Healthy Child, Wealthy Nation

ANNUAL REPORT

Essential Services for Health in Ethiopia

Project Year 2
July 1, 2004 - June 30, 2005

USAID Contract 663-C-00-04-00403-00

USAID
FROM THE AMERICAN PEOPLE

ESHE
ESSENTIAL SERVICES FOR HEALTH IN ETHIOPIA

JSI

John Snow, Inc.

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CONTENTS

ACRONYMS

BCC	Behavior Change Communication	**ICC**	Inter-Agency Coordinating Committee
BoFED	Bureau of Finance and Economic Development	**IMCI**	Integrated Management of Childhood Illnesses
CBRHA	Community Based Reproductive Health Agents	**ISCL**	Integrated Supervision Checklist
CHP	Community Health Promoter	**JSI**	John Snow, Incorporated
CHPI	Community Health Promoters Initiative	**LOP**	Life of Project
CS	Child Survival	**MBB**	Marginal Budgeting for Bottlenecks
DHS	Demographic and Health Survey	**MDG**	Millennium Development Goals
DTP3	Diptheria, Tetanus, Pertussis, full course	**MOH**	Ministry of Health
ENA	Essential Nutrition Actions	**PI**	Pathfinder International
EPI	Expanded Program on Immunization	**PTA**	Parent Teacher Association
ESHE	Essential Services for Health in Ethiopia	**RHB**	Regional Health Bureau
FHC	Family Health Card	**ROPPA**	Results-Oriented Performance Planning Assessment
FMoH	Federal Ministry of Health	**SNNPR**	Southern Nations, Nationalities and Peoples' Region
HC	Health Center	**SP**	Special Pharmacy
HCF	Health Care Financing	**TA**	Technical Assistance
HCP	Health Communication Partnership	**TOT**	Training of Trainers
HEC	Health Education Center	**TVET**	Technical, Vocational, and Educational Training Centers
HEW	Health Extension Worker	**USAID**	United States Agency for International Development
HHS	Household Survey	**WHO**	World Health Organization
HMIS	Health Management Information Systems	**WLE**	World Learning Ethiopia
HP	Health Post	**WorHO**	Woreda Health Office
HSEP	Health Services Extension Program	**ZHD**	Zonal Health Desk

LETTER FROM ESHE PROJECT DIRECTOR

Year Two of Essential Services for Health in Ethiopia (ESHE) Project's five-year USAID contract to assist 64 woredas in Amhara, Oromia and Southern Nations, Nationalities and Peoples' Regional Health Bureaus improve child health and accelerate health sector reform has been extremely busy and productive. We are all looking for the courage and energy to keep up the pace next year! The stakes are high with one in six Ethiopian children dying before their 5th birthday. Due to the large population coupled with high rates of child mortality, Ethiopia ranks sixth worldwide in terms of the number of child deaths. The 15 million people living in the 64 woredas are the direct beneficiaries of ESHE-supported interventions. There is early evidence of expanded impact of project benefits to the regional health programs in other woredas and zones of the three regions, thus expanding the reach of project interventions.

Key program interventions have taken off with over 9,000 Community Health Promoters now trained to first help their families and then serve their communities. Nearly 2,000 front-line health workers received refresher training in the Expanded Program on Immunization and have helped to greatly increase coverage this year. Essential Nutrition Actions advocacy and training of trainers reached the three regions through LINKAGES support. Strengthening supportive supervision and HMIS are underway. After four years of formulation and design work through studies, study tours and consensus building, the legal framework for health care financing reform has been ratified in Addis Ababa, SNNP, Oromia and Amhara. The HCF is moving fast into implementation, for instance, Oromia region has endorsed the required regulations and orientation provided to all woredas.

Strategic planning for child survival and health sector reform in the three regions was based on the evidence from four rich data sets. Four baseline survey instruments were used in each of the three regions to permit this evidence-based planning: Household Survey to ascertain current health status, knowledge and practices; Health Facility Survey to identify gaps in the quality of child care; Health Care Financing to determine baseline financing before implementation of new laws; and Health System Performance to clarify additional support needed for health systems. The sets of four studies were used in large participatory strategic planning exercises conducted in each region with government colleagues from health and related sectors at all levels, in collaboration with other key health partners. A summary analysis of all twelve studies was completed, shared and disseminated nationally at a conference in Addis Ababa in March 2005 moderated by the State Minster and USAID Health, Population and Nutrition Chief. Because this data represents the three largest regions of Ethiopia, covering nearly 56 million people, it provides a fresh database for developing the third five-year Health Sector Development Program.

Early in the year, a major internal study tour was organized to witness the successful Community Health Promoters Initiative in SNNPR. Over 100 participants from 40 focus woredas and regional health bureaus in Oromia and Amhara attended. This tour was organized because it was discovered during strategic planning that many woreda partners needed to witness this innovative approach in action before they could effectively plan for its implementation in their regions.

The Three Pillars Strategic Framework—strengthening health worker skills, strengthening health systems and strengthening positive health behaviors at household and community levels—has proven to be highly effective. This guiding paradigm has helped to constantly remind us and our partners of the importance of working on all three pillars to assure positive and lasting changes. Although it is common for many programs and projects to focus on one or two pillars, a lesson we learned during ESHE I is that it is crucial to work on all three pillars simultaneously to achieve synergies and amplify results.

ESHE is proving to be a successful program because of our commitment to coordination, collaboration and partnerships. We cannot achieve results or have an impact alone. Participation in the national Child Survival Partnership has been exciting. This partnership serves to coordinate and harmonize major health partners and works as an active force to guide Ethiopia to reach its Millennium Development Goal (MDG) for child health—two-thirds reduction in child mortality by 2015 compared to the 1990 rate. All ESHE-supported key child health interventions were reaffirmed in the *Lancet* June 2003 child health series. This series of five articles serves as a guidepost to the global and national Child Survival Partnerships. ESHE collaborated with World Bank and UNICEF to assist the Ethiopian FMoH to most effectively utilize the powerful budgeting, planning and advocacy tool, *Marginal Budgeting for Bottlenecks*. The exercise spot-lighted the serious shortfall in financial and human resources necessary to drive these key interventions to high enough coverage levels to achieve Ethiopia's child health MDG. The LINKAGES program is a critical ESHE partner through its assistance in developing Essential Nutrition Actions training materials and supporting nutrition training.

ESHE staff are honored to be one of the health partners in Ethiopia. I would like to thank USAID on behalf of JSI and its collaborating partners for their funding, continued support and confidence in our work. ESHE greatly appreciates the privileged and close-working relationship we have been afforded by the Federal Ministry of Health, the three regional health bureaus, the twelve zones and 64 woredas.

A true partnership with the staff and communities lies at the heart of any accomplishments that have occurred. ESHE looks forward to working with all the health partners in Ethiopia in the year ahead to continue its contribution to bringing more positive changes for Ethiopian families and their children.

Sincerely,

Mary A. Carnell, MD, MPH
ESHE Project Director

NOTE: This annual report reflects the time frame from July 1, 2004 through June 30, 2005. In the spirit of harmonization, the ESHE Project moved from reporting using the USAID fiscal year to the fiscal year of the Government of Ethiopia. Thus, this report covers July 1 through September 30, 2004, which was also reported in the ESHE Project Year 1 report.

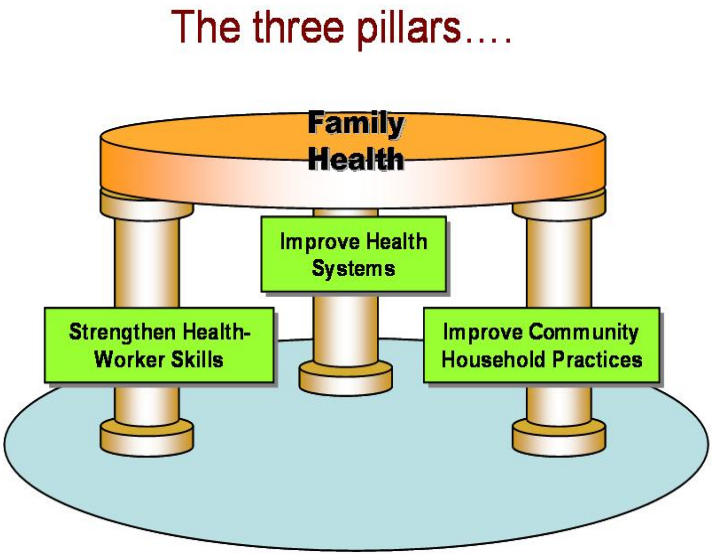
PROJECT INTRODUCTION

The Essential Services for Health in Ethiopia (ESHE) Project is an integrated program of child survival interventions and health sector reform designed to improve family health. Funded by the United States Agency for International Development (USAID), ESHE works in collaboration with health offices at all levels to reduce child deaths and strengthen the health system.

Experience has shown that it is difficult to have a positive impact on health outcomes without implementing a comprehensive three-pillar approach that addresses health provider skills, strengthens the health system, and engages families and communities to improve family health.

ESHE assists health offices in improving the quality and utilization of high-impact child survival interventions in the form of the Extended Program of Immunization (EPI), Essential Nutrition Actions (ENA), and Integrated Management of Childhood Illnesses (IMCI). Key approaches include capacity building, community mobilization, and behavior change communication.

In the health sector reform arena, ESHE works with the Ethiopia Federal Ministry of Health, regional health bureaus and district health offices to institute policy changes aimed at increasing resources available for —and improving service utilization in—the health sector. In that regard, ESHE is also examining health care financing and cost sharing for health services.



ESHE's work is targeted in twelve zones of three regions—Amhara, Oromia, and the Southern Nations, Nationalities and Peoples—encompassing 64 woredas and a population of 15 million. In addition, ESHE activities are designed to extend beyond the boundaries of the focus kebeles and woredas in the three regions through trainings and sharing of materials. This expanded impact of ESHE is already evident as different organizations and zonal health bureaus use ESHE training and behavior change materials for their own areas.

ESHE's success will not only improve the health system—and thus the health of Ethiopians—it will assist the country in achieving the Millennium Development Goals (MDG) established in 2000. MDG #4 commits the global community to reducing child deaths below five years of age by two-thirds from the 1990 baseline. Ethiopia has committed to decrease under-5 mortality from 200/1000 children to 67/1000 children. ESHE is assisting in this effort.

This report presents an overview of the ESHE roject activities between July 1, 2004 and June 30, 2005—ESHE Project Year 2. A brief summary of activities in each region is included, along with more detailed activities in each of the three pillar areas of emphasis. Constraints and lessons learned are reviewed in addition to the many areas of collaboration promoted by ESHE.

REGIONAL OVERVIEWS

AMHARA

The Amhara Regional State encompasses a population of 18.6 million. The remoteness of many communities presents a formidable challenge to the provision of health care, because reaching such populations is problematic and staffing rural health facilities is difficult.

The region's socio-economic and health problems are immense and highly interrelated. Since 1991, the region has worked to upgrade general health services through renovation and construction of health facilities, training and deployment of health personnel, and expansion of primary health care. As a significant portion of the population still lives beyond catchment areas of even peripheral health institutions, community-based volunteer health workers continue to play an important part in delivery of primary health care services.

In Amhara ESHE operates in 20 woredas of West Gojjam, South Gonder, North Wollo and South Wollo zones. About 4.8 million people are estimated to directly benefit from project activities in these woredas. It is expected that the project will benefit the entire Amhara region through the expanded impact of trainings and capacity building activities, as well as sharing of lessons learned during supportive supervision and review meetings.

