



USAID
FROM THE AMERICAN PEOPLE

Essential Services for Health in Ethiopia



Final Report
November 2003—September 2008

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

Essential Services for Health in Ethiopia

was a five-year project implemented by John Snow, Inc.,
in collaboration with
Abt Associates, Academy for Educational Development, and Initiatives, Inc.

This Report is made possible by the support of the American people through the United States Agency for International Development (USAID) under Contract 663-C-00-04-00403-00. The contents are the sole responsibility of John Snow, Inc. and do not necessarily reflect the views of USAID or the United States Government.



The **Essential Services for Health in Ethiopia (ESHE) Project** was 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 collaborated with health offices at all levels to reduce child deaths and strengthen the health system.

ESHE's work targeted 12 zones of three of Ethiopia's most populous regions—Amhara, Oromia, and the Southern Nations, Nationalities, and Peoples'—encompassing 101 woredas and a population of more than 15 million. In addition, ESHE activities were designed to extend beyond the boundaries of the focus kebeles and woredas in the three regions through trainings and sharing of materials.

ESHE's success contributed to Ethiopia's efforts as it moves toward achieving the Millennium Development Goals (MDG) of reducing child deaths under five years of age by two-thirds.

Table of Contents

Letter from the Project Director	2
Essential Services for Health in Ethiopia	4
Strengthening Health Worker Skills:	
Immunization	6
Nutrition	8
IMNCI	10
Community Mobilization:	
Community Health Promotion Initiative	12
Behavior Change Communication	14
School Health Activity	16
Support to the Health Extension Program	18
Improved Health Systems:	
Health Care Financing	20
Performance Improvement	22
Regional Overviews:	
Amhara	24
Oromia	26
SNNP	28
Monitoring and Evaluation for Health	30
 APPENDICES	
Appendix 1: ESHE Performance Indicators and Targets for Focus Woredas	32
Appendix 2: Training by Intermediate Result	35
Appendix 3: Summary of ESHE-Led Trainings	36
Appendix 4: ESHE-Produced Publications	37



Acronyms and Abbreviations

AED	Academy for Educational Development	ICC	Inter-agency Coordinating Committee
ANC	Antenatal Care	ID	Immunization Diploma
BCC	Behavior Change Communication	IMCI	Integrated Management of Childhood Illnesses
BoFED	Bureau of Finance and Economic Development	IMNCI	Integrated Management of Newborn and Childhood Illnesses
CBRHA	Community Based Reproductive Health Agents	ISCL	Integrated Supervisory Checklist
CHP	Community Health Promoter	JSI	John Snow, Incorporated
CHPI	Community Health Promot Initiative	MBB	Marginal Budgeting for Bottlenecks
CTC	Community Therapeutic Center	MDG	Millennium Development Goal
DHS	Demographic and Health Survey	M&E	Monitoring and Evaluation
DTP3	Diphtheria, Tetanus, Pertussis, full course	MOH	Ministry of Health
ENA	Essential Nutrition Actions	NGO	Nongovernmental Organization
EPI	Expanded Program on Immunization	PMTC	Prevention of Mother to Child Transmission
ESHE	Essential Services for Health in Ethiopia	PTA	Parent-Teacher Association
FHC	Family Health Card	RHB	Regional Health Bureau
FMoH	Federal Ministry of Health	SNNPR	Southern Nations, Nationalities, and Peoples' Region
HC	Health Center	TA	Technical Assistance
HCF	Health Care Financing	TOT	Training of Trainers
HCP	Health Communications Partnership	TVET	Technical, Vocational, and Educational Training Institution
HEC	Health Education Center	UNICEF	United Nations Children's Fund
HEP	Health Extension Program	USAID	United States Agency for International Development
HEW	Health Extension Worker	VCHW	Voluntary Community Health Workers
HHS	Household Survey	WHO	World Health Organization
HMIS	Health Management Information System	WorHO	Woreda Health Office
HP	Health Post	ZHD	Zonal Health Department

Letter from the Project Director

Between 2003-2008, Essential Services for Health in Ethiopia (ESHE) worked in support of child survival and health sector reform in Ethiopia's three most populous regions. ESHE operated in 101 woredas that are home to more than 15 million people.

ESHE worked in concert with many partners and, indeed, the changes and improvements seen in the health system, providers' skills, and family health would not have been possible without commitment from all levels. ESHE partnered with the Federal Ministry of Health and operated within existing structures of regional health bureaus, zonal health desks, woreda health offices, health facilities, and local communities. The very close collaboration and partnership with the Health Extension Program at woreda level resulted in the creation of a vast network of 54,500 community health promoters who are engaging their friends and fellow community members in improving their own families' health.

None of the successes of the ESHE project would have been accomplished without this significant teamwork and partnership.

Funded by USAID and implemented by John Snow, Inc., in collaboration with Abt Associates, Academy for Educational Development, and Initiatives, Inc., ESHE followed a three-pronged approach: strengthen health worker skills through training and supervision; improve community health through behavior change communication; and strengthen regional health systems with regard to health care financing, performance improvement and health management information system implementation. For health care financing reform, the interventions were national and regional in scope.

In 2004, ESHE with its partners in the three regions, conducted surveys that provided extensive baseline data to understand child and maternal health status, to assess performance of key systems, and to plan interventions strategically. In 2008, end-line surveys were conducted to evaluate progress after those interventions in the three regions. End-line survey findings revealed strong progress in the health system, documented enhanced health worker skills, and showed improved community household health practices.

In addition to these planned efforts, ESHE went beyond the call of its initial intentions. In 2006, USAID asked ESHE to pilot an approach to complement the Community Therapeutic Care program with funds from the Office of Foreign Disaster Assistance. ESHE activities in one woreda selected for that purpose focused on preventing and mitigating excess morbidity and improving health and nutrition preparedness for future emergencies.

This report provides an overview of ESHE's work in concert with its national and regional partners. It presents on-the-ground innovations and reviews efforts to reach households in order to engage them in changing health behaviors. It is by no means an exhaustive report of ESHE's five years; but is designed to give project-relevant information in an accessible format.

Ethiopian wisdom notes, “*When spider webs unite, they can tie up a lion.*” This proved true for the ESHE project, which found extraordinary success through collaboration. Over the past five years many partners joined us in our efforts. Each agency brought its special expertise, and made a valuable contributions to overall results. We extend deep thanks to all of our partners for their dedication and support. We could not have succeeded without them. We thank the Federal Ministry of Health and the regional health bureaus for the support they have provided to this project.

Peter Eerens

Project Director

Essential Services for Health in Ethiopia

The Essential Services for Health in Ethiopia (ESHE) project was the second five-year program funded by the United States Agency for International Development (USAID) that worked to integrate child survival interventions and health sector reform to improve family health. ESHE I, which ran from 1998-2002, focused primarily on the SNNP Region. ESHE II ran from 2003-2008 and expanded the work begun under ESHE I. The ESHE team worked closely with health offices at all levels to reduce child deaths and strengthen health systems.

The ESHE mandate was to work in what are now 101 woredas in the three most populous regions of Ethiopia, regions that account for more than three-quarters of the population: Amhara, Oromia, and Southern Nations, Nationalities and Peoples' (SNNP). In Amhara, Oromia, and SNNP, 24, 25, and 52 woredas, respectively, were selected for intervention, at the request of the regional health bureaus (RHBs). 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 evident as different organizations and zonal health desks (ZHDs) used ESHE training and behavior change materials for their own areas.

ESHE II followed “best practices” of ESHE I by strategically decentralizing, placing technical assistance as close to the client as possible. The woreda health office (WorHO), health facility, and community was the focus, with a small team of two technicians, one vehicle and driver located in each of four zones of the three regions. These 12 zonal teams focused their support on a cluster of five woredas each. At regional level, a small technical team was placed to not only support these four clusters but to cross-fertilize lessons learned and best practices to the RHB team in order to influence programming across the region. Likewise, a technical team in Addis was designed to cross-fertilize the three regions and bring lessons to the Federal Ministry of Health (FMOH) to influence the vision and policies at national level.

ESHE was designed for an expanded impact beyond the 101 woredas where a more intensive effort would be focused. A commitment was made to fully support the new government Health Extension Program (HEP) at federal level and in each of the focus regions. A renewed commitment was made to accelerate the health sector reform nationwide, with a focus on health care financing (HCF). The ESHE decentralized structure proved ideal to bring HCF from its regional legal framework to health facilities to create tangible changes through fee retention, revision of waiver and exemption guidelines, and special pharmacies, to name a few.

ESHE's success has not only improved the health system—and thus the health of Ethiopians—it has also assisted the country toward achieving 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-five mortality from 200/1,000 children to 67/1,000 children. ESHE is assisting in this effort.

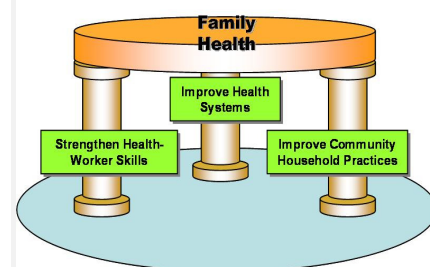
The Three Pillars Approach

Experience has shown that a positive impact on health outcomes is difficult without implementing comprehensive and integrated interventions that address three critical areas: health provider skills, health systems, and family and community health. ESHE called this the three-pillar approach

ESHE worked closely with health offices to improve the quality and utilization of high-impact child survival interventions in the form of the extended program on immunization (EPI), essential nutrition actions (ENA), and integrated management of newborn and childhood illnesses (IMNCI). Key approaches included training to build capacity, mobilizing communities, and encouraging personal behavior change through various communications.

In the health sector reform arena, ESHE worked 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 provided support to implementation of health care financing.

The three pillars....



This final report presents an overview of the ESHE project activities and results between November 2003 and the end of the project in September 2008. It covers the three pillars—strengthening health worker skills, mobilizing communities to improve household practices, and improving the health systems. 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.

Support from the ESHE project has contributed to notable progress by the three focus regions in the following areas:

- Where once communities only had limited access to health workers at health centers, today, health workers are in nearly every village. ESHE supported training of more than 54,500 volunteer community health workers to assist them—reaching more than 12 million people.
- Where once fewer than half of all infants under age one were fully immunized (DPT3/Penta3), today, DPT3/Penta3 coverage has increased in ESHE-supported areas from 44% to 66%.
- Where once less than half of all infants were immunized against measles (46%), today, more than two-thirds (64%) of children are immunized against measles.
- Where once mothers threw away the very beneficial colostrum first breastmilk, today, mothers realize its value to their newborns and start breastfeeding immediately. Early initiation increased from 46% to 72%.
- Where once only 59% of children aged 0 to 5 months were exclusively breastfed, today, 79% are realizing the health benefits of exclusive breastfeeding.
- Where once only 35% of children 6 to 23 months received vitamin A supplementation, today, that number has almost doubled to 65%.
- Where once only 29% of pregnant women were protected from anemia with iron folate supplementation, today, almost half (46%) of pregnant women receive the supplement.
- Where once only 2% of households had insecticide-treated bed nets, today, 52% of children under five years of age and pregnant women are protected from malaria by bed nets nationwide.
- Where once there were not enough funds to allocate budget for health services, today, per capita budgets have more than doubled across ESHE's three focus regions.
- Where once health facilities by law had to transfer income they collected out of the facility, today, those laws have changed and health facilities can retain and use their internal revenue.
- Where once selection of fee-waiver beneficiaries was not appropriate, it has now been systematized and, in one of ESHE-focus regions, more than 1 million beneficiaries have been selected and begun utilizing health services.

Strengthening Health Worker Skills

Immunization

Immunization is a cornerstone program to reduce child deaths. Vaccine-preventable diseases account for approximately 10% of the global burden of mortality in children under five years of age or 1.1 million child deaths each year. To ensure children receive a full course of immunizations in a timely, safe, and effective way, services must be accessible, of high quality, and utilized. The World Health Organization (WHO) estimates that one in four children's lives can be saved through the full Expanded Program on Immunization (EPI) series of vaccines. In Ethiopia, EPI coverage between 2001-2006 showed modest improvements but remained below the WHO-recommended coverage of 80%. Considering the large population of the country, the absolute number of children dying from vaccine-preventable diseases remains significant.

ESHE Approach

ESHE's goal was to scale-up to reach all frontline health workers in the 101 focus woredas, while also working to achieve expanded impact in non-focus zones and woredas of the three regions.

