- 2. From essential drug store and number ---------- .N 3. N/A
g. Aspirin	1.Y If yes. 1From regular store and number -------- 2. From essential drug store and number ---------- 2 .N 3. N/A
h. Tetracycline eye ointment	1.Y If yes. 1From regular store and number -------- 2. From essential drug store and number ---------- 2.N 3. N/A
i. Gentian violet	1.Y If yes. 1From regular store and number -------- 2. From essential drug store and number ---------- 2.N 3. N/A
j. Iron	1.Y If yes. 1From regular store and number -------- 2. From essential drug store and number ---------- 2.N 3. N/A
k. Vitamin A	1.Y Y If yes. 1From regular store and number -------- 2. From essential drug store and number ---------- 2.N 3. N/A
l. Mebendazole	1. If yes. 1From regular store and number -------- 2. From essential drug store and number ---------- Y 2.N 3. N/A
m. Sterile water for injection	1.Y If yes. 1From regular store and number -------- 2. From essential drug store and number ---------- 2.N 3. N/A
n. ORS	1.Y Y If yes. 1From regular store and number -------- 2. From essential drug store and number ---------- 2.N 3. N/A
o. IV solution for severe dehydration.	1.Y If yes. 1From regular store and number -------- 2. From essential drug store and number ---------- 2.N 3. N/A

p. Needles . . . . . 1.Y If yes. 1From regular store and number -------- 2. From essential drug store and number ---------- 2.N 3. N/A

q. Syringes . . . . . 1.Y If yes. 1From regular store and number -------- 2. From essential drug store and number--- 2.N 3. N/A

r. Are expired drugs in the health facility? . . . . . 1.Y If yes. 1From regular store and number -------- 2. From essential drug store and number 2.N 3. N/A

s. If YES, which ones? 1_____ 2 _____ 3_____

Vaccines- Available

t. BCG .. . . . . 1.Y If yes. 1From regular store and number ------- 2. From essential drug store and number--- 2.N 3. N/A

u. OPV . . . . . 1.Y If yes. 1From regular store and number ----- 2. From essential drug store and number--- 2.N 3. N/A

v. DPT . . . . . 1.Y If yes. 1From regular store and number ------ 2. From essential drug store and number-- 2.N 3. N/A

w. Measles . . . . . 1.Y If yes. 1From regular store and number ------ 2. From essential drug store and number-- 2.N 3. N/A

x. Tetanus toxoid . . . . . 1.Y If yes. 1From regular store and number ----- 2. From essential drug store and number-- 2.N 3. N/A

y. Are expired vaccines in the refrigerator?. . 1. Y 2.N 3. N/A

z. If YES, which ones?1 _____ 2 _____3_____

Are frozen vials of DPT or TT in the refrigerator? 1.Y 2.N 3. N/A

Rupture of stock in the last 30 days? . . . . . 1.Y 2.N 3. N/A

If YES-

Item	Number of Days of Stock-Outs/Last 30 Days
a. Vaccines	
b. Syringes/needles	
c. ORS	
d. Essential drugs	
e. Cards/forms	

Are drugs and other supplies adequately organized and appropriately stored?. . . . . 1.Y 2.N 3. N/A

Documentation and Record Keeping module
Are the following items present in the health facility?

a.Immunization a.register. . . . . 1.Y 2.N 3. N/A

b. If YES, is it up to date? . . . . . 1.Y 2.N 3. N/A

Immunization tally sheets. . . . 1.Y 2.N 3. N/A

Stock of vaccination/child health cards. . 1.Y 2.N 3. N/A

Stock of TT/maternal health cards. . . . . 1.Y 2.N 3. N/A

Stock of essential drugs cards. . . .. 1.Y 2.N 3. N/A

Notifiable disease report forms. . . . . 1.Y 2.N 3. N/A

All essential monthly reporting forms. . . 1.Y 2.N 3. N/A

If YES, are they up to date?. . . . . 1.Y 2.N 3. N/A

Is a patient register
(a)kept?. . . . . 1.Y 2.N 3. N/A

(b)If YES, is it up to date?. 1.Y 2.N

Number of patients seen in last month: _____

Number of patients 0-4 years of age seen in last month: _____

Average number of patients seen per day: _____

END OF EQUIPMENT AND SUPPLIES CHECKLIST

Care Ethiopia Child Survival Project
South Gondar Zone / Farta Woreda
Health Facility Survey
Form 5. Health Facility-Community Links

Zone: _____Woreda:_____ Date_____/_____/____
Facility Name_____ Facility Type_____ Facility Status_____
Surveyor ID: ___ ___ The

167. Does the health facility have outreach to the community?
(1)Yes
(2) No Skip to question 168
(88) Does not know Skip to question 168

167 a. What kind of outreach is provided by the facility?
1. Vaccination 2. Nutrition 3. Malaria
4. Family planning 5. The new Water and Sanitation
6. School health 7. General MCH 8.Home visits
9.Other, specify_____

167 b. How many times have staffs done out reach activities in the last three months? _____ times
168. Does the facility have an operational plan that includes community work? (1)Yes
(2) No

169. Does the facility work with any sort of community based worker?
(1)Yes (2) No

170. Does the facility have any formal agreements with any community based organizations in the catchment area?
(1)Yes (2) No

171. Has any one in the facility conducted a needs assessment/community diagnosis in the catchment area in the last two years? (1)Yes (2) No
172. if Q 170 yes

Name of CBOs	Services/ types of agreement
1.	
2.	
3.	