Year 2 Achievements vs Targets in Amhara Focus Woredas (%)

Indicator	Baseline	Target	Achieved
DPT 3	63	80	73
Polio 3	61	70	NDA
Vitamin A	18	65	NDA
DPT 1- DPT 3 dropout	9	10	7

NDA - No data available; See Annex 3 for details

ESHE began implementation in Amhara during the second quarter of Project Year 2. Preparatory activities, such as introducing the project, selecting focus woredas, recruiting staff for regional and cluster offices, opening offices in the regional capital and focus zones, and conducting baseline surveys, were completed during the first quarter of the year.

ESHE Amhara's work started with preparing the regional project strategic plan, conducting a series of trainings for health workers and Community Health Promoters (CHPs), providing capacity building trainings for government partners and our own staff, and making follow-up visits after trainings. Various meetings were held with government partners where ideas were shared, problems were discussed and solved. Such meetings enabled ESHE staff to get closer to and develop trust with government partners- a component crucial for success.

Major Achievements, Amhara Project Year 2

- EPI refresher training provided to 630 HWs
- ENA-BCC provided to 49 health staff
- Community Health Promoter Initiative (CHPI) taskforce established to advocate for effective implementation of CHPI.
- TVET instructors oriented 716 Health Extension Worker (HEW) students on CHPI synergy and communication and community mobilization skills.
- CHPI facilitators training provided for 131 health workers;44 community sensitization meetings conducted; and 387 new (CHP) trained.
- Four EPI radio spots were aired through 4 regional educational media.
- Supportive supervision training of trainers (TOT) conducted for 30 participants.
- HMIS refresher training conducted for 26 participants; HMIS review committees at RHB and ESHE ZHDs established.
- Health profiles of the 20 ESHE focus cluster woredas produced.
- Advocacy workshop on HCF reform initiatives and progress held for key stakeholders.
- Draft Health Service Delivery and Administration Proclamation approved by Regional Cabinet and referred to Council for ratification.

OROMIA

In the Oromia Region, the ESHE Project is operating in partnership with the regional health bureau (RHB) in 20 woredas in East Hararge, West Hararge, East Shoa and North Shoa zones. About 4 million people will benefit from the project's activities.

Oromia is the largest region in Ethiopia, with an estimated population of 25 million; 89% of the population resides in rural areas. The low health service coverage level in the region has contributed to low coverage of very important programs like immunization and family planning. The region has, however made significant progress in increasing health service coverage and expansion of health programs in recent years. Oromia region has recently embarked on an accelerated expansion of primary health care, a strategy that helps to ensure universal access to essential health services in the region.

In Oromia, ESHE started its activities at full scale in the second quarter of this Project Year, after completing staff recruitment in July and August 2004. Preparatory work such as project introduction to the region, selecting focus woredas, staff recruitment, and conducting baseline surveys were completed or at least started in the first year. ESHE's work in the Oromia region this year was marked by vigorous activities including preparing a life of project strategic plan, opening offices in cluster woredas, conducting a series of trainings for health workers and community health promoters, providing capacity building trainings for government partners and ESHE staff, and doing follow-up visits of the trainings.

Year 2 Achievements vs Targets in Oromia Focus Woredas (%)			
Indicator	Baseline	Target	Achieved
DPT 3	35	70	75
Polio 3	NDA	70	73
Vitamin A	30	53	98*
DPT 1- DPT 3 dropout	29	20	19

NDA - No data available; See Annex 3 for details
* Based on 5 EOS woredas

ESHE Oromia has been working closely with the RHB, focus zones, and woreda health offices and any achievements described in this report would have not been possible without the full support received from these partners. Various meetings and forums were held with government partners at all levels where ideas were shared, problems were discussed and solved as part of support to improve the health service in the region in general and in ESHE focus woredas in particular. In general, project start up, most of the trainings and other planned activities for the year have run smoothly and on track.

Major Achievements, Oromia Project Year 2

- EPI refresher TOT provided to 102 health managers and instructors from HPTI and HSEP training institutions.
- Four-day EPI refresher training provided to 552 health professionals, covering 98% of health workers in ESHE woredas.
- Regional ENA Technical TOT held for 29 RHB, ZHOs, and HPTI and HSEP training institutions health managers.
- Essential Nutrition Actions BCC TOTs conducted at regional and zonal levels for 120 participants; 64 health workers trained on ENA-BCC.
- Four TOT on CHPI sessions conducted for regional and zonal levels for 166 RHB, ZHOs, WorHOs, health facilities, and training institutions participants.
- Total of 4,955 CHPs trained in the 4 ESHE zones.
- Follow-up visits using ESHE integrated checklist conducted in 90 health facilities.

SOUTHERN NATIONS, NATIONALITIES AND PEOPLES' (SNNP)

ESHE has been operating in the SNNPR since 1998 in two previous phases, primarily to strengthen the regional health system. ESHE's current operation is both a continuation of previous health system strengthening efforts and new child survival initiatives. Community health promotion activities that were piloted previously are now adopted and taken to scale region-wide.

SNNP Region is administratively organized into 13 zones and 104 woredas. The population of the region, 14,484,000, makes up 20% of the nation's total population. Approximately 94 percent of the population lives in rural areas while the remaining is urban.

The Region is known for its cultural diversity, with over 65 nations, nationalities and languages. With 15 hospitals, 127 health centers and 347 health stations, the region's potential health service coverage has grown from 28% in 1993 to 48% at present. Family health services coverage for the previous Ethiopian fiscal year (2003/04) was: BCG 72%, DPT3 74%, ANC 40%, attended delivery 7% and family planning 28%.

ESHE works through the existing structures of the regional health bureau, zonal health desks and woreda health offices and enjoys strong partnerships with NGOs and other donor projects. The project currently operates in 24 woredas in four clusters: Gamo Gofa-Konso, Hadiya-Kambata and Tambaro, Wolayta-Alaba and Sidama.

The six million people directly served by ESHE represents 41% of the region's total population. However, the proportion of the region's total population served dramatically increases when the expanded impact is considered. Deliberate mechanisms—such as co-planning and programming, involving RHB and zonal health desks (ZHD) staff in the development of technical materials, training of trainers (TOT), consultations and review meetings, and joint supportive supervision—help transfer technical assistance to non-ESHE areas in the region.

Year 2 Achievements vs Targets in SNNP Focus Woredas (%)

Indicator	Baseline	Target	Achieved
DPT 3	60	80	97
Polio 3	50	80	95
Vitamin A	13	80	89*
DPT 1- DPT 3 dropout	19	10	6

NDA - No data available; See Annex 3 for details;
* Based on 20 EOS Woredas

Major Achievements, SNNP Project Year 2

- Health Services Delivery Proclamation approved by Regional Cabinet.
- EPI TOT provided for 85 health managers and EPI refresher training provided for 552 frontline health workers.
- ENA technical training provided for 18 health staff and ENA BCC training for 49 health staff.
- CHPI TOT provided for 160 health workers and CHP training for 3,896 volunteers. Follow-up CHP review meetings were conducted 3 to 5 months following training.
- Festivals involving 8 kebeles were organized to celebrate communities' 1-year CHPI efforts.
- EPI spots broadcast through 3 local radio stations.
- HMIS training provided for 38 RHB, ZHD, WorHO, and HC staff..
- Technical and financial assistance was provided to ZHDs and WorHOs for supportive supervision.
- Supportive supervision training was provided for 90 RHB and ZHD health managers.
- Periodic health review meetings were supported at zonal and woreda levels.

STRENGTHENED HEALTH WORKER SKILLS

CHILD SURVIVAL INTERVENTIONS

About 470,000 Ethiopian children die each year before their fifth birthday—almost one every minute. This tragic fact places Ethiopia sixth among the countries of the world in terms of the absolute number of child deaths. And yet there are effective and proven tools which can be used to achieve the Millennium Development Goal of reducing child deaths by two-thirds by 2015. These tools are within the reach of every country, provided that the necessary commitment and resources are made available, and the tools and services are adjusted to the conditions of the country.

In all regions, health profiles of the ESHE focus zones and cluster woredas have been produced to be used by regional and local staff in planning trainings and assisting in monitoring and decision-making activities.

To address these health situations, ESHE is supporting the Federal Ministry of Health (FMoH), and the Amhara, Oromia and SNNP regions to improve:

- immunization programs
- infant feeding practices, micronutrient supplementation, and
- integrated management of childhood illnesses

Immunization

Immunization is a cornerstone program to reduce child deaths. It is estimated by WHO that one in four children's lives can be saved through the full EPI series of vaccines, compared to the pre-vaccination era. Last year's national DPT3 coverage was 62%; this must be raised to over 90% to gain the maximum benefits for Ethiopia's children.

ESHE is working to increase immunization program performance and to build the capacity of service providers through refresher trainings in the Expanded Program for Immunization (EPI). ESHE's goal is to scale-up to reach all frontline health workers in the 64 target woredas, while also working to achieve expanded impact of training and information in non-focus zones and woredas of the three regions.

Once trainings were launched, the project realized the need for shorter yet comprehensive refresher training manuals in EPI. Existing EPI modules from WHO, BASICS, and several countries were consulted to design materials that address Ethiopia's major needs for use in refresher training. Materials included the development of the *EPI Training of Trainers Facilitator's Guide*. These products were field-tested and used for the trainings given by the three regional ESHE offices. Refresher trainings have been given in all ESHE focus

At a health clinic near Awassa, a junior nurse trained with ESHE project support provides immunizations at the same time a mother comes in for her family planning.

Photo by Penelope Riseborough/JSI

regions, zones and woredas during the year. Working in the three largest regions and coordinating at the Federal level, ESHE is becoming a major partner in Ethiopia's immunization program.

Nutrition

Malnutrition is the underlying cause of approximately 57% of all deaths of children under age five in Ethiopia. Chronic malnutrition plagues half of Ethiopia's children. Child malnutrition has its roots in sub-optimal breastfeeding practices, delay in start of adequate complementary feeding, and insufficient intake of essential micronutrients, like Vitamin A. Malnutrition continues to be a significant concern in Ethiopia.

ESHE collaborated with the LINKAGES and MOST projects to institutionalize preventive activities and build the capacity of the regional, zonal, woreda and health facility staff in Essential Nutrition Actions (ENA) in the three focus regions. ENA is designed to integrate key nutrition interventions into common contacts with the health system. The ESHE, LINKAGES and MOST projects are focused on optimal breastfeeding, complementary feeding and vitamin A this year.

LINKAGES and MOST assisted ESHE to train 383 regional teams and Regional Health Bureau staff in 12 TOTs for ENA and provided the necessary training materials for the roll-out of nutrition trainings during the year. Planned TOTs at regional and zonal levels have been completed during the Project Year and early next year frontline health service delivery staff at facilities and communities will be trained to strengthen the implementation of ENA strategies.

Integrated Management of Childhood Illnesses

IMCI is designed as a holistic approach to improve the quality of care by frontline health workers for sick children, as well as to improve immunization, nutrition counseling, and referral during sick child visits.

In support of the IMCI approach, ESHE is working with RHBs to improve health services delivery management and to build the capacity of

Abeba learned about the importance of colostrum in breastmilk while she was being trained as a CHP.
Photo by Dr. Tadele Bogale/ESHE Project

Abeba Tadesse, a 26 year old woman living in Meket woreda, Deferge Kebele was selected by her community to be a community health promoter (CHP). As part of the process, Abeba received training in child and maternal health information, so she can better inform and teach those within her community.

"The CHP training was the first time I learned that colostrum is an essential part of the breast milk and that it protects our children from disease," says Abeba. Most mothers in the kebele—and across Ethiopia—are not aware of the benefits that colostrum provides to newborns. According to a regional household survey conducted, 46% of women discarded this important component of the breast milk.

Abeba continues, "I am a mother of three children, but I have never breastfed the yellowish part of the breast milk for my children. We thought that it is dirty and not good for the new-born child. It has really stricken me and I worry that I was committing a crime on my children by discarding the colostrums." Abeba's regret can be seen on her face.