ESHE worked closely with the Amhara, Oromia, and SNNP Regional Health Bureaus to increase immunization program performance and to build the capacity of service providers through refresher trainings in EPI using project developed modules. Experiences gained in SNNP under ESHE I were used to promote improved coverage in all focus woredas.

Once ESHE was launched, the project realized the need for short, yet comprehensive, refresher training in EPI. ESHE staff consulted materials from WHO, BASICS, and several countries to design EPI materials geared to Ethiopia's needs for refresher training. Materials include five *EPI Modules* and one *Facilitator's Guide*, which address infectious diseases that can kill or disable children and the vaccines that can prevent them. These materials were updated to include the newly-introduced pentavalent vaccines. Counseling for behavior change and EPI system strengthening were emphasized. These products were field-tested and used for the trainings supported by the three regional ESHE offices. Following the trainings, EPI performance in ESHE focus woredas was compiled and analyzed. Those with low EPI performance were identified and targeted for more intensive follow-up. Due to high health center staff turnover, EPI refresher trainings were offered annually for new staff.

Health extension workers (HEWs) in communities play a very important role in opening access to immunization, critical to achieving high coverage rates and ensuring completion of immunization within the recommended period. Community volunteers play an essential role of increasing demand for immunization.

ESHE's multi-pronged approach reinforced the immunization trainings in communities by presenting Immunization Diplomas (IDS) to families who complete their children's vaccination schedule before their first birthday. The IDs mobilizing effect increased community turnout for immunization at health facilities and outreach sites.

Objectives

- To scale-up brief refresher trainings to reach all frontline health workers in the 101 focus woredas.
- To expand the impact of EPI training, community mobilization, and tools beyond the ESHE focus woredas

Interventions

- Develop EPI refresher training modules.
- Train and follow-up health workers and HEWs in EPI including orientation on new pentavalent vaccine.
- Provide behavior change tools to families to encourage positive health behaviors.



Photo: Penelope Riseborough

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 family planning.

Results

- Developed the EPI refresher training materials: *EPI Training of Trainers Facilitator's Guide* and five modules.
- Refresher trained and followed-up 3,882 providers in EPI.
- Improved access to high-quality immunization services in three regions.
- Increased percent of health facilities with equipment and supplies to support full vaccination from 70% at baseline to 89% in 2008.
- Raised DPT3/Penta3 coverage across 101 focus woredas from 44% in 2003/4 to 66% in 2008.
- Raised measles coverage from 46% in 2003/04 to 64% in 2008 across 101 focus woredas.
- Printed and disseminated Immunization Diplomas for families that had fully immunized their children.

Results

Information on DPT1 coverage provides a good indication of population access to immunization services. Findings show that in the three regions combined, DPT1 coverage increased significantly ($p < 0.0001$) from 65% in 2003/04 to 75% in 2008. The trend was not uniform across the three regions, however. In Amhara, there was a remarkable increase, from 65% to 83%; in SNNP, from 62% to 76%. No such trend was noted in Oromia. DPT3/Penta3 coverage, being an indicator of EPI completion, also has shown an increasing trend in the three regions combined, from 46% to 57% during the period.

Coverage and trend for measles are often confounded by campaign effects. In the three regions combined, measles coverage revealed that only a little more than half of children aged 12 to 23 months had received measles vaccines. The trend remains nearly unchanged at 53% and 55% in 2003/04 and 2008, respectively. In Amhara and SNNP, positive significant temporal trends in measles coverage were noted. A reversal trend seemed to occur in Oromia.

On the whole, findings suggest that immunization coverage in the 101 ESHE-supported woredas combined showed significant improvement since 2003/04, although far short of the universal target of 80%.

Challenges

The short time between the introduction of pentavalent vaccines and the withdrawal of trivalent vaccines affected routine EPI coverage.

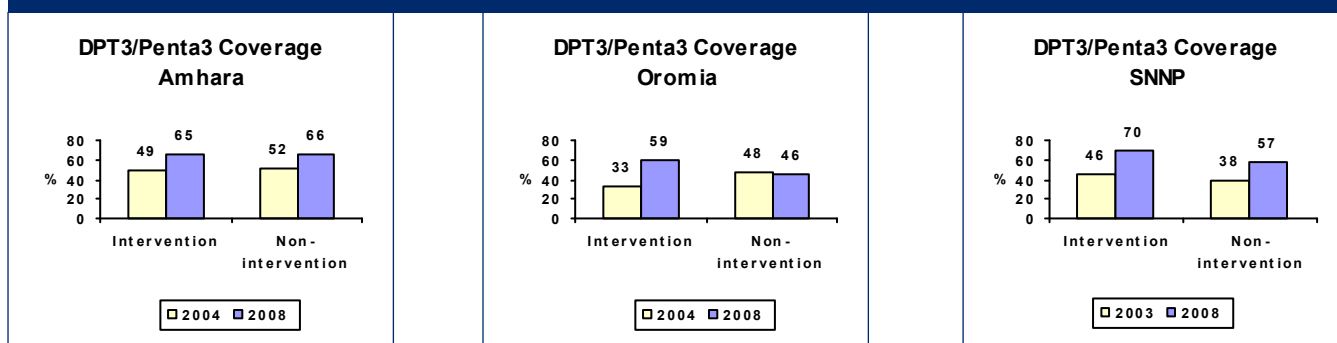
Orientation of frontline health workers on pentavalent vaccines was delayed, resulting in late introduction of DPT-Hib-HepB vaccine.

Inefficiency in operation and maintenance of refrigerators and lack of coordination among partners continue to affect EPI achievements.

Partnerships

In addition to collaborating with WHO and others on the EPI refresher training materials, ESHE worked closely with RHBs to promote all aspects of EPI, including outreach through the Reaching Every District initiative and building the capacity of health workers through trainings.

Figures 1, 2, 3: Sample Trends in DPT3/Penta3 Coverage in SNNP, Oromia, and Amhara, 2003/04-2008.
For complete results per woredas, see the 2008 Household Health Surveys.



Nutrition

According to the *Lancet*, 25% of child mortality could be averted by optimal breastfeeding and complementary feeding as well as micronutrient supplementation. In Ethiopia, malnutrition begins early in life and increases progressively through age two. Chronic malnutrition plagues half of Ethiopia's children and is the underlying cause of approximately 57% of all deaths of children under five years of age. 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, combined with infections such as diarrhea.

The Ethiopian government has adopted the Essential Nutrition Actions (ENA) framework in order to achieve the MDGs to reduce child mortality and malnutrition. The ENA framework comprises an integrated and preventive package of seven nutrition actions—covering infant and young child feeding, micronutrients, and women's nutrition—which is implemented through multiple approaches, including in communities and at health facilities, for greatest impact. The Ethiopian government, with partner support, also launched a bi-annual outreach strategy providing vitamin A for children 6 to 59 months and de-worming for children 24 to 59 months.

ESHE Approach

ESHE collaborated with the USAID-funded LINKAGES and MOST projects to institutionalize preventive activities and build the ENA capacity of the regional, zonal, woreda, and health facility staff in the three focus regions.

Within the focus woredas, ESHE promoted and supported optimal breastfeeding practices and the introduction of complementary feeding and vitamin A supplementation through training of health workers, HEWs, and volunteer community health workers. ESHE also provided counseling guides for health providers and reminder materials (e.g., the Family Health Card) for target audiences. ESHE worked to strengthen the capacity of health workers and HEWs in nutritional counseling and coordinated with volunteers regarding infant and young-child feeding practices. Incorporating ENA into the prevention of mother-to-child-transmission (PMTCT) of HIV has also been critical.

Objectives

- To increase use of Essential Nutrition Actions to improve children's health.

Interventions

- Engage government to incorporate nutrition into the national health agenda.
- Train health workers and HEWs in optimal breastfeeding, complementary feeding, and vitamin A supplementation.
- Ensure standardized approach and nutrition messages are received at all health interactions.
- Develop counseling and negotiation guides for health workers.

This mother brought her severely malnourished child to an ESHE-supported clinic in Awassa.

In 2006, ESHE received funds from the Office of Foreign Disaster Assistance to pilot an approach to complement the Community Therapeutic Centers (CTC) in one of its focus woredas. CTC focuses on the relatively small group of severely malnourished children. ESHE focused on addressing the much larger number of mildly and moderately malnourished children in an attempt to prevent them from becoming severely malnourished. In line with USAID's overall objective to increase resiliency in families and communities to contain bouts of drought and famine, this approach tackles significant missed opportunities.

In the new approach, children who are screened for severe malnutrition but rejected as not being malnourished enough to qualify for therapeutic foods (plumpy nuts), receive appropriate preventive treatment and their caretakers receive nutrition counseling. This approach needs to be incorporated into all CTC programs as a necessary companion to make a sustainable transition from emergency-to-development nutrition programs.



Photo: Penelope Riseborough

Results

- Trained and followed-up 2275 health workers in ENA.
- Trained 1777 HEW and 54,582 volunteers in BCC for ENA.
- Increased proportion of children exclusively breastfed in the 3 regions from 57% in 2003/04 to 77% in 2008.
- Increased complementary feeding for children in the three regions from 49% in 2003/04 to 82% in 2008.

Results

In the three regions combined (see Figure 4), the proportion of women who exclusively breastfed their children increased significantly. There appears a consistent and parallel increase in exclusive breastfeeding practice across the three regions—from 75% to 87% in Amhara, 45% to 79% in Oromia, and 54% to 66% in SNNP.

Timely introduction of complementary feeding is defined as the percentage of children aged 6 to 9 months who were fed solid or semi-solid foods in addition to breast milk. In the three regions combined, 82% of children aged 6 to 9 months in 2008 were reported to have been given semi-solid food. This represents a significant ($p < 0.0001$) increase from the 49% reported in 2003/04. There is consistent improvement across the three regions—from 43% to 62% in Amhara, 58% to 69% in Oromia, and 56% to 71% in SNNP (Figure 5).

In each of the three regions, at end-line, more pregnant women received iron/folic acid during antenatal care (ANC) in ESHE areas than non-project areas: Amhara 40% versus 32%; Oromia 27% versus 15%, and SNNP 57% versus 24%. In particular, in the SNNP intervention areas, there was a significant increasing trend in proportion of pregnant women who received iron/folate, from 27% in 2003 to 57% in 2008 ($p < 0.001$). There was no such trend in non-ESHE areas.

In Amhara, Oromia, and SNNP, 61%, 35%, and 50%, respectively, of mothers surveyed in exit interviews at health centers received appropriate nutrition counseling. Health workers advised 49% of caretakers to offer extra fluids and feeding to their sick child during illness. This trend should be maintained as health workers skills are strengthened through other programs in nutrition and HIV and AIDS.

Partnerships

ESHE worked with the FMOH Nutrition Unit and participated in the national nutrition activities led by the Ministry. ESHE helped organize ENA trainings for health workers and health managers, including those from non-ESHE regions (Afar, Harrari, Dire Dawa, and Somali). ESHE also played a significant advocacy role, expanding dissemination of “*Why Nutrition Matters*” and participating in discussions around national nutrition policy, micronutrients, community-based nutrition, enhanced outreach strategy, and emergency nutrition response. Discussions resulted in useful recommendations on future directions.

ESHE worked with partners such as International Medical Corps (IMC) in drought-affected areas in Boloso Sore Woreda towards a comprehensive prevention of severe malnutrition in children under-five years of age.

Figure 4. Proportion of Children Exclusively Breastfed to Age 6 Months Amhara, Oromia, and SNNP, 2003/04–2008, Household Health Survey

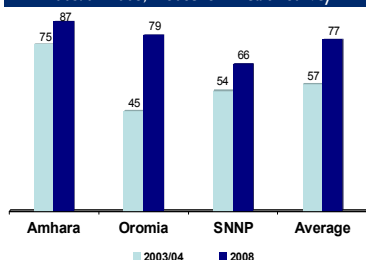
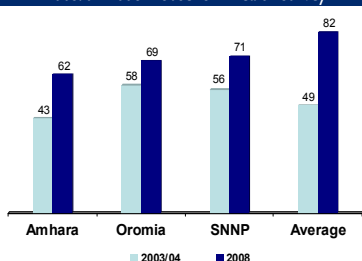


Figure 5. Proportion of Children Aged 6 to 9 Months Fed Semi-solids and Solid Foods, Amhara, Oromia, and SNNP 2003/04–2008 Household Health Survey



Integrated Management of Newborn and Childhood Illnesses

WHO introduced Integrated Management of Childhood Illnesses (IMCI) globally in the mid-1990s as an holistic approach to improve the quality of care for sick children by frontline health workers, and to improve immunization, nutrition counseling, and referral during sick-child visits.