"Now I am very happy. I promise to take on the responsibility of making sure that my village newborn children will not miss this golden opportunity. Thanks to the woreda health office and ESHE for bringing this training. From now onward, women in our village will not repeat the wrong practice when breastfeeding."

health facility staff to manage cases and create awareness at community and household levels in the prevention of major childhood illnesses. Baseline IMCI Health Facility Surveys were carried out in all three regions.

The standard international IMCI approach needs to be adapted and simplified for use in Ethiopia, however. As it stands, IMCI is overly technical for the majority of frontline health workers and the new health extension workers (HEWs). Furthermore, with pneumonia the number one killer of children under-5, pneumonia treatment must be raised as a priority in the Ethiopian IMCI adaptation. Neonatal causes account for nearly 40% of under-5 deaths in Ethiopia and are not yet included in IMCI.

ESHE has been consulting with the IMCI Unit in the FMoH on the possible adaptation of the training manuals and methodologies for IMCI to enable the scale-up of a cost-effective training. ESHE will work closely with WHO to coordinate adaptation of the training materials, and trainings will begin next year in the three focus regions.

Community-Based Management of Pneumonia

International and national evidence clearly support the need for a community-based pneumonia program to address the number one cause of child death in Ethiopia.

An ESHE key focus—primarily through the Child Survival Partnership—is on community-based treatment of pneumonia. The State Minister of Health requested the CS Core Working Group to develop a concept paper to justify the need for managing pneumonia at the community level. Drafted by the ESHE Project Director and endorsed by the Working Group, the paper was submitted to the State Minister through the FMoH Family Health Department (FHD). The concept paper includes the magnitude of the problem, global and national experience of treating pneumonia at the community level, the safety of community health workers handling oral antibiotics, additional costs the program may incur, and, most importantly, its impact on reducing the overall under-5 mortality.

ESHE also conducted a study tour to better understand the existing community-based treatment programs. Highlights were presented and discussed by the Working Group at the National Conference on Community-based Treatment of Pneumonia in March 2005.

The Health Services Extension Program (HSEP) will have the potential to take up this new initiative in a sustainable way as they are paid workers in communities and will cover the entire country in several years. The HSEP first needs to be strengthened in terms of drug logistics, supervision, and HMIS, then pneumonia can be added as an in-service training. The CS Core Working Committee will take up the challenge to assist in strengthening HSEP and later will introduce community IMCI treatment, including pneumonia case management.

TRAINING

ESHE is building the knowledge and skills of health workers, communities, and the health system in general through various trainings. Essential Nutrition Actions, Expanded Program on Immunization, Health Management Information System, Supportive Supervision and Community Health Promotion were major themes of ESHE training. A total of 12,261 participants from regions, zones, woredas, health facilities and communities attended the trainings. The table on page 12 summarizes participants by area and region.

Immunization against childhood diseases contributes to reduction in mortality and permanent disability among children. The annual EPI plan is to

serve all under-one children and reproductive-age women in woreda catchments. ESHE conducted EPI trainings for frontline health workers and gave continuous technical advice and support during EPI follow-up visits.

ESHE staff guided health managers and workers on how to prepare an EPI monitoring chart, how to interpret the data for decision-making, proper use of refrigerators, and use of an injection safety box. All 64 target WorHOs and 218 health facilities were included in the follow-up visits. In some areas, the findings were encouraging: staff are committed to improve the EPI coverage, EPI monitoring wall charts were in use, data were used for decision-making, injection safety was practiced, and foam pads were in use. In other areas, support was given to address areas demonstrating poor practice of cold chain monitoring and management, inadequate and inappropriate use of tally sheet, poor recording and reporting systems, errors in determining eligible targets, irregular outreach sessions, irregular integrated supportive supervision from WorHOs, poor integration of vitamin A with EPI sessions, and low DPT3 coverage and high drop out rate (DPT1-DPT3). The Woreda Health Offices and ESHE cluster teams will continue the technical support needed to further improve the coverage and quality of EPI. (see Annex 2, Table 1, Quality of EPI Services)

RESULTS

Service Delivery Standards Manual developed and disseminated

Management Performance Standards adapted for regional needs

Developed **Integrated Supervisory Checklists**

Drug logistics remains an important issue to be addressed. In the EPI follow up visits, availability of essential IMCI drugs and vaccines were also checked. Availability of these drugs and vaccines has not shown improvement from the baseline results (see Annex 2, Table 2: Availability of Oral Drugs and Vaccines). Year Two activities focused mainly on EPI. As ESHE will be deeply involved in IMCI activities in the coming year, more progress is expected.

ESHE's input is reflected in the EPI coverage of the 64 target woredas. Improvement can be attributed to the continuous capacity building of health workers and managers, together with EPI promotion by community health promoters. Continued improvement is expected in the coming years. With time, the regional performance as a whole is likely to improve as a result of expanded impact.

The graphs and table in Annex 2 and 3 show the ESHE woredas coverage compared to the respective regional coverage.

Table 1: Summary of ESHE Led Trainings

Training Type	Number of participants			
	Amhara	Oromia	SNNP	**Total**
CHPI				
CHPI TOT	104	166	160	430
CHP	387	4,955	3,896	9,238
ENA				
Technical TOT	23	29	18	70
BCC TOT	26	120	70	216
BCC	-	64	33	97
EPI				
TOT	103	102	85	290
Health Worker	534	552	524	1,610
HMIS				
Refresher	26	73	77	176
Supervision				
TOT	30	-	32	62
HSEP				
TOT	20	17	35	72

CHP - Community Health Promoter
CHPI - Community Health Promoter Initiative
EPI - Expanded Program for Immunization
HMIS - Health Management Information System
ENA - Essential Nutrition Action
HSEP - Health Services Extension Program
TOT - Training of Trainers

SUPPORTIVE SUPERVISION

RESULTS

63 health staff trained in **supportive supervision** during PY2

Supervision training guidelines drafted

Performance improvement baseline surveys indicated that supervision is generally irregular. Few supervisors use checklists as a guide. To address these gaps, ESHE worked with the regional health bureaus to develop Management and Service Delivery Standards and Supervision Checklists.

Once materials were developed, 63 health supervisors were trained in supportive supervision.

Management and Service Delivery Standards

ESHE adapted EPI Manuals and distributed them to health facilities to assist health workers in providing quality services in key child health areas. These service delivery standards included EPI, ENA, malaria treatment guidelines, diarrhea management guidelines, and guidelines on IMCI.

In collaboration with the regional health bureaus, ESHE also developed management performance standards for RHB, ZHD, WorHO, health center (HC) and health post (HP) levels. These were revised and adapted by regional ESHE teams into the specific contexts of the different regions. The standards are used during supervision to guide management performance at various levels of the health system. In SNNP, the management standards were finalized and copies were distributed to all departments of the RHB, ZHDs, WorHOs and woreda capacity building offices in ESHE clusters. The Standards are currently being finalized in the other two regions.

Integrated Supervisory Checklists (ISCLs)

In order to strengthen and standardize supervision across the regions, ESHE developed ISCLs based on the Management and Service Delivery Standards. To develop the ISCLs, various existing supervision checklists were collected and revised by ESHE teams in collaboration with the RHB.

ISCLs were developed for use at different levels in the regions: ZHDs, WorHOs, HCs and HPs. Draft ISCLs were reviewed and tested during regional supportive supervision trainings.

Supervision Training

Supportive supervision is critical for the provision of quality services, as it facilitates progressive improvement of performance by health staff. Supportive supervision, in contrast to the traditional style of "supervision" that focuses on targeting faults and reporting back to supervisors, emphasizes guiding, helping and encouraging staff to improve their performance against established standards and professional expectations. Through supportive supervision, supervisors are able to identify gaps in staff knowledge and skills, problems in service provision, and other limitations to good performance. Supervisors are then able to provide support and feedback to staff. Regularity and continuity in the supervision process enables supervisors to help service providers work toward higher standards of care.

A four-day course on supportive supervision was developed for training at the regional level. The training occurs in two rounds. The regional (Phase 1) training involves staff from the RHB, ZHD and ESHE staff. The zonal level (Phase 2) training, scheduled for Year 3 will involve the zonal, WorHO and health center staff.

Supportive supervision—in contrast to inspection—is the process of guiding, helping and encouraging staff to improve their performance so that they meet the defined standards of performance of their organization.

Improving Quality through Effective Supervision

"Supervisors from the woreda health office used to only visit the Chuko Health Center when something appeared wrong in monthly activity reports. On other occasions, they came to the health center, asked whatever they felt was important, gave commands and went back to their office," says Ato Abebe Tessema, Health Officer and head of Chuko Health Center in Aleta Wendo Woreda of SNNP Region.

These and other major problems in supervision were identified in a survey conducted by ESHE in collaboration with the Regional Health Bureau. The survey indicated that standards were lacking against which supervision could be done. Supervision was irregular and not guided by standardized checklists. Furthermore, when issues did arise, there was no joint problem-solving support or follow-up. Chuko Health Center was one of the health facilities included in the survey and was negatively affected by the existing supervision practices.

"Now the practice has been tremendously changed since the supportive supervision training last year," says Ato Abebe. "Since the training, a team from the woreda health office visits us every three months. They never come without their checklists. We complete them, seek solutions for the problems identified, and plan for continued supports required from the health office *together*. The woreda health office now provides us with practical support that helps us address the problems we identify."

"At our health center, we have started to observe improvements in the quality of services and how they are provided by each individual staff member," added Ato Abebe. "There is now motivation and commitment by the health center staff to provide good services."

In June 2005, 63 participants—33 in SNNP and 30 in Amhara—received regional-level training. Participants were mainly from the regional health bureaus and zonal health desks. There were also participants from non-ESHE zones—thus expanding the reach of the program beyond ESHE focus areas. The regional level training will be conducted in Oromia at the beginning of the next Project Year.

ESHE regional and cluster staff also received training to enable them to conduct effective follow-up visits in their respective clusters. The training/ facilitation approaches and the relevance and practicality of the course content were highly appreciated by the participants in the two regions.

A draft implementation guideline to accompany the supervision training was also developed for on-the-job guidance and to encourage good practices at supervisory and supervisee levels. Participants will use and field test these draft materials, so that they can provide important feedback that will be incorporated into the document. The guide will be finalized and disseminated widely in the coming year.

IMPROVED COMMUNITY AND HOUSEHOLD HEALTH PRACTICES

COMMUNITY MOBILIZATION PROGRAM

ESHE's Community Mobilization Program interventions focus on building the capacity for community mobilization in the three regions and increasing advocacy on the part of communities for improved health practices and use of health services. The Community Mobilization Program activities for Project Year 2 include:

- support of the rollout and/or expansion of the Community Health Promoter Initiative in the three regions
- developing the Kokeb Kebele Program for health and education
- collaborating with LINKAGES on the adaptation of nutrition materials for community-based counselors
- testing of Lot Quality Assurance Sampling (LQAS) methodology for use by ESHE field coordinators as a means to assess and follow community progress, and
- participating in the development of the Essential Health Trunk for SNNP.

Community Health Promoter Initiative

Ethiopia has a significant number of trained community health workers in different categories, an increasing number of health facilities, and a high number of new graduates from health professional training institutions. Despite these important inputs, health service utilization and program coverage is not optimal. Based on RHB/ESHE household surveys across the three regions, only 63% of the population has reasonable access (10 km or 2 hour walk) to a health facility. Frequently, outreach sessions to distant communities are irregular or poorly planned with low attendance by caretakers.

The launch of the Community Health Promoter Initiative (CHPI) in the three regions marks a significant step by communities to improve the health of their families. The CHPI builds the capacity of communities to improve child and family health through the promotion of small do-able actions that lead to improved health for children and families. When parents are informed about how to better care for their families, they can be very effective. Since program roll-out, the CHPI has received an extremely positive reception from communities, frontline health workers and managers alike.

The **Community Health Promoter Initiative** builds the capacity of communities to improve child and family health through the promotion of small do-able actions that lead to improved health for children and families.

Community health promoters (CHPs) are volunteers, selected by the community, who attend short, two-day trainings on key health themes. The training emphasizes action-based messages to bring about positive changes in health behaviors: **Having caretakers try something rather than just know**

Photo by Brian Mulligan/ESHE Project

Regional CHPI TOT for staff from East Shoa Zone, Oromia

something. Promoters are encouraged to first take action in their own home, and then promote messages among their friends and neighbors. In this way, the CHPI draws on volunteers' natural motivation to help their own families.

RESULTS

CHP training guide developed

Trained 9,238 CHPs

8 community festivals held

Regional CHP training of trainers sessions were conducted by ESHE in the three regions. CHP training guides were adapted for local use and distributed to the RHBs for use during zone-level TOTs and CHP trainings. Trained participants then serve as a pool of facilitators for community orientation meetings and promoter trainings.

Table 2 shows the number of participants involved in CHPI associated activities. In coordination with its partners, ESHE cluster offices have oriented over 8,000 community members representing kebele administrations, religious groups, women's groups, elders, and HEWs to the CHPI initiative. The orientation is an essential step for community acceptance and involvement in decision-making.

Selection of CHPs is the community's responsibility. During orientation meetings community members decide on the criteria for selecting promoters, as well as their role and composition.

Health extension workers in ESHE focus woredas have been involved in CHP training sessions both as trainees and trainers. This helps them to better understand the initiative and how to best support and collaborate with promoters.

Training of CHPs has been started in all three regions during the last year, and to date 9,238 CHPs have been trained. Amhara region has just begun the community initiative. ESHE's goal is to train a total of 60,000 CHPs during the life of the project.

In SNNP, where the initiative is more established, ESHE staff conducted review meetings at different levels to analyze problems and design strategies accordingly.

In addition, community festivals were conducted to motivate CHPs, to help promoters share experiences, and to celebrate achievements by communities. Eight community festivals were held. (See story below)

Table 2. CHPI Activities and Number of Participants

Region	TOT	Community Orientation	Trained CHPs		
			Female	Male	Total
Amhara	131	2,057	158	229	387
Oromia	166	3,859	2,074	2,881	4,955
SNNP	160	2,450	1,747	2,149	3,896
Total	**457**	**8,366**	**3,979**	**5,259**	**9,238**

Celebrating Promoters

Community festivals celebrate promoter and community accomplishments and encourage promoters and community leaders to continue supporting activities that lead to improved health practices and increased use of health services by the community.

During the festival, CHPs present key health messages through dramas, traditional song, and dance. Contests and games are also held. All share success stories on activities in the community and health facility staff report on major achievements, promoters' efforts, challenges and forthcoming activities.

An important aspect of the festival is that promoters receive certificates to recognize their efforts and prizes are awarded to individual kebeles who demonstrate progress. Thus far, ESHE has held eight community festivals. Many more will be held in the coming year.

Health Service Extension Program Strengthening

ESHE Project is committed to the success of the Health Service Extension Program, the government flagship program to deliver primary health care at the kebele level. The CHPI is a critical component in helping the HSEP have an impact. ESHE provided communication and community mobilization training to the first group of HEWs before graduation. About 2,000 HEWs and 84 instructors from 11 Technical Vocational and Educational Training centers (TVETs) in Amhara, Oromia, SNNP and Tigray regions were trained in community support and mobilization. Each of them was provided with a larger version of the Family Health Card (FHC). Feedback has indicated that the training intervention was critical to helping the HEWs do their jobs. As a result, Shashemene and Butajira TVET instructors are now planning to provide the training for the second batch of HEW trainees before they move to their assigned communities.

Collaboration between Health Extension Workers and Community Health Promoters has brought about noticeable changes in communities.

Importantly, the CHPI supports the HSEP. It is estimated that within the next five years, two HEW will be deployed to every kebele (village). With one CHP to 50 households, CHPs expand the promotion and organizational work of HEWs. Where the two initiatives overlap, collaboration between HEWs and CHPs has brought about noticeable changes in community engagement.

For effective implementation of CHPI in the regions and to serve as an advocacy group, Regional CHPI-HSEP Taskforces have been established in the three regions. Each taskforce is composed of members from the RHB, the Regional TVET Commission, and ESHE regional staff.

A quick survey was conducted on TVETs to assess gaps related to pre-service training in Oromia after a request by the Regional Health Bureau. Five assessment tools were developed in collaboration with the regional HSEP-CHPI task force to collect data from five training institutions in the region. Data collected through this survey is being compiled, and it should provide valuable information that represents the issues related to HSEP training in the country. This information is vital for stakeholders and the Federal Ministry to **understand/develop** the areas of intervention needed to improve the pre-service training.

The **Kokeb Kebele** program integrates health, education and HIV/AIDS programs at the community level.

Kokeb Kebele Program

ESHE is working in collaboration with USAID, the Health Communication Partnership (HCP), Pathfinder International (PI), and World Learning Ethiopia (WLE) to conceptualize and adapt the Kokeb Kebele approach. The Kokeb Kebele program integrates health, education and HIV/AIDS programs at the community level. The basic strategy is one of mobilizing and building the

HEW Communication and Mobilization Training in Assela, Oromia Region

Photo by Samuel Yalew/ESHE Project

capacity of the community to identify health and education related problems, propose solutions, set specific goals, develop plans and implement activities to attain those goals. Through newly created and/or strengthened links between existing groups, community leaders can more effectively draw upon the kebele's own resources, utilizing parent teachers associations (PTA), community health promoters, community-based reproductive health agents (CBRHA), and other social and religious community structures (edir, religious, women's, and youth groups), to attain the identified and agreed upon development goals.

RESULTS

Disseminated 285,000 **Family Health Cards**

Distributed 200,000 **Immunization Diplomas**

Gave 2,326 **t-shirts** to CHPs

Two field visits were conducted in October and December 2004 to better understand the realities on the ground between health and education, refine the approach based on what is already happening in communities, and clarify ideas about how collaborating partners can work at the woreda/ kebele level. As a result of these field visits, a regional workshop was conducted in Yirgalem in March to discuss and refine program roll-out in five woredas in SNNP. A concept paper has been submitted to USAID for review on the program approach, staffing needs, timelines for rollout, duration, and program assessment.

Community Nutrition Counselors

ESHE central office and SNNP regional team members collaborated with the LINKAGES project on a field visit in SNNP to assess current young child feeding practices. The assessment helped identify actions caretakers can take to improve feeding practices and to identify potential community members to act as nutritional counselors. The primary task of Community Nutrition Counselors is to negotiate with mothers for the adoption of optimal feeding practices, such as exclusive breastfeeding, timely introduction of complementary foods, and frequency of feeding.

Following the field visit, ESHE staff collaborated with LINKAGES during a two-day workshop to adapt the current training on the *Essential Nutrition Actions Counselor's Guide*. The *Guide* was initially developed for frontline health workers, but needed to be adapted for use with community volunteers, many of whom are illiterate.

BEHAVIOR CHANGE COMMUNICATION

The goal of the ESHE behavior change communication (BCC) component is to improve household practices and individual behaviors. To achieve this goal, ESHE is developing, pre-testing

FHC

Diploma

The FHC is a guide—written in simple text with detailed illustrations—of key health approaches that should be followed at home.

Immunization Diploma motivates caretakers to fully immunize their child by 1 year of age.

and producing various promotional materials and motivational tools, including:

- Printed materials and tools
- Radio programs and spots

Materials Development, Production and Distribution

The Family Health Card, Immunization Diploma and t-shirts are the primary BCC tools being used to promote key child health actions in households and at health facilities.

ESHE has been working on the development of the FHC in collaboration with the HCP and LINKAGES Projects. CHPs take 6-10 copies with them as they talk to people in the community. They give a copy to pregnant women and mothers who have a child under one-year old to help them carry out small, do-able health actions at home and to encourage them to seek available health services from a nearby health facility. ESHE pre-tested the materials and printed and distributed a total of 285,000 (220,000 Amharic and 65,000 Oromiffa) FHCs to the three regions.

Moreover, 200,000 (150,000 Amharic and 50,000 Oromiffa) Immunization Diplomas have been

Motivating Families to get their Children Immunized

Recently, three mothers near the Abiyot Fana heath post were given diplomas after their children were fully immunized. To enhance the value of the diplomas, Ato Assefa Keriebeh, a Junior Clinical Nurse at the health post, awarded mothers their diplomas at their respective churches one Sunday. The diplomas were awarded by religious and kebele leaders in the presence of elderly, mothers, fathers & youth who were attending the Sunday Orthodox church service.

The approach has motivated others in the community to complete their children's vaccination series before their child's first birthday so they can receive the diploma as their neighbors have.

Assefa has seen a change as mothers are now bringing their children to be immunized within three days after delivery—which was not common before. The number of children who drop-out after starting the series has also dramatically decreased in the third and fourth quarters of 1997 EFY.

"It is surprising; up to 97 babies were immunized on a single day in my catchment area. 28 had come for the first injection," says Assefa. 56 diplomas were given to mothers that day. Before the award of immunization diploma only 10-15 babies were immunized on a single day. When he asked mothers why they came to immunization site, one said, "I brought my child today to get the last vaccination and get a vaccination diploma. It is the least thing that I can do for my baby. I will be like that mother who took the diploma at the church."

Another mother, aged 25, said "I delivered a baby girl 3 days ago. I came today to start my child immunization because last time when I entered my neighbor's house to ask about her baby, I saw a beautiful immunization diploma posted in the wall covered with plastic. I want one!"

The Health Post EPI coverage reached above 90% this year. "Now a very simple thing is solved. I take many antigens and immunization diplomas to each session. It is no effort! Thank you ESHE," says Assefa, after a deep breath.

A 25 years old mother showing immunization diploma to her neighbors

Photo by Bizuhan Gelaw/ESHE Project

printed and distributed to the regions. The diplomas are awarded at the health facility or outreach site by health workers for children who complete the full series of vaccines before their first birthday. They have become status symbols for families, many of whom now display the diplomas on their walls.

RESULTS

Trained 64 **radio producers** in nutrition and EPI

Helped produce a **TV show** on community health promoters

After Community Health promoters finish their training, they receive a t-shirt with health messages printed on both sides. Over 2000 t-shirts have been dispersed. The t-shirts are a nice gift for the volunteers, but more importantly, make them easily recognizable and reinforce key messages.

Essential Health Trunk for SNNP Health Extension Workers

ESHE is a member of the working group for the development of an Essential Health Trunk. The trunk contains reference and communication materials for Health Extension Program workers at the health post level in SNNP. Working group members include the FMoH Health Education Center (HEC), HCP, the SNNP Regional Health Bureau, Development Cooperation Ireland (DCI), FMoH Health Service Extension Program, and the Carter Center.

The working group was formed to develop a standard list of essential manuals and operational communication materials for use in primary health care units. ESHE has given technical input throughout the process and has provided information on HEW needs, available references and communication materials.

Along with other working group members, ESHE will review and comment on the consultant's final report and recommendations. HEC, HCP and the SNNP Regional Health Bureau will conduct a workshop to gain consensus among health offices in the southern region on the content list before producing and delivering the Essential Health Trunk to HEW workers.

Radio and Television

Radio is an effective way to reach the general population in Ethiopia, because about 45-60% of the population listens to radio regularly, even though few actually own their own radio.

During Project Year 2, ESHE conducted a rapid assessment of regional radio stations, seeking opportunities to work together and develop partnerships. ESHE is also looking at ways to strengthen the relationship between regional health bureaus and radio stations, so the stations can be used to more effectively communicate health messages. There are 11 radio stations in the three focus regions which reach most of the region's population. They also have the capacity to produce and broadcast different programs during the week. The assessment and meetings resulted in the transmission of free EPI spots in all regional radio stations. Furthermore, the relationship between RHBs and radio stations has become stronger.