To meet Ethiopia's specific needs, ESHE led the adaptation and simplification of the standard international IMCI approach. IMCI was considered overly technical for the majority of Ethiopia's frontline health workers, including HEWs. In addition, neonatal causes account for nearly 40% of under-five deaths in Ethiopia and had not been included in IMCI. ESHE worked closely with the FMoH, WHO, UNICEF, and other stakeholders to adapt the training materials. Launched in 2007, the new Integrated Management of Neonatal and Childhood Illness (IMNCI) approach set new directions and standards for child care in Ethiopia.

ESHE Approach

In support of the comprehensive IMNCI approach, ESHE worked with RHBs to improve the management of health services and to build the capacity of health facility staff to manage cases and create awareness in communities and within households regarding preventing major childhood illnesses.

ESHE worked through the Child Survival Partnership led by the FMoH IMCI Unit to adapt the IMCI training manuals and methodologies to enable the scale-up of cost-effective training. ESHE then adapted and translated the algorithm into Amharic and created an Amharic version of the English training videos for better comprehension by HEWs.

The IMNCI training began with a training of trainer (TOT) for RHB staff. Regional IMNCI case management trainings were conducted to institutionalize its implementation and create a pool of facilitators in regions. Six modules were complemented with a video. During clinical practice, trainees assessed, classified, and identified appropriate treatment. They also counseled numerous cases based on the IMNCI algorithm at out-patient and in-patient sessions. Using this opportunity, the new IMNCI strategy was introduced to key persons from RHBs and focus zones. IMNCI was then introduced and scaled-up through pre-service and in-service trainings. ESHE also encouraged careful attention to support training with sufficient drug logistics and supervision.

The purpose of strengthening IMNCI as a key child survival intervention was to contribute to many other health service efforts underway to reduce high child mortality and morbidity. IMNCI implementation requires sustainable actions to improve: 1) knowledge and skills through training and supportive supervision, 2) health system capacity to provide necessary medicines and supplies to service providers and to ensure quality of services through regular supervision, and 3) household and community practices that positively impact child health. Of critical importance to IMNCI's impact on child and infant mortality is the correct identification of severe cases through iden-

Objectives

- To integrate essential newborn care and treatment of neonatal illnesses into standard IMCI approach.
- To adapt IMNCI training approach and materials to meet Ethiopia's needs for shorter trainings resulting in faster and less expensive scale-up.
- To ensure at least one provider trained in IMNCI in each health facility in ESHE focus areas.

Interventions

- Partner with national Child Survival Partnership led by FMoH to adapt training materials to new IMNCI approach for use by HEWs and clinicians.
- Develop TOT approach.
- Train providers.
- Ensure supportive supervision after training to increase sustainability.
- Integrate new IMNCI approach into pre-service training curricula.



Training HEWs using tools such as the family health card includes role playing to better counsel parents and improve household health practices. ESHE worked closely with the FMoH towards achieving preventive health care through the HEP.

Results

- Ethiopia is the first African country to develop Integrated Management of Neonatal and Childhood Illness.
- Conducted regional and zonal IMNCI case management trainings for 339 trainers and supervisors.
- Trained and followed-up 1,094 health workers and 94 HEWs in IMNCI.
- Increased proportion of health facilities with at least one health worker trained in IMNCI to 95%, 85%, and 100% in Amhara, Oromia, and SNNP, respectively.
- Printed and distributed 1,500 copies of each of IMNCI six modules and chart booklets, 3,800 IMNCI registration books, and 500 photo booklets.

Case management training and follow up is the core of building IMNCI capacity. It enables health workers to examine a child with great precision and determine with accuracy whether and how to treat the sick child or whether to refer a severely-ill child to another service within the tiered system. Training and follow-up were tested in Bolosso Sore Woreda and implemented in all project intervention areas.



tification of general danger signs or other signs of severe illness. ESHE worked to ensure that providers were trained and understood correct classifications for correct treatment.

Results

By the ESHE end-line surveys in 2008, 93% of facilities had at least one IMNCI-trained worker and 67% had 2 trained providers caring for sick children compared with very few IMCI-trained health workers in 2003/4. Credit goes to the rapid roll-out of in-service training, made possible by a new strategy and strong collaboration among ESHE, regions, zones, and woredas. The shortened course relied on less-qualified trainers, favoring a more rapid and less expensive roll-out.

End-line surveys showed important improvements in quality of care from baseline: seven of 10 assessment tasks were performed compared with four at baseline; more than 40% of children were checked for key danger signs compared with 2% at baseline; consultation time increased from a median of 9 minutes at baseline to 15 minutes at end-line.

HEWs are now treating the two major killers of children—diarrhea and malaria. The IMNCI approach of assessing and classifying these cases along with pneumonia has increased HEW efficiency and contributed to critical child care.

Challenges

The training scale up, uninterrupted provision of essential drugs and supplies, and regular supportive supervision are priority interventions required to assure expansion of quality community-based sick child care close to where families reside.

Due to high health worker turnover, practical and action-based pre-service training in all health training institutions should be emphasized. To maintain the availability of at least two frontline health workers in each health facility, ongoing IMNCI in-service trainings are necessary.

Strengthening the referral system and training physicians and health officers should be continued; they are referral center caretakers, supervisors, and potential trainers. At the same time, emphasis should be on IMNCI training in the specialized section of the treatment module entitled When Referral Is Not Possible due to many obstacles limiting effective referral.

Partnerships

Successfully introducing a significant new process takes concerted and consistent stakeholders effort. Successes of such collaboration were especially evident in the process ESHE used to adapt the WHO IMCI guidelines. ESHE brought together partners such as the FMoH, WHO, Save the Children/USA, and UNICEF staff, as well as trainers and providers to ensure that the adaptation met the needs of Ethiopia's health care providers.

Community Mobilization

Community Health Promotion Initiative

While Ethiopia's health system is growing, with more trained health providers and health facilities, neither health service utilization nor program coverage is optimal, and nearly 500,000 children die of preventable causes annually. In 2003, household surveys across the three ESHE focus regions found that only 63% of the population had reasonable access (10 km or two hour walk) to a health facility. Frequently, outreach sessions to distant communities are irregular or poorly planned, with low attendance by caretakers.

In July 2002, at the end of ESHE I, Community Health Promotion Initiative (CHPI) was launched in response to high child mortality rates and limited community access to health services in the SNNP Region. Since then, the CHPI has been scaled up, in collaboration with the ESHE focus regions' RHBs. The CHPI has been built into the national HEP in focus woredas and a generic label of voluntary community health workers has been adopted for use nationwide. The CHPI leverages and supports the HEP to advocate for increased use of health services.

ESHE Approach

The CHPI mobilizes parents and communities to undertake key health actions and to strengthen the link between communities and health services in order to improve the overall health of families. More than 54,500 trained VCHWs are now helping communities to improve child and family health by promoting small do-able actions. Most VCHWs, typically first implementing activities in their own homes, also serve as model families themselves.

VCHWs are selected by their community and trained in action-based health messages to bring about positive changes in household health behaviors.

VCHWs emphasize action-based messages and negotiation techniques with caregivers to identify problems, discuss possible solutions, and reach agreement on actions that will be taken. VCHWs are given a BCC tool, the FHC, developed to help them talk with community members and provide consistent messages with other health care workers, including HEWs.

ESHE developed a process that starts when community leaders are oriented to the Initiative—an essential step for community acceptance and involvement in decision-making. Promoter selection is the community's responsibility. During orientation meetings, community members decide on the selection criteria, their role, and composition. The CHPI asked communities to select both men and women. As primary caregivers, female volunteers more readily have access to the families during key periods such as pregnancy and delivery. Once CHPs are identified, they are trained by HEWs to use action-based messages in key health areas that can change health behaviors of the population, especially women's. The CHPI encourages use of everyday opportunities, such as coffee ceremonies, visits to neighbors, social events, and time spent at the well, spring, or markets, to talk about health actions.

Objectives

- To develop cadre of community-based VCHWs to be role models and demonstrate proven health actions families can take to improve their child and family health
- To train 40,500 VCHWs

Interventions

- Orient community members to the CHPI and have them select VCHWs.
- Develop easy-to-use BCC materials.
- Hold community festivals to motivate VCHWs.
- Conduct community and household follow-up to monitor progress.

Healthy actions VCHWs undertook and promoted included:

- Antenatal care services
- Essential newborn care
- Breastfeeding
- Fully immunizing children
- Introducing complementary foods at six months
- Modern family planning
- Recognizing and seeking care during illness
- Insecticide-treated bed nets
- Hand washing, safe water storage, and construction and use of latrines

Results

- Oriented more than 80,000 community members in 2,430 kebeles to CHPI.
- Supported HEWs in training more than 54,500 CHPs who are now called volunteer community health workers (VCHWs).

The CHPI adds momentum to existing services and programs, in particular to the HEP. The outstanding level of collaboration achieved between HEWs and VCHWs has provided HEWs with an opportunity to reach increased number of households. With one VCHW to 30 to 50 households, volunteers greatly expand health promotion by HEWs, who are responsible for a population of 5,000. Experience sharing meetings with HEWs provide opportunities to strengthen skills, appreciate volunteer contributions, and build group identification.

Results

The CHPI is a successful and well-structured approach to engage communities. VCHWs collaborating with HEWs reach the community in ways not possible by HEWs working alone. The CHPI has received positive reception from communities, frontline health workers, and health managers. It is a key approach incorporated into the HEP that several woredas expanded the CHPI using their own resources.

In coordination with its partners, ESHE oriented more than 80,000 community members representing kebele administrations, religious groups, women's groups, elders, and HEWs to the CHPI. 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 VCHWs to share experiences, and celebrate achievements by communities.

The 2008 end-line household health survey findings show that 50% of the kebeles in the three regions combined were served by VCHWs, 89% in the ESHE project intervention areas, and 38% in non-project areas. The median number of VCHWs per kebele was 25 in ESHE project areas and 19 in non-project areas.

Challenges

It can be difficult to maintain volunteer support. ESHE initiated community festivals to encourage and reward volunteers. Experience sharing meetings with HEWs provide the opportunity to strengthen skills, appreciate volunteer contributions, and build group identification.

ESHE launched community festivals to encourage promoters and community leaders to continue activities for improved family health. Promoters received certificates that recognized their efforts, and prizes were awarded to individual kebeles that demonstrated progress. VCHWs present key health messages through dramas and traditional song and dance. Contests and games are held. Success stories highlight activities, and health facility staff report on major achievements, VCHW's efforts, challenges, and forthcoming activities.



Behavior Change Communication

In any community or society, lasting change in health status requires individuals to take personal actions, from eating nutritional foods to washing hands. BCC is the strategic use of communication in a supportive environment to promote positive health outcomes and sustain risk-reducing behavior change in individuals and communities. Interpersonal communications based on strong negotiation skills has been proven to be the most important BCC approach to ensure positive health changes in developing countries. Mass media reinforces changes brought about through interpersonal communication.

ESHE's community mobilization and BCC interventions focused on building capacity of communities to improve families' health and advocate for increased use of health services using multi-channelled approaches to reach multiple audiences. BCC activities target families, caretakers, and service providers. Using consistent, targeted materials integrated into pre-and in-service training for health workers, pre- and in-service training for HEWs, and VCHWs.

ESHE Approaches

ESHE, through various modes of communication, improved household practices and individual behaviors by informing people about healthy actions they can take to improve their lives. ESHE developed, tested, and produced various promotional materials and motivational tools, including printed materials and tools and radio programs and spots.

Printed Materials

The Family Health Card (FHC) and Immunization Diploma (ID) were primary BCC tools used to promote key child health actions in households and at health facilities. ESHE developed the FHC in collaboration with the USAID-funded Health Communications Partnership (HCP) and LINKAGES projects. HEWs and VCHWs used it to counsel parents and caregivers about optimal child health and nutrition practices. The booklet contains illustrations and messages that help caretakers follow the growth and development of their child from birth to two years of age. The FHC also focuses on the health of mothers and pregnant women. VCHWs take 6 to 10 cards when they talk to people in the community and give a copy to pregnant women and

Objectives

- To change health behaviors.
- To reach multiple audiences with key health messages using multiple channels.