At national and regional stations, ESHE is also working to build the capacity of radio producers to develop programs and spots to inform listeners, influence family and health worker behavior, while supporting community activities.

At the Radio for Development Workshop in SNNP in June 2004, six EPI spots were developed, produced, pre-tested and finalized. The same spots were also translated, produced, pre-tested and finalized in Oromiffa. Four of the spots have been aired on 10 regional radio stations since April 2005.

Radio spots can support community-and facility-level activities by reinforcing the same messages given by HEWs and CHPs and highlighting tools such as FHCs and immunization diplomas.

Following the workshops, ESHE assisted radio stations in producing their own radio programs on child health. For example, FM Addis 97.1 ran a serial radio call-in program on breastfeeding practices last January. The objectives of the workshops were not only to produce radio spots, but also to build the capacity to produce interesting health programs and to expose producers to key child health messages.

ESHE also assisted the Health Education Center at the MOH to produce a TV program on ESHE's community activities in SNNP during the study tour to SNNP by Amhara and Oromia officials. This program was televised multiple times on the Ethiopian Television Monday evening health program.

Collaboration with Pathfinder International Ethiopia

ESHE provided production training to the Voice of Tigray radio producers in Mekele. Based on Pathfinder's request for assistance, ESHE co-facilitated the three day (May 21-23) training and produced more than ten spots and three radio dramas on family planning and reproductive health.

Promoting Breastfeeding through Radio

According to Yiftusira Tuji, a producer at Radio Ethiopia FM 97.1, no producer knew that breastfeeding is a problem in Ethiopia. "I came to know about optimal breastfeeding when I attended a workshop on Radio for Nutrition Behavior Change in November 2004. Although every Ethiopian mother breastfeeds her child, only 30% of them optimally breastfeed their children—yet optimal breastfeeding practices reduce child death by 20%.

"I learned that optimal breastfeeding means early initiation of breast milk, feeding colostrum, and exclusive breastfeeding up to six months without even giving water and butter. These are all new ideas I learnt during the workshop."

Yiftusira developed a radio call-in show to discuss optimal breastfeeding. "This particular show encouraged pregnant women and mothers who recently gave birth to call and ask me questions related to breastfeeding. I held the program for four consecutive Tuesdays in a month." The call-in show helped the audience learn current breastfeeding practices, breastfeeding difficulties and optimal practices.

Yiftusira continues, "I had more than 70 calls for this program, which is far more than I usually have in other call-in programs. Men also were engaged in finding out their role to support their wives to optimally breastfeed their babies."

Reaching rural families through targeted radio programs is proving a successful information dissemination and behavior change strategy.

Photo by Samuel Yalew/ESHE Project

IMPROVED HEALTH SYSTEMS

ESHE is working on several levels to improve health systems, the financing of health services, and the management of those systems and services. Specifically, ESHE assists in:

- Strengthening health care financing
- Building capacity to advocate for health
- Developing special pharmacies
- Improving skills in using data for decision-making
- Conducting review meetings

HEALTH CARE FINANCING REFORM

In Ethiopia, health care service delivery with per capita expenditure of US$5.60 in 2000 is generally under financed compared with the US$12 per capita average for sub-Saharan Africa. The Macroeconomics and Health Commission of the WHO recommends US$34 per capita for the delivery of essential health services in developing countries. In addition, the majority of funds are channeled to curative services and facilities and staff are absent in some areas, but underutilized in others.

To close this wide gap, the Health Care Financing (HCF) Reform component of the ESHE project aims to improve financial resources in the health sector, mobilize those resources, ensure efficiency in allocation and utilization of resources, and promote equity and quality in health service delivery. The component is national in scope and operates both at federal and regional levels.

At the federal level, ESHE is working with the Ministry of Health and other relevant government bodies, such as the Ministry of Finance and Economic Development. Regionally, ESHE provides support to the three focus regions and also works with other regions as appropriate.

Baseline Surveys and Project Planning

In Project Year 2, two health care financing baseline and needs assessment surveys were conducted in Oromia and Amhara, in July and September/October 2004, respectively. These surveys were preceded by a similar survey conducted in SNNPR in the previous year. Almost all of the focus woredas and selected city administrations were covered by the surveys.

The surveys provided baseline information on the different HCF reform components: revenue retention at facility level, magnitude of fee waivers at health centers, and mix of exempted services. They also identified capacity gaps related to decentralized planning and budgeting. ESHE Oromia and Amhara used the data from the surveys to prepare their regional strategic plans.

Legal Framework

ESHE continued working with the Ministry of Health to facilitate ratification of the *Health Service Delivery, Administration and Management Proclamation* and accompanying regulations. Revisions of the draft *Proclamation* were made in consultation with the FMoH. The revised draft *Proclamation* and regulations, a concept paper on the need for this legislation, and a justification note on the draft *Proclamation,* have been submitted to the Federal Council of Ministers through the MOH. The draft *Proclamation* is expected to be endorsed by the Council of Ministers and subsequently submitted to the Parliament for ratification.

At the regional level, it has been a year of success. The *Proclamation* was ratified by SNNP and Oromia. ESHE organized a series of consultation workshops for relevant stakeholders and provided technical support to review and

finalize the *Health Service Delivery Administration and Management Proclamations* of the two regions.

RESULTS

HCF Proclamation Ratified in Oromia and SNNP

Because the *Proclamation of SNNPR* was approved at the beginning of the year and 50% revenue retention has been practiced by hospitals, an experience-sharing visit was made to SNNPR in December 2004. Oromia BoFED and RHB heads learned from the experiences in the Southern Region.

Following successive consultations and dialogue on the draft, the Regional Cabinet of Amhara reviewed and endorsed the *Regional Proclamation*. Currently, the *Proclamation* is awaiting final approval by the Council. ESHE prepared supporting documents for clarifying the issues included in the *Proclamation.* The documents will play a key role in the Regional Parliament endorsing the legislation.

In non-ESHE focus regions, the Addis Ababa City Administration ratified the *Proclamation* in the previous year. ESHE facilitated consultation workshops to refine the draft regulation. Dialogue and consultation continued with the Addis Ababa RHB to facilitate Cabinet approval of the legislation and on overall progress of reform. There was communication and dialogue with non-ESHE focus regions—mainly Tigray and Dire Dawa City Administration—to facilitate engagement of these regions in the reform process.

CAPACITY BUILDING AND ADVOCACY MATERIALS

Development of the *HCF Implementation Manual* is well under way. The *Manual* will serve as an operational guide and will also be used in training.

To assist with the *Manual* drafting, field visits were conducted in the three focus regions. The financial management system in health facilities was examined, including operation of Special Pharmacies. A field visit was made to a pilot research project of Save the Children-UK in Debresina Woreda of South Wollo, where Save is establishing a system to create better health services access for the poor. This experience will help draw lessons for revising the fee waiver system. The *Manual* will be accompanied by presentation slides to facilitate capacity-building training exercises.

Health budget and expenditure analyses have been conducted in Amhara, Oromia and SNNP regions and in the country as a whole. Compiled data provide a clear picture of resource flows to the sector, categorizes budget and expenditures into recurrent and capital costs, and identifies sources of these resources such as domestic, external loans or external assistance. In addition to tracking the growth of government health expenditures, the data helped justify the ongoing HCF reform.

In collaboration with regional health bureaus and bureaus of finance and economic development, ESHE helped to develop advocacy materials targeting woreda-level cabinet members. Materials, focused on increasing the budget for the health sector, are designed to sensitize woreda cabinet members to the inadequacy of resources allocated for health and the need to increase funding. In Project Year 3, ESHE will conduct a series of advocacy workshops using the materials.

SPECIAL PHARMACIES

Special Pharmacies (SP) are retail pharmacies in public health facilities that operate on the principles of revolving drug funds (i.e., self-financing entities after an initial investment by the community, government, donors or suppliers). The SPs are

managed and operated by professionals who receive training from ESHE.

ESHE is working with the FMoH and RHBs to strengthen and expand Special Pharmacies by facilitating trainings based on the general establishment and operational guide developed during ESHE I, monitoring the pharmacies, and revising the supervision checklist.

Guidelines were developed and training was provided to those running the pharmacies. In 2004, 150 Special Pharmacies were opened throughout the country with USAID financial and technical support through ESHE. While the Special Pharmacies are relatively new, some are already seeing dramatic results.

RESULTS

150 Special Pharmacies opened

In Amhara, as part of the ongoing support to Special Pharmacies, ESHE served as part of the training team, training 126 staff at 42 health facilities selected to host Special Pharmacies. Supervision and technical support has been provided to 14 sample Special Pharmacies in the region in collaboration with the RHB.

Special Pharmacies operate in health facilities using revolving drug funds. After an initial investment, the pharmacies support themselves—and in some cases, provide a revenue stream for the hospital to which they are attached.

In Oromia, technical and logistic support for conducting supportive supervision of Special

Felege Hiwot Special Pharmacy Generates Income for the Hospital

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

Ato Tariku explains that the hospital used to be ranked one of the most poorly performing service delivery institutions (43rd out of 45 in 2003), based on civil service delivery standards. "This year, we ranked first!" he exclaims. "One of the major contributing factors to this great achievement is the existence of the Special Pharmacy in the hospital. In addition, the technical support given by the Regional Health Bureau and ESHE—including training on how to operate and manage pharmacy, drug selection and pricing, as well as supportive supervision by the Regional Health Bureau—has enabled the availability of essential drugs and supplies at affordable prices. Funds are also now available for priority needs of the hospital from the profit it generates with reasonable mark-up rate decided by the management."

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

Pharmacies were provided to the RHB. Supervision was conducted in 14 Special Pharmacies in five zones of the region. Consensus was reached with the RHB to make more comprehensive and integrated supportive supervision along with partners assisting SPs in the region, including Italian Cooperation. Previous SP supervision reports were reviewed and discussed with RHB to solve urgent problems, such as overstocking of drugs.

OTHER ENGAGEMENTS

ESHE is engaged in other relevant areas key to strengthening the health system.

Third Health Sector Development Program Preparation

During the year, the Ethiopian Government began preparation of the third Health Sector Development Program (HSDP-III), following completion of the HSDP-II. The Health Sector Development Program is designed to help the Government realize its targets set in various health policy documents. The Program is important for mobilizing financial and technical support from bilateral and multilateral development partners. ESHE participated in the shaping and overall formulation of the Program, and played a lead role in preparing the financing plan for the program which estimated the resource needs by level of health facilities and services using the Marginal Budgeting for Bottlenecks (MBB) model.

Essential Health Services Package Preparation

ESHE participates in the task force that is developing, reviewing and finalizing the Essential Health Services Package document, which defines the type of services to be rendered by level of health facilities, from health post to district hospital levels.

MDG Needs Assessment

In order to compute resource requirements towards achieving the Millennium Development Goals (MDG), the Ethiopian Government conducted an MDG Needs Assessment using the MBB model. ESHE has been heavily involved in adapting this tool for the Ethiopian context as well as in preparing the costing part of the Needs Assessment. The MBB helped the Government estimate the additional resources requirement to bring about desired health outcomes set by the global community and the commitment of the Ethiopian Government to them.

STRENGTHENING HMIS TO ENHANCE DATA FOR DECISION MAKING

The ability to accurately record, aggregate, analyze and use health data is a critical element of performance quality and service delivery in health systems. It requires skilled health workers at health facilities who can collect and analyze data and then follow-up and use the data to make critical decisions about the program.

ESHE developed a *Facilitators Guide for Health Management Information Systems Refresher Training* to create a system to use data for performance review and improvement in ESHE focus areas. In refresher trainings in Amhara, SNNP and Oromia regions, 176 participants (77 in SNNP, 73 in Oromia and 26 in Amhara) received training.