Interventions

- Work with the FMoH Health Education Department to harmonize health messages at the national level.
- Help develop the FHC for families' use to implement positive health actions.
- Award an Immunization Diploma to families completing the vaccination series for their under-one-year old children.
- Train mass media producers (TV, radio, print) in health communication.
- Strengthen VCHWs interpersonal communication and negotiation skills.

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 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 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."



Photo: Samuel Yalaw

Results

- Printed and disseminated >1,117,730 Family Health Cards in Amharic and Afan Oromo languages in A5 and A4 sizes.
- Printed and disseminated > 880,000 Immunization Diplomas in Amharic and Afan Oromo languages.
- Held four workshops for radio producers.
- Helped produce a TV show on VCHWs activities.



A VCHW uses the FHC to counsel women. The booklet serves as a helpful tool to remind both VCHWs and community members of positive health behaviors.

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 health services from a nearby health facility. With support from RHBs and other partners, FHCs are distributed far beyond ESHE focus areas.

The ID is awarded to parents who complete the full series of vaccines before their child is one year of age. It has become a motivational tool that encourages parents to get their child fully immunized by the child's first birthday. Proud parents, in both ESHE as well as non-ESHE areas, post the diploma in their home to show neighbors, relatives, and friends, becoming immunizations role models and promoters. Caregivers now request the ID when their children receive their last shot. This tool has helped health workers to continue encouraging parents and caregivers to have their children vaccinated.

Mass Media

While radio, television and print are effective mass media modes in Ethiopia, ESHE primarily focused on radio as the most effective way to reach a broad population. Radio spots supported community- and facility-level activities by reinforcing the same messages given by HEWs and VCHWs and highlighting tools such as FHCs and IDs.

ESHE worked with radio producers on maternal and child health issues so their spots would accurately inform and influence family and health worker behavior, and support community activities. ESHE worked to strengthen the relationship between RHBs and radio stations, to more effectively communicate health messages such as EPI and IMNCI. Radio for Development workshops were held to produce child health spots on various themes (EPI, breastfeeding, complementary feeding, vitamin A, women's nutrition, home management of diarrhea, feeding a sick child, essential newborn care, malaria, general danger signs).

Results

FHC and ID distribution significantly increased over the life of the project as health staff at all levels began to recognize their benefits. HEWs obtain FHCs and IDs during trainings, from health centers in their catchments areas, and WorHOs when delivering reports.

The FHC was revised and updated several times based on feedback from field practices, the FMOH Family Health Department, and child survival groups. ESHE pre-tested materials, printed, and distributed 285,000 (220,000 Amharic and 65,000 Afan Oromo). In the three regions, 16% of children aged 0-23 months owned a FHC, 48% in ESHE intervention areas, 6% in non-intervention areas.

The project distributed more than 237,000 IDs to focus woredas. Thanks to support from RHBs and partners, including UNICEF, more than 1.3 million IDs were printed and distributed to non-ESHE zones in the three regions.

School Health Activity

In order to extend the reach of HEWs' health messages promoted by health extension workers, ESHE launched the school health activity. The activity draws on HEWs' capacity to engage elementary school students in practicing health actions, assisting parents and neighbors in performing health actions, and communicating families' health needs.

The activity aims to improve families' health by using students to influence household behaviors that can improve health outcomes. Promoting full immunization and safe deliveries and identifying and acting on malaria and diarrhea danger signs help save lives and reduce morbidity.

As part of the HEP, two HEWs per kebele are tasked with implementing the family health and community packages. The school health activity provides an organized structure within which HEWs can successfully fulfill responsibilities for promoting health in schools. It strengthens links between HEWs and households via students, an invaluable connection when health needs arise.

The school health activity was designed with sensitivity to literacy realities at home. Tasking students with reading the FHC to their families helps effectively reach targeted households with messages on small, do-able actions.

ESHE Approach

The school health activity, launched as a pilot activity in 2007 in 10 woredas per ESHE focus region, sought to glean lessons learned prior to scale up.

ESHE worked with key stakeholders and consultants to develop, implement, and assess the pilot activity. Involving key stakeholders in the initial development phase encouraged early buy-in and assured realistic design. ESHE and partners finalized the School Activity Guide and Training Manual and conducted six woreda-level trainings. Pilot implementation began following the trainings and continued through the end of the school year in June 2008.

A consensus building workshop was conducted strengthened HEP implementation in schools. FMOH Health Extension and Education Center (HEEC) representatives, HEP coordinators from the three regions, WorHO heads, education bureau representatives, HEWs, ESHE staff, and an international consultant attended.

A training manual was developed to build HEW and teacher capacity to better enable them to work with students. A School Health Activity Guide was also developed to help HEWs introduce health behaviors to students. It presents messages in the FHC appropriate for school children.

The school health activity, designed for sustainability, targets fourth grade students. To enable easier implementation, it takes less class time within the school day and requires fewer trained teachers. The fourth grade was selected as children of this age have the maturity to actively engage in the activities, including reading materials to their families. Targeting one grade allows HEWs time for the new component in their on-going package of community responsibilities while allowing them to fulfill their family package mandate. Once each week, HEWs led an activity often with teacher's presence. Despite the relatively narrow target group, excitement generated by school health activities, graduation ceremonies, and secondary activities conducted by teachers have a spillover effect, reaching other students and parents.

Objectives

- To engage primary schools students to increase positive health behaviors

Interventions

- Prepare health messages appropriate for school children
- Encourage HEWs to engage school children in promoting health messages

ESHE designed the health messages taught in 30 schools, thus engaging the students to improve their health behaviors.



Results

- Developed and produced the *Implementer's Training Manual* and the *Activity Guide*
- Trained 214 HEWs and principals in school health project themes

The Training Manual and the Activity Guide were two key tools. The Activity Guide contains 25 behaviorally-based activities developed to deliver messages consistent with the FHC. Each activity, presented on a one-page card, lasts 20 to 30 minutes and is organized around a key action students are encouraged to take. Successes from the previous week are first shared and applauded. Then, an entertaining story, game, role play or physical activity that focuses on the activity follows. The subsequent section links the desired action or message with the previous activity and focuses on motivating behavior change. Students then identify personal benefits gained. Finally, they are asked a series of reinforcing questions to help them plan what they will say and do based on the activity. The Training Manual provides a skills-based training for program implementers and key stakeholders.

Results

The School Health Activity was initiated in one woreda and 10 schools in each region following training of 60 HEWs and 60 school principals and teachers in 30 kebeles and schools in the three regions. Trained HEWs explained the themes using FHCs, and gave children copies of the booklets to take home. In selected elementary schools with more than one fourth grade, all sections participated. Each year, a new fourth grade class will implement the program, thereby expanding programmatic reach to more elementary school students without overloading the system.

- ESHE carefully monitored this pilot activity. Monitoring visits, experience-sharing sessions, and documentation interviews revealed:
- The school health activity is viewed as easy to implement, effective, and fun.
- Students actively participated in class and shared messages with their parents, siblings, and friends.
- Some schools expanded activities beyond the Activity Guide by celebrating program completion and building model stoves or latrines.
- Changed behaviors most often mentioned by students and families related to hygiene.
- Students helped younger siblings and parents change behaviors.

Lessons Learned

Because of project timing, the activity started late in the school year. Implementing early in the school year ensures planning and sufficient time for full implementation of all 25 activities. Trained teachers, as effective as the HEWs, expand reach. Limited resources are required and the activity's child-centered approach contribute to success.

Health Extension Program Support

The Health Extension Program is the FMoH community-based program that supports the goals of universal coverage for primary health care. It is the government's flagship program to deliver primary health care at the community level. HEP encourages ownership and responsibility for better health at individual households. Two female HEWs assigned to a health post in each kebele spend about 75% of their time on outreach activities in households and communities. Each HEW is responsible for 500 to 1000 families.

HEWs recognize that working with volunteers is crucial to reach more community members. HEWs train and support volunteer community health workers (VCHWs) in such a way it enriches HEWs' routine activities. HEWs train and regularly mentor and encourage these volunteers. Through monthly experience sharing meetings, HEWs and VCHWs learn from one another and identify common problems and solutions.

ESHE Approach

ESHE worked closely with local partners to ensure HEP success and create synergy between the HEP and Community Health Promotion Initiative (CHPI). ESHE supported HEWs through training in communication skills, principles of volunteerism, community orientations, training facilitation, and behavior change communication through the use of the Family Health Card (FHC). Equipped with those skills and tools, trained HEWs recruited and trained VCHWs and model families willing to promote child survival, maternal health, and sanitation messages with women and their families.

Collaboration with the FMoH and RHBs was key to success in creating synergy among HEWs and community volunteers. ESHE developed the skill-based *Health Extension Worker Handbook* to help HEWs train VCHWs in their own village.

Objectives

- To develop cadre of community-based VCHWs to be role models and demonstrate proven health actions families can take to improve their child and family health
- To train 40,500 VCHWs

Interventions

- Orient community members to the CHPI and have them select VCHWs
- Develop easy-to-use BCC materials
- Hold community festivals to motivate VCHWs
- Conduct community and household follow-up to monitor progress

Elfinesh Duko is a HEW assigned to the Sore Homba Health Post in SNNP Region. Elfinesh coordinates activities of 32 community health promoters and 16 community nutrition promoters who, in turn, pass along health and nutrition messages in the kebele.

Elfinesh participated in a TOT organized by ESHE. "I have the confidence to train community volunteers after attending the three-day health extension worker orientation. I understand the basic health themes that need to be relayed to the community. My communication and negotiation skills have also improved with this training," she says.

Elfinesh is particularly impressed with the community visits required of HEWs as part of the TOT. "There isn't one household where basic health messages have not been shared, and each household I visited had a FHC. The community volunteers have paved the way for us. For my own sake, I will gladly train community volunteers."



Photo: Samuel Yalew

Elfinesh Duko explains the contents of the FHC to new VCHWs.

Results

- Trained 181 HEW instructors at TVETIs in 4 regions.
- Conducted TOT for 3,587 HEWs, who in turn trained community volunteers.
- Helped revise *Integrated Refresher Training Modules* in ENA, BCC, and M&E.
- Developed and disseminated *Training, Support, and Encouragement of Community Health Promoters: A Handbook for HEWs*.
- Developed TOT for *Introduction of Health Themes to Community Health Promoters by Health Extension Workers*.

An HEW orientation in Amhara.



Using the guide, HEWs conduct community orientation meetings, encourage communities to select volunteers, and train and mentor volunteers to serve as health promoters and role models. HEWs are also given a large-size copy of the FHC for use in training and counseling. HEWs trained 26,000 VCHWs in their communities. They provide ongoing support through monthly experience sharing meetings, during which volunteers have opportunities to discuss their activities, learn from one another, and identify common problems and solutions. This helps them better understand the initiative and how to best support and collaborate with volunteers.

With one VCHW to 50 households, VCHWs expand the promotion and organizational work of HEWs. Where the two initiatives overlap, collaboration between HEWs and VCHWs has brought noticeable changes in community engagement. Regional CHPI-HEP taskforces established in the three regions were composed of RHB, the Regional Technical, Vocational and Education Training Institutions (TVETIs), and ESHE regional staff. Each taskforce not only enabled effective CHPI implementation in the regions but also served as advocates for community health approaches.

Results

ESHE provided communication and community mobilization training to HEWs before their graduation from TVETIs. About 3,587 HEWs and 181 instructors from 11 TVETIs in Amhara, Oromia, and SNNP Regions were trained in community support and mobilization. Feedback indicates training intervention was critical to helping HEWs do their jobs. ESHE adapted its training strategy as HEP progressed. In addition to pre-service training on community mobilization, once HEWs were posted to kebeles in ESHE-supported woredas, they and health center staff were trained in technical child health interventions (EPI, ENA and IMNCI).

As a member of the HEP technical working group, ESHE assisted in the revision of *Integrated Refresher Training* modules on ENA, behavior change communication (BCC), and monitoring and evaluation (M&E). ESHE also developed a modular TOT curriculum for HEWs to strengthen their ability to train volunteers.

Challenges

HEWs need support and follow-up to ensure a committed engagement with their communities. However, WorHOs face many constraints to effectively follow HEP implementation. Local and international NGO support can complement FMoH support for the HEP and fill the gap where local capacity is lacking.

Improved Health Systems

Health Care Financing

Ethiopia's health care delivery per capita spending of US \$7.10 is low compared with sub-Saharan Africa's US\$12 average. WHO's Macroeconomics and Health Commission recommends operating levels of US\$34 per capita for delivery of essential health services.

To close this gap, the health care financing reform component of ESHE worked 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. HCF is national in scope and operates at federal and regional levels.

The strong commitment of the Ethiopian government to HCF reform has made a difference in the delivery of essential health services by improving the quality of health care.

ESHE Approach

At the federal level, ESHE worked closely with the FMoH and other relevant government bodies, such as the Ministry of Finance and Economic Development. ESHE supported implementation of the government HCF Strategy developed by the FMoH and endorsed by the Council of Ministers in 2000.

Regionally, ESHE provided support to the three focus regions, Amhara, Oromia, and SNNP, and worked with other regions, as appropriate. ESHE provided technical assistance to the regional governments in designing and ratifying legal instruments, achieving political commitments through continuous dialogue and consultations, and putting in place HCF reform operational frameworks and guidelines. ESHE also provided capacity-building support in the form of training, operational guidelines, and supportive supervision.

Results

Health care financing reform has gained momentum. Government authorities at various levels own the process and government support is strong. Over the last five years, the decentralization process has deepened considerably. All WorHOs are members of their woreda cabinets and both health offices and health centers play a significant role in planning and budgeting.

In the past four years, the share and absolute amount of health services resources at the woreda level have steadily. In the sampled woredas, total woreda health budgets for recurrent and capital costs have almost doubled. Per

Objectives

- To improve and mobilize financial resources in the health sector
- To ensure efficient allocation and use of health sector resources to promote quality in health care delivery
- To improve access to health services for the poor and promote equity

Interventions

- Engaged government to establish the healthcare financing reform legal framework
- Developed *Healthcare Financing Implementation Manual*
- Trained health officials and health facility finance and administrative staff in financial handling and HCF implementation
- Conducted facility-level supportive supervision HCF reform implementation



Retaining fees since September 2004, Awassa Health Center has retained more than US \$56,500. Part of these funds went to building the center's waiting area, left.

Results

- Per capita health budgets have more than doubled across the 3 regions
- In the 3 focus regions, regional laws now allow health facilities to retain and use their generated revenue
- Retained revenues in 2007 nearly exceeded total revenue retained in all prior years
- Almost all health centers across ESHE regions now have administration and finance units that have improved allocation and use of resources



Special pharmacies are retail pharmacies that operate in health facilities using revolving drug funds. After an initial investment, the pharmacies support themselves and provide a revenue stream for the hospital to which they are attached. The pharmacies receive technical support and training from the RHB and ESHE on pharmacy management, drug selection, pricing, and supportive supervision. This has enabled hospitals to make essential drugs and supplies more consistently available at affordable prices. ESHE supported the establishment of 150 special pharmacies.

capita health budgets more than doubled, and are now higher than the national average in two of the three regions.

In the three ESHE regions, regional laws now allow health facilities to retain and use their internal revenue as an addition to their government budget. The end-line surveys showed that revenue retention is occurring in all 78 surveyed health centers. The amount retained in surveyed woredas in 2007 alone nearly exceeds total revenue retained in all the prior years (Figure 6). Health centers are using retained revenue to make quality improvements, such as increasing availability of essential drugs and supplies and making facility improvements. They are using retained revenues to improve their infrastructure, information systems, and human resource capacity.

ESHE worked with health center staff to create governing bodies and hospital boards and put in place sustainable organizational structures and staffing that ensured health facility autonomy for reform implementation. While operations vary, almost all health centers have established governing bodies that are providing leadership and policy direction and making important decisions. Health centers are now allowed to have administration and finance managing units, which increase the stewardship of health facilities and improve allocation and use of financial and non-financial resources.

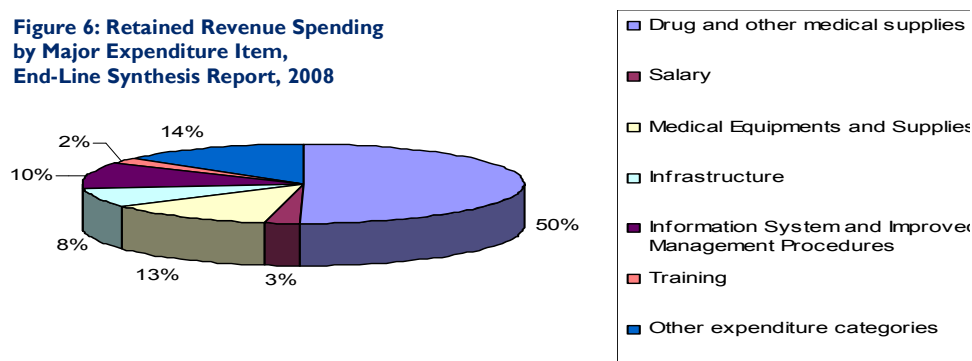
HCF reform has improved monitoring and evaluation capacity and practice at all levels. Health facilities increasingly and regularly report on their physical and financial performances. WorHOs are conducting regular supervision. HCF reform-related issues are checked and support provided, as needed.

Challenges

While there are encouraging developments in systematizing the fee waiver system aimed at protecting the poor, there is need to fully implement a waiver system in Oromia and SNNP and expand coverage to reach more poor in Amhara. There is also a need to periodically study how the fee waiver system is improving access to and use of health services by the poor and improving their overall health status.

Ethiopia has a long tradition of patients paying for health care in the form of user fees. However, fees have never been systematically revised to reflect increasing health care costs. Thus far, only 17 of the 78 (22%) health centers in the end-line surveys have revised user fees. There is strong need for further study on the implication of user fee revision on utilization of services and revenue of health centers.

Figure 6: Retained Revenue Spending by Major Expenditure Item, End-Line Synthesis Report, 2008



Performance Improvement

Sustaining improvements in health services depends not just on health workers having learned skills, but continued support and supervision. The performance improvement component of ESHE worked to enhance the way managers and staff perform their duties within the health system. When people are aware of the performance standards expected of them and receive timely supervision that is supportive and not fault-finding, they can perform well and contribute directly to the overall quality of the health system and patient care.

Performance improvement uses data from the health management information system (HMIS) to make informed decisions that address critical program issues. Such issues can range from how many staff need to be hired to meet demands of a particular health center to how to structure a vaccination program that meets a community's needs to how to gauge which staff members need on-the-job training.

At the start of ESHE, the 2003 baseline surveys showed performance standards in the three ESHE regions were inconsistent among various programs and departments. In addition, performance review meetings across levels and regions were not conducted regularly and supervision, when it did occur, was not designed to encourage staff to improve their performance or meet their organization's defined performance standards.

ESHE Approach

ESHE implemented performance improvement activities across all levels of the health system in the three focus regions, including RHBs, ZHDs, WorHOs, health centers, and posts.

To improve supervision, ESHE worked closely with the RHBs to develop management performance standards as well as a standard integrated supervisory checklist. This is an effective tool for managers to help them stay on track and ensure supervision meetings are supportive and collaborative. ESHE also trained WorHO and health center staff in supportive supervision and provided technical support in conducting regular supervision.

ESHE worked with clinics to prepare wall charts that publicly displayed up-to-date information on staffing, community maps, immunization coverage, and disease patterns. The data on display served as a transparent reminder, enabling clinics to remain focused on key issues within the clinic and the community.

Objectives

- To build health managers' management and supervision skills
- To work with the government to make resources available at the health facility level to improve services
- Prepare health messages appropriate for school children
- Encourage HEWs to engage school children in promoting health messages

Interventions

- Ensure service delivery and performance standards are in place at all health system levels
- Train health workers to use data to make informed decisions that solve problems
- Conduct supportive supervision to ensure health managers and workers understand their roles and are doing their jobs well
- Develop guidelines for conducting regular performance review meetings

"Previously, it was difficult to integrate and coordinate supervision activities. Every department planned and conducted its supervision using its own checklist. After ESHE provided supervision trainings, we experienced very encouraging outcomes by implementing supportive supervision. The well-designed integrated supervisory checklist has simplified our lives."

— Ato Asfaw Bekele, Planning and Programming Department Head, Oromia Regional Health Bureau



Photo: Mesfin Kifle

Results

- Trained almost 1,000 health managers in HMIS, which led to more than 85% of health facilities in the three ESHE regions conducting regular meetings to review health data
- Trained 847 health managers and staff in supportive supervision, which led to health staff across the three regions reporting that supervision has become supportive and participatory
- Review meetings are conducted in health center regularly across ESHE regions and used to address quality improvement issues
- Developed *integrated supervisory checklists*

ESHE provided HMIS training to 997 health managers from various health system levels in all three regions. Technical and material support and on-the-job training were provided to zones, woredas, and health centers to establish functioning monthly HMIS data reviews and develop action plans using the data to solve problems.

Results

ESHE's performance improvement end-line survey revealed great improvement in the frequency, regularity, and quality of supervision. Supervisors and supervisees reported that traditional supervision has been replaced by a supportive approach with participatory problem identification and analysis and joint action planning for improvement.

The end-line surveys showed that 87% of health facilities are using HMIS data for planning, as compared with 49% at baseline. Staff at all levels review action plans and compare actual performance to targets. Personnel at woreda and health center levels analyze and feel empowered and responsible for improving their performance. Up-to-date staffing wall charts exist at 76% of ZHDs, 91% of WorHOs, and 93% of health centers across the ESHE regions. Facilities are able to justify staffing needs based on documented gaps between staffing standards and actual staffing levels.

Of health center, 90% reported participating in at least one review meeting in the last six months compared with 40% at baseline. Minutes show that critical performance issues are discussed including performance and action plans, strategies for improving poor performing indicators, and quality improvement.

Regionally, Oromia and SNNP show the greatest gains in performance and service delivery standards, supervision, and review meetings. Amhara is doing well in HMIS management, but is generally weaker in other performance improvement areas.

Ato Tesfaye Bizuneh, head of the Bereti Clinic in Kuyu Woreda, Oromia Region, did not realize the clinic's collected data could help solve health service delivery problems. Usually, after aggregating the clinic's health data, he just sent it to the WorHO.

After attending an Expanded Program on Immunization training (organized by ESHE and Oromia RHB), Ato Tesfaye learned how to use his clinic's data to address critical issues such as immunization coverage rates. After the training, ESHE provided follow-up technical support to help Bereti Clinic analyze and use its data for monitoring.

Ato Tesfaye convened a data review meeting with his staff to assess the community's immunization status. Analyzing the data, the group decided that organizing immunization campaigns could improve immunization coverage. All kebele leaders participated by mobilizing families and establishing immunization outreach sites.



Regional Overviews: Amhara

The Amhara National Regional State is Ethiopia's second largest Region, with an area of 170,752 sq. kms and an estimated population of 20,130,000. Its average growth rate is 2.7%. Approximately 90% of the 18.6 million population is rural, living in heavily-populated farming communities (111 persons/sq. km.). Although the remoteness of many communities presents challenges to providing health care, potential health service coverage has improved, 93.1% in 2008, compared with 87% in 2007.

The region's socioeconomic and health problems are immense and highly interrelated. Since 1991, general health services have been upgraded, health facilities have been constructed or renovated, health personnel have been trained and deployed, and primary health care has been expanded. However, as a significant portion of the population still lives beyond catchment areas of even peripheral health institutions, community-based VCHWs are important in delivering primary health care services.

ESHE operated in 24 woredas in West Gojjam, South Gondar, North Wollo, and South Wollo Zones. In partnership with the Amhara RHB, programs were implemented in the existing health sector structure and local communities. The ESHE health sector reform component provided technical support to improve mobilization, allocation, and use of available resources.

About 4.8 million people are estimated to directly benefit from project activities in these woredas. Also benefiting were people beyond the ESHE-focus woredas, through the expanded impact of trainings, capacity building activities, and sharing lessons learned during supportive supervision and review meetings.

ESHE Approach

To launch its work in the three regions, ESHE conducted preparatory activities such as introduction meetings, selecting focus woredas, recruiting staff, and conducting baseline surveys.

ESHE conducted a two-day study tour to learn from initiatives started under ESHE I in the SNNP Region. Participants visited communities where CHPI was thriving and learned about data for decision-making using routine HMIS, with a detailed overview by the SNNP RHB Head.

ESHE held workshops to draft and approve Amhara's proclamation and regulations for HCF reform implementation. The workshops oriented stakeholders about HCF components and reform rationale and the need for a new health services delivery and management proclamation and related regulations and directives.