Following the training, the regional performance improvement teams established or revitalized HMIS review teams at the RHB, ZHD, and WorHO levels

and at health facilities in ESHE woredas. In Amhara, the RHB HMIS Review Committee analyzed and revised the reporting formats at each level. These efforts are being strengthened through follow-up and support by the regional health managers and ESHE cluster staff.

Support to Conduct Review Meetings

Periodic review meetings are important to monitor performance and achievements. Though the practice varies greatly from region-to-region, it is generally infrequent, irregular, and not accompanied by follow-up mechanisms. To bridge gaps and strengthen monitoring and follow-up, ESHE has provided technical and financial support to health managers at regional, zonal and woreda levels to enable quarterly, mid-year and annual review meetings. The meetings proved to be very effective for discussing activities and constraints and to find practical solutions to problems.

Clients waiting at a health clinic near Awassa. Providers at the clinic are now offering integrated child health services since attending ESHE-supported training.

Photo by Penelope Riseborough/JSI

PLANNING, MONITORING & INFORMATION DISSEMINATION

The ESHE Monitoring and Evaluation (M&E) unit is designed to monitor program implementation and assess project effectiveness and impact. The ESHE Monitoring and Evaluation Plan describes the methods and indicators the project will use to comprehensively document the project's effectiveness as well as its contribution to the USAID Ethiopia Mission's Strategic Results Framework and the health of Ethiopian children and families.

BASELINE SURVEYS

ESHE, in collaboration with staff at the Regional Health Bureaus, has supported the three regions in establishing a robust baseline data set that permits an evidence-based planning, monitoring and evaluation process. In each region, four survey instruments were utilized: Household, Health Facility, Health Systems Performance and Health Care Financing. Eleven of the 12 surveys were conducted in Project Year 2.

Key findings for each of the 12 surveys were disseminated at a national meeting in March 2005 by Regional Health Bureau and FMoH senior government staff. All the dissemination workshop participants received a printed copy of the summary document, *Twelve Baseline Health Surveys* and a CD-Rom containing all 12 survey reports. The ESHE Project Director presented the ESHE strategic plan, designed to address many of the gaps revealed in the surveys.

STRATEGIC PLANNING

Amhara and Oromia Regions shared the baseline results in strategic planning meetings in October and August 2004, respectively, facilitating evidence-based planning. ESHE stakeholders, including USAID, Federal Ministry of Finance and Economic Development, Regional Health Bureaus, Zonal Health Desks, Woreda Health Offices, as well as other organizations working in the regions participated in the meeting.

Using the results, the Five-Year Oromia and Amhara Life of Project (LOP) Plans and detailed Year 1 Workplans were produced. The meetings proved to be a good forum to share experiences and expectations and to identify limits among the wide-ranging health actors in the regions. The same strategic planning process was completed in SNNPR in Project Year 1.

PROJECT INDICATORS AND TARGETS

Following the baseline surveys, ESHE developed indicators and targets based on USAID indicators at the various levels of their SO14 M&E plan. The ESHE Indicator Matrix is organized according to the USAID Strategic Plan and includes indicators of project performance, as well as indicators of Mission Strategic Objectives and Intermediate Results and Sub-results. These indicators are measured to evaluate project *effectiveness* in contributing to higher-level improvements in service coverage, which depend not only on ESHE activities but also on other factors and other on-going social

development activities in these areas. Project targets are set to gauge annual and LOP achievements or progress.

COMMUNITY MONITORING

The Community Mobilization Team worked with the Monitoring Evaluation Teams from ESHE and the LINKAGES project to test approaches for monitoring community activities and progress on key indicators. The objective of the monitoring is to gather data on key indicators in a kebele, provide feedback to community health promoters, and community members on the status of immunization, sanitation, and infant feeding practices in their community, as well as to provide data to local health workers and woreda health offices.

Tools were developed for the collection of household data. Field trials have been attempted using Lot Quality Assurance Sampling methodology. This method has the advantage of providing feedback on the performance of a specified supervision area. Data can also be aggregated to give the ESHE team an estimate of coverage at the woreda or cluster level. Further field testing is planned to adapt the approach to be suitable for a one-day assessment that can be used by ESHE field officers, HEWs, and health facility staff.

Community Visit by Interim Deputy Director of USAID Global Health Bureau

ESHE assisted in organizing a community visit for Mr. Kent Hill, Interim Deputy Director of USAID Global Health Bureau, in March 2005. Guests walked to the *Lambuda* community in Misha Woreda of Hadiya zone and met community representatives (kebele leaders, elders, CHPs, CBRHAs, CHWs, health facility workers, woreda officials, teachers/students and others) who gathered in a primary school compound. The Kebele Chief Administrator made a welcome speech, presented a brief report of accomplishments and introduced key community representatives. Visitors asked the Chief Administrator questions on community issues, such as coordination and collaboration among different groups and sectors to enhance community contributions for health and education sector development. The community representatives discussed key health problems in their community with the guests.

Photo by Daniel Giday/ESHE Project

Following the discussion, the group walked to several households to observe how health promoters were talking about sanitation and hygiene, family planning, breastfeeding, and child immunizations. The guests also visited a health post which is under construction.

CHALLENGES AND CONSTRAINTS

In just two years, ESHE has already begun to see results, including improved provider skills, quality of services and shifts in client behavior. As with any significant program, ESHE faces constraints, some of which have been anticipated, some of which have not.

Ethiopia National Election. The election campaign and post-election uncertainty caused limited movement for grassroots-level activities of community orientation meetings, promoter trainings, and conducting post-training follow-ups. Now that the election is over, ESHE activities should be able to proceed on schedule.

Performance improvement is a new concept for the Ethiopian health system. It is also fairly complex, as it requires addressing health workers' knowledge/skills, attitudes, practices and creating systems conducive to improving performance. ESHE is working to build consensus with the RHBs and WorHOs to use the performance improvement approach while comprehensively addressing health workers needs through training.

Both **supportive supervision** and using **data for decision-making** (HMIS) require a deeper understanding, commitment, and follow-up at all health management levels (RHB, ZHD, WorHO and managers at the health facilities). Thus far, acceptance and understanding of these new processes have gone slowly, which has affected the speed of implementation. Through ESHE technical assistance and training this year, the processes are being accepted more readily.

Other National Health Activities. Emergency polio campaigns and unexpected 'public relation plan' orientations resulted in cancellation of planned ESHE activities.

It has taken longer than anticipated for the regions and the Federal Government to ratify the *Health Service Delivery, Administration and Management Proclamation*. High staff turnover contributed to the slow down in momentum of this reform. Approval of the **health sector reform** regulations, even by the Addis Ababa City Administration and SNNP, been delayed.

A care provider in Adami Tulu woreda - with her new Family Health Card.

Photo by Yemesrach Mamo/ESHE Project

COLLABORATION AND COORDINATION

In order to achieve results and maximize resources, ESHE works collaboratively with a wide range of local and international organizations.

ESHE participates in several working groups and partnerships targeted at ESHE's key mission areas—child survival and health sector reform.

Every aspect of ESHE's work in its three focus regions is dependent upon positive and mutually supportive relationships. Almost all activities described in this report reflect partnerships with regional, zonal, woreda, and kebele health offices. ESHE also participates in regional forums on key health issues.

In developing a legal framework for the successful implementation of health care financing reform activities at the regional level, the Project collaborates with Regional Councils, the Regional President's Offices, and the Bureau of Finance and Economic Development (BoFED).

For successful CHPI implementation, ESHE is working to create synergies with the Health Services Extension Program and to include key concepts of the major child survival intervention areas in pre-service training. In each region, ESHE collaborates with the TVET Commission of the Regional Education Bureau, TVETs, and health colleges in project areas and the region as a whole.

Nationally, ESHE has worked closely with the Federal Ministry of Health and the Ministry of Finance and Economic Development to review and set the national agenda around child survival and health sector reform, such as the *Health Service Delivery, Administration and Management Proclamation* (see page 22).

CHILD SURVIVAL PARTNERSHIP

The Child Survival Partnership in Ethiopia was initiated by a visit from members of the Global Child Survival Partnership in December 2003, followed by the National Child Survival conference in April 2004. The purpose of the Global and National Partnership is to refocus attention on the unfinished agenda of child survival.

ESHE actively participated with USAID, WHO, UNICEF, World Bank and CIDA in the technical committee which organized the National Child Survival Conference and the National Child Survival Partnership Core Committee established thereafter. The technical committee worked hard with the Federal Ministry of Health on the advocacy and sensitization activities for child survival and facilitated the development of the National Child Survival Strategy.

In response to the call for the 'second child survival revolution' following the June 2003 *Lancet* series, Ethiopia is one of the first countries in the world where the global child survival partnership visited to have a developed a child survival strategy. Ethiopia's child survival strategy used as its foundation the June 2003 *Lancet* five-part series on child survival. In collaboration with the World Bank and UNICEF, ESHE provided technical assistance in the use of the Marginal Budgeting of Bottlenecks tool to identify the gaps in financial and human resources required to achieve the Millennium Development Goals for child and maternal mortality reduction. Publication of 2,500 copies of the national strategy was also financially supported by ESHE.

COLLABORATION WITH OTHER USAID-FUNDED COOPERATING AGENCIES

ESHE works closely with other USAID-funded projects to strategically leverage resources, ensure synergies, and eliminate duplication among and between activities.

ESHE shares to coordinate partners' forums with agencies working in each region, including Pathfinder International, JSI/DELIVER, and Intra-health International. These meetings enable the agencies to look for potential areas for collaboration while coordinating grassroots-level activities.

The Kokeb Kebele initiative described on page 17 is another example of programs linking to achieve goals beyond those they could achieve individually.

On request from Pathfinder, ESHE provided radio production training to assist in strengthening their behavior change communication efforts.

ESHE also draws on the expertise of other agencies to support its work. For example LINKAGES has been instrumental in helping ESHE develop nutrition materials and conduct training for radio producers on breastfeeding.

SHARING RESOURCES TO MAXIMIZE IMPACT

While ESHE targets its work in three regions, there are many opportunities to expand the approaches and materials developed by the project by sharing with other agencies.

During trainings, ESHE regularly invites partner organizations working in child survival activities outside the focus woredas to participate for expanded impact of interventions and for better collaboration and coordination with the partners. ESHE's Community Health Promoter Initiative—and the corresponding training and BCC materials—is being replicated by the GOAL project in non-ESHE zones in SNNP, for instance.

ESHE has also conducted trainings for participants from GOAL and the Catholic Southern Vicariate to update them on nutrition and BCC approaches and strategies.

CHPs discussing the content of the FHC in preparation for field practice

Photo by Tefera Tamiru/ESHE Project

LESSONS LEARNED

The CHPI has opened a door and is enabling health professionals to work with communities and tap into their potential to improve family health.

Health professionals were not readily working with or involving community members in their own health. Involving key health staff in the CHPI has shifted health worker perceptions of the importance of community involvement. Health workers have restored trust and built bridges that are already improving heath at the local level.

The CHPI has also created awareness among health professionals about the importance of preventive activities in reducing child morbidity and mortality, as opposed to solely focusing on curative aspects of their work.

Creating synergy between Health Service Extension Workers and Community Health Promoters mutually benefits the work of both groups.

CHPI provides essential support to the national HSEP. HEWs, who work at a ratio of 1:2500 population, need to leverage and work with community health promoters, who serve fewer people and live in the communities they serve. Volunteer CHP need the continuous support and encouragement of the new HEWs cadre.

Volunteers can be satisfied under certain conditions, particularly when they see personal benefit.

When people can serve as role models and also receive the benefits they are prescribing to others (for example; a latrine, immunizations), they are more motivated to participate. The demand upon volunteers' time must be limited, however, and their contributions must be publicly acknowledged. The Community Festival approach that ESHE is implementing (see page 16) provides such recognition.

Community Health Promoters Training in Amhara, Meket woreda

Photo by Dr. Tadele Bogale/ESHE Project

Materials for local use must be translated centrally to standardize language, then be reviewed locally.

Initially, ESHE depended on CHP trainers and other trainers to translate materials simultaneously from English as they were conducting the training. ESHE staff quickly found that such spontaneous translations lead to a lack of standardization of key messages. Community health promoters were learning slightly different information, with different terminology.

In response, ESHE translated CHP materials centrally, using simple terms for its low-literacy audience, and disseminated them widely across the three regions.

Training modules for health facility staff must be adapted for community health promoters.

Some of the existing training materials on Essential Nutrition Actions were too technical for low-literacy community health promoters. They have been simplified and illustrations have been added to make them more understandable.

Conducting trainings in regional facilities has many benefits.

Regional trainings at various sites allow different facilities to benefit from serving as a practical training site. Staff members at the site can learn from changes as they are implemented—even if they do not attend the training. Pre-service trainees leave with the model of good services. Regional trainings are less expensive and require less travel time and time away from work for participants.

International materials and approaches must be adapted for local conditions.

The current WHO IMCI strategy is too technical and complex for local conditions in Ethiopia. As pneumonia is the number one cause of death for children under-5, pneumonia treatment must be raised as a priority in the Ethiopian IMCI adaptation for the Health Extension Workers. In Project Year 3, ESHE will work with the FMoH to revise and adapt the IMCI strategy and training materials to meet local needs.

There is a need for consistent follow-up and frequent consultations to introduce and institutionalize health system reform and change.

Follow-up to training is a critical component of success; it reinforces learning and enables trainers to modify behavior, correct misinformation and problem-solve on the job. Follow-up also enriches future trainings as the trainer can review any information that is not retained. If follow-up is not planned in advance, however, it often falls by the wayside—and consequently the training is less effective.

When health workers use data to improve programs at the local level, programs improve and data is improved at every level.

When health facility staff learn to collect HMIS data, they must also learn to use the data to assess their own facility's work before sending the data up to a higher level. Using data for local self-assessment, monitoring, and planning improves performance at each level. It also improves data collection, including completeness, timeliness, and accuracy of the entire HMIS.

ANNEX 1
SUMMARY OF TRAININGS

Summary of Trainees by Thematic Area

July 2004 - June 2005

Training	Amhara			Oromia			SNNP			Cumulative (3 regions)		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
CHPI												
CHPI TOT	93	11	**104**	117	49	**166**	149	11	**160**	359	71	**430**
CHP	229	158	**387**	2,881	2,074	**4,955**	2,149	1,747	**3,896**	5,259	3,979	**9,238**
ENA												
Technical TOT	21	2	**23**	25	4	**29**	14	4	**18**	60	10	**70**
BCC TOT	19	7	**26**	95	25	**120**	58	12	**70**	172	44	**216**
BCC			**-**	26	38	**64**	22	11	**33**	48	49	**97**
EPI												
TOT	93	10	**103**	91	11	**102**	70	15	**85**	254	36	**290**
Health Worker	345	189	**534**	284	268	**552**	392	132	**524**	1,021	589	**1,610**
HMIS												
Refresher	24	2	**26**	67	6	**73**	71	6	**77**	162	14	**176**
Supervision												
TOT	29	1	**30**	-	-	**-**	29	3	**32**	58	4	**62**
HSEP												
TOT	19	1	**20**	17	-	**17**	27	8	**35**	63	9	**72**

ANNEX 2
TABLES AND FIGURES

Table 1: Quality of EPI Service among Visited Health Facilities (%)

Quality Indicator	Amhara (n=66)	Oromia (n=90)	SNNP (n=62)	Total (n=218)
Provides EPI daily	80	61	80	72
Use of safety box	86	88	89	88
Functioning refrigerator	64	60	85	68
Blank vaccination card available	88	81	66	79
Use of foam pad	76	49	55	59
EPI monitoring chart in place and up-to-date	35	77	73	63
DPT 3 at or above plan	30	76	15	44

Table 2: Availability of Oral Drugs and Vaccines at the Time of Visit (%)

Oral drug and Vaccine	Amhara	Oromia	SNNP (n=58)	Total
ORS	97 (n=33)	91 (n=24)	98	95
Cotrimoxazole	88 (n=33)	67 (n=24)	93	83
Antimalarial drugs	67 (n=33)	100 (n=24)	93	87
Mebendazole/Albendazole	88 (n=33)	100 (n=24)	93	94
BCG vaccine	95 (n=66)	62 (n=90)	98	85
Polio vaccine	92 (n=66)	65 (n=90)	100	86
DPT vaccine	93 (n=66)	65 (n=90)	90	83
Measles vaccine	90 (n=66)	64 (n=90)	100	85

Table 3: DPT and Measles Performance from July 2004 - 2005 (%)

Region	DPT 1	DPT 3	DPT 1 -DPT 3 Dropout	Measles
Amhara				
ESHE woredas	78	73	7	56
Regional total	74	68	8	41
Oromia				
ESHE woredas	92	75	19	42
Regional total	87	65	25	37
SNNP				
ESHE woredas	103	97	6	87
Regional total	90	85	7	77

Figure 1: DPT 3 Performance of ESHE Focus Woredas Compared to Regional Performance in Amhara Region

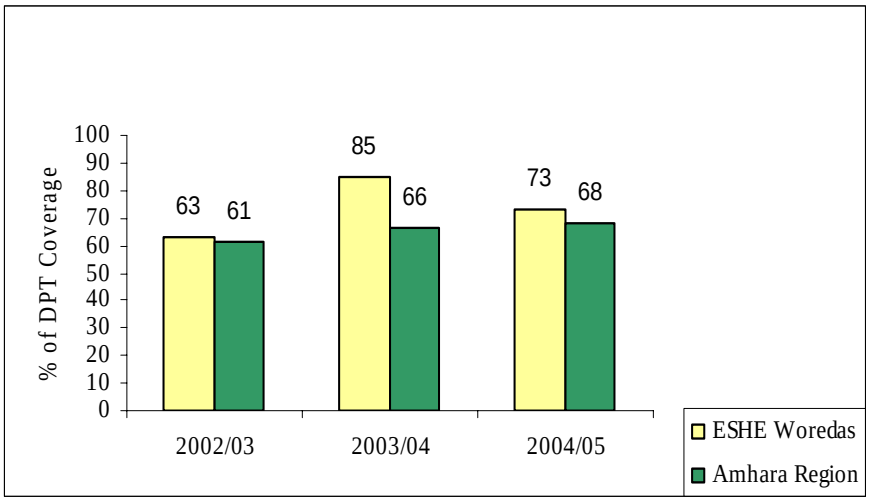


Figure 2: DPT 3 Performance of ESHE Focus Woredas Compared to Regional Performance in Oromia Region

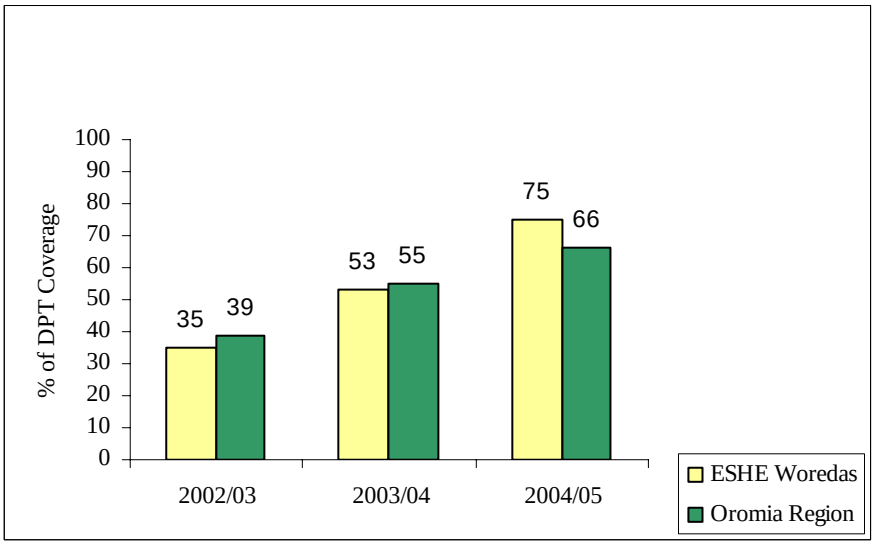
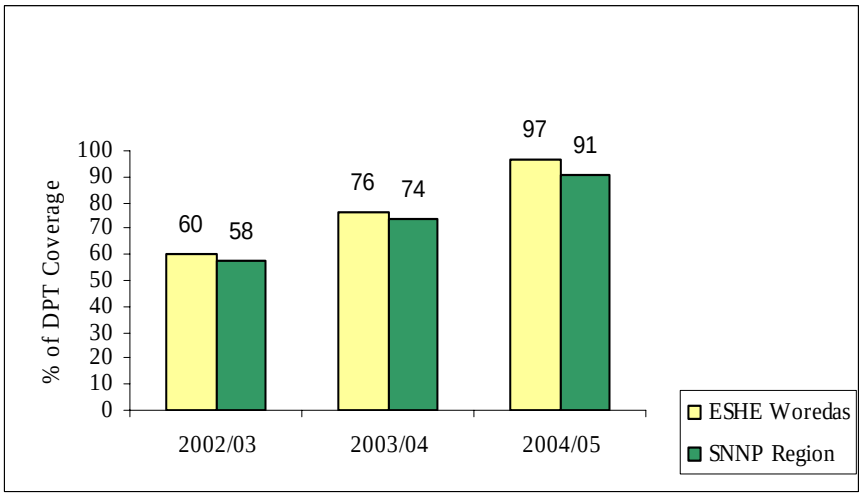


Figure 3: DPT 3 Performance of ESHE Focus Woredas Compared to Regional Performance in SNNP Region



ANNEX 3

ESHE FOCUS WOREDAS EPI PERFORMANCE

ESHE Focus Woredas EPI Performance (Data Source: RHBs)							
			DPT3 %		Measles %		Vit. A %
Region	Zone	Woreda	Baseline (2003-04) (See Note A)	Actual (2004-05)	Baseline (2003-04) (See Note A)	Actual (2004-05)	Actual (2005) (See Note B)
Amhara	West Gojam	Yilmana Densa	102	68	90	55	89
		Bahir Dar Zuria	90	55	71	47	94
		Mecha	100	91	84	84	104
		Achefer	93	78	77	67	100
		Jabi Tehnan	80	67	51	53	84
	South Gonder	Dera	71	45	35	46	92
		Estie	78	72	42	49	112
		Fogera	87	78	42	49	96
		Libo Kemekem	98	73	66	43	103
		Simada	52	58	44	41	98
	North Wello	Guba Lafto	82	54	41	89	91
		Gidan	75	75	44	36	96
		Meket	95	115	69	41	100
		Wadla	91	54	57	61	98
		Delanta Dawunt	81	66	51	108	72
	South Wello	Legambo	99	77	77	69	90
		Tenta	78	133	52	73	95
		Dessie Zuria	89	73	73	56	85
		Kutaber	66	59	55	42	104
		Tehuledere*	-	63	-	47	47
ESHE Focus Woreda Total**			**85**	**73**	**62**	**59**	**93**
Amhara Region Total			**66**	**68**	**54**	**64**	-
Oromia	West Harerge	Chiro	29	54	64	63	
		Darolebu	23	64	22	48	
		Doba	55	77	40	62	
		Goba Koricha	45	30	24	50	
		Mesela	74	90	57	104	93
	East Shewa	Adami Tulu	49	85	35	55	
		Ada'a Chukala	66	68	56	48	
		Boset	60	70	47	51	
		Gimbichu	94	74	85	66	
		Siraro	42	75	38	70	
	East Harerge	Haro Maya	65	97	52	87	119
		Fedis	31	65	35	53	98
		Meta	70	93	60	76	93
		Gursum	64	49	63	54	87
		Deder	87	102	74	82	94
	North Shewa	Dera	70	85	30	71	
		Gerar	74	90	41	67	
		Wuchalena Jido	41	53	41	46	
		Wara Jarso	70	104	55	91	
		Kuyu	35	57	28	26	
ESHE Focus Woreda Total			**53**	**75**	**44**	**64**	**97**
Oromia Region Total			**55**	**66**	**44**	**64**	**-**