Health workers were trained and materials, including FHCs were tested in the region to ensure information and graphics were relevant to front-line health workers, mothers, and RHB staff.

Materials, including the Immunization Diploma, were translated and tested in Amhara to ensure their relevance to health workers and mothers in the region.



Achievements vs. Targets in Amhara Focus Woredas November 2003-September 2008 (%)

Indicator	Baseline	5-year Target	Achieved
DPT3/ Penta3	63	90	95
Polio3	61	90	92
Vitamin A	ND	80	95
Penta1-3 drop-out rate	9	<10	4

ND= No Data
Source: Routine RHB HMIS Data

Major Achievements

Improved Child Health Interventions

- Collected and analyzed monthly EPI data and provided technical support to health facilities
- Conducted EPI mop-up training for 1,084 health workers
- Assisted 188 HEWs in cold chain management and safe injections
- Trained 1,137 health workers and HEWs in ENA-BCC
- Trained 323 health workers in IMNCI case management
- Distributed IMNCI registration books to health facilities, WorHOs, and clusters
- Provided technical assistance and follow-up to health facilities, WorHOs, and ZHDs in EPI, IMNCI, and ENA interventions

Improved Community and Household Practices

- Conducted CHPI TOTs for 1,364 HEWs
- Conducted school activity trainings for 44 HEWs and school directors
- Organized model kebele and annual review meetings
- Distributed FHCs and IDs to WorHOs and health facilities
- Organized review meetings for 360 HEWs and 56 health workers
- Trained VCHWs: Round 1, 17,446; Round 2, 7,767
- Trained VCHWs in 657 kebeles
- Distributed IDs to 288 fully-vaccinated children
- Households with a latrine: 751
- Households store water in narrow-necked/cover container: 918
- Households visited by HEW: 907
- Households visited by CHPs: 953

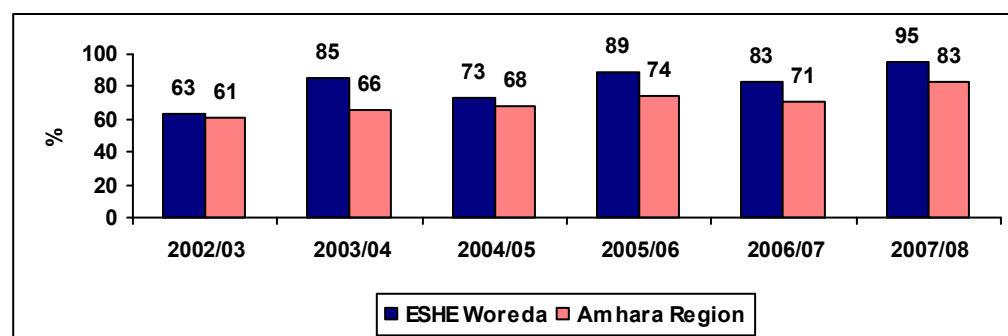
Improved Health Systems

- Trained 650 health managers in HMIS
- Provided technical and financial assistance for review meetings and supportive supervision in focus woredas
- Trained 244 zonal, woreda, and health facility professionals in supportive supervision
- Printed and distributed Review Meeting Guideline, Supportive Supervision Guideline, Integrated Supervisory Checklists, and Management Standard Guideline to 60 health facilities. Distributed service delivery standards to 100 health facilities and WorHOs
- Organized HCF implementation orientation workshops for health workers and hospital managers in ESHE and non-ESHE zones
- Translated the HCF Implementation Directive into Amharic

- Trained 2,389 participants from government organizations in HCF reform
- Trained 268 health center finance staff in accounts reform
- Retained fees at facilities in targeted government primary care facilities in 100% of the ESHE-focus woredas
- Assisted in woreda-based planning for EFY 2001

Figure 7:

DPT3/Penta Performance of ESHE Focus Woredas vs. Amhara Region Performance



Source: Routine RHB HMIS Data

Regional Overviews: Oromia

Oromia Regional State, the largest region in Ethiopia, has an estimated population of 27.75 million. Administratively, it is structured into 17 zones, 10 administrative towns, 281 woredas, and 7,064 kebeles. Of the population, 85% resides in rural areas. Women of child bearing age constitute 6,464,267 and pregnant women, 1,034,998. Children under-one and under-five years of age comprise 1,034,998 and 4,772,643, respectively.

Low health-service coverage in Oromia has contributed to low coverage of important programs, including immunization and family planning. The Region has made in recent years significant progress in increasing health service coverage and expanding health programs. Oromia recently embarked on an accelerated expansion of primary health care, a strategy that helps ensure universal access to essential health services.

ESHE worked in partnership with the RHB in 25 woredas in East Hararge, West Hararge, East Shoa, and North Shoa Zones. About 4 million people benefited from direct activities, although an estimated 12 million benefited from “echo” activities conducted in the region but outside ESHE woredas.

ESHE Approach

ESHE followed processes similar to Amhara’s to engage key stakeholders and create buy-in for new approaches. RHB staff also learned from the study tour to the SNNP Region.

ESHE’s work in Oromia was marked by vigorous activities to strengthen services, including trainings for health workers and VCHWs, capacity building trainings for government partners and ESHE staff, and follow-up visits after the trainings. ESHE provided technical assistances in IMNCI, ENA, and EPI to government counterparts.

Health service delivery improved thanks to continuous support and close follow-up by the regional government and commitment of development partners. ESHE assisted 29 hospitals, 247 health centers, 740 clinics, and 1,814 health posts. The estimated potential health service coverage—that is, access to basic health services within a 10km radius—is 82%.

“I started passing health messages to my own family before going to other households,” says Tigist Melka (L)

Tigist Melka was a 14-year-old student of Lafto Bulanta Primary School in Kuyu Woreda, Oromia Region. Her participation in her school’s sanitation club led to her selection by her school principal to be a student VCHW. Tigist was trained by Bonde Health Post HEWs.

Initially, it was difficult for Tigist to discuss health with people in their homes. Elders said they could not be taught by kids. Joining adult VCHWs during their household visits helped Tigist become accepted by the community. After gaining her community’s confidence, Tigist counseled three pregnant women and three mothers with new babies about colostrum and exclusive breastfeeding. She spoke with numerous households about health, sanitation, and latrine use. Nine have dug and begun using latrines. Tigist loves working as a VCHW. She says, “I want to become a medical doctor to serve my community and improve its health.”



Photo: Saleem Melaku

Achievements Vs. Targets in Oromia focus Woredas November 2003-September 2008(%)			
Indicator	Baseline	5-year Target	Achieved
DPT3/Penta3	35	90	97
Polio3	ND	90	100
Vitamin A	ND	80	100
Penta1-3 drop-out rate	29	<10	3

ND= No Data
Source: Routine RHB HMIS Data

Major Achievements

Child Health

- Trained 1,291 HEWs and health workers in ENA-BCC.
- Trained 214 health workers in IMNCI case management.
- Supported national immunization days and enhanced outreach services.
- Trained 1,248 HEWs and health workers in EPI refresher training.
- Trained 1,291 health workers and HEWs in ENA.

Improved Community and Household Practices

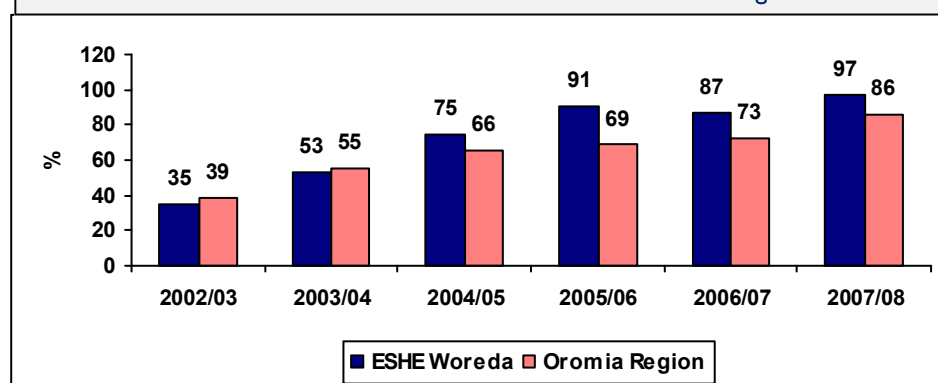
- Trained 826 health workers and HEWs in CHPI.
- Trained 77 HEWs and health facility staff in first round CHPI themes.
- Trained 637 HEWs and 189 health workers in second round CHPI themes.
- Organized experience sharing meetings for 271 HEWs and 35 health facility staff.
- Assisted HEWs in introducing second round theme to 3,727 CHPs
- Conducted follow-up visits to 507 kebeles, 434 HEWs, and 3,000 households in focus areas
- Conducted a school health activity review meeting for 38 HEWs, three WorHO staff, and 35 teachers
- Trained 475 graduating HEWs in communication and community mobilization skills
- Trained VCHWs: Round 1, 16,513; Round 2, 7,896
- Trained VCHWs in 578 kebeles
- Distributed IDS to 662 fully-vaccinated children
- Households with a latrine: 1,405
- Households store water in narrow-necked/covered container: 2,051
- Households visited by HEW: 1,852
- Households visited by CHPs: 2,730

Improved Health Systems

- Trained 211 RHB staff in HMIS refresher training.
- Trained 298 regional health managers, experts and woreda health workers in supportive supervision.
- Trained 50 newly-assigned health managers in supportive supervision and performance scoring system.
- Provided technical and financial support to conduct review meetings.

Figure 8:

DPT3/Penta3 Performance of ESHE Focus Woredas vs. Oromia Region Performance



Source: Routine RHB HMIS Data

- Facilitated printing and distribution of 3,500 copies of the legal framework.
- Translated the HCF Implementation Manual into Afan Oromo.
- Trained 1,351 in HCF reform implementation.
- Assisted in woreda-based planning for EFY 2001.
- Trained 510 health center governing bodies and 126 hospital board members in HCF reform implementation.

Regional Overviews: SNNP

The Southern Nations, Nationalities and Peoples' Region is known for its cultural diversity, with over 56 nations, nationalities and languages. It has an area of 118,000 sq km. and an estimated population of 16.2 million. It has 13 zones, eight special woredas, 133 woredas, 22 town administrations and 3,553 rural kebeles. Close to 94% of the population 14,484,000 lives in rural areas. The population of the region, makes up 20% of the nation's total.

ESHE had been operating in the SNNP Region since 1998 in two previous phases, primarily to strengthen the regional health system. The end-line surveys showed: 44% of children 12-23 months are fully vaccinated; 30% of women of childbearing age currently use modern family planning methods; 65% of women attended antenatal services; and 15% delivered with trained birth assistance.

ESHE Approach

ESHE II was both a continuation of previous health system strengthening efforts and new child survival initiatives. CHPI activities piloted previously were adopted and taken region-wide. The project partnered with the SNNP RHB in planning, implementing, and following-up child survival and health sector reform interventions. These were then transferred to non-ESHE areas through collaboration with government and non-governmental counterparts.

SNNP's potential health service coverage has grown from 28% in 2002 to 74% at present through services provided in 15 government, four NGO, and two private hospitals, 164 health centers, 194 developing health centers, and 2,904 health posts. ESHE worked through RHB, ZHD, and WorHO structures and enjoyed strong partnerships with NGOs and other projects. ESHE directly supported 54 woredas and town administrations, covering approximately 6.5 million people.

Ever since *Health Service Delivery, Administration and Management Regulation of the SNNPR* was ratified in December 2006, all hospitals began retaining and utilizing 100% of their revenue. Consequently, several hospitals have shown remarkable improvements in service quality; and available drugs, medical supplies and equipment and are providing a clean and attractive service compound.

Aman Hospital is one of 15 hospitals in SNNP that quickly saw the benefits of HCF reform. The hospital has improved quality of services. Drugs are available at affordable prices and examination rooms are equipped with necessary medical supplies. Ato Shiferaw Debebe, hospital planning and programming officer, says, "The hospital has constructed three maternal and child health rooms, expanded the latrine by constructing two additional rooms, and set up a comfortable cafeteria for staff and clients. The facility also fixed a generator for continuous power supply."

A journalist of *South Mass Media* who participated in a HCF reform workshop organized with ESHE support, testifies, "I was amazed by the dramatic change in the hospital. The compound looks like a recreation park. It is neat and attractive, as are the toilets. It is amazing how the fee retention and utilization I heard about in the workshop brought so many improvements."