ESHE Focus Woredas EPI Performance (Data Source: RHBs)							
			DPT3 %		Measles %		Vit. A %
Region	Zone	Woreda	Baseline (2003-04) (See Note A)	Actual (2004-05)	Baseline (2003-04) (See Note A)	Actual (2004-05)	Actual (2005) (See Note B)
SNNP	Sidama	Awassa Zuria	63	124	74	97	99
		Boricha	73	117	73	91	92
		Shebedeno	110	140	86	133	100
		Dale	82	111	68	95	83
		Aleta Wondo	80	102	61	106	83
	Hadiya -KT	Angacha	95	92	79	83	104
		Kedida Gamela	53	100	39	98	118
		Omo Sheleqo	75	70	73	65	93
		Misha	104	102	79	105	105
		Lemo	75	81	73	75	77
		Badewacho	86	98	70	71	130
		Soro	68	101	61	88	82
	Gamugo-Konso	Arba Minich Zuria	55	50	45	44	70
		Bonke	62	73	52	77	83
		Merab Abaya	92	99	71	95	100
		Kucha	70	97	59	90	83
		Gofa Zuria	28	44	25	42	
		Konso Sp. W.	75	107	64	88	74
	Wolayita Alaba	Bolsso Sore	120	107	130	103	105
		Damot Gale	60	100	57	82	105
		Damot Weyide	79	104	69	93	106
		Kindo Koyisha	78	111	66	100	
		Sodo Zuria	97	92	88	85	91
		Alaba Sp. W.	67	84	56	66	
ESHE Focus Woreda Total			**76**	**97**	**67**	**86**	**93**
SNNP Region Total			**74**	**91**	**55**	**83**	**43**

Note A: Actual data for 2003/04 serves as baseline for ESHE focus woredas

Note B: Vitamin A supplementation in EOS woredas January - June 2005 only. No systematic Vitamin A supplementation conducted in woredas where no data listed.

* New ESHE woreda replaces Kalu, no baseline data available

** Total baseline includes Kalu woreda and Actual includes Tehueledere.

ANNEX 4

ESHE TARGETS v ACHIEVEMENTS

Indicator	Operational Definition	Survey Baseline			Routine HMIS Baseline			Year 2 Target (Routine)			Year 2 Achieved (Routine)		
		Amhara 04	Oromia 04	SNNP 03	Amhara 02/03	Oromia 02/03	SNNP 02/03	Amhara	Oromia	SNNP	Amhara	Oromia	SNNP
IR 14.1 Use of high impact health, family planning, and nutrition services, products and practices increased													
DPT3	No. of children 12-23 mo. old vaccinated with DPT3 by age 12 mos/no. of children 12 -23 months old surveyed	49%	33%	46%									
	No. DPT3 doses dispensed to children to 0-11 months old / estimated no. of surviving infants				63%	35%	60%	80%	70%	80%	73%	75%	97%
Protected against neonatal tetanus	% women with children 0-11 months old who received at least two TT doses during last pregnancy or adequate no. before that pregnancy	41%	48%	62%									
Polio3	No. children 12-23 months old vaccinated with OPV3 by age 12 mos./no. of children 12-23 months old	50%	39%	57%									
	No. OPV3 doses dispensed to children to 0-11 months old/ estimated no. of surviving infants				61%	NDA	50%	70%	70%	80%	NDA	73%	95%

NDA = No Data Available; * Based on 5 EOS woredas; ** Based on 20 EOS woredas
Amhara 02/03 routine HMIS baseline data refers to ESHE target zones

Indicator	Operational Definition	Survey Baseline			Routine HMIS Baseline			Year 2 Target (Routine)			Year 2 Achieved (Routine)		
		Amhara 04	Oromia 04	SNNP 03	Amhara 02/03	Oromia 02/03	SNNP 02/03	Amhara	Oromia	SNNP	Amhara	Oromia	SNNP
Exclusive Breast-feeding	Number of children 0-5 months exclusively breastfed / children 0-5 months surveyed	75%	45%	54%									
Vitamin A	No. of children 6-23 months receiving vitamin A supplementation/no. of 6-23 mo. olds surveyed	18%	30%	13%				65%	53%	80%	NDA	98%*	89%**
Sub-IR 14.1.2 Availability of key health services and products improved													
Index of essential oral drugs (out of 7)	Facilities with ORS, Cotrimoxazole, anti-malarial, Vitamin A, iron, mebendazol, paracetamol/aspirin	6.4	5.7	6.4									
Index of essential child vaccines (out of 4)	BCG, Polio, DPT, Measles	3.7	3.3	3.6									
Sub IR.14.1.3 Quality of key health services improved													
DPT1 to DPT3 dropout rate	% children 0-11 months who received DPT1 minus % who received DPT3 / % of 0-11 mos. olds who received DPT1	21%	33%	29%	9%	29%	19%	10%	20%	10%	7%	19%	6%
% WorHOs conduct supervision quarterly	WorHOs conducted at least one supportive supervision to the health facilities / WorHOs visited by ESHE staff	19%	6%	40%				30%	30%	30%	50%	13%	31%

NDA = No Data Available; * Based on 5 EOS woredas; ** Based on 20 EOS woredas

TRAINING

Indicator	Operational Definition	Amhara			Oromia			SNNP			Three Regions		
		Target	Achieved	% Achieved	Target	Achieved	% Achieved	Target	Achieved	% Achieved	Target	Achieved	% Achieved
Sub-IR 14.1.1 Community support for high impact health interventions increased													
Community													
CHP Trained	No. of Community Health Promoters trained in ESHE-supported training	5,500	387	7%	6,000	4,955	83%	5,500	3,896	71%	17,000	9,238	54%
# Kebeles with CHP		226	11	5%	311	311	100%	216	382	177%	753	704	93%
Sub-IR 14.1.2 Availability of key health services and products improved													
Technical Trainings													
EPI		630	637	101%	530	654	123%	500	609	122%	1,660	1,900	114%
ENA		600	49	8%	600	213	36%	620	121	20%	1,820	383	21%
Health Managers													
Management Supervision/ HMIS		40	56	140%	40	73	183%	40	109	273%	120	238	198%

ANNEX 5
ESHE PUBLICATIONS AND TOOLS IN THE LIFE OF THE PROJECT

- ESHE and Amhara RHB, "Health Care Financing Survey," 2004
- ESHE and Oromia RHB, "Health Care Finance Survey," 2004
- ESHE and SNNP RHB, "Health Care Finance Survey," 2004
- ESHE and Amhara RHB, "Household Survey," 2004
- ESHE and Oromia RHB, "Household Survey," 2004
- ESHE and SNNP RHB, "Household Survey," 2003
- ESHE and Amhara RHB, "Health Facility Survey," 2004
- ESHE and Oromia RHB, "Health Facility Survey," 2004
- ESHE and SNNP RHB, "Health Facility Survey," 2004
- ESHE and Amhara RHB, "Performance Improvement Survey," 2004
- ESHE and Oromia RHB, "Performance Improvement Survey," 2004
- ESHE and SNNP RHB, "Performance Improvement Survey," 2004

- Summary of Twelve Baseline Health Surveys, 2005

- Refresher Training for Frontline Health Workers, EPI target diseases, vaccines and their administration, EPI Module 1, 2005
- Refresher Training for Frontline Health Workers, The cold chain, EPI Module 2, 2005
- Refresher Training for Frontline Health Workers, How to provide safe and quality immunization service, EPI Module 3, 2005
- Refresher Training for Frontline Health Workers, Communicating with caretakers and communities for improved routine immunization coverage, EPI Module 4, 2005
- Refresher Training for Frontline Health Workers, monitoring immunization coverage, drop-out and quality of service, EPI Module 5, 2005
- Integrated Supervisory Checklist for Zonal Health Desk
- Integrated Supervisory Checklist for Woreda Health Office
- Integrated Supervisory Checklist for Health Center
- Integrated Supervisory Checklist for Health Post
- ESHE Health Facility Follow up Checklist
- ESHE Woreda Health Office Follow up Checklist
- ESHE Cluster Staff Monthly Reporting Format
- ESHE Regional Office Quarterly Reporting Format

- Management Performance Standards for Regional Health Bureau
- Management Performance Standards for Zonal Health Desk
- Management Performance Standards for Woreda Health Office
- Management Performance Standards for Health Center
- Management Performance Standards for Health Post
- Facilitators Guide for HMIS Refresher Training
- Facilitators Guide for Supportive Supervision Training
- Family Health Card (FHC)
- Immunization Diploma (ID)
- Training Guide on How to use the FHC and ID
- EPI Radio Spots
- Community Health Promoters Initiative TOT Manual
- Community Health Promoters Training Manual
- Health Service Extension Program Training Guide

ANNEX 6
ESHE FOCUS WOREDAS POPULATION

Amhara Region			Oromia Region			SNNP Region		
Zone	**Woreda**	**Popn.**	**Zone**	**Woreda**	**Popn.**	**Zone**	**Woreda**	**Popn.**
South Gondor	Esite	384,431	***North Shewa***	Dera	183,428	***Gamo Gofa***	Arba Minch Zuria	217,707
	Kemekem	288,416		Wara Jarso	151,277		Bonke	146,982
	Dera	276,249		Wuchalena Jido	134,847		Gofa Zuria	227,765
	Simada	242,514		Kuyu	132,502		Kucha	137,676
	Fogera	243,296		Gerar Jarso	112,234		Merab Abaya	101,417
North Wello	Meket	250,071	***East Shewa***	Siraro	236,712	***Hadiya***	Badawacho	237,675
	Delanta Dawunt	187,907		Ada'a Chu-kala	332,017		Lemo	319,390
	Guba Lafto	178,683		Boset	149,085		Misha	203,491
	Gidan	175,621		A/Tulu Jido Kombolcha	156,508		Soro	255,242
	Wadla	137,365		Gimbichu	82,739			
South Wello	Dessie Zuria	259,387	***West Hararge***	Chiro	391,013	***Kambata Tembaro***	Angacha	209,123
	Tehuledere	156,168		Goba Koricha	183,026		Kedida Gamela	191,699
	Legambo	205,221		Mesela	146,625		Omo Shekelo	169,735
	Tenta	178,427		Darolebu	147,409			
	Kutaber	163,712		Doba	120,489			
West Gojam	Merawi	318,075	***East Harerge***	Meta	227,899	***Sidama***	Aleta Wendo	367,639
	Adet	318,016		Deder	239,019		Awassa Zuria	484,337
	Achefer	310,044		Haro Maya	223,562		Boricha	255,062
	Bahir Dar Zuria	256,901		Fedis	197,026		Dale	416,842
	Jabi Tehnan	257,668		Gursum	200,505		Shebedino	300,152
						Wolaita	Boloso Sore	338,992
Total	**20 Woredas**	**4,788,172**	**Total**	**20 Woredas**	**3,747,922**		Damot Gale	294,572
							Damot Weyde	201,126
							Kindo Koysha	189,090
							Sodo Zuria	279,744
						Special Woreda	Konso	212,255
							Alaba	255,127
						Total	**24 Woredas**	**6,012,840**

Total Project Woredas **64**

Total Project Woredas Population **14,548,934**

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