Achievements vs. Targets in SNNP Focus Woredas November 2003-September 2008 [%]			
Indicator	Baseline	5-year Target	Achieved
DPT3/Penta3	60	90	95
Polio3	50	90	93
Vitamin A	ND	80	92
Penta I-3 dropout rate	19	<10	5

ND= No Data

Source: Routine RHB HMIS Data

Major Achievements

Child Health

- Trained 1,448 HEWs, health workers, and health science college tutors in EPI.
- Trained 17 regional and zonal experts in cold chain equipment maintenance.
- Trained 1,590 HEWs, health workers, and health science college tutors in ENA and management of acute severe malnutrition.
- Assisted in CTC management training for 25 nurses.
- Trained 563 health workers in IMNCI case management.
- Trained 55 HEWs in IMNCI case management.

Improved Community and Household Practices

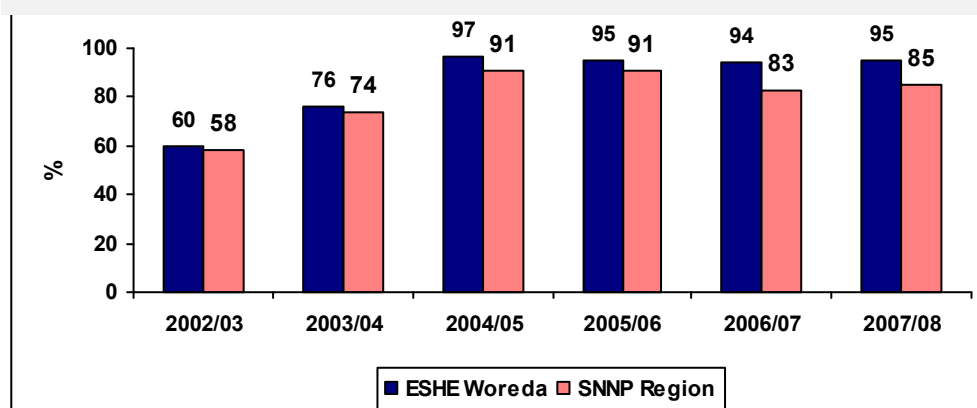
- Provided CHPI TOT for 2,013 health workers.
- Conducted CHPI review meeting for 477 HEWs and 85 health workers.
- Conducted BCC workshop on HCF reform for 25 radio producers.
- Conducted CHPI TOT for 54 teachers and HEWs.
- Conducted school health activity review meetings for 54 teachers and HEWs.
- Trained VCHWs: Round 1, 19,283; Round 2, 11,860.
- Children fully vaccinated who received ID: 398.
- Households with a latrine: 1,284.
- Households store water in narrow-necked/cover container: 1,354.
- Households visited by HEWs: 1,338.
- Households visited by VCHWs: 1,368.

Improved Health Systems

- Conducted a HCF reform orientation workshop for 53 hospital board members.
- Trained 1,025 participants in HCF reform implementation in ESHE woredas.
- Trained 133 accountants in HCF reform and government accounts procedures.
- Trained 305 managers and experts in supportive supervision.
- Assisted in woreda-based planning for EFY 2001.
- Provided technical and financial support for performance review meetings and supportive supervision.

Figure 9:

DPT3/Penta3 Performance of ESHE Focus Woredas vs. SNNP Region Performance



Source: Routine RHB HMIS Data

Monitoring and Evaluation for Health

Since its 2003 start, ESHE has included evaluation as a vital component of monitoring progress, refining approaches, and assessing project effectiveness and impact. The ESHE M&E Unit tracked achievement of established targets and goals. It assembled and analyzed data gathered from project activity and health system records. Information collected and disseminated has enabled stakeholders to make informed decisions for expansion or to refine approaches as they move forward.

Key evaluation questions for ESHE included: 1) Is there increased use of high-impact child survival interventions? 2) Are there increased health sector resources and are key systems improved? ESHE's Performance Monitoring System provided data to measure timely and efficient implementation of activities.

In the project's early days, ESHE developed a Monitoring and Evaluation Plan that described the methods and indicators used to document project effectiveness and its contribution to the USAID Ethiopia Mission's Strategic Results Framework and the health of Ethiopian children and families. This Plan became the guiding document for ESHE over its five-year implementation.

Using a variety of methods, ESHE tracked key indicators obtained from routine monitoring systems, project administrative records, and data collected at households and health facilities.

Baseline Surveys

In Year I, ESHE and RHBs staff established a robust baseline data set of key health indicators in the three regions, enabling an evidence-based planning, monitoring, and evaluation process. In each region, four survey instruments used focused on household practices, health facility quality of care, health systems performance, and HCF. The surveys provided extensive baseline data that enabled stakeholders and ESHE to better understand child and maternal health status in the three regions and to design intervention strategies.

The baseline results became the foundation for strategic planning in the regions. ESHE facilitated evidence-based planning workshops with stakeholders, including USAID, MOFED, RHBs, ZHDs, WorHOs, and others working in the regions. The meetings proved to be excellent opportunities to share experiences and expectations and identify limits among the wide-ranging health actors.

Project Indicators and Targets

Following the baseline surveys, ESHE developed its monitoring and evaluation plan based largely on USAID indicators at the various levels of their SO14 M&E plan. The ESHE Indicator Matrix (Appendix 1), organized according to the USAID Strategic Plan, includes project performance and indicators of Mission strategic objectives, intermediate results, and sub-results. These indicators were 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, including ongoing social development activities.

Objectives

- To demonstrate impact of high-impact child survival interventions.
- To demonstrate increased revenues and improved health systems.

ESHE used data to:

- Provide timely information to fine-tune implementation strategies and adjust program inputs as necessary.
- Measure effectiveness and impact achieved.
- Provide evidence to stakeholders and development communities that strategies employed by the project led to desired results.

ESHE Evaluation Reports

- Regional baseline studies, looking at household, health facility, performance improvement, and HCF across the 3 regions, 2003/04.
- Joint mid-term ESHE and LINKAGE household survey assessment, 2006.
- Regional end-line studies, looking at household, health facility, performance improvement, and HCF across the three regions, 2008.
- Qualitative assessment through focus groups and individual interviews of ESHE BCC community interventions, 2006.

Midterm Assessment

A joint ESHE and LINKAGES assessment was conducted in 2006 to determine community behavior change in the three regions where VCHWs had been trained and deployed for a minimum of six months. The assessment gathered information on EPI, use of latrines, hygiene, use of insecticide treated nets, vitamin A supplementation, sick child treatment, and contacts with VCHWs. It served as a mid-term status report. Results were used to advocate for the continuation of nutrition and community-based interventions.

End-line Surveys

In the final project year, end-line surveys were conducted to assess progress since project start in the three regions. Four surveys looked at household, health facility, performance improvement, and HCF. The surveys revealed tremendous achievement in the health system, enhancement of health worker skills, and improved community household health practices. Findings will serve as a baseline for the follow-on project. (All reports can be accessed and downloaded at the ESHE website, www.eshe.org.et)

Qualitative Assessment

ESHE conducted a qualitative community assessment to assess household practices after project activities had been implemented. Focus group discussions and individual interviews were used to gather data on collaboration and BCC materials used in focus regions. The assessment targeted mothers and fathers of children under one year of age, CHPs, HEWs, community leaders (kebele and religious), health workers, and people from other sectors (agriculture development workers, school directors). General findings showed that interviewees knew of the health messages, could explain the desired health behaviors, and were familiar with the FHC and ID. Findings revealed strong collaboration between HEWs and CHPs.

Follow-up Visits

ESHE followed-up local health centers to help them use data they were collecting to make informed decisions. Follow-up visits were made to WorHOs, health centers, health posts, and households to provide assistance and transfer knowledge and skills. Health managers were mentored on data use for decision-making and techniques of supportive supervision. Additionally, visits were made to communities. The community follow-up strengthened synergy between HEWs and VCHWs for better household health practices. Mothers of under-two-years of age children were counseled on feeding practices, immunization, and sanitation.

Appendix I: ESHE Performance Indicators and Targets for Focus Woredas

Appendix 1: ESHE Performance Indicators and Targets for Focus Woredas																							
Indicator	Operational Definition	Survey Baseline			Routine HMIS			Cumulative LOP Target (survey)			LOP Target (Routine HMIS)			LOP Achievement (Survey)			LOP Achievement (Routine HMIS)						
		Amhara 04	Oromia 04	SNNPR 03	Amhara 03	Oromia 03	SNNPR 02	Amhara	Oromia	SNNPR	Amhara	Oromia	SNNPR	Amhara	Oromia	SNNPR	Amhara	Oromia	SNNPR				
IR 14.1 Use of high impact health, family planning, and nutrition services, products and practices increased																							
DPT3	% children 12-23 months old vaccinated with DPT3 by age 12 mos/ no. of children 12 -23 months old surveyed	49	33	46	-	61	35	42	-	75	75	75	-	90	90	-	65	59	70	-	95	97	-
	% DPT3 doses dispensed to children to 0-11 months old / estimated no. of surviving infants	-	-	-	-	-	-	-	-	-	-	-	-	90	90	-	60	50	76	-	95	95	-
	% women with children 0-11 months old who received at least two TT doses during last pregnancy or adequate no. before that pregnancy	29	48	62	-	-	-	-	-	80	80	80	-	-	-	-	60	50	76	-	95	95	-
Polio3	% children 12-23 months old vaccinated with OPV3 by age 12 mos./ no. of children 12-23 months old surveyed	50	39	57	-	-	-	-	75	75	75	-	-	-	-	-	69	66	73	-	95	95	-
	% OPV3 doses dispensed to children to 0-11 months old / estimated no. of surviving infants	-	-	-	60	ND*	50	-	-	-	-	-	90	90	90	-	-	-	-	92	95	93	
	% of under 6-month-olds exclusively breastfeeding within past 24 hours/total no. of under 6-month-olds surveyed	75	40	58	-	-	-	-	80	50	80	-	-	-	-	81	83	76	-	95	95	-	

Indicator	Operational Definition	Survey Baseline			Routine HMIS			Cumulative LOP Target (survey)			LOP Target (Routine HMIS)			LOP Achievement (Survey)			LOP Achievement (Routine HMIS)		
		Amhara 04	Oromia 04	SNNPR 03	Amhara 03	Oromia 03	SNNPR 02	Amhara	Oromia	SNNPR	Amhara	Oromia	SNNPR	Amhara	Oromia	SNNPR	Amhara	Oromia	SNNPR
IR 14.1 Use of high impact health, family planning, and nutrition services, products and practices increased																			
Early Initiation of Breastfeeding	% children 0-11 months who initiated breastfeeding within 1 hour after birth	31	43	60	-	-	-	41	57	74	-	-	-	52	78	85	-	-	-
Vitamin A	% children 6-23 months receiving vitamin A supplementation / no. of 6-23 mo. olds surveyed	14	39	13	-	-	-	80	80	80	-	-	-	62	71	62	-	-	-
Sub-IR 14.1.2 Availability of key health services and products improved																			
Availability of essential oral drugs (%)	ORS	98	92	100	-	-	-	98	98	100	-	-	-	78	8%	83	-	-	-
	Cotrimoxazole	80	65	89	-	-	-	98	98	98	-	-	-	98	93	9%	-	-	-
	Antimalarial drugs	98	88	97	-	-	-	98	98	98	-	-	-	73	88	9%	-	-	-
	Mebendazole/Albendazole	95	62	84	-	-	-	98	98	98	-	-	-	93	88	8%	-	-	-
	Vitamin A	75	40	66	-	-	-	98	98	98	-	-	-	75	95	9%	-	-	-
Availability of essential child vaccines (%)	BCG	77	78	84	-	-	-	98	98	98	-	-	-	90	85	8%	-	-	-
	Polio	95	83	87	-	-	-	98	98	98	-	-	-	83	88	9%	-	-	-
	DPT	98	58	90	-	-	-	98	98	98	-	-	-	93	93	9%	-	-	-
	Measles	98	85	92	-	-	-	98	98	98	-	-	-	93	98	9%	-	-	-

Indicator	Operational Definition	Survey Baseline			Routine HMIS			Cumulative LOP Target (survey)			LOP Target (Routine HMIS)			LOP Achievement (Survey)			LOP Achievement (Routine HMIS)		
		Amhara 04	Oromia 04	SNNPR 03	Amhara 03	Oromia 03	SNNPR 02	Amhara	Oromia	SNNPR	Amhara	Oromiya	SNNPR	Amhara	Oromiya	SNNPR	Amhara	Oromiya	SNNPR
Sub IR. 14.1.3 Quality of key health services improved																			
DPT dropout rate	% children 0-11 months who received DPT1 minus % who received DPT3/ % of 0-11 mos. olds who received DPT1	21	33	29	8	29	19	<10	<10	<10	<10	<10	<10	21	21	17	4	3	5
Sub IR. 14.1.4 Health sector resources and system improved																			
% HFs with fee retention	% Facility fee retention in targeted government primary care facilities in focus woredas	0	0	0	-	-	-	100	100	100	-	-	-	100	100	100	-	-	-

ND* = No Data

Appendix 2: Training by Intermediate Result

Appendix 2: Training by Intermediate Result															
Indicator	Operational Definition	Survey Baseline			Routine HMIS			Cumulative LOP Target				Cumulative LOP Achievement			
		Amhara 04	Oromia 04	SNNPR 03	Amhara 03	Oromia 03	SNNPR 02	Amhara	Oromia	SNNPR	Total 3 Regions	Amhara	Oromia	SNNPR	Total 3 Regions
Sub-IR 14.1.1 Community Support for high impact interventions increased															
Community Training															
CHPs Trained	Round 1	0	0	530	-	-	-	10,500	16,000	14,000	40,500	17,446	16,513	19,287	53,246
	Round 2	-	-	-	-	-	-	3,500	0	3,500	7,000	7,767	7,896	11,860	27,523
# kebeles with CHP		0	0	-	-	-	-	496	471	1,055	2,022	657	580	1,193	2,430
Sub-IR 14.1.2 Availability of key health services and products improved															
Facility Health Workers															
EPI		-	-	-	-	-	-	750	650	900	2,300	937	849	778	2,564
ENA		-	-	-	-	-	-	720	720	740	2,180	715	630	896	2,241
IMCI		12	7	101	-	-	-	450	450	450	1,350	316	208	525	1,049
Health Extension Workers															
EPI		-	-	-	-	-	-	600	600	800	2,000	147	501	670	1,318
ENA		-	-	-	-	-	-	600	600	800	2,000	422	661	694	1,777
IMCI		-	-	-	-	-	-	600	600	800	2,000	0	0	31	31
CHPI		-	-	-	-	-	-	600	600	800	2,000	1,202	852	2,973	5,027
Health Managers															
HCF		-	-	-	-	-	-	237	285	266	788	2,389	1,351	1,025	4,765
Mngt/Superv./HMIS		-	-	-	-	-	-	140	140	160	440	894	509	441	1,844

Appendix 3: Summary of ESHE-Led Trainings

November 2003 to July 2008

Training	Amhara			Oromia			SNNP			Total 3 Regions		
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
CHPI/CNP												
CHPI ToT	93	11	104	174	135	309	239	1,816	2,055	506	1962	2,468
HEW ToT	115	1,249	1,364	40	685	725	133	1,365	1,498	288	3,299	3,587
CHP 1st round	10,449	6,997	17,446	9,539	6,974	16,513	10,768	9,855	20,623	30,756	23,826	54,582
CHP 2nd round	4,755	3,012	7,767	4,736	3,160	7,896	6,722	6,271	12,993	16,213	12,443	28,656
CHPI to HEP Instructors	86	10	96	47	3	50	27	8	35	160	21	181
ENA												
ENA	520	617	1,137	364	927	1,291	623	1,001	1,624	1,507	2,545	4,052
EPI												
EPI	624	460	1,084	491	859	1,350	672	776	1,448	1,787	2,095	3,882
IMNCI												
IMNCI	205	118	323	125	89	214	318	270	588	648	477	1,125
HMIS												
HMIS	342	308	650	186	25	211	119	17	136	647	350	997
Supportive Supervision												
Supervision	197	47	244	265	33	298	275	30	305	737	110	847
Health Care Financing												
HCF	1,983	406	2,389	1,126	225	1,351	948	77	1,025	4,057	708	4,765
School Health Activity												
SA	18	26	44	54	62	116	32	22	54	104	110	214

ESHE publications were targeted to meet the specific needs of Ethiopian government officials, health managers, health providers, and end-clients. Materials were designed to update skills, improve performance, and encourage behavior change. ESHE worked to widely disseminate all materials produced through regional workshops and trainings as well as mailings.

Evaluations

Health Systems Performance Survey, Amhara Region, 2004
Health Systems Performance Survey, Oromia Region, 2004
Health Systems Performance Survey, SNNP Region, 2004
Health Facility Survey, Amhara Region, 2004
Health Facility Survey, Oromia Region, 2004
Health Facility Survey, SNNP Region, 2004
Health Care Financing Survey, Amhara Region 2004
Health Care Financing Survey, Oromia Region 2004
Health Care Financing Survey, SNNP Region 2004
Household Survey, Amhara Region, 2004
Household Survey, Oromia Region, 2004
Household Survey, SNNP Region, 2004
Twelve Base Line Health Surveys, March 2005
Health Profiles, ESHE Project focus woredas, Oromia, SNNP Regions, 2005
Bolosso Sore Woreda Household Survey, October 2005
Health Profiles, ESHE Project Focus Woredas, Amhara Oromia, and SNNP Regions, 2006
Community Assessment in Selected ESHE Focus Woreda in Amhara, Oromia and SNNP Regions, June 2006
ESHE-Oromia Cluster Zones Health Profile, 2004
Qualitative Assessment through Focus Groups and Individual Interviews of ESHE BCC Community Interventions, Sept 2006
Experience Sharing Meeting for HEWs: First Review Meeting 3 Months After Health Extension Worker TOT, March 2007
Health Care Financing Reform Assessment Report, December 2007
Special Pharmacies Impact Assessment Report. February 2008
Evaluation of ESHE's Health and Nutrition Sector Interventions in Bolosso Sore Woreda, Wolayita Zone, SNNPR, June 2008
Health Care Financing Reform Implementation End-line Survey, Amhara. July 2008
Health Care Financing Reform Implementation End-line Survey, Oromia. July 2008
Health Care Financing Reform Implementation End-line Survey, SNNP. July 2008
Health Facility End-line Survey, Amhara. August 2008
Health Facility End-line Survey, Oromia. August 2008
Health Facility End-line Survey, SNNP. August 2008
Household Health End-line Survey, Amhara. August 2008
Household Health End-line Survey, Oromia. August 2008
Household Health End-line Survey, SNNP. August 2008
Health Systems Performance Improvement End-line Survey, Amhara. August 2008
Health Systems Performance Improvement End-line Survey, Oromia. August 2008
Health Systems Performance Improvement End-line Survey, SNNP. August 2008
Health Care Financing End-line Survey Synthesis Report, September 2008
Health Facility End-line Survey Synthesis Report, September 2008
Health Systems Performance Improvement End-line Survey Synthesis Report, September 2008
Household End-line Survey Synthesis Report, September 2008

Training Materials

Implementation Manual for Health Care Financing Reform, Final Document. December 2005.

Health Care Financing Reform Implementation Manual, September 2006. (Amhara, Amharic)

Health Care Financing Reform Implementation Training, Facilitators Guide, October 2007. (Amhara, Amharic)

Health Care Financing Reform Implementation Manual, Participants Guide, October 2007. (Amhara, Amharic)

Implementation Manual for Health Care Financing Reform, March 2007. (Oromia, English)

Facilitators Guide to Health Care Financing Reform Implementation Manual Training, March 2007. (Oromia, English)

Health Care Financing Reform Implementation Manual Training, Participants Manual, March 2007. (Oromia, English)

Health Care Financing Reform Implementation Manual, October 2006. (SNNP, Amharic)

Health Care Financing Reform Implementation Manual, Facilitator's Guide, October 2006. (SNNP, Amharic)

Health Care Financing Reform Implementation Manual, Participants Guide, October 2006. (SNNP, Amharic)

Health Care Financing in Ethiopia, Status and Next Step. June 2008

Checklist for Integrated Supportive Supervision to Health Centers

Checklist for Integrated Supportive Supervision to the Woreda Health Office

Checklist for Integrated Supportive Supervision to the Zonal Health Desk/Office

Communication and Community Mobilization Training for TVET Instructors

EPI Module 1: EPI Target Diseases, Vaccines and Their Administration, January 2005

EPI Module 2: The Cold Chain, January 2005

EPI Module 3: How to Provide Safe and Quality Immunization Services, January 2005

EPI Module 4: Communicating with Care Takers and Communities for Improved Routine Immunization Coverage, Jan 2005

EPI Module 5: Monitoring Immunization coverage, Drop-out and Quality of Service, January 2005

Refresher Training for Frontline Health Workers in EPI

Facilitators Guide [for EPI], January 2005

Facilitator's Guide for HMIS Refresher Training, April 2005

Strengthening Supportive Supervision in the Amhara Regional State Region. Phase I: Regional Level Training. Facilitators Guide, May 2005

Guide to Supervision, May 2005

Guideline for Performance Review Meetings in Health Systems, July 2006

Strengthening Supportive Supervision in the Health Sector. Phase I: Regional Level Training, Facilitators Guide, May 2005

Strengthening Supportive Supervision in the Health Sector. Phase 2: Woreda and Health Center Training. Facilitators Guide, August 2005

CHPI: Community Orientation and Health Promoter Training Manual (Module I), March 2005

CHPI: Health Promoter Training Manual (Module II), March 2005

CHPI. Training of Trainers (Module I - Facilitators Guide), March 2006

CHPI: Bolosso Sore Woreda. Health Promoter Training Manual (Module I), October 2005

CHPI: Bolosso Sore Woreda. Training of Trainers (Module II - Facilitators Guide), April 2006

Integrated Refresher Training for Health Services Extension Program: Supportive Supervision Module, January 2006

Integrated Supervisory Checklists and Management Performance Standards for Government Health System, March 2006

Training, Support, and Encouragement of Community Health Promoters: A Handbook for HEWs, August 2006.

TOT for Introduction of Health Themes to Community Health Promoters, August 2006

TOT for Introduction of Health Themes to Community Health Promoters by Health Extension Workers, May 2007

Management Performance Standards for the Regional Health Bureau, Zonal Health Desks, Woreda Health Offices, Health Centers, Health Posts, August 2006

Guideline to Conduct Supportive Supervision in the Health System, October 2006

IMNCI Module I: Introduction, 2007
IMNCI Module II: Management of Sick Young Infant from Birth up to 2 Months, 2007
IMNCI Module III: Assess and Classify the Sick Child Age 2 Months up to 5 Years, 2007
IMNCI Module IV: Identify Treatment and treat the Child, 2007
IMNCI Module V: Chart Booklet, 2007IMNCI Council the Mother, 2007
IMNCI Module VI: Facilitator's Guide for Modules, 2007IMNCI Follow-up, 2007
IMNCI Chart Booklet for Health Extension Workers and DVD (Adopted from the WHO IMCI and translated into Amharic)
IMNCI Exercise Booklet and DVD
Integrated Under-five Registration Book from 2 Months up to 5 Years
Integrated Under-five Registration Book from Birth up to 2 Months
Guidelines for Supportive Supervision in the Health Sector, July 2007
Guidelines for Performance Review Meetings in Health System, July 2007
Guidelines for Performance Review Meetings, January 2008

Provider Materials

Essential Nutrition Actions Handout (Amharic), January 2005
Essential Nutrition Actions Handout (English), January 2005
Complementary Feeding Tools Amharic
Complementary Feeding Tools Oromiffa

BCC Materials

Family Health Card A4 & A5 sizes (Afan Oromo and Amharic), January 2008
Immunization Diploma (Afan Oromo and Amharic), January 2008

Other Publications

Stories To Tell, 2006
A School Health Program Pilot, September 2008
Along the Road to Health Extension, September 2008

Materials available at www.eshe.org.et



Ethiopia Contact
ESHE Project Central Office/Oromia
P.O. Box 1392 code 1110
Addis Ababa, Ethiopia
Tel. 251-11-416 9416
Fax 251-11-467 2367

Email: eshe@healtheth.org.et
www.eshe.org.et

Implementing Agency
John Snow, Inc.
44 Farnsworth St
Boston, MA 02210
USA
1.617.482.9485
Fax: 617.482.0617

Email: jsiinfo@jsi.com
www.jsi.com